

TRICARE® Program Manuals - Definitions

The following definitions are a mixture of TRICARE Regulatory definitions listed in 32 CFR 199.2 and 199.17, operational definitions used by TRICARE personnel and contractors in the daily administration of the TRICARE Program, and terminology found in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Regulatory definitions may not be changed or elaborated upon without a regulatory change. Further explanations/elaborations of TRICARE Regulatory definitions may be found in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) where appropriate. For a complete listing of TRICARE Regulatory Definitions refer to 32 CFR 199.2 and 199.17. Included are acronyms for some of the words being defined. An acronym is a word formed from the first (or first few) letters of a series of words.

Absent Treatment (Defined in 32 CFR 199.2)

Services performed by Christian Science practitioners for a person when the person is not physically present. Technically, "Absent Treatment" is an obsolete term. The current Christian Science terminology is "treatment through prayer and spiritual means," which is employed by an authorized Christian Science practitioner either with the beneficiary being present or absent. However, to be considered for coverage under TRICARE, the beneficiary must be present physically when a Christian Science service is rendered, regardless of the terminology used.

Abuse (Defined in 32 CFR 199.2)

Any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary cost, or TRICARE payment for services or supplies that are:

1. Not within the concepts of medically necessary and appropriate care, as defined in the Regulation (32 CFR 199), or
2. That fail to meet professionally recognized standards for Health Care Providers (HCPs).

The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim.

Note: Unless a specific action is deemed gross and flagrant, a pattern of inappropriate practice will normally be required to find that abuse has occurred. Any practice or action that constitutes fraud, as defined by the Regulation (32 CFR 199), would also be abuse.

Access, Health Care

The ability to receive necessary health care services of high quality within specific time frames, at locations and from the providers that satisfy patient health care needs. This is frequently associated with the contractor's provision of an adequate network. Access to care standards are established in 32 CFR 199.17 and 45 CFR 156.230. See the definition of "Access Standards."

Access, Information

1. The availability and the permission to consult records, archives, or manuscripts.
2. The ability and opportunity to obtain sensitive, classified, or administratively controlled information or records readily.

Access Standards (Defined in 32 CFR 199.17)

Preferred Provider Networks (PPNs) will have attributes of size composition, mix of providers and geographical distribution so that the networks, coupled with the Military Medical Treatment Facility (MTF) capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in TRICARE Prime to a beneficiary group, the Market Director/MTF Director (or other authorized person) will assure that the capabilities of the MTF plus PPN will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

1. Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.
2. The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.
3. Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers within the service area 24 hours a day, seven days a week.
4. The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.
5. Office waiting times in nonemergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

Accuracy

A directory entry that contains correct information for all of the following data elements: provider name, provider specialty, sub-specialty (if applicable), gender, work address, and work telephone number for each service area.

Action Plan

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

Active Duty (Defined in 32 CFR 199.2)

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

Active Duty Member (Defined in 32 CFR 199.2)

A person on active duty in a Uniformed Service under a call or order that does not specify a period of 30 days or less.

Activities of Daily Living (ADL) (Defined in 32 CFR 199.2)

Care that consists of providing food (including special diets), clothing and shelter; personal hygiene services; observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and other such elements of personal care that can reasonably be performed by an untrained adult with minimal instruction or supervision. ADL may also be referred to as “essentials of daily living”.

Adequate Medical Documentation, Mental Health Records (Defined in 32 CFR 199.2)

Adequate medical documentation provides the means for measuring the type, frequency, and duration of active treatments mechanisms employed and progress under the Treatment Plan (TP). Under TRICARE, it is required that adequate and sufficient clinical records be kept by the provider to substantiate that specific care was actually and appropriately furnished, was medically or psychologically necessary (as defined in 32 CFR 199.2), and to identify the individual(s) who provided the care. Each service provided or billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under the general acceptable standards (e.g., standard of an accrediting organization approved by the Director, and the provider’s state or local licensing requirements) and other requirements specified in 32 CFR 199. The psychiatric and psychological evaluations, physicians orders, the TP, integrated progress notes (and physician progress notes if separate from the integrated progress notes), and the discharge summary are the more critical elements of the mental health record. However, nursing and staff notes, no matter how complete, are not a substitute for the documentation of services by the individual professional provider who furnished treatment to the beneficiary. In general, the documentation requirement of a professional provider are not less in the outpatient setting than the inpatient setting. Furthermore, even though a hospital that provides psychiatric care may be accredited under the Joint Commission (TJC) manual for hospitals rather than TJC Behavioral Health (BH) standards, the critical elements of the mental health record listed above are required for TRICARE claims.

Adequate Network (Network Adequacy)

A network with a sufficient number of providers to meet access to care standards for TRICARE Prime enrollees as defined in 32 CFR 199.17(p)(5) (where providers are available).

Adjunctive Dental Care (Defined in 32 CFR 199.2)

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

Adjustment

A correction to the information in the TRICARE Encounter Data (TED) records and/or Beneficiary History Files (Hard Copy Files and Automated Beneficiary History and Deductible Files) related to a claim previously Processed To Completion (PTC). Adjustments include any recoupments, additional payment(s), all cancellations (total or partial), and corrections to statistical data, whether or not the changes result in changes to the financial data.

Adjustment, Identification Of Receipt

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

Administrative Efficiencies

The capacity of an organization, institution, or business to produce desired results with a minimum expenditure of energy, time, money, personnel, materials, etc. For TRICARE purposes, this includes (but is not limited to) standardizing resources, utilizing resources efficiently, and leveraging economies of scale to the maximum extent practicable, with the goal of reducing administrative costs while adhering to all aspects of the TRICARE program and benefits.

Administrative Fee, Pharmacy

The offered price that represents all administrative charges relative to prescription, prior authorization and medical necessity determination transaction processing.

All-Inclusive Per Diem Rate (Defined in 32 CFR 199.2)

The TRICARE-determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the TP established for a patient and accepted by TRICARE.

Allowable Charge (Defined in 32 CFR 199.2)

The TRICARE-determined level of payment to institutions, physicians, and other categories of individual professional providers based on one of the approved reimbursement methods set forth in the 32 CFR 199.14.

Allowable Charge Complaint

A request for review of a contractor determination of the allowable charge for covered services and supplies furnished under TRICARE. An allowable charge complaint does not fall within the meaning of an "appeal", in the technical sense, but does require a careful review or reconsideration by the contractor of how the claim was processed to ensure accuracy of the payment made.

Allowable Charge Reduction

The difference between the reimbursement determination made by a contractor and the amount billed by the provider of care (prior to determination of applicable cost-shares and deductibles). This is also referred to in the industry as the contractual allowance.

Allowable Cost (Defined in 32 CFR 199.2)

The TRICARE-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods set forth in 32 CFR 199.14. The allowable charge may also be referred to as the TRICARE-determined reasonable or allowable cost.

Amount In Dispute (Defined in 32 CFR 199.2)

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

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact. See 32 CFR 199.10 and TOM, Chapter 12.

Appealable Issue (Defined in 32 CFR 199.2)

Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of TRICARE benefits, or approval as an authorized provider in accordance with this part. An appealable issue does not exist if no facts are in dispute, if no TRICARE benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See 32 CFR 199.10 for additional information concerning the determination of “appealable issue” under this part.

Appealing Party (Defined in 32 CFR 199.2)

Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this part.

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 US;
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.

Asynchronous Telehealth

Asynchronous, or store and forward, telemedicine encounters transmit medical images or information in one direction at a time via electronic communications. Common types of asynchronous services include teleconsultations involving radiology, pathology, cardiology, and dermatology. Teleconsultation supports the delivery of healthcare at a distance via the asynchronous transmission of electronic medical information and associated or stand-alone digital images or video over a secure connection between healthcare providers for the purpose of obtaining an expert opinion or diagnostic support regarding the care of a patient. In the process of teleconsultation, the remote consultant does not interact directly with the patient. The consultant prepares and transmits comments, recommendations, or an official interpretation back to the referring provider for their review and consideration. A teleconsultation is not a traditional patient referral whereby patient care is transferred to the consultant.

At-Risk

The chance or potential that something will harm or otherwise negatively affect a person's physical or mental health.

Authorization

The authorization determination addresses whether a particular service may be covered by TRICARE, including whether it appears necessary and appropriate in the context of the patient's diagnosis and 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.

Behavioral Health (BH)

All-inclusive term that describes all aspects of mental health, substance use disorder, and associated physical and psychological health disorders. BH encompasses programs, processes of promoting general well-being, and preventing and intervening in mental health disorders. Mental disorders are defined in 32 CFR 199.2.

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 Medicare 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

A beneficiary is an individual eligible for benefits. The beneficiary, Sponsor, or representative of the beneficiary, including the parent of a beneficiary under 18 years of age, the beneficiary's attorney, legal guardian or representative specifically designated by the beneficiary may on his or her behalf regarding the benefit at issue. An individual who is subject to the conflict of interest provisions of 32 CFR 199.10(a)(2)(i)(B), may not act as the beneficiary's representative under this section.

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."

Beneficiary History File

A system of records consisting of any record or subsystem of records, whether hard copy or electronic, which reflects diagnosis, treatment, medical condition, family history records, correspondence, memorandum, or any other personal information with respect to any individual, including all such records/reports acquired or utilized by the contractor in delivery of health care services, in the development and processing of claims, or in performing any other functions under a TRICARE contract.

1. **Medical Management (MM) Files:** These records include the medical and mental health case files, all clinical history documentation, plans of care, TPs, case notes for beneficiaries past and present under Case Management (CM) (to include Extended Care Health Option (ECHO), Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC) and Custodial Care Transitional Policy (CCTP)), ECHO Home Health Care (EHC), case notes for beneficiaries past and present under Disease Management (DM), claims and Explanations Of Benefits (EOBs).
2. **Preauthorization/Authorization/Referrals:** This includes all those medical and mental health records generated within the health care services function involving preauthorization, authorization, referrals, beneficiary and provider denials letters, beneficiary and provider authorization letters, medical review, transition of care, peer review, concurrent review, and second level review performed by the medical directors, all Utilization Management (UM) appeal/reconsideration case files. These notes include copies of medical records and copies of prescriptions and other annotations that are maintained elsewhere in the original case files.
3. **Mental Health Case Files:** These files consist of all documents required in the processing of mental health claims. This series includes cases which have gone to peer review or have been denied at the contractor level. Peer reviews and all associated papers shall be filed in the case file, not kept separate.
4. **Hard Copy Claim Files.**
5. **Automated History Files.** The electronically maintained record of a beneficiary's medical care and related administrative data, including such data on charges, payments, deductible status, services received, diagnoses, adjustments, etc.

Note: The term "TRICARE Contractor Claims Records" is used by the National Archives and Records Administration (NARA) "Medical/Dental Claims History files (formerly "Beneficiary History and Deductibles Files") includes but is not limited to "TRICARE Contractor claims Records."

Beneficiary Liability (Defined in 32 CFR 199.2)

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

Benefit

Services, supplies, payment amounts, cost-shares and copayments authorized by Public Law (PL) 89-614, 32 CFR 199, and outlined in the TPM and the TRM.

Best Practices

A best practice is a method or technique that has consistently shown results superior to those achieved with other means, and that is used as a benchmark. In addition, a "best" practice can evolve to become better as improvements are discovered.

Breach

A breach, as defined in Department of Defense Directive (DoDD) 5400.11 (2014), is a loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII)/Protected Health Information (PHI), whether in paper or electronic form. Breaches are classified as either possible or confirmed (see the definition of “Possible Breach” and “Confirmed Breach”) and as either cyber or non-cyber (i.e., involving either electronic PII/PHI or paper/oral PII/PHI).

Business Associate

1. A person or organization that performs a function or activity on behalf of a covered entity, but is not part of a covered entity’s workforce. A business associate may also be a covered entity in it’s own right.
2. For a full definition, refer to the 45 CFR 160.103, Definitions of HIPAA of 1996.

Business Day

For claims processing purposes, one business day is defined as the business day following the day of transmission at the close of business at the location of the receiving entity. A business workday is Monday through Friday, excluding federal holidays.

Capability Of A Provider

The scope of services the provider is both capable of performing and willing to perform under a TRICARE contract. For example, a neurologist under TRICARE contract to perform sleep studies may not be considered to have capability to perform as a general neurology specialist.

