
Glossary of Healthcare Terminology



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FOREWORD

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This Manual (DoD 6015.1-M) is reissued under the authority of DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs)," December 9, 1996. It prescribes a uniform glossary of healthcare terminology for use throughout the Department of Defense.

This Manual applies to the Office of the Secretary of Defense (OSD), the TRICARE Management Activity, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Defense Agencies, and the DoD Field Activities (hereafter referred to collectively as "the DoD Components").

This Manual is effective immediately and is mandatory for use by all the DoD Components. The Heads of DoD Components may issue supplementary instructions only when necessary to provide for unique requirements within their organizations.

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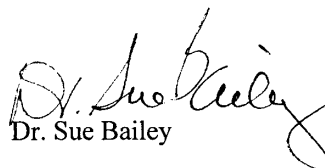

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REFERENCES

- (a) DoD 6010.13-M , "Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities," October 1995, authorized by DoD Directive 6010.13, February 3, 1986
- (b) Title 37, United States Code
- (c) Chapter 105, Section 2801 of title 10, United States Code
- (d) DoD Directive 8000.1, "Defense Information Management (IM) Program," October 27, 1992
- (e) DoD 7220.9-M, "Department of Defense Accounting Manual," October 1983, authorized by DoD Instruction 7220.9, October 22, 1981
- (f) Joint Pub 4-02, "Doctrine for Health Service Support in Joint Operations," April 26, 1995
- (g) DoD Instruction 4165.14, "Inventory of Military Real Property," December 21, 1966
- (h) American Academy of Pediatrics, "Guidelines for Perinatal Care," 1988
- (i) Section 17 of title 38, United States Code

AL1. ABBREVIATIONS AND/OR ACRONYMS

AL1.1. <u>AABB.</u>	American Association of Blood Banks
AL1.2. <u>AAPCC.</u>	Adjusted Average Per Capita Cost
AL1.3. <u>ACH.</u>	Army Community Hospital
AL1.4. <u>ACLS.</u>	Advanced Cardiac Life Support
AL1.5. <u>ACNM.</u>	American College of Nurse Midwifery
AL1.6. <u>AD.</u>	Active Duty
AL1.7. <u>ADAL.</u>	Authorized Dental Allowance Lists
AL1.8. <u>ADFM.</u>	Active Duty Family Member
AL1.9. <u>ADPL.</u>	Average Daily Patient Load
AL1.10. <u>ADS.</u>	Ambulatory Data System
AL1.11. <u>ADT.</u>	Active Duty for Training
AL1.12. <u>AFHPSP.</u>	Armed Forces Health Professions Scholarship Program
AL1.13. <u>AFIP.</u>	Armed Forces Institute of Pathology
AL1.14. <u>AHC.</u>	Army Health Clinic
AL1.15. <u>AHIMA.</u>	American Health Information Management Association
AL1.16. <u>AIS.</u>	Automated Information System
AL1.17. <u>AJBPO.</u>	Area Joint Blood Program Office(r)
AL1.18. <u>ALOS.</u>	Average Length of Stay
AL1.19. <u>AMA.</u>	Against Medical Advice
AL1.20. <u>AMAL.</u>	Authorized Medical Allowance Lists
AL1.21. <u>APG.</u>	Ambulatory Patient Group
AL1.22. <u>APN.</u>	Advanced Practice Nurse
AL1.23. <u>APU.</u>	Ambulatory Procedure Unit
AL1.24. <u>APV.</u>	Ambulatory Patient Visit
AL1.25. <u>ARC.</u>	Alcoholism Rehabilitation Center
AL1.26. <u>ART.</u>	Accredited Records Technician
AL1.27. <u>ASBBC.</u>	Armed Services Blood Bank Center
AL1.28. <u>ASBP.</u>	Armed Services Blood Program
AL1.29. <u>ASBPD.</u>	Armed Services Blood Product Depot
AL1.30. <u>ASBPO.</u>	Armed Services Blood Program Office
AL1.31. <u>ASDC.</u>	Automated Source Data Collection
AL1.32. <u>ASF.</u>	Aeromedical Staging Flight or Facility
AL1.33. <u>ASP.</u>	Additional Special Pay
AL1.34. <u>ASWBPL.</u>	Armed Services Whole Blood Processing Laboratory

AL1.35. <u>AT</u> .	Annual Training
AL1.36. <u>ATC</u> .	Air Transportable Clinic
AL1.37. <u>ATH</u> .	Air Transportable Hospital
AL1.38. <u>ATLS</u> .	Advanced Trauma Life Support
AL1.39. <u>AQCESS</u> .	Automated Quality of Care Evaluation Support System
AL1.40. <u>AVG</u> .	Ambulatory Visit Group
AL1.41. <u>AWOL</u> .	Absent Without Leave
AL1.42. <u>AWU</u> .	Ambulatory Work Unit
AL1.43. <u>BDC</u> .	Blood Donor Center
AL1.44. <u>BLS</u> .	Basic Life Support
AL1.45. <u>BOD</u> .	Beneficial Occupancy Date
AL1.46. <u>BOQ</u> .	Base Officers' Quarters
AL1.47. <u>BPR</u> .	Business Process Reengineering
AL1.48. <u>BSN</u> .	Bachelor of Science in Nursing
AL1.49. <u>CAPOC</u> .	Computer-Assisted Processing of Cardiology
AL1.50. <u>CAPOC I</u> .	Computer-Assisted Processing of Cardiograms I
AL1.51. <u>CAPOC II</u> .	Computer-Assisted Processing of Cardiograms II
AL1.52. <u>CAT</u> .	Computed Axial Tomography
AL1.53. <u>CBPR</u> .	Computer-Based Patient Record
AL1.54. <u>CCC-A</u> .	Certificate of Clinical Competence in Audiology
AL1.55. <u>CCC-SLP</u> .	Certificate of Clinical Competence in Speech & Language Pathology
AL1.56. <u>CCD</u> .	Contract Completion Date
AL1.57. <u>CCEP</u> .	Comprehensive Clinical Evaluation Program
AL1.58. <u>CCQAS</u> .	Centralized Credentialing and Quality Assurance System
AL1.59. <u>CCU</u> .	Coronary Care Unit
AL1.60. <u>CDC</u> .	Centers for Disease Control and Prevention
AL1.61. <u>CDIP</u> .	CHAMPUS Data Integration Program

AL1.62. <u>CDIS.</u>	CHAMPUS Detail Information System
AL1.63. <u>CEIS.</u>	Corporate Executive Information System
AL1.64. <u>CHAMPUS.</u>	Civilian Health and Medical Program of the Uniformed Services
AL1.65. <u>CHAMPVA.</u>	Civilian Health and Medical Program of the Department of Veterans Affairs
AL1.66. <u>CHCC.</u>	Comprehensive Health Care Clinic
AL1.67. <u>CHCS.</u>	Composite Health Care System
AL1.68. <u>CHCSII.</u>	Composite Health Care System II
AL1.69. <u>CIO.</u>	Chief Information Officer
AL1.70. <u>CIS.</u>	Clinical Information System
AL1.71. <u>CIW.</u>	Clinical Integrated Workstation
AL1.72. <u>CIW-A.</u>	Clinical Integrated Workstation-Ambulatory
AL1.73. <u>CLV.</u>	Composite Lab Value
AL1.74. <u>CMI.</u>	Case Mix Index
AL1.75. <u>CMIS.</u>	CHAMPUS Management Information System
AL1.76. <u>CNM.</u>	Certified Nurse Midwife
AL1.77. <u>CONUS.</u>	Continental United States
AL1.78. <u>COR.</u>	Close Observation Room
AL1.79. <u>COTA.</u>	Certified Occupational Therapy Assistant
AL1.80. <u>CPD.</u>	Central Processing and Distribution
AL1.81. <u>CPHA.</u>	Commission of Professional and Hospital Activities
AL1.82. <u>CPhT.</u>	Certified Pharmacy Technician
AL1.83. <u>CPNP.</u>	Certified Pediatric Nurse Practitioner
AL1.84. <u>CPR.</u>	Cardiopulmonary Resuscitation
AL1.85. <u>CPT.</u>	Current Procedural Terminology
AL1.86. <u>CRNA.</u>	Certified Registered Nurse Anesthetist
AL1.87. <u>CRO.</u>	Carded for Record Only

AL1.88. <u>CRTS.</u>	Casualty Receiving and Treatment Ship
AL1.89. <u>CS.</u>	Clinical Services
AL1.90. <u>CSH.</u>	Combat Support Hospital
AL1.91. <u>CSS.</u>	Clinical Support Staff
AL1.92. <u>DASD.</u>	Deputy Assistant Secretary of Defense
AL1.93. <u>DBMIS.</u>	Defense Blood Management Information System
AL1.94. <u>DBSS.</u>	Defense Blood Standard System
AL1.95. <u>DC.</u>	Doctor of Chiropractic
AL1.96. <u>DDS.</u>	Doctor of Dental Surgery
AL1.97. <u>DDSS.</u>	Defense Dental Standard System
AL1.98. <u>DEERS-ACTUR.</u>	Defense Enrollment Eligibility Reporting System-Automated Central Tumor Registry
AL1.99. <u>DEERS-DNA.</u>	Defense Enrollment Eligibility Reporting System- Deoxyribonucleic Acid
AL1.100. <u>DEERS-Eligibility.</u>	Defense Enrollment Eligibility Reporting System-Eligibility
AL1.101. <u>DEERS-Enrollment.</u>	Defense Enrollment Eligibility Reporting System-Enrollment
AL1.102. <u>DEERS-NAS.</u>	Defense Enrollment Eligibility Reporting System- Nonavailability Statement
AL1.103. <u>DEERS-Panograph.</u>	Defense Enrollment Eligibility Reporting System-Panoral Radiographs
AL1.104. <u>DEERS-RDDB.</u>	Defense Enrollment Eligibility Reporting System-Reportable Diseases Data Base
AL1.105. <u>DENMIS.</u>	Dental Management Information System
AL1.106. <u>DEPMEDS.</u>	Deployable Medical Systems
AL1.107. <u>DHP.</u>	Defense Health Program
AL1.108. <u>DMAC.</u>	Defense Medical Advisory Council
AL1.109. <u>DMD.</u>	Doctor of Medical Dentistry

AL1.110. <u>DMIM.</u>	Defense Medical Information Management
AL1.111. <u>DMIS.</u>	Defense Medical Information System
AL1.112. <u>DMIS ID.</u>	Defense Medical Information System Identification Code
AL1.113. <u>DMFO.</u>	Defense Medical Facilities Office
AL1.114. <u>DMHRS.</u>	Defense Medical Human Resources System
AL1.115. <u>DMLSS.</u>	Defense Medical Logistics Standard System
AL1.116. <u>DMRIS.</u>	Defense Medical Regulating Information System
AL1.117. <u>DNBI.</u>	Disease Non-Battle Injury
AL1.118. <u>DNR.</u>	Do Not Resuscitate
AL1.119. <u>DO.</u>	Doctor of Osteopathy
AL1.120. <u>DOA.</u>	Dead on Arrival
AL1.121. <u>DOB.</u>	Date of Birth
AL1.122. <u>DMERB.</u>	DoD Medical Examination Review Board
AL1.123. <u>DOW.</u>	Died of Wounds
AL1.124. <u>DPDB.</u>	Defense Practitioner Data Bank
AL1.125. <u>DPM.</u>	Doctor of Podiatric Medicine
AL1.126. <u>DPHARM.</u>	Doctor of Pharmacology
AL1.127. <u>DQM.</u>	Data Quality Manager
AL1.128. <u>DRG.</u>	Diagnosis-Related Group
AL1.129. <u>DSS.</u>	Decision Support System
AL1.130. <u>DTF.</u>	Dental Treatment Facility
AL1.131. <u>DTR.</u>	Dental Treatment Room
AL1.132. <u>DVM.</u>	Doctor of Veterinary Medicine
AL1.133. <u>EA.</u>	Executive Agent
AL1.134. <u>EAS.</u>	Expense Assignment System
AL1.135. <u>EBC.</u>	Enrollment-Based Capitation
AL1.136. <u>ECODS.</u>	Executive Committee of Dental Staff
AL1.137. <u>ECOMS.</u>	Executive Committee of Medical Staff