Capacity Of A Provider

The amount of time or number of services a provider is able to perform in conjunction with a TRICARE contract. For example, a Primary Care Manager (PCM), whose practice is full has no available capacity for services.

Capped Rate

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

Care Coordination

A comprehensive method of client assessment designed to identify client vulnerability, needs identification, and client goals which results in the development plan of action to produce an outcome that is desirable for the client. The goal is to provide client advocacy, a system for coordinating client services, and providing a systematic approach for evaluation of the effectiveness of the client’s life plan.

Case Files (Records Management)

A file(s), regardless of media, containing material on a specific action, event, person, place, project, or other subjects. Sometimes referred to as a “project file” or a “transaction file.” Also a collection of such folders or other file units.

Case Management (CM) (Defined in 32 CFR 199.2)

A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, including mental health and Substance Use Disorder (SUD) needs, using communication and available resources to promote quality, cost-effective outcomes.

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](#). NDAA FY 2017 amended Title 10, USC to change calculations to a calendar year basis, beginning January 1, 2018. The last quarter of calendar year 2017 was applied to the FY 2017 calculations to bridge the gap.

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 (CoE)

A center of excellence for clinical care is a healthcare team that focuses on a specific area of medicine that uses evidence-based practice and produces consistently outstanding measurable outcomes for the patient at a reasonable cost. CoEs focus on an associated group of clinical conditions and create value by achieving improvement in outcomes through clinical, educational, and research activities.

1. CoEs develop pathways of care covering the clinical spectrum from prevention through reintegration or transition.
2. Products of paths of care development include:
 - Guidance regarding structured documentation (Electronic Health Record (EHR));
 - Clinical practice guidelines;
 - Process and outcome measures;
 - Educational materials;
 - Innovation and identification of research priorities; and
 - Strategies for improving access to care.

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 Department of Veterans Affairs (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)/Veterans Health Administration (VHA).

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.

Note: If two or more forms for the same beneficiary are submitted together, they shall constitute one claim unless they qualify for separate processing under the claims splitting rules. (It is recognized that services may be provided in situations in which no claims, as defined here, are generated. This does not relieve the contractor from collecting the data necessary to fulfill the requirements of the TED record for all care provided under the contract.)

Note: Any request for reimbursement of a dispensed pharmaceutical agent or diabetic supply item. For electronic media claims, each prescription must be submitted for reimbursement via a separate claim. For paper claims, reimbursement for multiple prescriptions may be requested on a single paper claim.

Claim File

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

Claim Form

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

Claims Cycle Time

That period of time, recorded in calendar days, from the receipt of a claim into the possession/custody of the contractor to the completion of all processing steps (see the definition of "Processed to Completion (or Final Disposition)," and the TSM, Chapter 2, Section 2.4, "Date TED Record Processed to Completion").

Claims Payment Data

The record of information contained on or derived from the processing of a claim or encounter.

Clinical Quality Management Program (CQMP)

The integrated processes, both clinical and administrative, that provide the framework for the contractor to objectively define and measure the quality of care received by beneficiaries.

Clinical Quality Outcomes

The American College of Medical Quality in their 2010 revision of their recommended Core Curriculum for Medical Quality Management describes clinical outcomes as part of the definition of quality measures. These are:

- 1.** Structural Measures - health care setting, appropriate equipment and supplies, education, certification and experience of clinicians;
- 2.** Process Measures - actions taken and how well these were performed to achieve a given outcome, use of evidence-based clinical guidelines;
- 3.** Outcome Measures - capture of changes in health status following the provision of a set of healthcare processes and including the cost of delivering the processes -- hospitalizations, physician office visits, or care provided in post-acute care setting, patient satisfaction.

Clinical Support Agreement (CSA)

An arrangement requested by the military, between a Market/MTF and the TRICARE contractor for the contractor to provide needed clinical personnel at a Market/MTF. The arrangement must be formalized by modification to the TRICARE contract prior to implementation of the provisions of the arrangement.

Code Set (HIPAA/Privacy Definition)

Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions, as outlined in HIPAA of 1996.

Code Set Maintaining Organization (HIPAA/Privacy Definition)

An organization that creates and maintains the code sets adopted by the Secretary of Home Health Services (HHS) for use in the transactions for which standards are adopted as outlined in HIPAA of 1996.

Combined Daily Charge (Defined in 32 CFR 199.2)

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

Complaint

All forms of complaints, to include but not limited to phone calls, emails and written complaints.

Complex Medical Conditions

Having two or more medical conditions requiring coordination of multiple specialties for at least 12 months.

Concurrent Review/Continued Stay Review

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

Confidentiality Requirements

The procedures and controls that assure the privacy of personal medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, the Privacy Act, and HIPAA of 1996.

Confirmed Breach

An incident in which it is known that unauthorized access could occur. For example, if a laptop containing PII/PHI is lost and the contractor knows that the PII/PHI is unencrypted, then the contractor should classify and report the incident as a confirmed breach, because unauthorized access could occur due to the lack of encryption (the contractor knows this even without knowing whether or not unauthorized access to the PII/PHI has actually occurred). If the laptop is subsequently recovered and forensic investigation reveals that files containing PII/PHI were never accessed, then the possibility of unauthorized access can be ruled out, and the contractor should re-classify the incident as a non-breach incident.

Conflict Of Interest (Defined in 32 CFR 199.2)

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

Connected Health (Telehealth)

- A generic term broadly referring to the support of patient or Population Health (PH) or health care via electronic means.
- Telehealth is a form of Connected Health.

Consultation (Defined in 32 CFR 199.2)

A deliberation with a specialist physician, dentist, or qualified mental health provider requested by the attending TRICARE authorized provider primarily responsible for the medical care of the patient, with respect to the diagnosis or treatment in any particular case. A consulting physician or dentist or qualified mental health provider may perform a limited examination of a given system or one requiring a complete diagnostic history and examination. To qualify as a consultation, a written report to the attending TRICARE authorized provider of the findings of the consultant is required.

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

Consultation Appointment (Defined in 32 CFR 199.2)

An appointment for evaluation of medical symptoms resulting in a plan for management which may include elements of further evaluation, treatment and follow-up evaluation. Such an appointment does not include surgical intervention or other invasive diagnostic or therapeutic procedures beyond the level of very simply office procedures, or basic laboratory work but rather provides the beneficiary with an authoritative option.

Consulting Physician or Dentist (Defined in 32 CFR 199.2)

A physician or dentist, other than the attending physician, who performs a consultation.

Content Management System (Records Management)

An application that provides capabilities for multiple users with different permission levels to manage content, data, or information.

Continued Health Care Benefit Program (CHCBP)

A TRICARE benefit program that provides temporary continued health care for certain former beneficiaries of the MHS. Coverage under the CHCBP is purchased on a premium basis.

Continuity of Care

Follow on of health care services from a specific individual professional provider or care team as part of a specific procedure or service that was performed within the previous six months in order to not disrupt therapy or repeat services. For certain conditions, continuity of care may last up to one year.

Continuum of Care

All patient care services provided from “pre-conception to grave” across all types of settings. Requires integrating processes to maintain ongoing communication and documentation flow between the DC system and network.

Contract Performance Evaluation (CPE)

A review by DHA, of a contractor’s level of compliance with the terms and conditions of the contract. Usually, an operational audit performed by DHA staff that focuses on timeliness, accuracy, and responsiveness of the contractor in performing all aspects of the work required by the contract.

Contract Physician

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

Contracting Officer’s Representative (COR)

A Government representative, appointed in writing by the Contracting Officer (CO), who represents the CO in the administration of technical matters involving contract requirements.

Contractor

An organization with which DHA has entered into a contract for delivery of and/or processing of payment for health care services, and the performance of related support activities, such as, pharmacy services, quality monitoring and/or customer service.

Contractor Records (Records Management)

All data produced and maintained by a contractor for DHA.

Control Of Claims

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

Controlled Substances

Those medications which are included in one of the schedules of the Controlled Substances Act of 1970 and as amended.

Controlled Unclassified Information (CUI)

Information that is not classified in accordance with national security directives, but that otherwise requires safeguarding or dissemination controls pursuant to and consistent with applicable law, regulations, and Government-wide policies.

Coordination Of Benefits (COB) (Defined in 32 CFR 199.2)

The coordination, on a primary or secondary payer basis of the payment of benefits between two or more health care coverages to avoid duplication of benefit payments.

Cost-Share (Defined in 32 CFR 199.2)

The amount of money for which the beneficiary (or sponsor) is responsible in connection with otherwise covered inpatient and outpatient services (other than the annual deductible or disallowed amounts) as set forth in 32 CFR 199.4(f) and 32 CFR 199.5(b). Cost-sharing may also be referred to as "copayment."

Note: See also TRM, Chapter 2, and 32 CFR 199.17 for additional cost-share information.

Correctional Institution (HIPAA Definition)

Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the US, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial as defined in HIPAA of 1996.

Note: For the purposes of TRICARE, the term "correctional institution" includes military confinement facilities, but does not include internment facilities for enemy prisoners of war, retained personnel, civilian detainees and other detainees provided under the provisions of DoDD 2310.1 (reference (b)).

Covered Entity (HIPAA Definition)

Any business entity that must comply with HIPAA regulations, which includes, health plans, health care clearinghouses, and HCPs. For the purposes of HIPAA, HCPs include hospitals, physicians, and other caregivers. See 45CFR Section 160.103 of HIPAA regulation for additional information.

Note: In the case of a health plan administered by the DoD, the covered entity is the DoD Component (or subcomponent) that functions as the administrator of the health plan.

Covered Functions (HIPAA Definition)

Those functions of a covered entity, the performance of which, makes the entity a health plan or HCP as outlined in HIPAA of 1996.

Credentialing

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

Credentials Package

Information required for all clinical personnel supplied by the contractor who will be working in a Market/MTF. Similar information may be required for non-clinical personnel. Complete information shall contain the following:

1. All documents, required per regulation/directive/instruction/policy which are needed to verify that the individual is certified/authorized/qualified to provide the proposed services at the involved facility. This shall include licensure from the jurisdiction in which the individual will be practicing and a National Practitioner Data Bank (NPDB) query as specified by the facility.
2. A completed a Criminal History Background Check (CHBC), for all personnel required by law to have a CHBC prior to awarding of privileges or the delivery of services with the following considerations:
 - If a CHBC has been initiated, but not completed, the Market Director/MTF Director has the authority to allow awarding of privileges and initiation of services if delivered under clinical supervision.
 - The mechanism for accomplishing the CHBC may vary between Markets/MTFs and should be determined during phase-in/transition and be agreed to by the Market Director/MTF Director.
 - Regardless of the mechanism for initiating and completing a CHBC, the cost shall be borne by the contractor.
3. Medicare Provider ID number/National Provider Identifier (NPI) number.
4. Evidence of compliance (or scheduled compliance) with the Market/MTF specific requirements including all local Employee Health Program (EHP), Federal Occupational Safety Act and Health Act (OSHA), and Bloodborne Pathogens Program (BBP) requirements.

Custodial Care (Defined in 32 CFR 199.2)

The treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that:

1. Can be rendered safely and reasonably by a person who is not medically skilled; or
2. Is/are designed mainly to help the patient with the ADLs.

Cybersecurity Incident

A cybersecurity incident is a violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices, with respect to electronic PII/PHI. A cybersecurity incident may or may not

involve a breach of PII/PHI. For example, a malware infection would be a possible breach if it could cause unauthorized access to PII/PHI. However, if the malware only affects data integrity or availability (not confidentiality), then a non-breach cybersecurity incident has occurred.

Cycle Time

The elapsed time, as expressed in calendar days including any part of the first and last days counted as two days, from the date a claim, piece of correspondence, grievance, or appeal case was received by a contractor through the date (PTC). See the definition of "Claims Cycle Time", for added detail.

Data

Any information collected, derived, or created as a result of operations as a TRICARE contractor. All data is the property of the Government regardless of where it is maintained/stored.

Data Aggregation

The combining of PHI by a business associate with the PHI received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities as outlined in HIPAA of 1996.

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. Effective January 1, 2018, deductibles are determined on a calendar year basis. Deductible amounts are outlined in the TRM, Chapter 2.

Deductible Certificate

A statement issued to the beneficiary (or sponsor) by a TRICARE contractor certifying to the deductible amounts satisfied by a beneficiary for any applicable program year.

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.