AL1.138. <u>EIS.</u>	Executive Information System
AL1.139. <u>EMS.</u>	Emergency Medical Services
AL1.140. <u>EMT.</u>	Emergency Medical Technician
AL1.141. <u>EPTS.</u>	Existed Prior to Service
AL1.142. <u>ESRD.</u>	End-Stage Renal Disease
AL1.143. <u>FAP.</u>	Financial Assistance Program
AL1.144. <u>FDA.</u>	Food and Drug Administration
AL1.145. <u>FH.</u>	Fleet Hospital
AL1.146. <u>FMP.</u>	Family Member Prefix
AL1.147. <u>FTE.</u>	Full-Time Equivalent
AL1.148. <u>FTTD.</u>	Full-Time Training Duty
AL1.149. <u>FY.</u>	Fiscal Year
AL1.150. <u>FYDP.</u>	Future Years Defense Program
AL1.151. <u>GME.</u>	Graduate Medical Education
AL1.152. <u>GPMRC.</u>	Global Patient Movement Requirements Center
AL1.153. <u>HA.</u>	Health Affairs
AL1.154. <u>HBA.</u>	Health Benefits Advisor
AL1.155. <u>HB&P.</u>	Health Budgets and Programs
AL1.156. <u>HCF.</u>	Health Care Finder
AL1.157. <u>HCFA.</u>	Health Care Financing Administration
AL1.158. <u>HCI.</u>	Health Care Institution
AL1.159. <u>HCP.</u>	Health Care Provider
AL1.160. <u>HCPCS.</u>	Health Care Financing Administration's Common Procedural Coding System
AL1.161. <u>HFO.</u>	Health Facilities Office
AL1.162. <u>HIM.</u>	Health Information Manager
AL1.163. <u>HIS.</u>	Hospital Information System
AL1.164. <u>HMO.</u>	Health Maintenance Organization
AL1.165. <u>HSF.</u>	Health Services Financing

AL1.166. <u>HSO&R.</u>	Health Services Operations and Readiness
AL1.167. <u>ICD-9-CM.</u>	International Classification of Diseases, 9th Revision-Clinical Modification
AL1.168. <u>ICU.</u>	Intensive Care Unit
AL1.169. <u>IDC.</u>	Independent Duty Corpsman
AL1.170. <u>IDS.</u>	Integrated Delivery System
AL1.171. <u>IG.</u>	Inspector General
AL1.172. <u>III.</u>	Incapacitating Illness or Injury
AL1.173. <u>IPA.</u>	Independent Practice Association
AL1.174. <u>ISP.</u>	Incentive Special Pay
AL1.175. <u>ITR.</u>	Inpatient Treatment Record
AL1.176. <u>IWU.</u>	Inpatient Work Unit
AL1.177. <u>JBPO.</u>	Joint Blood Program Office(r)
AL1.178. <u>JCAHO.</u>	Joint Commission on Accreditation of Healthcare Organizations
AL1.179. <u>JMRO.</u>	Joint Medical Regulating Office
AL1.180. <u>KIA.</u>	Killed in Action
AL1.181. <u>LA.</u>	Lead Agent
AL1.182. <u>LCSW.</u>	Licensed Clinical Social Worker
AL1.183. <u>LIP.</u>	Licensed Independent Practitioner
AL1.184. <u>LOD.</u>	Line of Duty
AL1.185. <u>LOE.</u>	Level of Effort
AL1.186. <u>LOS.</u>	Length of Stay
AL1.187. <u>LPN.</u>	Licensed Practical Nurse
AL1.188. <u>LVN.</u>	Licensed Vocational Nurse
AL1.189. <u>MAF.</u>	Man-Hour Availability Factor
AL1.190. <u>MAPS.</u>	Manpower Analysis and Planning System

AL1.191. <u>MASS.</u>	Medical Analysis Support System
AL1.192. <u>MCO.</u>	Managed Care Organization
AL1.193. <u>MCQA.</u>	Managed Care Query Application
AL1.194. <u>MCS.</u>	Managed Care Support
AL1.195. <u>MD.</u>	Doctor of Medicine
AL1.196. <u>MDC.</u>	Major Diagnostic Category
AL1.197. <u>MDIS.</u>	Medical Diagnostic Imaging System
AL1.198. <u>MEB.</u>	Medical Evaluation Board
AL1.199. <u>MEPRS.</u>	Medical Expense and Performance Reporting System
AL1.200. <u>MEPRS-EAS II.</u>	Medical Expense and Performance Reporting System-Expense Assignment System II
AL1.201. <u>MEPRS-EAS III.</u>	Medical Expense and Performance Reporting System-Expense Assignment System III
AL1.202. <u>MEQS.</u>	Medical Expense and Performance Reporting System Executive Query System
AL1.203. <u>MHCAC.</u>	Military Health Care Advisory Council
AL1.204. <u>MHCMIS.</u>	Military Health Care Management Information System
AL1.205. <u>MHS.</u>	Military Health System
AL1.206. <u>MICU.</u>	Medical Intensive Care Unit
AL1.207. <u>MIA.</u>	Missing in Action
AL1.208. <u>MILCON.</u>	Military Construction
AL1.209. <u>MLT.</u>	Medical Laboratory Technician
AL1.210. <u>MOH.</u>	Masters in Occupational Health
AL1.211. <u>MOT.</u>	Masters in Occupational Therapy

AL1.212. <u>MOU</u> .	Memorandum of Understanding
AL1.213. <u>MPH</u> .	Masters in Preventive Health
AL1.214. <u>MRA</u> .	Medical Records Administrator
AL1.215. <u>MRI</u> .	Magnetic Resonance Imaging
AL1.216. <u>MSN</u> .	Masters of Science Nursing
AL1.217. <u>MSP</u> .	Multi-Year Special Pay
AL1.218. <u>MSPT</u> .	Masters of Science in Physical Therapy
AL1.219. <u>MSW</u> .	Masters of Social Work
AL1.220. <u>MSDS</u> .	Material Safety Data Sheet
AL1.221. <u>MT</u> .	Medical Technologist
AL1.222. <u>MTF</u> .	Military Treatment Facility
AL1.223. <u>MWU</u> .	Medical Work Unit
AL1.224. <u>NADD</u> .	Non-Active Duty Dependent
AL1.225. <u>NAS</u> .	Nonavailability Statement
AL1.226. <u>NATO</u> .	North Atlantic Treaty Organization
AL1.227. <u>NCCPA</u> .	National Commission on Certification of Physician Assistants
AL1.228. <u>NCHS</u> .	National Center for Health Statistics
AL1.229. <u>NFH</u> .	Nonfederal Hospital
AL1.230. <u>NICU</u> .	Neonatal Intensive Care Unit
AL1.231. <u>NMIS</u> .	Nutrition Management Information System
AL1.232. <u>NOAA</u> .	National Oceanic and Atmospheric Association
AL1.233. <u>NOK</u> .	Next of Kin
AL1.234. <u>NPDB</u> .	National Practitioner Data Bank
AL1.235. <u>NPRC</u> .	National Personnel Records Center
AL1.236. <u>OASD(HA)</u> .	Office of the Assistant Secretary of Defense (Health Affairs)
AL1.237. <u>OBD</u> .	Occupied Bed Day
AL1.238. <u>OCONUS</u> .	Outside the Continental United States

AL1.239. <u>OD.</u>	Doctor of Optometry
AL1.240. <u>OFMDP.</u>	OCONUS Family Member Dental Program
AL1.241. <u>OHMIS.</u>	Occupational Health Management Information System
AL1.242. <u>OSD.</u>	Office of the Secretary of Defense
AL1.243. <u>OSHA.</u>	Occupational Safety and Health Administration
AL1.244. <u>OTR.</u>	Outpatient Treatment Record
AL1.245. <u>OTR/L.</u>	Occupational Therapist, Registered/Licensed
AL1.246. <u>OWCP.</u>	Office of Worker's Compensation Program
AL1.247. <u>PA.</u>	Physician Assistant
AL1.248. <u>PALS.</u>	Pediatric Advanced Life Support
AL1.249. <u>PARRTS.</u>	Patient Accounting and Reporting Realtime Tracking System
AL1.250. <u>PCE.</u>	Potentially Compensible Event
AL1.251. <u>PCM.</u>	Primary Care Manager
AL1.252. <u>PCS.</u>	Permanent Change of Station
AL1.253. <u>PCM.</u>	Primary Care Manager
AL1.254. <u>PDASD.</u>	Principal Deputy Assistant Secretary of Defense
AL1.255. <u>PDRL.</u>	Permanent Disability Retired List
AL1.256. <u>PEB.</u>	Physical Evaluation Board
AL1.257. <u>PEC.</u>	Pharmacoeconomic Center
AL1.258. <u>PFPP.</u>	Partnership for Peace
AL1.259. <u>PHD.</u>	Doctor of Philosophy
AL1.260. <u>PharmD.</u>	Doctor of Pharmacy
AL1.261. <u>PHS.</u>	Public Health Service
AL1.262. <u>PMI.</u>	Patient Movement Item
AL1.263. <u>PMPM.</u>	Per Member Per Month
AL1.264. <u>POS.</u>	Point of Service Plan
AL1.265. <u>PPBS.</u>	Planning, Programming, Budgeting System

AL1.266. <u>PPC</u> .	Policy and Planning Coordination
AL1.267. <u>PPO</u> .	Preferred Provider Organization
AL1.268. <u>PT</u> .	Physical Therapist
AL1.269. <u>PTA</u> .	Physical Therapist Assistant
AL1.270. <u>PV</u> .	Prime Vendor
AL1.271. <u>PWS</u> .	Performance Work Statement
AL1.272. <u>QA/RM</u> .	Quality Assurance/Risk Management
AL1.273. <u>RAC</u> .	Risk Assessment Code
AL1.274. <u>RAPS</u> .	Resource Analysis and Planning System
AL1.275. <u>RCMAS-OSE</u> .	Retrospective Case Mix Analysis System-Open Systems Environment
AL1.276. <u>RCMI</u> .	Relative Case Mix Index
AL1.277. <u>RD</u> .	Registered Dietitian
AL1.278. <u>RN</u> .	Registered Nurse
AL1.279. <u>RPh</u> .	Registered Pharmacist
AL1.280. <u>RRA</u> .	Registered Record Administrator
AL1.281. <u>RTF</u> .	Residential Treatment Facility
AL1.282. <u>RWP</u> .	Relative Weighted Product
AL1.283. <u>SADR</u> .	Standard Ambulatory Data Record
AL1.284. <u>SCU</u> .	Special Care Unit
AL1.285. <u>SDS</u> .	Same Day Surgery
AL1.286. <u>SNF</u> .	Skilled Nursing Facility
AL1.287. <u>SNPMIS</u> .	Special Needs Program Management Information System
AL1.288. <u>STANAG</u> .	Standardization Agreement
AL1.289. <u>STS</u> .	Specialized Treatment Service
AL1.290. <u>TA</u> .	Table of Allowances
AL1.291. <u>TACC</u> .	Tanker Airlift Control Center
AL1.292. <u>TAD</u> .	Temporary Additional Duty (NAVY)

AL1.293. <u>TAMMIS</u> .	Theater Army Medical Management Information System
AL1.294. <u>TCSDP</u> .	Triservice CHAMPUS Statistical Database Program
AL1.295. <u>TDA</u> .	Table of Distribution and Allowances
AL1.296. <u>T-DBSS</u> .	Theater-Defense Blood Standard System
AL1.297. <u>TDRL</u> .	Temporary Disability Retired List
AL1.298. <u>TDY</u> .	Temporary Duty
AL1.299. <u>TEC</u> .	TRICARE Executive Committee
AL1.300. <u>TFMDP</u> .	TRICARE- Active Duty Family Member Dental Plan
AL1.301. <u>THCSSR</u> .	Total Health Care Support Resource Requirements Allocation Plan
AL1.302. <u>T-Med</u> .	Telemedicine
AL1.303. <u>TMC</u> .	Troop Medical Clinic
AL1.304. <u>TMIP</u> .	Theater Medical Information Program
AL1.305. <u>TOC</u> .	TRICARE Outpatient Clinic
AL1.306. <u>TO&E</u> .	Table of Organization and Equipment
AL1.307. <u>TOP</u> .	Triple Option Plan
AL1.308. <u>TPCP</u> .	Third Party Collection Program
AL1.309. <u>TPMRC</u> .	Theater Patient Movement Requirements Center
AL1.310. <u>TPOCS</u> .	Third Party Outpatient Collection System
AL1.311. <u>TRC</u> .	TRICARE Readiness Committee
AL1.312. <u>TSO</u> .	TRICARE Support Office
AL1.313. <u>TRAC2ES</u> .	TRANSCOM Regulating and Command and Control Evacuation System
AL1.314. <u>UBU</u> .	Unified Biostatistical Utility
AL1.315. <u>UM</u> .	Utilization Management
AL1.316. <u>USCG</u> .	United States Coast Guard

AL1.317. <u>USTF.</u>	Uniformed Services Treatment Facility
AL1.318. <u>USUHS.</u>	Uniformed Services University of the Health Sciences
AL1.319. <u>VA.</u>	Veterans Affairs, Department of
AL1.320. <u>VAMC.</u>	Veterans Affairs Medical Center
AL1.321. <u>VSI.</u>	Very Seriously Ill
AL1.322. <u>VSP.</u>	Variable Special Pay
AL1.323. <u>VTC.</u>	Video Teleconference
AL1.324. <u>WAM.</u>	Workload Assignment Module
AL1.325. <u>WCD.</u>	Work Center Description
AL1.326. <u>WHNP.</u>	Women Health Nurse Practitioner
AL1.327. <u>WIA.</u>	Wounded in Action
AL1.328. <u>WMSN-D.</u>	Workload Management System for Nursing-DoD
AL1.329. <u>WWR.</u>	Worldwide Workload Report
AL1.330. <u>WWW.</u>	World Wide Web

P1. PART 1
GLOSSARY A

P1.1. TERMINOLOGY

P1.1.1. ABSENT SICK. An Active Duty (Army, Navy, Air Force, and Marine Corps) member hospitalized in other than an U.S. Military Treatment Facility and for whom administrative responsibility has been assigned to an U.S. Military Treatment Facility (MTF).

P1.1.1.1. ABSENT SICK MOVED TO MTF. Patients who have been moved from a non-U.S. military facility to a MTF.

P1.1.1.2. TOTAL ABSENT SICK. Patients who are absent sick the total time (never moved to a MTF).

P1.1.2. ACCOUNT CODE, MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM. Accounts established that provide a title of and a description for each of the functions and activities performed in a Military Treatment Facility (MTF). The account codes will be treated as accounting entities and used in the step-down process. The step-down process is established by DoD 6010.13-M (reference (a)). All MEPRS account codes will not be considered a work center, but all work centers will be a MEPRS account code. (See definition of WORK CENTER.)

P1.1.3. ACCOUNTING ENTITY. A subdivision of an Agency (an organization) for which a separate, complete system of accounts is maintained. The system of accounts will include the balances of appropriations (fund resources), and such balances, not part of appropriation balances, for which the accounting entity is administratively held accountable (assets and liabilities). Asset and liability balances imply determining the results of operations and the operating expense accounts.

P1.1.4. ACCREDITATION. A formal process by which an Agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards.

P1.1.5. ACCREDITED RECORDS TECHNICIAN. An accredited records technician performs technical medical record functions in various health care facilities. These functions include coding diseases and operations, maintaining

health record indexes, transcribing medical reports, and controlling the usage and release of health information.

P1.1.6. ACCRUAL BASIS OF ACCOUNTING. A system of accounting that consists of recognizing in the books and records of the accounting entity the significant and accountable aspects of financial transactions or events as they occur. That is, to recognize revenues when earned and expenses when incurred. For a more detailed discussion of this accounting practice, see DoD 6010.13-M (reference (a)).

P1.1.7. ACTIVE DUTY. Full-time duty in the active military service of the United States. It includes Federal duty of the active list (for National Guard personnel), full-time training duty, annual training, and attendance while in the active military Service at a school designated as a service school by law or the Secretary of the Military Department concerned. As it relates to medical care, the term Active Duty does not include Active Duty for Training.

P1.1.8. ACTIVE DUTY FOR TRAINING. A tour of active duty that is used for training members of the Reserve components to provide trained units and qualified persons to fill the needs of the Armed Forces in time of war or national emergency and such other times as the national security requires. The tour of duty is under orders, which provide for return to non-active status when the period of active duty for training is completed. It includes annual training, special tours of active duty for training, school tours, and the initial tour performed by non-prior service enlistees.

P1.1.9. ACTIVE DUTY MEMBER. A person appointed, enlisted, inducted, or called, ordered, or conscripted into a military service. Active duty members include members of the National Guard or Reserve who are ordered to active duty or active duty for training.

P1.1.10. ACUTE CARE. A pattern of healthcare in which the patient is treated for an acute episode of illness for the sequel of an accident of other trauma or during recovery for surgery. It may involve intensive care and is often necessary for only a short period of time.

P1.1.11. ACUTE CARE SERVICES. Coordinated services related to the examination, diagnosis, care, treatment, and disposition of acute episodes of illnesses.

P1.1.12. ACUTE DISEASE. Disease characterized by a single episode of fairly short duration, usually less than 30 days, and from which the patient can be

expected to return to his or her normal or previous state and level of activity.

P1.1.13. ADDITIONAL DIAGNOSIS. Any diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the physician considers of sufficient significance to warrant inclusion for investigative medical studies.

P1.1.14. ADDITIONAL SPECIAL PAY (ASP). Medical and dental officers, not undergoing internship or initial residency training, and who execute a written agreement to remain on active duty for a period of not less than one year, are entitled to receive an annual ASP bonus at the rates prescribed by 37 U.S.C. (reference (b)). ASP is intended to provide an incentive for all medical and dental officers to remain on active duty, regardless of specialty. Certain Reservists may be eligible under Section 302f of reference (b).

P1.1.15. ADDITIVE (MANPOWER). Work done that is not part of the basic work center description and therefore not part of the basic work center manpower standard.

P1.1.16. ADJUSTED AVERAGE PER CAPITA COST. Used by the Health Care Financing Administration (HCFA) as the calculation for the funds required to care for Medicare recipients; calculated by county for a 5-year moving average and based on 95 percent of "fee-for-service" Medicare costs for that county; the standard monthly payment to a Federally-qualified Medicare HMO contractor containing 122 actuarial stratifications for age, sex, Medicaid eligibility, institutional status, end-stage renal disease (ESRD), and the patient's eligibility for Part A and Part B of Medicare. (Reference DoD Medicare demonstration, pending the outcome of negotiations or legislation.)

P1.1.17. ADJUSTMENT. The process of adding, subtracting, or otherwise modifying MTF incurred expenses into an array or format that reflects the Medical Expense and Performance Reporting System recognized expenses and statistics, as prescribed by DoD 6010.13-M (reference (a)).

P1.1.18. ADMISSION. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day on which the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. When reporting admission data always exclude: total absent-sick

patients, carded-for-record only (CRO) cases, and transient patients. Admission data can be reported in three ways:

P1.1.18.1. ADMISSION-LIVE BIRTH. The admission of a live birth in a MTF. The admission of a live birth is deemed to occur at the time of birth.

P1.1.18.2. ADMISSION-EXCLUDING LIVE BIRTH. Admissions minus Admission-Live Birth.

P1.1.18.3. ADMISSION-TOTAL. All admissions excluding the three exclusions cited in P1.1.18., above.

P1.1.19. ADMISSION AND DISPOSITION REPORT. A daily hospital report reflecting patients gained and lost, changes in status, the numerical strengths of transient patients and boarders, and other transactions such as CRO cases, interward transfers, and passes.

P1.1.20. ADMITTING DIAGNOSIS. The immediate condition that caused the patient's admission to the MTF for the current, uninterrupted period of hospitalization.

P1.1.21. AEROMEDICAL EVACUATION. The movement of patients under medical supervision to and between Military Treatment Facilities by military or military chartered air transportation. See also: TRANSIENT PATIENT.

P1.1.22. AEROMEDICAL EVACUATION CONTROL CENTER. The control facility established by the commander of an air transport division, air force or air command. It operates in conjunction with the command movement control center and coordinates overall medical requirements with airlift capability. It also assigns medical missions to the appropriate aeromedical evacuation elements in the system and monitors patient movement activities.

P1.1.23. AEROMEDICAL EVACUATION CONTROL OFFICER. An officer of the air transport force air command controlling the flow of patients by air.

P1.1.24. AEROMEDICAL EVACUATION COORDINATING OFFICER. An officer of an originating, intransit, or destination medical facility and/or establishment who coordinates aeromedical evacuation activities of the facility and/or establishment.

P1.1.25. AEROMEDICAL EVACUATION OPERATIONS OFFICER. An

officer of the air transport force or command who is responsible for activities relating to planning and directing aeromedical evacuation operations, maintaining liaison with medical airlift activities concerned, operating an Aeromedical Evacuation Control Center, and otherwise coordinating aircraft and patient movements.

P1.1.26. AEROMEDICAL EVACUATION SYSTEM. A system that provides control of patient movement by air transport, specialized medical attendants and equipment for inflight medical care, facilities on or in the vicinity of air strips and air bases, for the limited medical care of intransit patients entering, en route via, or leaving the system, and communication with originating, destination, and enroute medical facilities concerning patient transportation.

P1.1.27. AEROMEDICAL EVACUATION UNIT. An operational medical organization concerned primarily with the management and control of patients being transported via an aeromedical evacuation system or system level.

P1.1.28. AEROMEDICAL STAGING FACILITY. A medical facility that has aeromedical staging beds, located on or in the vicinity of an emplaning or deplaning air base or air strip that provides reception, administration, processing, ground transportation, feeding and limited medical care for patients entering or leaving an aeromedical evacuation system. Transient patient workload is reported as the number of patients processed by staging facilities.

P1.1.29. AIR TRANSPORTABLE UNIT. A unit other than airborne whose equipment is adapted for air movement.

P1.1.30. ALCOHOLISM REHABILITATION CENTER. A facility with an organized professional and trained staff that provides treatment and rehabilitative services to patients, and to their families, with a primary diagnosis of alcoholism and/or other substance abuse.

P1.1.31. ALTERNATIVE DELIVERY SYSTEMS. Healthcare delivery modes that provide an alternative to traditional fee-for-service by integrating financing issues with patient care services. Anything done outside the inpatient setting or the physician's office is based on a payment structure other than an fee-for-service medicine used to be considered "alternative." However, today's rapidly changing healthcare environment with the growth of HMO's, PPOs and other managed care entities, has made the "alternative" more like the norm. The shape of healthcare reform also indicates this trend will continue throughout the decade.

P1.1.32. ALTERNATIVE PRIMARY CARE PRACTITIONER. These non-physician care givers, such as nurse practitioners, midwives, nurses, physician assistants and other extenders, provide primary medical care services at locations varying from rural health clinics to physician offices. The range of primary care services they can deliver is defined by State law, as is the level of physician supervision they require. The current shortage of primary care physicians and the increased emphasis on primary care delivery demands that new ways and means of care provision be examined.

P1.1.33. AMBULATORY CARE. The examination, diagnosis, treatment and proper disposition of all categories of eligible inpatients and outpatients presenting themselves to the various ambulatory care specialty and/or subspecialty clinics.

P1.1.34. AMBULATORY CARE CLINIC. An entity or unit of a medical or dental treatment facility that is organized and staffed to provide medical treatment in a particular specialty and/or subspecialty; and holds regular hours in a designated place.

P1.1.35. AMBULATORY DATA SYSTEM. An interim AIS to validly collect ambulatory encounter data using optimal mark reader technology.

P1.1.36. AMBULATORY PATIENT VISIT. A term that refers to immediate (day of procedure), pre-procedure and immediate post-procedure care in an ambulatory setting. Care is required in the facility for less than 24 hours.

P1.1.37. AMBULATORY PROCEDURE UNIT. A term that refers to a location or organization within an MTF (or freestanding outpatient clinic).

P1.1.38. AMBULATORY SURGERY PROGRAM. A facility program for the performance of elective surgical procedures on patients who are admitted and discharged on the day of surgery.

P1.1.39. AMERICAN ASSOCIATION OF BLOOD BANKS (AABB). A civilian blood banking association that sets policies and standards for blood banks within the United States. The AABB also publishes Standards for Blood Banks and Transfusion Services and a Technical Manual, both of which have been adopted for peacetime use by the Military Services as official publications.

P1.1.40. AMERICAN MANAGED CARE AND REVIEW ASSOCIATION. A trade association representing managed care indemnity plans, PPOs, MCOs, and

HMOs. It tends to focus on issues important to open panel types of plans.

P1.1.41. AMOUNT ALLOWED. The amount on a claim that has been allowed by the FI/Contractor for services and supplies as justifiably reasonable. These allowable amounts may vary depending on the area of the country and will also vary depending upon whether or not the provider is an authorized CHAMPUS provider. A claim will have a Total Amount Allowed for the total of items on the claim and also an individual breakdown of the Amount Allowed per Service, etc.

P1.1.42. AMOUNT BILLED. The amount billed on a claim for services and supplies is the provider's charge(s) for healthcare treatment rendered. These amounts will vary depending on the physician, the area of the country, and whether or not the provider is an authorized CHAMPUS provider having pre-agreed to charge certain rates. A claim will have a Total Amount Billed for the total of items on the claim and also an individual breakdown of the Amount Billed per Service, etc.

P1.1.43. AMOUNT PAID BY GOVERNMENT AND/OR GOVERNMENT CONTRACTOR. The amount on a claim to be paid by the Government and /or Government contractor. A professional services claim has only a total amount for amounts to be paid by the Government and/or Government contractor, so individual breakdowns for each service must be prorated using amounts allowed for the claim.