1. CoEs develop pathways of care covering the clinical spectrum from prevention through reintegration or transition.
2. Products of pathway of care development include:
 - Guidance regarding structured documentation (EHR);
 - 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, methods to improve quality, value, and satisfaction, 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 MM 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 (DSM)

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

Direct Care (DC) and Private Sector Care (PSC) Systems

The delivery of high quality clinical and other related services in the most economical manner for the Military Health System (MHS) that optimizes the DC system while delivering the highest level of customer service.

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 the definition of "Indirect Treatment Relationship."

Directed Referral

Any provider generated by-name request for services.

Director

The Director of the DHA; Director, TRICARE Management Activity (TMA); or Director, Office of CHAMPUS (OCHAMPUS). Any reference to the Director, Office of CHAMPUS, or OCHAMPUS, or TMA shall mean the Director, DHA. Any reference to Director shall also include any person designated by the Director to carry out a particular authority. In addition, any authority of the Director may be exercised by the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

Disaster Response Duty

For purposes of TPM, Chapter 10, Section 10.1 only, the term "disaster response duty" means duty performed by a member of the National Guard in State status pursuant to an emergency declaration by the Governor of the State (to include the four US territories, or with respect to the District of Columbia, the mayor of the District of Columbia) in response to a disaster or in preparation for an imminent disaster.

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.

Disposal (Records Management)

Physical destruction of temporary records.

Disposition (Records Management)

Actions taken regarding federal records after they are no longer needed to conduct current agency business. Records disposition is any activity that includes:

- Disposal of temporary records by destruction or donation;
- Transfer of records to federal agency storage facilities or Federal Records Centers (FRCs);
- Transfer to the Archives of the US, records determined to have sufficient historical or other value to warrant continued preservation; or

- Transfer of records from one federal agency to any other federal agency.

Disposition Instructions (Records Management)

Directions for cutting off records and carrying out their disposition in compliance with NARA’s regulations. Includes directions for screening out nonrecord materials and carrying out their disposal when no longer needed by the agency.

Distant Site (Telehealth)

The “distant site” is where the physician or practitioner providing the professional service is located at the time the services are provided via an interactive telecommunications system.

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.

Documentation (Records Management)

Documentation concerns the creation of records and the assembly or consolidation of this information. This applies to records in all media (e.g., paper, electronic).

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 programs or the 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/VHA 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 US 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 Information Systems (EISs) (Records Management)

Records generated in systems used/created to perform DHA/TRICARE mission related functions (claims, EOBs, etc.) and used by office or organizational personnel, computer operators, programmers, and systems administrators. These systems are usually identified by a specific name or acronym, and contain structured data.

Electronic Mail (Records Management)

A document created or received on an agency electronic mail system, including brief notes, more formal or substantive documents, and any attachments and routing information which may be transmitted with the message. Electronic mail may be a record or a non-record.

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.

Electronic Recordkeeping (Records Management)

The creation, maintenance, use and disposition of records created and stored by using a computer. Electronic recordkeeping is part of the solution to manage, preserve, and provide access to electronic records.

Electronic Recordkeeping System (Records Management)

An electronic recordkeeping system collects, organizes, and categorizes electronic records in their native file form instead of requiring the user to print and file them in a manual filing system. Such a system automates the preservation, retrieval, use, and disposition of the electronic record.

Electronic Records (Records Management)

Records stored in a form that only a computer can process and satisfies the definition of a federal record, also referred to as machine-readable records or automatic data processing records.

Electronic Standard Form 135 (SF-135) (Records Management)

The electronic SF-135 is modeled after the transmittal document SF-135, which is designed for metadata about the paper records. When transferring electronic records, the metadata is different than the paper records (see TOM, Chapter 9, Addendum B). The metadata collected for electronic transfers are the key identifiers used to search and retrieve the record.

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.

Enrollment Fees

The amount required to be paid by some MHS beneficiaries eligible to enroll in and receive the benefits of TRICARE Prime, TRICARE Select 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 plan must include actions for TRICARE Select and must be approved by the Government. 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 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 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 is care that may be recaptured by the direct care system to maintain readiness. 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.”

Evidence

Information, facts or data supporting (or contradicting) a claim, assumption or hypothesis or come from scientific research.

Evidence-Based

The management of decisions based on a combination of critical thinking and the best available evidence.

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.

Expert Witness (Program Integrity)

An individual having acquired a special skill or knowledge through training or experience on a particular subject being discussed.

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.

Explanation Of Payment (EOP) Pharmacy

A document provided to either the beneficiary after paper claims are processed or network pharmacies for each payment cycle. This document describes the action taken for each claim processed to a final determination (paid or denied). EOPs are not generated for beneficiaries processing claims electronically at the point of sale.

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 (FRC)

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

File (Records Management)

An accumulation of records or non-record materials arranged according to an approved plan. Used primarily in reference to current records in an office/organization. This includes a unit, such as a folder or electronic medium, containing records, non-records, or personal files. In electronic records, an organized collection of related data, usually arranged into logical records stored together and treated as a unit. The unit is larger than a data record but smaller than a data system and is sometimes known as a "data set" referred to collectively as "files."

File Plan (Records Management)

A survey of agency records used to develop a disposition schedule. This includes a descriptive listing of each record series of a system, together with an indication of where it is located and other pertinent data.

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.

First Call Resolution

Properly addressing the stakeholder's need the first time they call, thereby eliminating the need for the stakeholder to engage in a follow up call.

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.

Former Member

An individual who is eligible for, or entitled to, retired pay, at age 60, for non-regular service in accordance with Chapter 1223, Title 10, USC but has been discharged and maintains no military affiliation. These former members, at age 60, and their eligible dependents are entitled to medical care, commissary, exchange, and MWR privileges. Under age 60, they and their eligible dependents are entitled to commissary, exchange, and MWR privileges only.

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 Market/MTF systems, or obtain care from a provider not affiliated with the contractor and seek reimbursement under the terms and conditions of the TRICARE Standard (TRICARE Select starting January 1, 2018) 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 (TRICARE Select starting January 1, 2018) 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."

Freeze (Also Record Freeze) (Records Management)

An action or event that suspends the destruction of records to include:

- Updates to records disposition schedules
- Litigation
- Natural Disasters

Frozen Records (FRs) (Records Management)

Temporary records that cannot be destroyed according to scheduled retention because of special circumstances, such as a preservation or court order, which requires a temporary extension of the approved retention period.

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.

Government Designated Authority (GDA)

To be determined (TBD)

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 A and B

With respect to beneficiary cost-sharing, deductibles and catastrophic cap, the NDAA 2017 divided beneficiaries enrolled in TRICARE Prime or TRICARE Select into two groups:

- Group A (or grandfathered) beneficiaries: consists of sponsors and their family members who first became affiliated with a Uniformed Service through enlistment or appointment before January 1, 2018.
- Group B (or non-grandfathered) beneficiaries: consists of sponsors and their family members who first became affiliated with a Uniformed Service through enlistment or appointment on or after January 1, 2018.

Effective January 1, 2018, enrollees in the TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), or the CHCBP have Group B cost-shares, deductibles, and catastrophic caps, regardless of when the sponsor first became affiliated with a Uniformed Service through enlistment or appointment.

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 geographic area of responsibility, 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 US, 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.

High-Cost Claim Status

Having claims totaling \$100,000/year or above (TRICARE payment).

High-Quality Care

Care that is delivered at or above the 75th percentile of a nationally benchmarked measure.

High-Risk

A higher-than-average risk for developing a particular disease or condition.

HIPAA Breach

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

HIPAA-Covered Entities

A health plan, a health care clearinghouse, and a HCP who transmits any health information in electronic form in connection with a transaction.

Hold Time

Time period begins when the call is placed on hold by the live agent and ends when the agent returns to the live call. Queue time is not included in hold time calculations.

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.

Inactive Records (Records Management)

Inactive records are documents which are no longer referenced on a regular basis (yearly) and tend to be stored in a less accessible place. Records become inactive when the cut-off, as defined on a Records Retention Schedule, has been reached. Inactive records may also be referred to as “closed” records.

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.

Information System (Records Management)

The organized collection, processing, transmission, and dissemination of information in accordance with defined procedures, whether automated EIS or manual.

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.

Inpatient Rehabilitation Facility (IRF)

A facility classified by CMS as an IRF and meets the applicable requirements established by 32 CFR 199.6(b)(4)(xx) (which includes the requirement to be a Medicare participating provider).

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.

Intensive Outpatient Program (IOP)

An outpatient treatment setting capable of providing an organized day or evening program that includes assessment, treatment, CM, and rehabilitation for individuals not requiring 24-hour care for mental health disorders, to include SUDs, as appropriate for the individual patient. The program structure is regularly scheduled, individualized, and shares monitoring and support with the patient's family and support system.

Interactive Telecommunications System

Interactive telecommunications systems are defined as multimedia communications modalities that include, at a minimum, secure audio and video equipment permitting two-way, real-time services or consultations. This includes smartphones, tablet computers, and personal computers equipped with the necessary camera and software to enable two-way, encrypted real-time audio and video interaction; as well as dedicated video conferencing and telemedicine systems.

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.

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.

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 US, 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.

Life Cycle of Records (Records Management)

The stages or period of records from receipt, capture, creation, active use, inactive use, distribution, storage, transfer, migration, disposition, and archiving of the official record.

Lifts (Records Management)

An action or event that removes a freeze from records that are suspended from destruction.

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 Care Hospital (LTCH)

A hospital that is classified by the CMS as an LTCH and meets the applicable requirements established by 32 CFR 199.6(b)(4)(v) (which includes the requirement to be a Medicare participating provider).

Low Quality Care

Care that is delivered at or above the 25th percentile of a nationally benchmarked measure.

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 US medical care reimbursement system. DRG codes are also mapped, or grouped, into the MDC codes.

Managed Care Support Contractor (MCSC)

A civilian contractor under contract with the DoD that provides a managed care program which integrates a standardized health benefits package with Markets/MTFs and civilian network providers on a regional basis. The result is the establishment of an integrated system of health care delivery that influences utilization of services and cost of services, and delivers high value by giving TRICARE eligible beneficiaries access to high quality, cost-effective health care. Includes underwritten health care costs provided in civilian facilities and by private practitioners to eligible MHS beneficiaries authorized under TRICARE.

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 TOM, 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.

Medical Emergency (Defined in 32 CFR 199.2)

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

Medical Necessity Determination

A review to determine if the recommended health care services are reasonable for the prevention, diagnosis and treatment of illness, injury, pregnancy, and mental disorders and appropriate for well-baby care.

Medical Supplies And Dressings (Consumables) (Defined in 32 CFR 199.2)

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

Medical Management (MM)

An integrated managed care model that includes UM, Referral Management (RM), CM, BH, and PH programs to manage patient care and the clinical and social needs of eligible beneficiaries.

Medically or Psychologically Necessary (Defined in 32 CFR 199.2)

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

Medicare (Defined in 32 CFR 199.2)

The medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), Medicare Bureau.

Medicare Economic Index (MEI)

An index used by Medicare to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expenses factors including malpractice, personnel costs, rent, and other expenses.

Medication Assisted Treatment (MAT)

MAT for diagnosed SUD is a holistic modality for recovery and treatment that employs evidence-based therapy, including psychosocial treatments and psychopharmacology, and FDA-approved medications as indicated for the management of withdrawal symptoms and maintenance of sobriety.

Medication Error (FDA Definition)

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use as defined by the FDA.

Medium/Media (Records Management)

The physical form of recorded information: such as paper, film, disc, magnetic tape, and other materials on which information can be recorded and stored.

Member

An individual who is affiliated with a Service, either an active duty member, reserve member, active duty retired member, or retired reserve member. Members in a retired status are not former members. Also referred to as the sponsor.

Memorandum of Understanding (MOU)

A written document, signed by two or more parties, which describes the support processes to be executed in good faith to facilitate the operation of the TRICARE Program.

Mental Disorder, To Include SUD

For purposes of the payment of TRICARE benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. An SUD is a mental condition that involves a maladaptive pattern of substance use leading to clinically significant impairment or distress; impaired control over substance use; social impairment; and risky use of a substance(s). Additionally, the mental disorder must be one of those conditions listed in the current edition of the DSM. "Conditions Not Attributable to a Mental Disorder," or **V** codes, or ICD-10-CM **Z** codes, are not considered diagnosable mental disorders.

Mental Health Therapeutic Absence (Defined in 32 CFR 199.2)

A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Metadata (Records Management)

Data describing stored data: that is, data describing the structure, data elements, interrelationships, and other characteristics of electronic records.