P1.1.44. AMOUNT PAID BY OTHER SOURCES. The amount on a claim to be paid by other sources such as other insurance companies. A professional services claim has only a total amount for amounts to be paid by other sources, so individual breakdowns for each service must be prorated using amounts allowed for the claim.

P1.1.45. AMOUNT PAID BY PATIENT. The amount on a claim that is to be paid by the beneficiary and/or sponsor, after the deduction of all amounts due by other sources (other insurance companies) and amounts to be paid by the Government and/or Government contractor. The patient paid amount will include patient deductibles due from the claim, patient cost shares, etc. A professional services claim has only a total amount due from the patient, so individual breakdowns for each service must be prorated using amounts allowed for the claim.

P1.1.46. ANCILLARY. The tests and procedures ordered by healthcare providers to assist in patient diagnosis or treatment (radiology, laboratory, pathology, etc.).

P1.1.47. ANCILLARY SERVICES. Those services that participate in the care

of patients principally by assisting and augmenting the talents of attending healthcare providers in diagnosing and treating human ills. Ancillary services generally do not have primary responsibility for the clinical management of patients.

P1.1.48. ANESTHESIA MINUTES OF SERVICE. The elapsed time during any procedure involving an anesthesiologist and/or anesthesiologist multiplied by the number of anesthesiologists and/or anesthesiologists, including residents and student nurse anesthesiologists (when replacing a person trained in anesthesia) participating in the procedure.

P1.1.49. ANTITRUST LAWS. A group of statutes that outline fair trade practices in a competitive marketplace. The chief enforcer of these laws is the Federal Trade Commission (FTC). The FTC is a five-person administrative Agency that conducts investigations, announces rules and regulations and enforces statutory provisions prohibiting unfair trade and competitive practices (especially in the instances of collaboration, merger or acquisition). As many health systems move toward collaboration, combinations and closer relations, the presence of antitrust liability will have a definite impact on the future of healthcare delivery.

P1.1.50. APPOINTMENT STATUS. A term that reflects the relationship of the provider to the medical staff. Privileges define the limits of patient care services the provider may render.

P1.1.51. APPROPRIATE AND NECESSARY HEALTH SERVICES. The services needed to maintain an enrollee in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services and preventive health services delivered by authorized practitioners acting within their scope of practice.

P1.1.52. AREA JOINT BLOOD PROGRAM OFFICE. A tri-Service staffed office responsible for joint blood product management in an assigned geographic area within a Unified Command. Each area includes at least one blood transshipment center (BTC) and any number of blood supply units (BSU) and medical treatment elements (MTE).

P1.1.53. ARMED FORCES INSTITUTE of PATHOLOGY. A tri-Service Agency with a mission of consultation and research in the field of pathology for the Department of Defense.

P1.1.54. ARMED FORCES HEALTH PROFESSIONS SCHOLARSHIP

PROGRAM (AFHPSP). As prescribed under Chapter 105, of 10 U.S.C. (reference (c)), the AFHPSP was established by an Act of Congress in 1972 for the purpose of obtaining adequate numbers of commissioned officers on active duty who are qualified in the various health professions. Under the program, the Department of Defense pays for individuals to attend medical, dental, or some other health professions school, in exchange for a commitment to serve on active duty as a commissioned officer for a prescribed period of time.

P1.1.55. ARMED FORCES OF THE UNITED STATES. A term used to denote collectively all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

P1.1.56. ARMED SERVICES BLOOD PROGRAM. The combined military blood programs of the individual Services and the Unified Commands in an integrated blood products support system.

P1.1.57. ARMED SERVICES BLOOD BANK CENTER (ASBBC). A tri-Service staffed blood bank responsible for the collection and processing of blood products. The ASBBC provides blood products for Military Treatment Facilities of the two or more of the Armed Services.

P1.1.58. ARMED SERVICES BLOOD PRODUCTS DEPOT. The Armed Services Blood Products Depot is DoD Component staffed and responsible for strategic storage of frozen blood products in a Unified Command. Frozen blood products are provided to each command component based on JBPO instructions.

P1.1.59. ARMED SERVICES BLOOD PROGRAM OFFICE (ASBPO). A tri-Service staffed joint health Agency responsible for ensuring implementation of blood program policies established by the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Also, it is responsible for coordination of the blood programs of the Military Services and Unified Commands to affect standardization of policies, procedures and equipment. The ASBPO is the overall DoD manager for blood products (class VIII B) during military contingencies and when directed by appropriate national command authorities, civilian relief efforts.

P1.1.60. ARMED SERVICES WHOLE BLOOD PROCESSING LABORATORY (ASWBPL). A tri-Service staffed organization responsible for central receipt and re-processing of blood products from CONUS blood banks, and shipment of these products to designated unified command Blood Transshipment Centers (BTC).

P1.1.61. ASSIGNED. The state of belonging to a unit and being counted as part of that unit's assigned strength.

P1.1.62. ASSIGNMENT FACTOR. The workload ratio used to distribute costs from one work center to two or more other work centers. The assignment factor quantifies the amount of cost reassigned from the intermediate to the final operating expense accounts. See DoD 6010.13-M (reference (a)).

P1.1.63. ASSIGNMENT OF BENEFITS. The payment of medical benefits directly to a provider of care rather than to a member. It generally requires either a contract between the health plan and the provider, or a written release from the subscriber to the provider allowing the provider to bill the health plan.

P1.1.64. AT RISK PROVIDER. Either the MTF or the Government-selected contractor is a provider at risk for benefit dollars by taking the full financial risk on a prospective basis for the provision of all TRICARE-covered health benefits.

P1.1.65. ATTENDING PHYSICIAN. The physician with defined clinical privileges who has the primary responsibility for diagnosis and treatment of the patient. A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case. There will always be only one primary physician; however, under very extraordinary circumstances, because of the presence of complex, serious and multiple, but related, medical conditions, a patient may have more than one attending physician providing treatment at the same time.

P1.1.66. AUDIT TRAIL VISIT. An audit is a retrospective validation of a patient's episode of care, resulting from a review of the documentation generated by the provider or clinic at the time the care was provided. Audit trail documentation may consist of such things as a log, an appointment schedule, or other lists for selected providers, which lead back to the patient's record. The audit process should include a check of the name of the patient, whether inpatient or outpatient, family member prefix, sponsor's social security number, category of beneficiary, and date of visit, which is then compared to individual patient records to determine if the episode of care was either a valid visit or an occasion of service.

P1.1.67. AUTHENTICATE. A method to denote authorship of an entry made in a patient's medical or dental record by means of a written signature, identifiable initials, a computer key, or a personally-used rubber stamp; also refers to the process

of certifying copies as genuine.

P1.1.68. AUTHORIZED RECORD OF MEDICAL TREATMENT. It includes the medical record and other medical information that may be maintained on an individual evaluated or treated in a Military Treatment Facility or contract facility. Other medical information includes information from contract clinics maintained by an MTF, specialty clinics, or identifiable by patient and/or provider.

P1.1.69. AUTOMATED INFORMATION SYSTEM (AIS). Computer hardware, computer software, telecommunications, information technology, personnel, and other resources that collect, record, process, store, communicate, retrieve, and display information. An AIS can include computer software only, computer hardware only, or a combination of the above. (See DoD Directive 8000.1, reference (d).)

P1.1.70. AUTOMATED SOURCE DATA COLLECTION (ASDC). An automatic data processing capability provided to high volume ancillary services for collection of detailed data required for step-down of costs to requesting work centers.

P1.1.71. AVAILABLE HOURS. Those hours for which pay is earned (regular, overtime, and holiday), which are made available by the presence of an assigned employee for the performance of work center functions, or other medical mission needs.

P1.1.72. AVAILABLE TIME. Those hours worked or expended in support of the healthcare mission.

P1.1.73. AVERAGE DAILY CENSUS. The average number of inpatients, excluding newborns, receiving care each day during a reported period.

P1.1.74. AVERAGE DAILY PATIENT LOAD (ADPL). The average number of inpatients, including live births, in the hospital receiving care each day during a reported period. It includes patients admitted and discharged on the same day. It excludes patients on convalescent leave and patients authorized to subsisting out. (Formula: $ADPL = (\text{Census Bed} + \text{Bassinet Days in period}) / \text{No. of days in period}$.)

P1.1.74.1. AVERAGE DAILY PATIENT LOAD-BASSINET (ADPL-BASS). The average number of live births assigned to a bassinet and receiving care each day during a reported period. (Formula: $ADPL-BASS = \text{Census Bassinet Days in period} / \text{No. days in period}$.)

P1.1.74.2. AVERAGE DAILY PATIENT LOAD-LIVE BIRTH (ADPL-LB). The average number of live births receiving care each day during a reported period. This includes bassinet (Nursery) and bed (NICU) days for the live birth. (Formula: $ADPL-LB = (\text{Census Bed} + \text{Bassinet Days for Live Births in period}) / \text{No. days in period.}$)

P1.1.74.3. AVERAGE DAILY PATIENT LOAD-EXCLUDING LIVE BIRTHS (ADPL-XLB). The average number of inpatients, excluding live births, in the hospital receiving care each day during a reported period. It includes patients admitted and discharged on the same day. (Formula: $ADPL-XLB = \text{Census Bed Days (excluding live births) in period} / \text{No. days in period.}$)

P1.1.75. AVERAGE DAILY PATIENT LOAD INPATIENT (ADPL-IP). The average number of inpatients, excluding live births, in the hospital receiving care each day during a reported period. It includes patients on pass or liberty not in excess of 72 hours and patients admitted and discharged on the same day. It excludes days on convalescent leave, and patients authorized to subsist out. Inpatient ADPL is calculated by dividing the number of inpatient bed days during the period by the total number of days in the report period. (Formula: $ADPL-IP = \text{No. Inpatient bed days in period} / \text{No. days in period.}$)

P1.1.76. AVERAGE DAILY PATIENT LOAD TOTAL (ADPL-TOT). The average number of inpatients, including live births remaining after discharge of the mother, in the hospital receiving care each day during a reported period. It includes patients admitted and discharged on the same day. It excludes newborns, patients on convalescent leave, and patients authorized to subsist out. Total ADPL is calculated by dividing the sum of occupied bed days during the period by the total number of days in the report period. (Formula: $ADPL-TOT = \text{OBDs in period} / \text{No. days in period.}$)

P1.1.77. AVERAGE LENGTH OF STAY (ALOS). The average number of days spent in a Military Treatment Facility by an inpatient. It is derived by dividing the total number of discharge bed + bassinet days generated by the dispositions within a period by those dispositions. This computation excludes patients still occupying beds. The SIDR record will be used to compute the ALOS. The ALOS cannot be computed using Medical Expense and Performance Reporting System (MEPRS) data. The formulas for:

P1.1.77.1. ALOS-BED. = Discharge Bed Days (generated by

dispositions) in the period/ No. Dispositions (excludes live birth) in period.

P1.1.77.2. ALOS-BASSINET. = Discharge Bassinet Days (generated by dispositions) in the period/No. Live Birth Dispositions in period.

P1.1.77.3. ALOS-BED + BASSINET. = (Discharge Bed + Bassinet Days (generated by dispositions) in the period)/No. Dispositions (includes live birth) in period.

P1.1.77.4. ALOS-LIVE BIRTH. = (Discharge Bed + Bassinet Days (generated by live birth dispositions) in the period)/No. Live Birth Dispositions in period.

P2. PART 2
GLOSSARY B

P2.1. TERMINOLOGY

P2.1.1. BAD DEBT EXPENSE. The expenses from patient bills that the provider is unable to collect. Determination of bad debt expense usually is made after services are rendered and after debt collection efforts have failed.

P2.1.2. BALANCE BILLING. The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copays, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).

P2.1.3. BASIS OF VALUATION. The amounts recorded as obligations and accrued expenditures and revenues in accordance with DoD 7220.9-M (reference (e)), and used in recording assets, liabilities, and operating results. Except for material in stock funds and in industrial fund inventories that are revalued at current catalog prices, no revaluation adjustments are made in the accounts maintained by DoD accounting entities. Donated assets are recorded at fair market value, estimated to equal original acquisition costs less accumulated depreciation at the time of acquisition.

P2.1.4. BASSINET. An accommodation with supporting services maintained in the newborn nursery for infants live born in the hospital.

P2.1.5. BASSINET DAY. See: DAYS, BASSINET DAY.

P2.1.6. BASSINET, OPERATING. A bed designed for the care of an infant that is currently set up in the newborn nursery and ready in all respects for use. It must include space, equipment, medical material, ancillary and support services and staff to operate under normal circumstances. Infant Transporters are excluded.

P2.1.7. BASSINET, INACTIVE. A bassinet, in the newborn nursery, designed for the care of an infant that is ready in all respects except for the availability of staff; that is, space, equipment, medical materiel, and ancillary support services have been provided but the bassinet is not staffed to operate under normal

circumstances.

P2.1.8. BATTLE CASUALTY. Any casualty (death, wound, missing, capture, or internment) provided such loss is incurred in action. "In action" characterizes the casualty status as having been the direct result of hostile action; sustained in combat and related thereto; or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. Included are persons killed or wounded mistakenly or accidentally by friendly fire directed at a hostile force or what is thought to be a hostile force. However, not to be considered as sustained in action and thereby not to be interpreted as battle casualties are injuries due to the elements, self-inflicted wounds, and, except in unusual cases, wounds or death inflicted by a friendly force while the individual is in absent-without-leave or dropped-from-rolls status or is voluntarily absent from a place of duty.

P2.1.9. BED, AVAILABLE. An operating bed not currently assigned to a patient.

P2.1.10. BED CONSTRUCTED (Replaces: Normal Bed). A bed originally designed and constructed for the delivery of peacetime inpatient care in a Medical Treatment Facility (MTF); usually spaced on 8-foot centers (approximately 140 - 200 square feet) and furnished with suction, medical gas and nurse call capacity; meets standards applied by common hospital accreditation bodies.

Includes:

- LDRP (combined labor, delivery, recovery and postpartum)
- Special and/or intensive care
- Pediatric cribs set up in patient rooms

Excludes:

- Transient patient beds
- Bassinets
- Incubators
- LDR (combined labor, delivery, recovery not used for postpartum)
- External partnership or external VA bed
- Internal non-DoD bed

P2.1.11. BED, EXPANDED CAPACITY. The total number of beds in an MTF that can be set up in rooms designed for inpatient care when spaced on 6-foot centers (approximately 72 square feet per bed), but with electrical and gas utility support for each bed.

Excludes:

Examination rooms
Physical therapy
Nursery
Space outside the MTF (e.g., hotels, gyms, BOQs, Air Transportable Hospital, Aeromedical Staging Facilities)

P.2.1.12. BED, INACTIVE. A constructed bed ready for peacetime inpatient care to include space, equipment, medical materiel, and ancillary support services but the bed is not staffed to operate under normal circumstances. Beds need not be set up, but must be able to be set up and activated within 72 hours. It includes constructed bed space occupied by another function that could be relocated to other existing space on a permanent basis and continue to operate assigned function (e.g., storage space, office space that could be consolidated, lounge and locker space). It does not include former bed space that has been permanently altered for other use or bed space that cannot be readily reconverted to active bed space.

P.2.1.13. BED, MOBILIZATION/CONTINGENCY CAPACITY. An expanded bed capacity plus the number of beds that can be set up in areas not originally designed for patient care, such as troop billets, hotels, motels, schools and business occupancy space in medical facilities used to support the contingency mission but does not meet the expanded bed definition.

P.2.1.14. BED, OCCUPIED BY TRANSIENT PATIENT. A bed assigned as of midnight to a patient who is being moved between Military Treatment Facilities and who stops over while en route to his or her final destination.

P.2.1.15. BED, OPERATING. A constructed bed in an MTF that is currently staffed, equipped, set up and ready in all respects for peacetime inpatient care.

P.2.1.16. BEDS, TOTAL PEACETIME. The sum of total operating beds and total inactive beds.

P.2.1.17. BED, TRANSIENT PATIENT. A bed that a designated hospital operates for the care of a patient who is being moved between Military Treatment Facilities and who must stop over for a short period of time while enroute to his final destination.

P.2.1.18. BED CAPACITY. The number of available hospital inpatient beds both occupied and vacant on any given day.

P.2.1.19. BED DAY. See: DAYS.

P2.1.20. BEDS, LICENSED. The number of beds that a hospital is licensed, certified, or otherwise authorized and has the capability to operate. That is, space equipment, medical materiel, and ancillary and support services have been provided, but the required staff is not necessarily available. Licensed beds equal the sum of operating beds and inactive beds.

P2.1.21. BENCHMARKING. The comparison of like provider's performance. It is a standard from which to establish what is "quality" medical care and develop measurement from which to evaluate providers and patient outcomes.

P2.1.22. BENEFICIAL OCCUPANCY DATE (BOD). The date on which a facility is available to serve the mission for which it is constructed.

P2.1.23. BENEFICIARY, MEDICAL. An individual who has been determined to be eligible for medical benefits and is therefore authorized treatment in a Military Treatment Facility.

P2.1.24. BENEFICIARY CATEGORY. A grouping of individuals in the same beneficiary class; e.g., active duty, family members of active duty, retired, family members of retired, and so forth.

P2.1.25. BENEFICIARY GROUPS. The combinations of individual Beneficiary Categories grouped together for reporting purposes.

P2.1.26. BILLED BRANCH OF SERVICE (BBS). The branch of Service responsible for the healthcare treatment and/or payment for healthcare of a beneficiary. If the patient resides in a catchment area, the billable branch of service (BBS) is the MTF's branch of Service. If the patient resides in a non-catchment area, then the BBS is the sponsor's branch of Service.

P2.1.27. BILLED MILITARY TREATMENT FACILITY (MTF) CODE (BMC). The MTF (catchment area) responsible for the healthcare treatment and/or payment of healthcare for a beneficiary. If a patient resides in a non-catchment area, the BMC code is zero-filled and financial responsibility reverts to the sponsor's branch of Service.

P2.1.28. BIRTH CERTIFICATE. An official record of an individual birth, certified by a physician, and including birth date, place of birth, parentage, and other required identifying data, filed with the local registrar of vital statistics or with the Department of State for infants born of American parents overseas.

P2.1.29. BLOOD DONOR CENTER (BDC). The location for the collection and processing of blood products.

P2.1.30. BOARD-CERTIFIED. A term that describes a physician or other health professional who has passed an examination given by a professional specialty board and has been certified by that board as a specialist in that subject.

P2.1.31. BOARDER. A person other than a patient, physician, or staff member, such as a parent or spouse of an inpatient, who is temporarily housed in a hospital but who is neither admitted to an inpatient status nor assigned a register number.

P2.1.32. BORROWED LABOR. That quantity of productive work or service provided to the Military Treatment Facility by personnel other than staff and student personnel normally carried on the staffing (manpower) documents of the facility or worksite receiving the benefit of the labor. Patient personnel are excluded from this definition. The work or services provided are in positions and/or assignments that would be customarily filled by full-time staff personnel and are performed on a regularly scheduled basis in satisfaction of a continuing need. For a more detailed discussion of borrowed labor, see DoD 6010.13-M (reference (a)).

P2.1.33. BRANCH OF SERVICE. Army, Navy, Air Force, and Marine Corps.

P2.1.34. BUDGET. A detailed financial plan for carrying out specific institutional program activities in a specified time period, usually a fiscal year.

P2.1.35. BUDGET RECONCILIATION. A Federal Government budgeting process in which Congress changes programs and laws so that program costs match the amount Congress wants to spend.

P2.1.36. BUDGETING. The process of translating approved resource requirements (manpower and materiel) into time-phased financial requirements.

P2.1.37. BUILDING CODES. The standards or regulations for construction that are developed to provide a building that is safe for its intended use.

P2.1.38. BUNDLING. The process of combining into one payment the charges for various medical services rendered during one healthcare encounter. Bundling often combines the payment from physician and hospital services into one reimbursement. It is also called "package pricing."

P2.1.39. BUSINESS PROCESS REENGINEERING. MHS Business Process Reengineering is a radical improvement approach that critically rethinks and redesigns product and service processes within a political environment to achieve dramatic MHS mission performance gains.

P3. PART 3
GLOSSARY C

P3.1. TERMINOLOGY

P3.1.1. CAPITAL BUDGETING. The funding provided to the Services for the operation of their MTFs based on the number of full-time equivalents (FTE) utilizing the Service's healthcare system inside and outside catchment areas.

P3.1.2. CAPITATED BASIS. A fixed per member per month payment or (less often) a percentage of premium paid to a provider, group, organization or facility who assumes the full risk of the cost of contracted services without regard to the type, value, or frequency of services provided.

P3.1.3. CAPITATION. A payment arrangement on a per-member basis for a given number of patients under a provider's care; a set amount of money received or paid out, based on a prepaid agreement rather than on actual cost of separate episodes of care and services delivered, usually expressed in units of per member per month (PMPM); may be varied by such factors as age, sex, and benefit plan of the enrolled member.

P3.1.4. CARDED FOR RECORD ONLY (CRO). The special cases that are not admitted to an inpatient status but require the assignment of a register number.

P3.1.5. CARDIOPULMONARY RESUSCITATION (CPR). A lifesaving technique that provides artificial circulation and breathing to a person whose heart and lungs have stopped functioning because of a heart attack, shock, drowning, or other cause.

P3.1.6. CASE MANAGEMENT. Also referred to as Large Case Management. A method of managing the provision of healthcare to members with catastrophic or high cost medical conditions. The goal is to coordinate the care so as to both improve continuity and quality of care as well as lower costs. This generally is a dedicated function in the utilization management department.

P3.1.7. CASE MIX. Categories of patients, classified by disease, procedure, method of payment, or other characteristics, in an institution at any given time, usually measured by counting or aggregating groups of patients sharing one or more characteristics.

P3.1.8. CASUALTY. Any person who is lost to the organization by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing, missing in action, beleaguered, besieged or detained.

P3.1.9. CASUALTY CATEGORY. A term used to classify a casualty for reporting purposes. (See Joint Pub 4-02 reference (f).)

P3.1.10. CASUALTY RECEIVING AND TREATMENT SHIP (CRTS). Amphibious helo/landing craft carriers (LHA, LHD) that convert to casualty receiving ships after troop disembarkment. CRTS provides resuscitative and limited rehabilitative care for casualties resulting from amphibious operations.

P3.1.11. CASUALTY STATUS. A term used to classify a casualty for reporting purposes. (See Joint Pub 4-02 reference (f).)

P3.1.12. CASUALTY TYPE. A term used to identify a casualty as either a hostile casualty or a nonhostile casualty.

P3.1.13. CATASTROPHIC CASE CUTOFF LIMIT AMOUNT. For budgetary purposes only, each catchment area or predefined geographical area has a specific computed catastrophic case cutoff limit amount that is the specific amount that an individual CHAMPUS beneficiary patient case and/or episode must exceed to be considered catastrophic. A case limit amount is computed annually for each MTF or geographical area by utilizing past historical data and choosing the limit amount where historical "catastrophic" totals are at a predetermined percentage of the area's total annual budget. The case limit amount is then applied to individual patient cases in that geographical area during the upcoming fiscal year to determine whether or not they have exceeded the catastrophic case limit and are thus considered to be catastrophic.

P3.1.14. CATASTROPHIC CASE WITHHOLD AMOUNT. For budgetary purposes only, once a catastrophic case limit amount for an MTF or geographical area has been computed for an upcoming fiscal year, the limit is applied back to the prior historical period's data to see what the total catastrophic amount would have been for the geographical area using that specific patient case limit cutoff amount using the previous beneficiary cases for the period. The total of all catastrophic amounts for the geographic area for the previous period is then defined as the catastrophic case withhold amount. For those tri-Service areas using this catastrophic resource management tool, the catastrophic withhold amount is then

withheld from the catchment area or geographical area when given their CHAMPUS operating funds at the beginning of the fiscal year. Subsequently, after each quarter of the current fiscal year, the catastrophic case limit, applied to the actual geographical area, is reimbursed for the total of those catastrophic payments out of their withheld catastrophic budgetary fund.

P3.1.15. CATASTROPHIC RISK. The potential loss due to the actual cost of claims exceeding the AAPCC “credit” or revenue provided by HCFA for enrolled patients for which the MTF is “at risk”; the cost of claims may include the MTF’s actual cost of providing care, plus the cost of any “downtown” or network care from the TRICARE Managed Care Support Contractor.

P3.1.16. CATCHMENT AREA. The defined geographic area served by a hospital, clinic, or dental clinic and delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. For the DoD Components, those geographic areas are determined by the Assistant Secretary of Defense (Health Affairs) and are defined by a set of 5-digit zip codes, usually within an approximate 40-mile radius of military inpatient treatment facilities.

P3.1.17. CEILING. A numerical limitation imposed by the Office of the Secretary of Defense (OSD) on the number of military and civilian manpower spaces authorized to each Service.

P3.1.18. CENSUS, AVERAGE DAILY. See: AVERAGE DAILY PATIENT LOAD.

P3.1.19. CENSUS BASSINET DAYS (CBAD). See: DAYS.

P3.1.20. CENSUS, BED DAYS (CBD). See: DAYS.

P3.1.21. CENSUS, BED + BASSINET DAYS (CBBDD). See: DAYS.

P3.1.22. CENSUS, INPATIENT. The number of inpatients in a hospital at a given time. That time is the census taking hour and is usually midnight.

P3.1.23. CENSUS, LIVE BIRTH BED + BASSINET DAYS (CLBBD). See: DAYS.