Migration (Records Management)

The techniques and strategies used to move electronic information from one storage medium to another over time to prevent the loss of needed information because of technological obsolescence.

Military Health System (MHS) Beneficiary

Any individual who is eligible to receive treatment in a Market/MTF. Eligibility is determined by the Uniformed Services and is reported on DEERS.

Note: The categories of MHS beneficiaries shall be broadly interpreted unless otherwise specifically restricted. (For example: Authorized parents and parents-in-law are not eligible for TRICARE Program, but may receive treatment in a Market/MTF (on a space available basis) and may access the Nurse Advise Line (NAL)).

Military Treatment Facility (MTF)

A Uniformed Services hospital or clinic.

Market/Military Medical Treatment Facility (MTF)

Filling every appointment and bed available within the MTF or in the Market (when medically appropriate) based on the capacity and capabilities of the Market/MTF and the Market's/MTF's readiness/training requirements, as defined by the Market Director/MTF Director before referral to outside civilian providers.

Market/Military Medical Treatment Facility (MTF) Referred Care

Medical care or services/supplies required by a patient that are not available at the MTF or in the Market area and therefore must be provided by an outside civilian provider. Such care requires a Market/MTF referral for the civilian medical care.

Mobilization Plan - TRICARE

A detailed proposal designed to ensure the Government's ability to continue to meet the health care needs of the TRICARE-eligible beneficiaries in the event of a military mobilization that precludes the use of all or parts of the military DC system for provision of care to TRICARE-eligible beneficiaries.

Monthly Pro-Rating

A calculation process for determining the amount of the enrollment fee to be credited to a new enrollment period. For example, if a beneficiary pays their annual enrollment fee, in total, on January 1, (the first day of their enrollment period) and a change in status occurs on February 15. The beneficiary will receive credit for 10 months of the enrollment fee. The beneficiary will lose that portion of the enrollment fee that would have covered the period from February 15 through February 28.

Most-Favored Rate (Defined in 32 CFR 199.2)

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

National Appropriate Charge Level

The charge level established from a 1991 national appropriate charge file developed from July 1986 - June 1987 claims data, by applying appropriate MEI updates through 1990, and prevailing charge cuts, freeze or MEI updates for 1991 as discussed in the September 6, 1991, Final Rule.

National Conversion Factor (NCF)

A mathematical representation of what is currently being paid for similar services nationally. The factor is based on the national allowable charges actually in use.

National Disaster Medical System (NDMS)

A Federally coordinated framework that augments the nation's medical response capability. The primary purpose of the NDMS is to supplement an integrated national medical response for assisting state and local authorities in dealing with medical impacts of major peacetime disasters and to provide support to the military and the DVA/VHA medical systems in caring for casualties evacuated back to the US from overseas armed conventional conflict. The NDMS framework involves private sector hospitals located throughout the US that will provide care for victims of any incident that exceeds the medical care capability of any affected state, region, or federal medical care system. For more detailed information see NDMS at the DHHS web site.

National Prevailing Charge Level

A rate that does not exceed the amount equivalent to the eightieth (80th) percentile of billed charges made for similar services during a 12 month base period.

National Provider Identifier (NPI) (HIPAA Definition)

A 10-digit number assigned to all HCPs mandated by HIPAA of 1996. These numbers are to be used for all financial and administrative transactions. The 10-digit number, containing checksum, prevents technical errors during data transmission. The number doesn't have built-in correlation with any other identifier associated with the provider.

Native File Format

Allows a program to distinguish the type of file and how to display that file when opened. If a file is unrecognized, it will be unable to display the file or not display the file properly. For example, when you save a Microsoft Word document, the data in the file is customized and optimized to be read in Microsoft Word.

Negotiated (Discounted) Rate

An amount that represents the reimbursable amount that a provider agrees to accept for covered services.

Network

The providers or facilities (owned, leased, or arranged) the TRICARE contractor has contracted with to provide health care services to TRICARE eligible beneficiaries at a pre-negotiated rate as the total charge for services provided by the provider and to file claims for beneficiaries. The agreements for health care delivery made between the MTF and the Market and the TRICARE contractor are also included in this definition.

Network Adequacy

See definition for Adequate Network.

Network Care

Health care services and supplies provided by providers and facilities (owned, leased, arranged) the TRICARE contractor has contracted with to provide necessary treatment to TRICARE eligible beneficiaries.

Network Inadequacy

Insufficient TRICARE contractor contracted providers to meet the access standards required by the TRICARE contract.

Network Provider

An individual or institutional provider that has contracted with a TRICARE contractor to provide care to TRICARE eligible beneficiaries, usually at a discounted rate.

Note: All network providers MUST be participating providers.

Non-Appealable Issue

Denial of benefits based on a fact or condition outside the scope of responsibility of DHA and the TRICARE contractor.

Note: For example, the establishment of eligibility is a Uniformed Service responsibility and if the service has not established that eligibility, neither DHA nor a TRICARE contractor may review the action. Similarly, late claim filing, late appeal filing, amount of allowable charge (the contractor must verify it was properly applied and calculated), and services or supplies specifically excluded by law or regulation, such as routine dental care, clothing, routine vision care, etc., are matters subject to legislative action or regulatory rule making not appealable under TRICARE. TRICARE contractors shall not make a determination that an issue is not appealable except as specified in TOM, Chapter 13 and 32 CFR 199.10.

Non-Claim Health Care Data

Information captured by the TRICARE contractor to complete the required TED record for care rendered to TRICARE beneficiaries in those contractor owned, operated and/or subcontracted facilities where there is no claim submitted by the provider of care.

Non-Compliant, Pharmacy

Action which results in a medication being returned to stock for various reasons such as the medication was not picked by the patient within the given 10 day grace period, pharmacy/physician cancelled the prescription, etc.

Note: A subsequent reversal is automatically sent to Pharmacy Data Transaction Service (PDTs) which will result in the removal of the prescription fill from the patient profile. A reversed or adjusted TED record is also submitted to DHA resulting in a financial credit to the Government.

Non-Current Records

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

Non-Department Mental HCP

For the purposes of establishing a mental HCP readiness designation as mandated by the National Defense and Authorization Act (NDAA) for Fiscal Year (FY) 2016, Section 717, a non-Department mental HCP is a HCP who specializes in mental health, is not a HCP of the DoD at a facility of the Department, and provides health care to members of the Armed Forces. It includes psychiatrists, psychologists, psychiatric nurses, social workers, mental health counselors, marriage and family therapists, and other mental HCPs designated by the Secretary of Defense.

Non-DoD Information System (IS)

An IS that is not owned, controlled, or operated by the DoD, and is not used or operated by a contractor or other non-DoD entity exclusively on behalf of the DoD.

Non-DoD TRICARE Beneficiaries

A special category of individuals sponsored by non-DoD Uniformed Services (the Commissioned Corps of the United States Public Health Service (USPHS), the United States Coast Guard (USCG), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA)) who are eligible for TRICARE.

Non-Network Care

Services and supplies received from a civilian provider authorized to provide health care but has no contractual relationship with the TRICARE contractor.

Non-Network Provider

An individual or institutional provider that not has contracted with a TRICARE contractor to provide care to TRICARE eligible beneficiaries at a discounted rate.

Non-Participating Provider (Defined in 32 CFR 199.2)

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

Non-Prime TRICARE Beneficiaries

Individuals, eligible for the TRICARE Program, who are not enrolled in the TRICARE Prime program.

Non-Record Material (Records Management)

US Government-owned documentary material that does not meet the conditions of records status or that is specifically excluded from the statutory definition of a record (see 44 USC 3301). There are three specific categories of materials excluded from the statutory definition of records:

- Library and museum material (but only if such material is made or acquired and preserved solely for reference or exhibition purposes), including physical exhibits, artifacts, and other material objects lacking evidential value.
- Extra copies of documents (but only if the sole reason such copies are preserved is for convenience of reference).
- Stocks of publications and of processed documents. Catalogs, trade journals, and other publications that are received from other Government agencies, commercial firms, or private institutions and that require no action and are not part of a case on which action is taken. (Stocks do not include serial or record sets of agency publications and processed documents, including annual reports, brochures, pamphlets, books, handbooks, posters and maps.)

North Atlantic Treaty Organization (NATO) Member

A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the US For a list of member nations, see https://www.nato.int/cps/ie/natohq/topics_52044.htm.

Office-Based Opioid Treatment (OBOT)

TRICARE authorized providers acting within the scope of their licensure or certification to prescribe outpatient supplies of the medication to assist in withdrawal management (detoxification) and/or maintenance of opioid use disorder, as regulated by 42 CFR Part 8, addressing OBOT.

Open Enrollment Period

The yearly period when non-active duty beneficiaries can enroll in or change their TRICARE enrolled plan coverage for the following calendar program year. The open enrollment period for TRICARE begins on the Monday of the second full week in November to the Monday of the second full week in December of each calendar year. See TPM, Chapter 10, Section 2.1.

Opioid Treatment Program (OTP)

OTPs are service settings for opioid treatment, either freestanding or hospital-based, that adhere to the DHHS' regulations at 42 CFR Part 8 and use medications indicated and approved by DHA. OTPs provide a comprehensive, individually tailored program of medication therapy integrated with psychosocial and medical treatment and support services that address factors affecting each patient, as certified by the Center for Substance Abuse Treatment (CSAT) of the DHHS' Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment in OTPs can include management of withdrawal symptoms (detoxification) from opioids and medically supervised withdrawal from maintenance medications. Patients receiving care for substance use and co-occurring disorders care can be referred to, or otherwise concurrently enrolled in, OTP.

Optical Disc (OD) (Records Management)

A non-contact, random-access disc tracked by optical laser beams and used for mass storage and retrieval of digitized text and graphics. Sometimes called an optical digital disc or optical digital data disc. Types include:

- Write Once Read Many (WORM);
- Compact Disc-Read Only Memory (CD-ROM); and
- Digital Video Disc (DVD).

Organized Health Care Arrangement (HIPAA Definition)

1. A clinically integrated care setting in which individuals typically receive health care from more than one HCP;
2. An organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities such as utilization review, quality assessment and improvement activities, or payment activities.
3. A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to PHI created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;
4. A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or
5. The group health plans described in paragraph 4 of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

For full details refer to HIPAA of 1996.

Originating Site (Telehealth)

The originating site is where the beneficiary is located at the time the services are provided via an interactive telecommunications system. The originating site must be either (a) where an otherwise authorized TRICARE provider normally offers professional medical or psychological services, such as the office of a TRICARE authorized individual professional provider (e.g., physician's office), (b) a TRICARE authorized institutional provider, or (c) a patient's home or other secure location as outlined in this policy.

Other Health Insurance (OHI)

Alternate or additional health plan coverage other than TRICARE. This does not include Medicare or supplemental insurance plans.

Other Special Institutional Providers (Defined in 32 CFR 199.2)

Certain specialized medical treatment facilities, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in 32 CFR 199; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by an accrediting organization approved by the Director, DHA if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

Out-Of-Area Care

Treatment received by TRICARE eligible beneficiaries while traveling outside their TRICARE region.

Out-Of-Network Care

See definition for Non-network Care.

Out-Of-Region Beneficiaries

Individuals who resides in one TRICARE region but receives care within another TRICARE region.

Outcome-Oriented

The degree to which the focus is on results or outcomes rather than on techniques and processes used to achieve these outcomes.

Over-The-Counter (OTC) Medications

Drugs that by law can be sold to a consumer without a prescription from a health care professional.

Note: OTC drugs/items covered by the TRICARE Pharmacy (TPharm) benefit (see <https://www.tricare.mil/CoveredServices/Pharmacy/Drugs/OTCDrugsSupplies.aspx> for covered items) will be reimbursed by the TPharm contractor when purchased with or without a prescription, as long as the purchase was from a retail pharmacy. Covered OTC's purchased without a prescription from a medical supply house or venue other than a retail pharmacy will be processed for reimbursement by the TRICARE regional contractor.

Partial Hospitalization

A treatment setting capable of providing an interdisciplinary program of medically monitored therapeutic services, to include management of withdrawal symptoms, as medically indicated. Services or appointment availability may include day, evening, night, and weekend treatment programs which employ an integrated, comprehensive, and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental disorders, to include substance disorders, and a transition from an inpatient program when medically necessary.