P3.1.24. CENSUS BED DAYS PER DISPOSITION (CBDD). The average census bed days of all or a class of inpatients over a given time period, calculated by

dividing the sum of census bed days by the number of dispositions in that given time frame. This computation includes patients still occupying beds. This will be the computation used by the Medical Expense and Performance Reporting System (MEPRS). The CBDD replaces what was previously referred to as ALOS in MEPRS. (Formula: $CBDD = \text{Total OBDs reported for a period} / \text{Total dispositions reported for the period}$).

P3.1.25. CENTRAL PROCESSING AND DISTRIBUTION (CPD) SYSTEM.

A medical logistics AIS that provides supply distribution on non-pharmaceuticals to ward and clinics. It processes include inventory management and inventory financial accounting.

P3.1.26. CERTIFICATE OF NEED (CON). The requirement that a healthcare organization obtain permission from an oversight Agency before making changes. It generally applies only to facilities or facility-based services.

P3.1.27. CERTIFICATION. The process by which a Governmental or non-Governmental Agency or association evaluates and recognizes a person who meets predetermined standards; it is sometimes used with reference to materials or services. "Certification" is usually applied to individuals and "accreditation" to institutions.

P3.1.28. CERTIFIED NURSE MIDWIFE (CNM). See: NURSE MIDWIFE, CERTIFIED (CNM).

P3.1.29. CHAMPUS DETAIL INFORMATION SYSTEM (CDIS). The online data views, at a detail level, of the OCHAMPUS beneficiary and provider CHAMPUS HCSR records.

P3.1.30. CHAMPUS MEDICAL INFORMATION SYSTEM (CMIS). The online data views, at a summary level, of the OCHAMPUS beneficiary and provider CHAMPUS HCSR record data.

P3.1.31. CHARGE. The dollar amount charged by a hospital, physician, or other healthcare provider for a unit of service, such as a stay in an inpatient unit or a specific medical or dental procedure.

P3.1.32. CHIEF EXECUTIVE OFFICER. A job-descriptive term used to identify the individual appointed by the governing body to act on its behalf in the overall management of the hospital.

P3.1.33. CHIEF OF SERVICE. The member of a hospital staff who is elected or appointed to serve as the medical and/or administrative head of a clinical service.

P3.1.34. CHRONIC DISEASE. A disease that develops slowly and persisting for a long period of time, usually for the remainder of the lifetime of the patient.

P3.1.35. CHURNING. The practice of a provider seeing a patient more often than is medically necessary, primarily to increase revenue through an increased number of services. Churning may also apply to any performance-based reimbursement system where there is a heavy emphasis on productivity (in other words, rewarding a provider for seeing a high volume of patients whether through fee-for-service or through an appraisal system that pays a bonus for productivity).

P3.1.36. CIVILIAN EXTERNAL PEER REVIEW PROGRAM. The program whereby military healthcare services are assessed by civilian experts (professional peers) with collaboration with pertinent military consultants. The program is performed for the Department of Defense under contract.

P3.1.37. CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS). An indemnity-like program called TRICARE standard that is available as an option under DoD's TRICARE program. There are deductibles and cost shares for care delivered by civilian healthcare providers to active duty family members, retirees and their family members, certain survivors of deceased members and certain former spouses of members of the seven Uniformed Services of the United States.

P3.1.38. CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA). A program administered by the Department of Defense for the Department of Veterans Affairs that cost-shares for care delivered by civilian health providers to family members of totally disabled veterans that are eligible for retirement pay from a Uniformed Service of the United States.

P3.1.39. CLAIM. Any request for payment for services rendered related to care and treatment of a disease or injury that is received from a beneficiary, a beneficiary's representative, or an in-system or out-of-system provider by a CHAMPUS FI/Contractor on any CHAMPUS-approved claim form or approved electronic media. Types of claims and/or data records include Institutional, Inpatient

Professional Services, Outpatient Professional Services (Ambulatory), Drug, Dental, and Program for the Handicapped.

P3.1.40. CLAIM TYPE AND/OR RECORD TYPE. The type of data submitted on a CHAMPUS claim, dependent on the type of services that were provided. CHAMPUS claim and/or record types are Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug, Dental, and Program for the Handicapped.

P3.1.41. CLINIC. A health treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and ambulatory services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, preventive medicine services, and health promotion activities to support a primary military mission. In some instances, a clinic may also routinely provide therapeutic services to hospitalized patients to achieve rehabilitation goals; e.g., occupational therapy and physical therapy. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for the care of cases that cannot be cared for on an outpatient status, but that do not require hospitalization. Such beds shall not be considered in calculating occupied-bed days by MTFs.

P3.1.42. CLINIC SERVICE. A functional division of a department of a Military Treatment Facility identified by a three-digit MEPRS code.

P3.1.43. CLINICAL PRACTICE GUIDELINES. Systematically developed statements to assist provider and patient decisions about appropriate healthcare for specific clinical conditions.

P3.1.44. CLINICAL PRIVILEGES. The permission to provide medical, dental, and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment.

P3.1.45. CLINICAL SUPPORT STAFF. Personnel who are required to be licensed but are not included in the definition of healthcare Practitioners. This category includes dental hygienists and non-privileged nurses.

P3.1.46. CLINICIAN. A “clinician” is defined as a physician or dentist practitioner normally having admitting privileges and primary responsibility for care

of inpatients. Interns and resident physicians and dentists are considered clinicians only for purposes of meeting the requirements of the Manual and NOT for the purposes of JCAHO accreditation, credentialing, etc. A physician or dentist assigned to and/or working at a clinic with no inpatient capability will still be considered a clinician on the premise that if assigned to a hospital, he or she would have admitting privileges. For manpower purposes, all physicians and dentists are considered clinicians. For expense purposes, clinician salary expenses are processed in a manner that will align inpatient expenses to permit comparison between civilian facility and military facility inpatient care costs. Salary expenses to be accounted for separately will be for those clinicians whose services are normally provided in the civilian sector by clinicians not employed by the hospital and who bill the patient directly.

P3.1.47. CLINICIAN, MEPRS. A physician or dentist practitioner normally having admitting privileges and primary responsibility for care of inpatients. Intern and resident physicians and dentists are considered to be clinicians as far as the reporting categories only for the purposes of meeting the requirements for MEPRS.

P3.1.48. CLOSED PANEL. A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients for another managed care organization. Examples include staff and group model HMOs. It could apply to a large private medical group that contracts with an HMO.

P3.1.49. CLOSE OBSERVATION ROOM (COR). A room on an inpatient nursing unit or ward, located near the nursing station, specifically designated a COR in the facility plan, for patients who require a higher level of nursing care than is typical for the nursing unit or ward but a lower level of care than that provided in a Special Care Unit.

P3.1.50. COINSURANCE. A provision in a member's coverage that limits the amount of coverage by the plan to a certain percentage, commonly 80 percent. Any additional costs are paid by the member out of pocket.

P3.1.51. COMBATANT COMMAND. One of the Unified Commands established by the President.

P3.1.52. COMBAT SERVICE SUPPORT. The essential capabilities, functions, activities and tasks necessary to sustain all elements of operating forces in theater at all levels of war. (See Joint Pub 4-02 reference (f).)

P3.1.53. COMMAND AND CONTROL. The exercise of authority and direction by a properly designated commander over assigned forces in the accomplishment of the mission. (See reference (f).)

P3.1.54. COMMUNICATIONS ZONE. The rear part of a theater of operations (behind but contiguous to the combat zone) that contains the lines of communication, establishments for supply and evacuation and other agencies required for immediate support and maintenance of the field forces.

P3.1.55. COMORBIDITY. A preexisting condition on admission that will, because of its presence with a specific diagnosis, prolong the length of stay by at least one day in 75 percent of the patients.

P3.1.56. COMPETENCE. The ability to make an informed choice.

P3.1.57. COMPLETE PHYSICAL EXAMINATION, COUNT OF. A total record of the number of persons given complete physical examinations (except flight physical examinations, which are counted separately). Annual, enlistment, reenlistment, appointment, and promotion are examples of complete physical examinations. Visits made to various clinics incident to the physical examination are counted as visits in addition to this selective reporting.

P3.1.58. COMPLICATION. A condition that arises after the beginning of hospital observation and treatment and alters the course of the patient's illness or the medical care required.

P3.1.59. COMPOSITE HEALTH CARE SYSTEM (CHCS). A medical AIS that provides patient facility data management and communications capabilities. Specific areas supported include: MTF healthcare (administration and care delivery), patient care process (integrates support--data collections and one-time entry at source), ad hoc reporting, patient registration, admission, disposition, and transfer, inpatient activity documentation, outpatient administrative data, appointment scheduling and coordination (clinics, providers, nurses, and patients), laboratory orders (verifies and processes), drug and lab test interaction, quality control and test reports, radiology orders (verifies and processes), radiology test result identification, medication order processing (inpatient and outpatient), medicine inventory, inpatient diet orders, patient nutritional status data, clinical dietetics administration, nursing, order-entry, eligibility verification, provider registration, and the Managed Care Program.

P3.1.60. COMPOSITE LAB VALUE (CLV). A weighted time factor for dental laboratory procedures.

P3.1.61. COMPOSITE TIME VALUE (CTV). A weighted time factor for clinical dental procedures.

P3.1.62. COMPREHENSIVE HEALTHCARE CLINIC (CHCC). A facility planned, designed and constructed to provide comprehensive ambulatory care services, to include ambulatory surgery, and limited holding bed capability.

P3.1.63. COMPUTER-ASSISTED PROCESSING OF CARDIOGRAMS I (CAPOC I). A medical AIS that provides computer-assisted interpretation of ECG data. Specific capabilities include: ECG reading, analysis, and transmission site locator, hard copy report generator, machine analysis at central site, physician review and confirmation, patient records updates, records storage and retrieval, and patient demographic data collection.

P3.1.64. COMPUTER-ASSISTED PROCESSING OF CARDIOGRAMS II (CAPOC II). Same as CAPOC I. A medical AIS that will provide MTFs and clinics an ECG database and reporting capability similar to CAPOC I, but augmented by an interpretation functionality.

P3.1.65. COMPUTED AXIAL TOMOGRAPHY (CAT). An x-ray imaging device that produces highly definitive cross-sectional images of the body by computer manipulation.

P3.1.66. COMPUTER-BASED PATIENT RECORD. It contains information about an individual's longitudinal health status and health care. Appropriate portions are easily accessible to authorized users when and where needed. The computer-based patient record integrated computer systems facilitate the worldwide delivery of healthcare, assist individuals and clinicians in making healthcare decisions, and support leaders in making operational and resource allocation decisions.

P3.1.67. CONSTRUCTION. The erection, installation, or assembly of a new facility; the addition, expansion, extension, alteration, conversion, or replacement of an existing facility; or the relocation of a facility from one activity or site to another activity or site. It includes equipment installed in (Real Property Installed Equipment) and made a part of such facilities, related site preparation, excavation, filling and landscaping, or other land improvements.

P3.1.68. CONSULTANT. An expert in a specific medical, dental, or other health services field who provides specialized professional advice or services upon request.

P3.1.69. CONSULTATION. A deliberation with a specialist concerning the diagnosis or treatment of a patient. To qualify as a consultation (for statistical measure) a written report to the requesting healthcare professional is required.

P3.1.70. CONTINENTAL UNITED STATES (CONUS). United States territory, including the adjacent territorial waters located within the North American continent between Canada and Mexico. Alaska and Hawaii are not part of the CONUS.

P3.1.71. CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP). The CHCBP provides temporary continued CHAMPUS benefits for certain former CHAMPUS beneficiaries. Coverage is purchased on a premium basis.

P3.1.72. CONTINUING EDUCATION. Officers, equivalent civilians, and selected enlisted personnel working in a medical specialty, have a responsibility to maintain their knowledge within their professional discipline. Often this responsibility has been codified into a professional requirement either by nationally recognized certifying associations and/or boards, State licensure bodies, or military medical departments. This type of training requirement has become known as continuing education. The salary expenses of military and civilian personnel meeting these requirements shall be included. It is education beyond initial professional preparation that is relevant to the type of patient care delivered in the organization, and/or provides current knowledge relevant to the individual's field of practice, and/or healthcare delivery in general.

P3.1.73. CONTINUUM OF CARE. A way of looking at the level and type of care provided to individuals from the most acute and intensive to the least acute and least intensive. The concept of the continuum is important because integrated health networks of the future will be expected to provide the entire range of services contained on the continuum.

P3.1.74. CONTRACT COMPLETION DATE (CCD). The date when a contractor has fulfilled all contract requirements and the Government assumes control of the contractor's product.

P3.1.75. CONTRACTOR (TRICARE/GOVERNMENT CONTRACTOR). A

Government-selected civilian healthcare organization designated on a region by region and/or area by area bid-price contractual basis. Each TRICARE contractor supplements all tri-Service military direct care for beneficiaries in the applicable geographical area. The Contractor provides managed care support to TRICARE Prime enrollees and organizes the Preferred Provider Network (PPN) for beneficiaries in TRICARE Prime and those utilizing TRICARE Extra.

P3.1.76. CONVALESCENT CARE. The care rendered to patients who are ambulatory. The complexity of care requires limited therapeutic intervention and administration of oral medications performed by the patient. Patients are in the final stages of recovery and could be returned to limited duty. Emphasis is on physical reconditioning.

P3.1.77. CONVALESCENT LEAVE. An authorized leave status, not chargeable to the individual, granted to active duty Uniformed Service members while under medical or dental care that is part of the care and treatment prescribed for a member's recuperation or convalescence. Convalescent leave days are not counted as occupied bed days but are counted as sick days when the convalescent leave occurs before the disposition of the patient. Convalescent leave occurring after disposition of the patient while en route to a new command or convalescent leave granted by a line commander after patient discharge from the hospital is not counted as occupied bed days or sick days.

P3.1.78. COOPERATIVE CARE. Those medical inpatient and/or outpatient services and supplies provided to non-active duty beneficiaries under specified circumstances and by a civilian source. During cooperative care, CHAMPUS shares in the cost even though the patient remains under the primary control of the Military Treatment Facility.

P3.1.79. COPAYMENT. That portion of a claim or medical expense that an individual must pay out of pocket. It is usually a fixed amount, such as \$5 in many HMOs.

P3.1.80. CORONARY CARE UNIT (CCU). A medical care unit in which there is appropriate equipment and a concentration of physicians, nurses, and others who have special skills and experience to provide optimal medical care for critically ill coronary or cardiac patients.

P3.1.81. CORPORATE EXECUTIVE INFORMATION SYSTEM (CEIS). The CEIS is a target tri-Service system for integrating executive information support

requirements across the MHS.

P3.1.82. COST ASSIGNMENT. MEPRS uses a standard cost assignment methodology to distribute expense from MEPRS cost pool accounts, MEPRS ancillary accounts, and MEPRS support service accounts to other MEPRS accounts (i.e., inpatient, outpatient, dental specialty programs and readiness accounts). “Cost distribution” is often used as a synonym for cost assignment.

P3.1.83. COST-EFFECTIVE. A way of relating the cost of care to the achievement of a desired health outcome. The most cost-effective method is the one that achieves the health outcome at the least cost.

P3.1.84. COST POOL. MEPRS provides for the use of these accounts to collect expenses that cannot be readily identified with a particular MEPRS workcenter and/or account. These expenses are charged to MEPRS cost pool accounts and subsequently assigned in MEPRS to appropriate MEPRS final workcenter accounts (i.e., inpatient, outpatient, dental, special programs, and readiness MEPRS accounts).

P3.1.85. COST SHIFTING. The practice of charging certain groups of patients higher rates to offset lower rates negotiated with, or mandated by, other payers.

P3.1.86. COVERED SERVICE. This term refers to all of the medical services the enrollee may receive at no additional charge, or with an incidental copayment under the terms of the prepaid healthcare contract.

P3.1.87. CREDENTIALING. The most common use of the term refers to obtaining and reviewing the documentation of professional providers. Such documentation includes licensure, certifications, insurance, evidence of malpractice insurance, malpractice history, and so forth. It generally includes both reviewing information provided by the provider as well as verification that the information is correct and complete. A much less frequent use of the term applies to closed panels and medical groups and refers to obtaining hospital privileges and other privileges to practice medicine.

P3.1.88. CENTRALIZED CREDENTIALS AND QUALITY ASSURANCE SYSTEM (CCQAS). CCQAS is a window database for managing medical readiness training certification, credentials, and risk management information of healthcare providers.

P3.1.89. CREDENTIALS. The documents that constitute evidence of qualifying education, training, licensure, certification, experience and expertise of healthcare providers. It includes professional qualifications such as a professional degree, post-graduate training and education, board certification, and licensure, etc.

P3.1.90. CREDENTIALS PROCESS AND REVIEW. The application and screening process whereby healthcare providers have their credentials evaluated before being granted clinical privileges or assigned patient care responsibility.

P3.1.91. CURRENT PROCEDURAL TERMINOLOGY 4th EDITION (CPT-4). A set of five-digit codes that apply to medical services delivered. They are frequently used for billing by professionals.

P3.1.92. CURRENT PROCEDURAL TERMINOLOGY 4th EDITION (CPT-4) MODIFIER. A modifier to a CPT-4 coded procedure provides a means by which a reporting professional services provider can indicate that a rendered service or procedure has been altered by some specific circumstance but not changed in its definition or code. For instance, this modifier may show that a procedure was performed by more than one physician and/or at more than one location, whether a service or procedure was performed more than once, only partially, with an adjunctive service, or as a bilateral procedure.

P3.1.93. CUSTODIAL CARE. The care rendered to a patient who is mentally or physically disabled. Such disability is expected to continue and be prolonged. The patient requires a protected, monitored or controlled environment and requires assistance to support the essentials of daily living. The patient is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability enough so that the patient can function outside the protected, monitored or controlled environment of the institutional setting. Custodial care occurs when a patient is medically stabilized and when all reasonable therapeutic efforts have been completed but, despite maximum reasonable rehabilitation, the patient still requires the protected, monitored or controlled environment of an institutional setting. A custodial care determination is not prevented by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or to provide for

the patient's comfort, or to assure the manageability of the patient. Further, this determination is not precluded because an RN, LPN, or LVN is providing the required and prescribed services and supplies.

P4. PART 4
GLOSSARY D

P4.1. TERMINOLOGY

P4.1.1. DATE BILLED. The date the institution or provider billed the FI/Contractor on a claim for services.

P4.1.2. DATE CARE BEGAN. The date professional services were first rendered on billing for which claim corresponds.

P4.1.3. DATE CARE ENDED. The date professional services were last rendered on billing for which claim corresponds.

P4.1.4. DATE, HOSPITAL BEGIN DATE. The beginning date of billing period on an institutional claim for which the claim corresponds.

P4.1.5. DATE, HOSPITAL END DATE. The ending date of the billing period on an institutional claim for which the claim corresponds.

P4.1.6. DATE OF ADMISSION. The date the patient was admitted into a treatment facility.

P4.1.7. DATE OF CLAIM. The date the institution or provider's claim was received by the FI/Contractor.

P4.1.8. DATE OF DISCHARGE. The date the patient was discharged from a treatment facility and/or the ending date of the billing period.

P4.1.9. DATE, VOUCHER NOTICE DATE (VND). The (CYMM) date a claim was paid by the FI or assumed by the Contractor. It may or may not be before all CHAMPUS edits were completed.

P4.1.10. DATE, VOUCHER PROCESSING DATE (VPD). The (CYMM) date any CHAMPUS claim completed all OCHAMPUS edits, was processed into their database, and was distributed by batch to other CHAMPUS database users.

P4.1.11. DAYS.

P4.1.11.1. BASSINET DAY. A day in which a live birth at the reporting

facility occupied a bassinet in the newborn nursery at the census taking hour (normally midnight). The stay must be continuous since birth. The stay is also not dependent on the status of the mother. This excludes days spent by infants in a bassinet on a pediatric nursing unit, pediatric or neonatal intensive care unit, or other nursing unit.

P4.1.11.2. BED DAY. A day in which a patient occupied an operating bed at the census taking hour (normally midnight). The following are also counted as bed days: Same day transfer out if a patient is transferred to a non-Military Treatment Facility. When the patient occupies a bed day in more than one inpatient care area in one day, the bed day shall be counted only in the inpatient care area where the patient is located at the census-taking hour. This definition excludes days during which the inpatient is subsisting out, on convalescent leave, on authorized or unauthorized leave, or in a transient status. Active duty military patients not requiring inpatient care, and assigned for administrative or other non-medical reasons, shall not be counted as a bed day.

P4.1.11.3. BED + BASSINET DAYS (BBD). The sum of bed plus bassinet days at the census taking hour.

P4.1.11.4. CENSUS BED DAYS (CBED). The total number of beds occupied at the census taking hour for a specified period. (Excludes live births). (Formerly called occupied bed days).

P4.1.11.5. CENSUS BASSINET DAYS (CBAD). The total number of beds occupied at the census taking hour for a specified period.

P4.1.11.6. CENSUS BED + BASSINET DAYS (CBBDD). The total number of beds plus bassinets occupied at the census taking hour for a specified period.

P4.1.11.7. CENSUS LIVE BIRTH BED + BASSINET DAYS (CLBBDD). The total number of live birth beds + bassinets occupied at the census taking hour for a specified period.

P4.1.11.8. DISCHARGE BED DAYS (DBED). The total number of bed days generated by dispositions excluding live births within a specified period.

P4.1.11.9. DISCHARGE BASSINET DAYS (DBAD). The total number of bassinet days generated by live birth dispositions within a specified period.

P4.1.11.10. DISCHARGE BED + BASSINET DAYS (DBBD). The total number of beds plus bassinet days generated by dispositions (including live births) within a specified period.

P4.1.11.11. DISCHARGED LIVE BIRTH BED + BASSINET DAYS (DLBBD). The total number of live birth bed + bassinet days generated by dispositions within a specified period.

P4.1.12. DAYS PER THOUSAND. A standard unit of measurement of utilization. It refers to an annualized use of the hospital or other institutional care. It is the number of hospital days that are used in a year for each thousand covered lives.

P4.1.13. DEAD ON ARRIVAL (DOA). A patient who expires prior to arrival at a Military Treatment Facility.

P4.1.14. DEATH. The irreversible loss of life, which is indicated by decapitation, rigor mortis, or the demonstration of cardiovascular unresponsiveness to acceptable resuscitative techniques. It includes those dead on arrival (DOA) at the hospital, those dying in the emergency room, and those dying while inpatients at the hospital.

P4.1.15. DEATH CERTIFICATE. An official record of individual death, including the cause of death certified in accordance with local requirements by a physician and any other data defined by State law, filed with the local registrar of vital statistics.

P4.1.16. DEATH RATE, HOSPITAL. The number of deaths of inpatients in relation to the total number of inpatients over a given period.

P4.1.17. DEDUCTIBLE. That portion of a subscriber's (or member's) healthcare expenses that must be paid out-of-pocket before any insurance coverage applies: It is commonly \$100 to \$300 in insurance plans and PPOs but uncommon in HMOs. It may apply only to the out-of-network portion of a point-of-service plan.

P4.1.18. DEERS REGISTRATION. The process whereby a potentially eligible DoD healthcare beneficiary presents documentation that establishes his or her eligibility for healthcare in the MHS system, and that fact is documented in the Defense Enrollment Eligibility Reporting System (DEERS).

P4.1.19. DEFENSE BLOOD MANAGEMENT INFORMATION SYSTEM (DBMIS). A medical AIS that supports the Armed Services Whole Blood Processing Laboratory (ASWBPL) mission to maintain a quality blood product reserve supply. Processes supported include incoming and outgoing (logging and/or processing), confirmatory testing (collects, evaluates, and stores test results for liquid products), inventory, management reports, and quality assurance.

P4.1.20. DEFENSE BLOOD STANDARD SYSTEM (DBSS). As the standard DoD blood AIS, this system will provide comprehensive blood management capabilities to the entire DoD medical community. Functional requirements encompass collection (adds or modifies blood donor registry, phlebotomy and deferral information), incoming and outgoing (logging and processing), confirmatory testing (collects, evaluates and stores test results), inventory, management reports, frozen blood products (receives, stores and ships), tracking data (AIDS), transfusion services (processes requests, cross-matches samples, and checks products), look-back (traces products using unit number or social security number), communication (blood program elements), theater support and quality assurance.

P4.1.21. DEFENSE DENTAL STANDARD SYSTEM (DDSS). As the standard DoD Dental AIS, will provide comprehensive dental service capabilities to the entire DoD medical community. It will support clinical laboratory management, including field offices. Projected functional requirements include patient appointing and scheduling, management reports (workload, expenses, and personnel), enrollment eligibility verification, electronic healthcare record imaging, care documentation (POS), requirements collection (dental treatment), periodic dental exam program, workload capture (clinics and laboratories), interactive logistics management, order entry (prosthetics and oral pathology labs, and imaging services), case design support (prosthetic labs), interactive consultation (teleradiology), forensic dentistry support, personnel fitness classifications for readiness reporting, theater support, and patient registration.

P4.1.22. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS). An automated system of verification of a person's eligibility to receive Uniformed Service benefits and privileges.

P4.1.23. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM-AUTOMATED CENTRAL TUMOR REGISTRY (DEERS-ACTUR). A medical AIS that supports tumor registration through patient tracking. Functions are patient tracking and profiling, including diagnosis, treatment, follow-up, and

management reporting.