Participating Provider (Defined in 32 CFR 199.2)

A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a TRICARE beneficiary and that submits a TRICARE claim form and accepts assignment of the TRICARE-determined allowable cost or charge as the total payment (even though less than the actual charge), whether paid for fully by the TRICARE allowable amount or requiring cost-sharing by the beneficiary (or sponsor).

Partnership for Peace (PfP)

The PfP Status of Forces Agreement (SOFA) is a multilateral agreement between NATO member states and countries participating in the PfP program. It deals with the status of foreign forces while present on the territory of another state. See https://www.nato.int/cps/en/natolive/topics_50349.htm for a more detailed definition and <https://www.nato.int/cps/en/natohq/51288.htm> for a list of current countries.

Patient Harm

A fraudulent or abusive practice directly causing a patient who is undergoing treatment for a disease, injury, or medical (or dental) condition to suffer actual physical injury or acceleration of an underlying condition. The determination that patient harm has occurred must be based on the opinion of a qualified medical or dental provider or pharmacist in the case of pharmacy claims. Refer to TOM, Chapter 13 for additional information.

Patient Profile, Pharmacy

A complete record for each beneficiary receiving prescriptions under the TRICARE program including: name, address, telephone number, date of birth, gender, patient identification number (sponsor's SSN and DEERS dependent suffix), DEERS Identifier, service sponsorship, status category, chronic medical conditions (diagnosis code), allergies and adverse drug experiences, past medication history, prescriptions dispensed, non-receipt of prescriptions, status on interventions and prescription problems resolved, prior authorizations approved or denied, and any other information supplied by the beneficiary in the patient data form or updates.

Peer Review

Peer Review activities are carried out by physicians and other qualified health care professionals. Peer review is concerned primarily with medical judgements regarding the quality and appropriateness of health care services. A major attribute of peer review is that medical judgements are made (directly or pursuant to guidelines and subject to direct review) by reviewers who are peers of the health care providers providing the services under review.

Pending Claim, Correspondence, Or Appeal

The claim/correspondence/appeal case has been received but has not been processed to final disposition.

Performance Standard

Government approved and developed criteria measuring specific aspects of a contractor's execution of a TRICARE contract.

Permanent Records (Records Management)

Records appraised by the Archivist of the United States as having enduring value because they document the organization and functions of the agency that created or received them or they contain significant information on persons, things, problems, and conditions with which the agency deals.

Pharmacoeconomic Center (PEC)

An activity under the DoD Pharmacy Operations Division (POD) with the mission to improve the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed care missions of the MHS. The PEC is comprised of pharmacists, physicians, and pharmacy technicians from each of the three services, as well as civilian pharmacists and support personnel who monitor drug usage, and cost trends, and performs analysis to support DoD formulary management and national pharmaceutical contracts, and clinical practice guidelines.

Pharmacy and Therapeutics (P&T) Committee

A DoD chartered committee with representatives from Market/MTF providers and Market/MTF pharmacists. The P&T Committee's primary role is establishing and maintaining the DoD Uniform Formulary for the purchased care system and the DC system (Markets/MTFs).

Pharmacy Data Transaction Service (PDTs)

A bi-directional data transaction service that provides a pharmaceutical data warehouse and electronically transmits encrypted prescription data using the National Council of Prescription Drug Program (NCPDP) standards to the pharmacy contractor. The PDTs provides the capability to perform Prospective Drug Utilization Review (ProDUR) and houses prior authorization/medical necessity history by integrating pharmacy data from all three points of service (DC, mail order, and retail pharmacies) with increased clinical screening and medication-related outcomes.

Pharmacy Operations Center (POC)

The DoD organization responsible for Tier I and Tier II (systems and software) support of the PDTs project. The POC:

1. Resolves ProDUR POS conflicts between Markets/MTFs and the TPharm contractor;
2. Monitors quantity limits (which are cumulative between all three POSs);
3. Issues NCPDP provider numbers for DC pharmacies; and
4. Maintains "lock out" and "include" databases for closed class and mandatory use requirements contracts.

Plain Writing

Writing that is clear, concise, well-organized, and follows other best practices appropriate to the subject or field and intended audience.

Point Of Service (POS) Option

Allows TRICARE Prime enrollees and TRICARE Prime Remote for Active Duty Family Members (TPRADFMs) enrollees to receive non-emergent health care services from any TRICARE authorized civilian provider, in or out of the network without requesting a referral from a PCM. Using this benefit results in the beneficiary incurring more out of pocket expenses. For further details, refer to the TRM, Chapter 2, Section 3.

Population Health (PH)

Improving the health of a defined group by assessing determinants of health and enabling optimal health outcomes. In TRICARE, the population of concern is the total beneficiary population. PH's purpose is to address opportunities and gaps in needed care, generally involving identification of indicated evidence-based interventions lacking in individuals and groups. PH also focuses on gaps in preventative care.

Possible Breach

An incident where the possibility of unauthorized access is suspected (or should be suspected) and has not been ruled out. For example, if a laptop containing PII/PHI is lost, and the contractor does not initially know whether or not the PII/PHI was encrypted, then the incident must initially be classified as a possible breach, because it is impossible to rule out the possibility of unauthorized access to the PII/PHI. In contrast, that possibility can be ruled out immediately, and a possible breach has not occurred, when misdirected postal mail is returned unopened in its original packaging. However, if the intended recipient informs the contractor that an expected package has not been received, then a possible breach exists until and unless the unopened package is returned to the contractor. In determining whether unauthorized access should be suspected, the contractor shall consider at least the following factors:

- How the event was discovered;
- Did the information stay within the covered entity's control;
- Was the information actually accessed/viewed; and
- Ability to ensure containment (e.g., recovered, destroyed, or deleted).

Post-Payment Review (Program Integrity)

A review of claims after payment has been made. This type of review allows the contractor the opportunity to assess if an overpayment was made due to an administrative error, claims processing error, inappropriate billing, or claims that are supported by allegations of fraud and abuse.

Potential Quality Issue (PQI)

A clinical or system variance warranting further review and investigation for determination of the presence of an actual Quality Issue (QI).

PQI Jurisdiction

The contractor with geographic jurisdiction has the ability to have meaningful “quality interventions,” and has the best opportunity to demonstrate improved quality by providers within its jurisdiction. Thus, consistent with the TOM requirements, cross-region PQI issues are handled as follows: the contractor who receives and identifies PQI shall conduct an initial clinical assessment based upon the information on hand and if a PQI exists, forward the case and all supporting information to the contractor with the geographic jurisdiction for the case review, investigation, and intervention(s).

Preauthorization (Defined in 32 CFR 199.2)

A decision issued in writing or electronically by the Director, Defense Health Agency (DHA), or a designee, that TRICARE benefits may be payable for certain services that a beneficiary has not yet received. The term prior authorization is substituted for preauthorization and has the same meaning.

A more comprehensive review process for certain services to determine that requested treatment may be covered as medically necessary, delivered at the appropriate setting, and is a TRICARE benefit before services are rendered to the beneficiary. Preauthorizations are required for certain services per the TOM, Chapter 7, Section 4.

Predictive Analytics

The use of data, statistical algorithms and machine learning techniques (i.e., artificial intelligence) to identify the likelihood of future outcomes based on historical data. The goal is to go beyond knowing what has happened to providing a best assessment of what will happen in the future.

Preferred Provider Organization (PPO)

A type of health plan that has contracts with a network of doctors, hospitals and other health care professionals to provide services to plan beneficiaries at a reduced rate.

Prescriber

A physician or other individual professional provider of services specifically authorized to write a prescription for medications or supplies in accordance with all applicable federal and state laws.

Prescription

A legal order from an authorized prescriber to dispense pharmaceuticals or other authorized supplies.

Prevailing Charge

A rate submitted by certain non-institutional providers which fall within the range of rates that are most frequently used in a state for a particular health care procedure or service. The top of the range establishes the maximum amount TRICARE will authorize for payments of a given health care procedure or service, except where unusual circumstances

or medical complications warrant an additional charge. The calculation methodology and use is determined according to the reimbursement instructions outlined in the TRM.

Preventive Care (Defined in 32 CFR 199.2)

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

Primary Care

The initial medical care given by a HCP to a patient especially, as part of regular ambulatory care, and sometimes followed by referral to other medical providers.

Primary Caregiver (Defined in 32 CFR 199.2)

A PCM is a medical doctor or nurse practitioner who can evaluate, diagnose, treat or refer for specialty care any medical or emotional condition. A PCM can treat both acute and chronic illnesses and provide preventive care and health education. All Prime enrollees select or are assigned a PCM.

Primary Care Manager (PCM)

A HCP a patient sees first for their health care needs responsible for providing and coordinating the patient's care, maintaining the patient's health record and when necessary refers the patient for specialty care.

Primary Payer (Defined in 32 CFR 199.2)

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

Prime Contractor

The main individual or organization that has a contract with the owner of the contract and has full responsibility for its completion/execution and may employ (and manage) one or more subcontractors to carry out specific parts of the contract.

Prime Enrollee

An Individual who has signed up to receive health care under the TRICARE Prime option.

Prime Service Area (PSA)

PSAs are areas in which the contractor offers enrollment in TRICARE Prime in compliance with the travel time access standard. PSAs encompass the entire area of all the ZIP codes lying within or intersected by the 40 mile radius around enrolling Markets/MTFs (both hospitals and clinics) and Base Realignment and Closure (BRAC) sites. ZIP codes enclosed entirely within a PSA's boundary shall also be included. For BRAC sites, the 40 mile radius shall be determined based on the physical address of the former MTF location. If the former MTF address is no longer valid, the 40 mile radius shall be determined from the geographic center of the BRAC site ZIP code as of the date of contract award.

Prior Authorization, Medical Care

See definition for Preauthorization.

Prior Authorization, Pharmacy

Pre-approval required for the filling of certain drugs ordered by a HCP.

Note: Criteria, developed by the DoD P&T Committee, will be provided by the to the contractor for use in the filling of certain drugs. However, the contractor will be responsible for developing pre-approval criteria for quantity limit override, etc.

Priority Correspondence

Official communications, received by mail, faxes, email, cables, telexes and other media of record, received by the contractor from the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)), DHA, and any elected or appointed, federal, state, local, foreign, and tribal officials and Members of Congress and Governors, or any other correspondence designated for priority status by the contractor's management.

Privacy Act, 5 USC 552a (Records Maintained on Individuals)

Federal Law which established a Code of Fair Information Practice that governs the collection, maintenance, use and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies. The law prohibits the disclosure of a System Of Records (SOR) without the written consent of the individual. Additionally, the law provides the individual with a means by which to seek access for amendment of their records, and set forth various agencies record keeping requirements.

Privacy Act, 5 USC 552a System of Records (SOR)

A group of records containing PHI and PII maintained by or on behalf of the DoD where PHI and PII in the records is specifically retrieved by personal identifiers.

Private Sector Care

Provides for all medical and dental care plus pharmaceuticals received by MHS-eligible beneficiaries in the private sector. This includes the TRICARE Program, MCSC contracts, USFHP, TRICARE Overseas Program (TOP), Supplemental Health Care Program (SHCP), TPharm, TRS, and various support activities.

Probe Audit (Program Integrity)

A sample of a limited number of claims that are identified to determine if claims are being billed inappropriately and to evaluate overpayment variability.

Processed To Completion (PTC)

A date or time frame when specific portions of claims processing work has been completed, resolved or received a final disposition. Under the TRICARE MCSCs there are specific dates/time frames for:

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

- All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and
- Payment, deductible application or denial action has been posted to ADP history.

- 2. Correspondence.** Correspondence is considered PTC, when the final reply is mailed to the individual(s) submitting the written inquiry or when the inquiry is fully answered by telephone.
- 3. Telephonic Inquiry.** A telephonic inquiry is considered PTC or resolved, when the final reply is provided by either telephone or letter. A final telephone reply means that the caller's inquiry has been fully responded to, there are no unanswered issues remaining, and no additional call-backs are necessary. If the contractor must take a subsequent action to correct a problem or address an issue raised during the telephone call, the telephone inquiry is considered resolved when the contractor identifies the need for the subsequent action, and so notifies the inquirer. For example, if a claim requires adjustment as a result of a telephone inquiry, the call is resolved when the contractor initiates the claim adjustment and the inquirer is so notified (i.e., it is not necessary to keep the call open until the actual processing of the claim adjustment occurs).
- 4. Appeals.** Final disposition of an appeal case occurs when the previous decision by the contractor is either reaffirmed, reversed, or partially reversed and the decision is mailed.
- 5. Referrals and Authorizations.** Following the receipt of all required information, a determination is issued and response is provided to referring provider, beneficiary and referred to provider.

Procuring Contracting Officer (PCO)

A Federal employee with specific contracting authorization having ultimate authority and responsibility for the Governments' side for the contract execution regardless of whatever additional support team may be outlined in the contract. The Government employee is responsible for overseeing the contract from start to finish, including the drawing up the procurement package, Request for Proposal (RFP) and contract award, as well as administration during the contracts life cycle.

Profiled Amount

An amount that is the lower of the prevailing charge or the maximum allowable prevailing charge.

Program Integrity System

A software system for detecting overutilization or fraud and abuse.

Program Year

The appropriate year (e.g., calendar year, fiscal year, rolling 12-month period) specified in the administration of TRICARE programs for application of unique requirements or limitations (e.g., enrollment fees, deductibles, catastrophic lose protection) on covered health care services obtained or provided during the designated time period.

Project Files (Records Management)

A project file contains material on a specific action, transaction, event, person, project, or other subject. As an example, project files may cover one or several subjects that relate to a particular project.

Proof of Concept

A realization of a certain method or idea in order to demonstrate its feasibility, or a demonstration in principle with the aim of verifying that some concept or theory has practical potential.

Prospective Drug Utilization Review (ProDUR)

A process used to identify any potential medication problems that may occur, based on a patient's current prescription, applicable patient profile information, and medication history, prior to the point of dispensing. ProDUR is used to detect over-utilization, under-utilization, therapeutic duplication, drug-disease complications, drug interactions, incorrect dosages and duration of therapy.

Prospective Review

Prior assessment of a request for treatment before the treatment is rendered to determine if the treatment is appropriate for the patient. Another term for preauthorization.

Protected Health Information (PHI) (HIPAA Definition)

1. IIHI that is:
 - a. Transmitted by electronic media;
 - b. Maintained in electronic media; or
 - c. Transmitted or maintained in any other form or medium.

Note: Sometimes referred to as Electronic Protected Health Information (ePHI).

2. PHI excludes IIHI in:
 - a. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g;
 - b. Records described at 20 USC 1232g(a)(4)(B)(iv); and
 - c. Employment records held by a covered entity in its role as an employer.
 - d. Regarding a person who has been deceased for more than 50 years.

Note: As defined in HIPAA of 1996.

Provider (Defined in 32 CFR 199.2)

A hospital or other institutional provider, a physician or other individual professional provider, or other provider of services or supplies in accordance with 32 CFR 199.6.

Provider Exclusion And Suspension (Defined in 32 CFR 199.2)

The terms "exclusion" and "suspension", when referring to a provider under TRICARE, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under TRICARE. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized TRICARE provider based on:

1. A criminal conviction or civil judgment involving fraud;
2. An administrative finding of fraud or abuse under TRICARE;
3. An administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority;
4. An administrative finding that the provider has knowingly participated in a conflict of interest situation; or
5. An administrative finding that it is in the best interests of TRICARE or TRICARE beneficiaries to exclude or suspend the provider.

Provider Network

A group of HCPs with which a managed care contractor has made contractual or other arrangements with to provide health care at a discounted rate.

Provider Termination (Defined in 32 CFR 199.2)

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

Psychotherapy Notes (HIPAA Definition)

Notes recorded (in any medium) by a HCP who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the TP, symptoms, prognosis, and progress to date, as defined in HIPAA of 1996.

Public Health Authority (HIPAA Definition)

An agency or authority of the US, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, that is responsible for public health matters as part of its official mandate as well as a person or entity acting under a grant of authority from or under a contract with a public health agency, as defined in HIPAA of 1996.

Note: The term "public health authority" includes any DoD Component authorized under applicable DoD regulation to carry out public health activities, including medical surveillance activities under DoD Directive 6490.2.

Qualified Mental Health Provider

Psychiatrists or other physicians, clinical psychologists, Certified Psychiatric Nurse Specialists (CPNSs), Certified Clinical Social Workers (CCSWs), certified marriage and family therapists, TRICARE Certified Mental Health Counselors (TCMHCs), pastoral counselors under a physician's supervision, and supervised mental health counselors under a physician's supervision.

Qualifying Life Event (QLE)

A change in a beneficiary's situation, like getting married, having a baby, or losing health coverage, that allows a beneficiary to enroll in or change their TRICARE health plan coverage outside of the annual open enrollment period. See TPM, Chapter 10, Section 2.1, for a list of authorized QLEs.

Quality Assurance (QA), Pharmacy

A process for developing controls to prevent mistakes in the dispensing of drugs. QA is the responsibility of both the pharmacy and the contractor.

Quality Assurance Program

A system-wide process established and maintained by the contractor to monitor and evaluate the quality of patient health care and clinical performance.

Quality of Care

The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered.

1. **Safe.** Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors.
2. **Effective.** Providing services based on scientific knowledge and evidence-based guidelines.
3. **Timely.** Reducing delays in providing and receiving health care.
4. **Efficient.** Delivering health care in a manner that maximizes resource use and avoids waste.
5. **Equitable.** Delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.
6. **People-Centered.** Providing care that takes into account the preferences and aspirations of individual service users and the culture of their community.

Quality Control, Pharmacy

Processes and procedures employed to ensure that pharmaceuticals are dispensed accurately and timely. These should be employed by both the contractor and the pharmacy.

Quality Improvement

An approach to quality management that builds upon traditional quality assurance methods by emphasizing:

1. The organization and systems (rather than individuals);
2. The need for objective data with which to analyze and improve processes; and
3. The ideal that systems and performance can always improve even when high standards appear to have been met.

Quality and Value Improvement Initiative (QVII)

A QVII is a set of related activities designed to achieve measurable improvement in processes and outcomes of care. QVIIs are structured with appropriate elements such as clearly defined sample sizes and inclusions/exclusion criteria. They are appropriately operationalized, meaning appropriate scientific methodology and rigor is applied such as using written research questions and statistically significant analysis as applicable. QVIIs include interventions that lead to measurable improvements in beneficiary health status and quality of life as well as improved clinical quality for health care providers, plans and measures. QVIIs may address administrative processes, beneficiary health, error reduction, patient safety improvement, beneficiary functional status, beneficiary or provider satisfaction, high-value and high-risk issues. QVIIs are appropriately documented by including the following elements:

Description and purpose of topic.

- Description of the population.
- Rationale for selection of the QVII baseline data.
- Description of data collection.
- Goals and time frames.
- Action plan/interventions.
- Periodic (at least quarterly) re-measurements and outcomes.

Quality Issue (QI)

A verified deviation, as determined by a qualified reviewer, from acceptable standards of practice or standards of care as a result of some process, individual, or institutional component of the health care system.

- **Severity Level 1.** QI is present with minimal potential for significant adverse effects on the patient.
- **Severity Level 2.** QI is present with the potential for significant adverse effects on the patient.
- **Severity Level 3.** QI is present with significant adverse effects on the patient.
- **Severity Level 4.** QI is present with the most severe adverse effect and warrants exhaustive review.
- **Sentinel Event.** A sentinel event is defined by the TRICARE Program utilizing the most current definition as published by TJC.

Receipt Of Claim, Correspondence Or Appeal

Delivery of a claim, correspondence, or appeal into the custody of the contractor by the post office or other party.

Reconsideration

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

Record Object (Records Management)

A record object is a container (typically, a computer file) for a group of related information. The information can be formatted as either text or images, and the computer file-type indicates the format of the information. For example, scanned images are typically stored in Tagged Imaged File Format (TIFF) or as Portable Document Format (PDF) files.

Note: For the purpose of electronic RM, a record object is not necessarily a row of data in a database.

Records

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

Also any item, collection, or grouping of information about a beneficiary which is maintained, collected, used or disseminated, by TRICARE or a TRICARE contractor, including, but not limited to his or her education, financial transactions, medical history, and criminal or employment history, and which contains the beneficiary's name or identifying number, symbol or other personal identifiers.

Records (Records Management)

In accordance with 44 USC 3301, the term “records” includes “all recorded information, regardless of form or characteristics, made or received by a Federal agency under Federal law or in connection with the transaction of public business and preserved or appropriate for preservation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the United States Government or because of the informational value of data in them. Library and museum material made or acquired and preserved solely for reference or exhibition purposes, and duplicate copies of records preserved only for convenience are not included.”

Records Liaisons (RLs) (Records Management)

Individuals appointed within each reporting office to perform the records management functions within their organizations and liaison with the Component Records Management Officer (CRMO). These appointments will be made in writing and furnished to the CRMO. Appointment memos will be updated upon the departure or change of the individual(s).

Records Management

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

Records Management (Records Management)

The planning, controlling, directing, organizing, training, promoting, and other managerial activities involved with respect to records creation, records maintenance and use, and disposition in order to achieve adequate and proper documentation of the policies and transactions of the federal government and effective and economical management of agency operations.

Referral (Defined in 32 CFR 199.2)

The act or an instance of referring a TRICARE beneficiary to another authorized provider to obtain necessary medical treatment. Generally, when a referral is required to qualify health care as a covered benefit, only a TRICARE-authorized physician may make such a referral unless regulation (32 CFR 199.2) specifically allows another category of TRICARE-authorized provider to make a referral as allowed within the scope of the provider’s license.

A referral is a request from one physician to another to assume responsibility for evaluation or management of one or more of a patient’s specified problems. A consult is a request from one physician to another for an advisory opinion. Referrals and consults written by Market/MTF or Civilian TRICARE providers are sent to the contractor for authorization or preauthorization (if needed per TOM, Chapter 7, Section 4). A PCM (physician) does not require a preauthorization or authorization from the contractor to generate a referral or consult to and from a network provider.

Referral Management (RM)

Process by which all referrals written by the Market/MTF authorized providers and network and non-network providers are tracked for care coordination, patient safety, and accountability. The RM process ends when the referring provider is provided the clear and legible report, informed the patient did not use or activate their referral, or if the referral was denied by the contractor.

Region

A geographic area determined by the Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Regional Review Authority (RRA)

An entity responsible for performing Peer Review Organization (PRO) functions. Under TRICARE the contractor shall be responsible for performing the duties of the RRA.

Reliants

Refers to a subset of TRICARE eligible beneficiaries who are dependent on TRICARE and not the DC system or OHI for the coverage/reimbursement of vaccines under the well-child and preventive benefits. This includes, but is not limited to: All TRICARE Active Duty Family Members (ADFM) not enrolled to a DC PCM who are reliant on TRICARE as their primary form of insurance, and retirees and their family members who do not have OHI and are not dependent on the DC system but are dependent on TRICARE as their primary form of insurance.

Remote Health Monitoring (RHM) (Telehealth) (also known as Remote Patient Monitoring)

- A continuous or regular monitoring of patient symptoms, biometric values, health, or functional status, via electronic means. RHM is integrated into the patient's daily routine and the patient's information is gathered by means of sensors or self-report in the patient's home or community. Relevant biometric data and responses to structured queries are risk stratified per an evidence-based algorithm and then fed back to a monitoring dashboard.
- Information from a number of patients are reviewed by a nurse or other care coordinator on a daily, consistent basis with patient contact or intervention arranged when monitored parameters exceed predetermined tolerances.

Remote Patient Monitoring (see Remote Health Monitoring)

Remote Physical Exams

Some primary and specialty services require a physical examination of the patient. If done via telehealth, this is typically accomplished by using specialized telehealth equipment at the patient end (tele-exam cameras, stethoscopes, otoscopes, dermoscopes, endoscopes, ultrasound, Electrocardiogram (ECG), vitals, etc). In a clinic setting, this equipment is operated, under the provider's remote direction, by a nurse, physician assistant (PA), med tech, or similar extender. The data coming back to the provider aids in accurate assessment and diagnosis. Typically, the patient-side clinical extender, known as a telepresenter, requires special training in operating the equipment, using the equipment properly with the patient, and collaborating with the provider to successfully complete the exam. In some cases, RHM equipment can be used by patients, under provider guidance, to enable the provider to visualize medical issues in a home environment. Evidentiary support for the latter application is still being developed.

Representative (Defined in 32 CFR 199.2)

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

Required By Law (HIPAA Definition)

A mandate contained in law that compels a covered entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to HCPs participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a Government program providing public benefits as defined in HIPAA of 1996.

Note: For TRICARE required by law also includes any mandate contained in a DoD Regulation that mandates a covered entity (or other person functioning under the authority of a covered entity) to make a use or disclosure and is enforceable in a court of law. The attribute of being enforceable in a court of law means that in a court or court-martial proceeding, a person required by the mandate to comply would be held to have a legal duty to comply or, in the case of noncompliance, to have had a legal duty to have complied. Required by law also includes any DoD regulation requiring the production of information necessary to establish eligibility for reimbursement or coverage under TRICARE.

Research (HIPAA Definition)

A systematic investigation, including research, development, testing, and evaluation, designed to develop or contribute to generalizable knowledge as defined in HIPAA of 1996.

Residence

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

Residential Treatment Center (RTC)

A facility or distinct part of a facility which meets the criteria in 32 CFR 199.6(b)(4)(vii).

Residual Claim

A claim for health care services rendered during the health care delivery period of one contract, but processed under a different (incoming) contract.

Resource Sharing Agreement (External) (Defined in 32 CFR 199.2)

A type of external Partnership Agreement established in the context of the TRICARE Program by agreement of the MTF Commander and an authorized TRICARE contractor. External resource sharing agreements may incorporate TRICARE features in lieu of standard TRICARE features that would apply to stand external Partnership Agreements.

Respite Care (Defined in 32 CFR 199.2)

Short-term care for a patient in order to provide rest and change for primary caregivers who have been caring for the patient at home, usually the patient's family.

Note: Although this is usually the patient's family, it may be a relative or friend who assists the member with their ADL. Respite care consists of providing skilled and non-skilled services to a beneficiary such that in the absence of the primary caregiver, management of the beneficiary's qualifying condition and safety are provided. Respite care services are provided exclusively to the Service member beneficiary.

1. Qualifying Condition For Receipt Of Respite Benefits. For the purposes of receiving respite benefits, a qualifying condition is defined as a serious injury or illness resulting in, or based on the clinical assessment of the member's provider or CM team that will result in a physical disability, or an extraordinary physical or psychological condition.

2. Limitations On Respite Benefits:

- The services performed by the primary caregiver are those that can be performed safely and effectively by the average non-medical person without direct supervision of a HCP after the primary caregiver has been trained by appropriate medical personnel.
- Respite care services are limited to a maximum of eight hours per calendar day, five days per calendar week for beneficiaries in the EHC Program.

Resubmissions

A group of TED records submitted to DHA to correct those TED claims and adjustments which generated edit errors when originally processed by DHA. These groups of records will be identified by the batch number and resubmission in the TED Header Record.

Retention Period

The length of time for particular documents/records (normally a series) are to be kept.

Retiree (Defined in 32 CFR 199.2)

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

Retired Category

Retirees and their family members who are beneficiaries covered by 10 USC 1086(c), other than Medicare-eligible beneficiaries as described in 10 USC 1086(d).

Retirement (Records Management)

The movement of inactive files having a permanent or long-term value to an FRC for storage, servicing, and ultimate disposition.

Retrospective Drug Utilization Review

A process of appraising and reconsidering the usage of drugs to determine the effectiveness of drug treatment after a medication is dispensed. The process includes evaluation for therapeutic appropriateness, over-utilization and under-utilization, therapeutic duplication, drug-disease contraindications, drug interactions, incorrect dosage and /or duration of therapy.

Retrospective Review

A post-treatment assessment of care already delivered. The assessment evaluates the appropriateness of care and conformance to pre-established criteria for utilization. The purpose for this type of assessment may be to validate utilization decisions made and/or to validate payment made for care provided (by examining the actual record of treatment).

Returned Claim

A bill of health care services the contractor returns to the sender because there is missing information that is needed for processing, and the missing information cannot be obtained from in-house sources.

Reversed

Status of claim once a reversal transaction is transmitted for the removal of the PAID claim from a patient's profile.

Routine Correspondence

All communications received by mail, faxes cables, telexes, and other media or record, is not designated as Priority Mail.

Routine Use

With respect to the disclosure of a record from a Privacy Act System of Records (SOR) 5 USC, 552a, the use of a record for a purpose that is compatible for which it was information collected. See also Defense Privacy and Civil Liberties Office's (DPCLO's) published list of blanket routine uses for sharing PII.

Same Day Referral

The act or instance of referring a TRICARE beneficiary to another authorized provider to obtain necessary medical treatment within 24 hours of a request for care. This includes immediate (STAT), 24 hours (as soon as possible (ASAP)), and Today referral priority requests from the Composite Health Care System (CHCS) or MHS Genesis.

Sanction (Defined in 32 CFR 199.2)

For the purposes of 32 CFR 199.9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer (Defined in 32 CFR 199.2)

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

Secretary Of Health And Human Services (HHS)

The head of the US DHHS concerned with health matters.

Segment (HIPAA Definition)

A group of related data elements in a transaction as defined in HIPAA of 1996.

Seventy-Two Hour Referral

The act or instance of referring a TRICARE beneficiary to another authorized provider to obtain necessary medical treatment within 72 hours of a request for care.

Skilled Nursing Facility (SNF) (Defined in 32 CFR 199.2)

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

Skilled Nursing Service (Defined in 32 CFR 199.2)

Skilled nursing services includes application of professional nursing services and skills by and Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) that are required to be performed under the general supervision/direction of a TRICARE authorized physician to ensure the safety of the patient and achieve the medically desired result in accordance with accepted standards of practice.

Note: Skilled nursing services are other than those services that provide primarily support for the Activities of Daily Living (ADL) or that could be performed by an untrained adult with minimum instruction or supervision.

Special Checks

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

Special Inquiries

Requests for information under the Freedom of Information Act, Privacy Act, and the news media. Also includes requests received for surveys, audits, and requests by Government agencies including DoD agencies, entities other than DHA and Congressional Committees.

Specialty Care

Specialized medical services provided by a physician specialist.

Specified Authorization Staff (SAS)/Defense Health Agency-Great Lakes (DHA-GL) (formerly Military Medical Support Office (MMSO))

A Joint Services Organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty. SAS/DHA-GL is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. The SASs for Army, Navy, Marine Corps, and Air Force Service members are assigned to the DHA-GL. For more information, see TOM, Chapter 17 for additional information.

Split-Billing

The division of a medical claim for service provided into two or more parts. Claims may be split to divide work between clients, payers or for reimbursement to different service providers for performing a shared service. Such claims may or may not require Coordination of Benefits (COB).

Split Enrollment

A TRICARE Prime option which allows an entire family to enroll in TRICARE Prime even if part of the family is living in another TRICARE region.

Sponsor

An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her family members' eligibility for TRICARE is based. See also 32 CFR 199.2 for a more complete definition.

Spouse (Defined in 32 CFR 199.2)

A lawful husband or wife, who meets the criteria in 32 CFR 199.3, regardless of whether or not dependent upon the active duty member or retiree.

Stakeholders

Any party who has a direct interest in the success of a business, governmental, or charitable concern. For TRICARE purposes, stakeholders include Congress, DoD, DHA, MHS, Market Directors, MTF Directors, and all employees thereof, contractors, other elected officials, MHS beneficiaries, Military and Veterans Service Organizations (MSOs and VSOs), etc.

Standard Transaction (HIPAA Definition)

A transaction that complies with the applicable standard adopted by HIPAA.

Start Of Service

The date a contractor officially begins delivery of health care services, processing claims, and/or delivery of other services in a production environment, as specified in the contract requirements.

State (Defined in 32 CFR 199.2)

For the purposes of the 32 CFR 199, any of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, and each territory and possession of the US.

State (HIPAA Definition)

1. For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the USC for such health plan.
2. Each of the several states, the District of Columbia, Puerto Rico, the US Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Statement of Responsibility (SOR)

A written document, signed by two or more parties, which establishes management processes unique to each market or standalone MTF to address individual market and MTF specific issues and procedures.

Student Status (Defined in 32 CFR 199.2)

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

Subcontractor

An individual or in many cases a business that signs a contract to perform part or all of the obligations of another's contract. This includes but is not limited to enrolled program health benefits business entities at whatever level of the contract organization they exist. It does not include institutional or non-institutional providers of health care. This definition does not exclude business entities that are not specifically addressed herein but whose legal status within the contract organization establishes them as subcontractors because that term may be otherwise defined in the Federal Acquisition Regulation (FAR).

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

Subcontractor (HIPAA Definition)

A person to whom a business associate delegates a function, activity, or service other than in the capacity of a member of the workforce of such business associate.

Subcontracts

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

Substance Use Disorder Rehabilitation Facility (SUDRF)

A facility or a distinct part of a facility that meets the criteria in 32 CFR 199.6(b)(4)(xiv).

Summary Health Information (HIPAA Definition)

Information that may be IIHI, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
2. From which the information has been deleted, except that the geographic information may be aggregated to the level of a five digit ZIP code.

As defined in HIPAA of 1996.

Supplemental Care

Medical care received by Service members of the Uniformed Services and other designated patients pursuant to a Market/MTF referral (Market/MTF Referred Care). Supplemental Health Care also includes specific episodes of Service member non-referred civilian care, both emergent and authorized non-emergent care (non-Market/MTF Referred Care).

Supplemental Funds

Funds used to pay for supplemental care.

Supplemental Insurance Plan (Defined in 32 CFR 199.2)

A health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service HMO.

1. An indemnity supplemental insurance plan must meet all the following criteria:
 - a. It provides insurance coverage, regulated by the state insurance agencies, which is only available only to beneficiaries of TRICARE.
 - b. It is premium based and all premiums relate only to the TRICARE supplemental coverage.
 - c. Its benefits for all covered TRICARE beneficiaries are predominately limited to non-covered services, to the deductible and cost-shared portions of the predetermined allowable charges and/or to amounts exceeding the allowable charges for covered services.
 - d. It provides insurance reimbursement by making payment directly to the TRICARE beneficiary or to the participating provider.
 - e. It does not operate in a manner which results in lower deductibles or cost-shares than those imposed by law, or that waives the legally imposed deductibles and cost-shares.
2. A supplemental insurance plan offered by a HMO must meet all of the following criteria:
 - a. The HMO must be authorized and must operate under relevant provisions of state law.
 - b. The HMO supplemental plan must be premium based and all premiums must relate only to TRICARE supplemental coverage.
 - c. The HMO's benefits, above those which are directly reimbursed by TRICARE, must be limited predominantly to services not covered by TRICARE and TRICARE deductible and cost-share amounts.
 - d. The HMO must provide services directly to TRICARE beneficiaries through its affiliated providers, who in turn, are reimbursed by TRICARE.
 - e. The HMO's premium structure must be designed so that no overall reduction to the amount of the beneficiary deductibles or cost-shares will result.

Suspension Of Claims Processing (Defined in 32 CFR 199.2)

The temporary suspension of processing (to protect the Government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific TRICARE beneficiary pending action by the Director, DHA, or a designee, in a case of suspected fraud or abuse. The action may include administrative remedies provided for in 32 CFR 199.9 or any other DoD issuance (e.g., DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by DHA, or referral to the DoD-Inspector General (IG) or the Department of Justice (DOJ) for action within their cognizant jurisdictions.

Synchronous Telehealth

Services involve interactive, electronic information exchange in at least two directions in the same time period. A common type of synchronous encounter is clinical video teleconference (VTC). Clinical VTC supports the delivery of health care at a distance via real-time, two-way transmission of digitized video images between two or more locations. Providers and/or providers and patients can exchange medical information via clinical VTC for the purpose of obtaining an expert opinion, diagnostic support regarding the care of a patient, and/or direct patient care.

Tele-XXXXX (Telehealth)

The hyphenated prefix "Tele-", followed by the name of a specialized health care service or specialty, denotes a form of telehealth specialized for that health care service or specialty.

Tele-Behavioral Health (Telehealth)

Behavioral Health Services delivered via telehealth.

Teleconsultation Capability

Ability of a PCM to place a non-urgent telehealth query to a pool of specialists & receive a response within 24 hours. This capability will enable PCMs to practice at the top of their license and should reduce unnecessary referrals for specialty care. The contractor's teleconsultation capability should allow for both text queries and upload of images and other data and should protect PHI/PII.

Tele-Mental Health (Telehealth)

See "Tele-Behavioral Health."

Tele-Critical Care (TCC) (Telehealth)

- Synonymous with Virtual Critical Care (VCC).
- The application of telehealth tools, technologies, and processes to provide care for critically ill and injured patients irrespective of physical location.
- Services provided to patients located in Emergency Departments (EDs), Operating Rooms (ORs), Intensive Care Units (ICUs), and for (if the capability supports it) the pre-hospital (or field) environment.

Telehealth (Telehealth)

The delivery of health assessment, diagnosis, health care, consultation or supervision, symptom and/or health status monitoring, care coordination or case management, patient education, or similar services, at a distance via electronic means.

Telemedicine

The use of information and telecommunications technology to provide medically and psychologically necessary and appropriate diagnostic and treatment services across distances. Overall, telemedicine facilitates the exchange of medical information between providers and/or providers and patients through electronic means. Medical information includes but is not limited to medical images, output data from medical devices, and verbal diagnostic information. The telemedical interaction may involve a variety of technologies, including live two-way audio and video modalities (e.g., clinical video-teleconferencing or VTC between patients at the “originating site” and providers at the “distant site”). Telemedicine may be conducted in many clinical specialties including but not limited to telemental health and teleprimary care.

Tele-Present (Telehealth)

To operate the equipment, or provide other vital clinical information, on the patient end of a telehealth visit, often as part of a remote physical examination.

Telepresenter (Telehealth)

A telepresenter is an individual at the originating site (when the originating site is other than the patient’s home) who has the necessary skills, training, and/or clinical background (e.g., Licensed Practical Nurse (LPN), Registered Nurse (RN), trained medical technician, etc.) to operate the telemedicine technology and facilitate examinations under the direction of the provider at the distant site. For example, a nurse may use a device connected to a telemedicine system, such as a digital stethoscope or otoscope, in order to provide diagnostically relevant imagery, sound, or other data/information about the patient to the distant provider in real time.

Termination

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

Third-Party Billing Agent (Defined in 32 CFR 199.2)

Any entity that acts on behalf of a provider to prepare, submit, and monitor claims, excluding those entities that act solely as a collection agency.

Third-Party Liability (TPL) Claims

Reimbursements to the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA) (42 USC paragraphs 2651-2653).

Third-Party Liability (TPL) Recovery

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

Third-Party Payer (Defined in 32 CFR 199.2)

Third-party means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies. For the purposes of the definition of "third-party payer," an insurance medical service or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a personal injury protection plan or medical payments benefit plan for personal injuries resulting from the operation of a motor vehicle.

Note: TRICARE is secondary payer to all third-party payers. Under limited circumstances in 32 CFR 199.8, TRICARE payment may be authorized to be paid in advance of adjudication of the claim by certain third-party payers. TRICARE advance payment will not be made when a third-party provider is determined to be a primary medical insurer under 32 CFR 199.8.

Timely Filing

The submitting of TRICARE claims within the prescribed time limits as set forth in 32 CFR 199.7 and the requirements of the TRICARE contract.

Toll-Free Telephones

Having or using a direct line or number for a call that is not charged to the caller. Under the TRICARE contract all telephone calls are considered toll-free for the purposes of measuring the standards contained in TOM, Chapter 1, Section 3, paragraph 3.4.

Trading Partner Agreement (HIPAA Definition)

An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

As defined in HIPAA of 1996.

Transaction (HIPAA Definition)

The transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

1. Health care claims or equivalent encounter information.
2. Health care payment and remittance advice.
3. Coordination of benefits.
4. Health care claims status.
5. Enrollment and disenrollment in a health plan.
6. Eligibility for a health plan.
7. Health plan premium payments.
8. Referral certification and authorization.
9. First report of injury.
10. Health claims attachments.
11. Other transactions that may be prescribed by regulation.

Transfer

The term “transfer” has replaced the older term “accession” for temporary records. Like an accession, a transfer is a unique identifier used by NARA to track the records transferred using the transmittal document SF-135 for paper, or for electronic records.

Transfer Claims

A bill received by a contractor for services received and billed from another contractor’s jurisdiction. See TOM, Chapter 8 for processing requirements related to these types of claims.

Note: Claims for Service members which are sent to the appropriate Uniformed Service are not considered to be “transfer claims.”

Transition

The process of changing contractors or contract in a Government designated service area. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

Transitional Patients Or Cases

Beneficiaries for whom active care is in progress on the date of a contractor’s start work date.

Note: If the care being provided is for covered services, the contractor is financially responsible for the portion of care delivered on or after the contractor’s start work date.

Transmission and Receipt Data (Records Management)

- **Transmission Data:** Information in electronic mail systems regarding the identities of sender and addressee(s), and the date and time messages were sent.
- **Receipt Data:** Information in electronic mail systems regarding date and time of receipt of a message, and/or acknowledgment of receipt or access by the addressee(s).

Treatment (HIPAA Definition)

The provision, coordination, or management of health care and related services by one or more HCPs, including the coordination or management of health care by a HCP with a third-party; consultation between HCPs relating to a patient; or the referral of a patient for health care from one HCP to another.

Treatment Encounter

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

Treatment Plan (TP) (Defined in 32 CFR 199.2)

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

Triage

The process of determining the priority of patients' treatment based on the severity of their condition.

Note: For the TRICARE Program this function is performed by the contractor's 24-hour telephone Nurse Advice Line (NAL).

TRICARE

The DoD's managed health care program for Service members and their families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's DC system of hospitals and clinics and civilian providers. Through December 31, 2017, TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions in this section and in 32 CFR 199.17). Beginning January 1, 2018, TRICARE offers three options: TRICARE Prime, TRICARE Select, and TRICARE For Life (TFL) (see definitions below and in **32 CFR 199.2**).

TRICARE Beneficiary

An individual determined by the Uniformed Services to be eligible for TRICARE benefits, as set forth in 32 CFR 199.3.

TRICARE Contractor

An organization with which DHA has entered into a binding agreement for:

1. The delivery of and/or processing of payment for health care services through contracted providers;
2. The processing of claims for health care services received from non-network providers; and
3. The performance of related support activities.

TRICARE Encounter Data (TED)

A data set of information required for all care received/delivered under the contract and provided by the contractor in a Government-specified format and submitted to DHA via a telecommunication network. The information in the data set can be described in the following broad categories:

1. Beneficiary identification.
2. Provider identification.
3. Health information:
 - Place and type of service
 - Diagnosis and treatment-related data
 - Units of service (admissions, days, visits, etc.)
4. Related financial information.

TRICARE Encounter Data (TED) Record Transmittal Summary

A single record which identifies the submitting contractor and summarizes, for transmittal purposes, the number of records and the financial information contained within the associated "batch" of TED records.

TRICARE Extra (Defined in 32 CFR 199.2)

The preferred-provider option of the TRICARE program made available prior to January 1, 2018, under which TRICARE Standard beneficiaries may obtain discounts on cost-sharing as a result of using TRICARE network providers.

TRICARE For Life (TFL) (Defined in 32 CFR 199.2)

The Medicare wraparound coverage option of the TRICARE program made available to an eligible beneficiary by reason of 10 USC 1086(d).

TRICARE Operations Manual (TOM) (6010.62-M)

A DHA authored book which provides instructions and requirements for claims processing and health care delivery under TRICARE.

TRICARE Pharmacy (TPharm) Benefits Program

A plan to provide outpatient prescription drugs through military pharmacies, TRICARE Pharmacy Home Delivery, and TRICARE retail network and non-network pharmacies.

TRICARE Policy Manual (TPM) (6010.63-M)

A DHA authored book which provides the description of TRICARE Program benefits, adjudication guidance, policy interpretations, and decisions for use in determining benefits under the TRICARE Program.

TRICARE Plus

A primary care program offered at some military hospitals and clinics for beneficiaries not enrolled in TRICARE Prime. Beneficiaries are enrolled with a Primary Care Coordinator (PCC) at a Market/MTF. Markets/MTFs may limit enrollment based on capability and capacity. There is no enrollment fee.

Note: These Market/MTF enrollees are to receive primary care appointments within the TRICARE Prime access standards. TRICARE Plus “enrollment” will be annotated in DEERS and the Market’s/MTF’s Electronic Medical Records. When a TRICARE Plus enrollee receives care from civilian providers, TRICARE Standard/Extra rules will apply (through December 31, 2017). For services payable by Medicare, Medicare rules will apply, with TRICARE as second payer for TRICARE covered services and supplies. Specialty care in the Market/MTF will be on referrals from the primary care provider or on a self-referral basis. TRICARE Plus enrollees are not guaranteed specialty care appointments within the TRICARE Prime access standards.

TRICARE Prime (Defined in 32 CFR 199.2)

The managed care option of the TRICARE program established under 32 CFR 199.17.

TRICARE Prime Remote (TPR) Program

A managed care option under TRICARE designed to provide health care services to Service members and command sponsored family members assigned to remote locations in the US.

TRICARE Prime Remote (TPR) Work Unit

A uniformed services group whose members have to be designated by the Military Services to be eligible to enroll in the TPR Program.

TRICARE Program (Defined in 32 CFR 199.2)

A program established under the 32 CFR 199.17.

TRICARE Quality Management Contract (TQMC)

A national-level contractor responsible to the DoD and DHA that performs second level reconsiderations for payment denials and focused retrospective quality of care reviews.

TRICARE Retired Reserve

The program established under 10 USC 1076e and 32 CFR 199.25.

TRICARE Regulation (Defined in 32 CFR 199.2)

This regulation prescribes guidelines and policies for the administration of the TRICARE Program for the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA. It includes the guidelines and policies for the administration of the TRICARE Program.

TRICARE Reimbursement Manual (TRM) (6010.64-M)

A DHA authored book which provides and outlines payment methodologies under the TRICARE Program.

TRICARE Representative

A highly qualified individual knowledgeable about TRICARE responsible for providing information and assistance to providers, whether network or non-network, to Beneficiary Counseling and Assistance Coordinators (BCACs) in their service area and to Congressional offices.

TRICARE Select

The self-managed, preferred provider network option under the TRICARE program established by 10 USC 1075 and 32 CFR 199.17 to replace TRICARE Extra and Standard after December 31, 2017.

TRICARE Standard

The TRICARE program made available prior to January 1, 2018, under which the basic program of health care benefits generally referred to as CHAMPUS was made available to eligible beneficiaries under 32 CFR 199.

TRICARE Systems Manual (TSM) (7950.4-M)

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

Unactivated Referrals

No claim is located in the contractor's claims system after a referral is made.

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 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 (WWW) and in the Catchment Area Directory.

United States (US)

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

Unscheduled Records (Records Management)

Records whose final disposition has not been approved by NARA. Unscheduled records may not be destroyed or deleted.

Unstructured Data (Records Management)

Any data stored in an unstructured format at the atomic level. Refers to computerized information which does not have a data structure that is easily readable by a machine and requires human intervention to make the data machine readable. Examples of unstructured data are e-mail, spreadsheets, or word processing documents.

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.

Urgent Care Center (UCC)

A TRICARE authorized UCC is a qualified corporate services provider under 32 CFR 199.6(f) with a location distinct from a hospital Emergency Room (ER), an office, or a clinic; and whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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.

Utilization Management (UM)

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

Utilization Review

A process for monitoring the use, delivery, quality, medical necessity, and cost-effectiveness of health care services especially those provided by medical community.

Validated Date and Diagnosis

The date a DoD physician (military or civil service) validates the diagnosis of a service-related condition and validates that the condition can be resolved within 180 calendar days.

Veteran (Defined in 32 CFR 199.2)

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

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

Vital Records

Records essential to the continued functioning or reconstitution of an organization during and after an emergency and includes those records essential to protecting the rights and interests of that organization and of the individuals directly affected by its activities (includes both emergency- operating and rights-and-interests records). Vital records considerations are part of an agency’s records disaster prevention and recovery program.

Virtual Critical Care (Telehealth)

Synonymous with Tele-Critical Care (TCC).

Virtual Health (Telehealth)

In common usage, is synonymous with Telehealth. Sometimes used to describe a super-set of telehealth that includes artificial intelligence, augmented reality, and similar healthcare technology applications.

Widow Or Widower (Defined in 32 CFR 199.2)

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

Workday

Any day on which full-time business can be conducted. See the definition of “Business Day.”

Worker's Compensation Benefits (Defined in 32 CFR 199.2)

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

Workforce (HIPAA Definition)

Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity is under the direct control of such entity, whether or not they are paid by the covered entity or business associate as defined in HIPAA of 1996.

Written Correspondence

Any written or digital communication exchanged between two or more parties.

- END -