P4.1.24. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM-DEOXYRIBONUCLEIC ACID (DEERS-DNA). A medical AIS that provides centralized, automated support to the Army, Navy and Air Force medical departments in the tracking of DNA samples.

P4.1.25. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM-ELIGIBILITY (DEERS-Eligibility). A medical AIS that provides information for eligibility verification and ID card issuance for individuals entitled to Uniformed Services benefits. Verification data includes sponsor eligibility, dependent eligibility, dental (premium data), beneficiary data, quality control (update accuracy), reports and extracts, medical and dental records tracking (MTF/DTF), and non-availability statements (NAS) (beneficiary treatment).

P4.1.26. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM-ENROLLMENT (DEERS-Enrollment). A medical AIS that provides enrollment verification information for individuals entitled to Uniformed Services benefits.

P4.1.27. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM-PANORAL RADIOGRAPH (DEERS-Panograph). This medical AIS provides a central repository to receive, process, store, and retrieve key casualty identification documents; i.e., panoral radiographs (Panographs).

P4.1.28. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM REGISTRATION-(DEERS- Registration). The process whereby a potentially eligible DoD health care beneficiary presents documentation that establishes his or her eligibility for healthcare in the MHS system, and that fact is documented in the Defense Enrollment Eligibility Reporting System (DEERS).

P4.1.29. DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM-REPORTABLE DISEASES DATA BASE (DEERS-RDDB). A medical AIS that provides centralized, automated support to the Army, Navy, and Air Force medical departments in the tracking of HIV and other reportable diseases.

P4.1.30. DEFENSE HEALTH PROGRAM (DHP). The process for financial management oversight of the MHS funding.

P4.1.31. DEFENSE HEALTH PROGRAM (DHP) APPROPRIATION. Provides all resources for the DoD healthcare beneficiary population, including the

development of the DHP Program Objective Memorandum (POM), the DHP Budget Estimate Submission (BES), the DHP President's Budget Submission, and the DHP execution plan.

P4.1.32. DEFENSE MEDICAL ADVISORY COUNCIL (DMAC). Consists of members from the Joint-Staff-J4 and the Vice Commanders from the three Military Departments. This Council provides members an opportunity to discuss mutual issues related to medical support of Service line and Theater operations.

P4.1.33. DEFENSE MEDICAL INFORMATION MANAGEMENT (DMIM). The principal advisor to the ASD(HA) on information management, architecture, systems migration, standards and information systems policy; oversees and evaluates the execution of the MHS IM/IT program.

P4.1.34. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS). A medical AIS that supports the collection, integration, validation, analysis, and reporting of data related to MHS. Functions include: analyses (budget formulation, resource allocation, utilization management, and quality improvement), catchment area directory, CHAMPUS use and expense, MEPRS-based use and expense, inpatient biometrics, outpatient biometrics, facilities data (MTF and higher), and MIS/Micro DMIS (summary of inpatient and outpatient utilization data).

P4.1.35. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) IDENTIFICATION CODE (ID). The Defense Medical Information System identification code for fixed medical and dental treatment facilities for the tri-Services, the U.S. Coast Guard, and USTFs. In addition, DMIS IDs are given for non-catchment areas, administrative units such as the Surgeon General's office of each of the tri-Services, and other miscellaneous entities.

P4.1.36. DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT (DMLSS). As the standard DoD Medical Logistics AIS, DMLSS will provide automated, comprehensive logistical support for all the Military Services. Functional requirements include: biomedical maintenance management, catalog data management, central processing and distribution, facility management, property accountability and management, purchasing and contract management, reported incidents of safety and quality management, retail inventory management, supply control management, system maintenance and reporting, and theater support.

P4.1.37. DEFENSE MEDICAL REGULATING INFORMATION SYSTEM (DMRIS). A medical AIS that supports MTF personnel in regulating patients to

other MTFs for specialized care. Functionality includes: peacetime individual patient information reporting (evacuation), automated patient transfer determination considering patient and physician requirements, after review, automatically notify origination and destination MTFs and patient airlift center, and wartime patient reporting (evacuation).

P4.1.38. DEFENSE PRACTITIONER DATA BANK (DPDB). A medical AIS process that supports the reporting requirements of each Military Department's Surgeon General and the ASD(HA) to the National Practitioner Data Base maintained by the Department of Health and Human Services. Data includes physician profiles and administrative and management reports.

P4.1.39. DEFERRED NON-EMERGENCY CARE. Medical or dental care (such as eye refraction, immunizations, dental prophylaxis, and so on) that can be delayed without risk to the patient.

P4.1.40. DELIVERY. The act of giving birth to a liveborn infant and/or dead fetus by manual, instrumental, or surgical means. A delivery may result in a single birth, multiple births, or fetal death (stillbirth).

P4.1.41. DELIVERY ROOM. A unit for obstetric delivery and infant resuscitation.

P4.1.42. DENTAL. Of, pertaining to, or dealing with the healing art and science of dentistry.

P4.1.43. DENTAL ASSISTANT. A person trained to assist the dentist in all phases of dental treatment.

P4.1.44. DENTAL CARE, ADJUNCTIVE. The care provided to dental and oral tissue that is necessary to improve or ameliorate systemic medical or surgical conditions. Adjunctive care includes oral examination and diagnosis at the request of a physician. When a dentist and physician certify that they are essential to the control of the primary conditions, adjunctive care includes procedures for the treatment of infection, lesions, or fractures of oral and maxillofacial tissues; and surgical correction of developmental or acquired oral and facial deformities. Restoration of dental, oral and maxillofacial tissues or prosthesis is considered adjunctive when injured, affected or fractured during the medical or surgical management at a Uniformed Services Military Treatment Facility.

P4.1.45. DENTAL CARE, EMERGENCY. The care provided for the purpose

of relief of oral pain, elimination of acute infection, control of life-hazardous oral conditions (e.g., hemorrhage, cellulitis, or respiratory difficulties), and treatment of trauma to teeth, jaws, and associated facial structures.

P4.1.46. DENTAL CARE, PREVENTIVE. The care provided for the purpose of promoting oral health and preventing oral disease and injury. Military dental organizations provide or assist other organizations in providing primary preventive measures: systemic fluorides, topical application of fluorides, plaque control education, dietary counseling, oral prophylaxis, protective mouth guards, pit and fissure sealants, tobacco risk education, and preventive orthodontics. Secondary preventive measures such as periodic examination or screening and referral are considered to be preventive dental care.

P4.1.47. DENTAL CLINIC. A healthcare treatment facility appropriately staffed and equipped to provide outpatient dental care that may include a wide range of specialized and consultative support. Postgraduate education in the arts and sciences of dentistry may be conducted in this facility based upon the requirements of each Service.

P4.1.48. DENTAL HYGIENIST. A person who, under the supervision of a dentist, assumes delegated responsibility for providing preventive and therapeutic dental services for patients.

P4.1.49. DENTAL MANAGEMENT INFORMATION SYSTEM. The Navy automated dental workload reporting system used on personal computers.

P4.1.50. DENTAL OFFICER. A dentist with officer rank.

P4.1.51. DENTAL RECORDS. Outpatient dental treatment records including summaries of dental treatment from inpatient medical records and dental radiographs.

P4.1.52. DENTAL SERVICE. The provision of services providing preventive care, diagnosis, and treatment of patients to promote, maintain, or restore dental health.

P4.1.53. DENTAL TREATMENT FACILITY (DTF). See: DENTAL CLINIC.

P4.1.54. DENTAL TREATMENT FACILITIES AFLOAT. The facilities described in General Specifications for Ships of the Navy and Authorized Dental Allowance Lists (ADALs).

P4.1.55. DENTAL TREATMENT ROOM (DTR). A properly outfitted room including a dental chair, dental unit, and dental light where clinical dental procedures are performed.

P4.1.56. DENTIST. A person qualified by a degree in dental surgery (DDS) or dental medicine (DMD).

P4.1.57. DENTIST, CONTRACT. A member of a hospital medical staff or dental clinic staff who, under a full-time or part-time contract, provides care in the hospital or dental clinic, and whose payment as defined in the contract may be an institutional responsibility, on a fee basis, or on another agreed upon basis.

P4.1.58. DEPARTMENT. An organizational unit of the Military Treatment Facility or of the medical staff.

P4.1.59. DEPENDENT. A person who is eligible for care because of his or her relationship to a member or former member of a Uniformed Service.

P4.1.60. DEPENDENT DENTAL INSURANCE PROGRAM. A dental insurance program for family members of active duty members.

P4.1.61. DEPLOYABLE MEDICAL SYSTEM (DEPMEDS). Contingency medical treatment facilities that are capable of being transported and located in a desired or required area of operation during a contingency, war, or national emergency. Deployable medical systems are composed of fixed contingency hospitals and other than fixed contingency hospitals, which are not normally used for patient care during peacetime.

P4.1.62. DEPRECIATION. The decrease in the service potential of property as a result of wear, deterioration, or obsolescence, and the subsequent allowance made for the process in the accounting records of the activity. For a more detailed discussion of depreciation and methods of depreciation, see DoD 6010.13-M (reference (a)).

P4.1.63. DEVIATION (MANPOWER). A situation in or affecting a work center that causes man-hours required to do approved work to vary from man-hours established by the manpower standard. Such deviations exist only within the framework of approved work center descriptions and result in added or subtracted man-hours to the basic standard. Typical causes are travel distances, climatic conditions, work distribution, unique mission requirements, equipment differences,

and procedural differences.

P4.1.64. DIAGNOSIS. A word or phrase used to identify a disease or problem from which an individual patient suffers or a condition for which the patient needs, seeks, or receives healthcare.

P4.1.65. DIAGNOSIS-RELATED GROUP (DRG). A patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed. It provides a framework for specifying hospital case mix and identifies classifications of illnesses and injuries for which payment is made under prospective pricing programs.

P4.1.66. DIED OF WOUNDS (DOW) RECEIVED IN ACTION. Battle casualties who died of wounds or other injuries received in action, after having reached any Military Treatment Facility. It is essential to differentiate these from battle casualties found dead or who died before reaching a Military Treatment Facility (the "killed in action" group). Reaching a Military Treatment Facility while still alive is the criterion. Civilian battle casualties are not classified as DOW.

P4.1.67. DIETITIAN. An individual qualified by graduation from a college or university with a major in foods or nutrition or institution management and possessing either a baccalaureate or a masters degree and registered by the American Dietetic Association.

P4.1.68. DIRECT CONTRACTING. A term describing a provider of integrated healthcare. A delivery system contracting directly with employers rather than through an insurance company or managed care organization; not to be confused with direct contract model.

P4.1.69. DIRECT CONTRACT MODEL. A managed care health plan that contracts directly with private practice physicians in the community, rather than through an intermediary such as an IPA or a medical group; a common type of model in open panel HMOs.

P4.1.70. DIRECT MEPRS EXPENSE. MEPRS direct expenses are the value, measured in dollars, of the transactions and events of workcenters and/or accounts.

P4.1.71. DISABILITY SEPARATION. The release of members from active duty for a disability that prevents them from performing their military duties satisfactorily.

P4.1.72. DISCHARGE. The end of hospitalization by order of the physician, against medical advice or by death.

P4.1.73. DISCHARGE BED DAYS (DBED). See: DAYS.

P4.1.74. DISCHARGE DIAGNOSIS. Any one of the diagnoses recorded after all data accumulated in the course of a patient's hospitalization or other circumscribed episode of medical care have been studied.

P4.1.75. DISCHARGE, INPATIENT. See: DISPOSITION, INPATIENT.

P4.1.76. DISCHARGE LIVE BIRTH BED + BASSINET DAYS (DLBBD). See: DAYS.

P4.1.77. DISEASE. An illness; sickness; and interruption, cessation, or disorder of body functions, systems, or organs due to an entity characterized usually by at least two of these criteria: a recognized etiologic agent (or agents), an identifiable group of signs and symptoms, or consistent anatomical alterations.

P4.1.78. DISEASE NON-BATTLE CASUALTY. A person who is not a battle casualty but who is lost to the organization by reason of disease or injury, including persons dying of disease or injury, or by reason of being missing where the absence does not appear to be voluntary or due to enemy action or to being interned.

P4.1.79. DISEASE NON-BATTLE INJURY (DNBI). An accident or injury that is not the direct result of hostile action by or against an organized enemy. This includes injuries due to the elements, self-inflicted wounds, and in most cases, wounds or death inflicted by a friendly force while the individual is absent without leave or in a dropped-from-rolls status or is voluntarily absent from a place of duty. It includes all injuries during peacetime.

P4.1.80. DISENGAGEMENT. The discontinuance of medical treatment of a non-active duty patient for a single episode of care when the Military Treatment Facility lacks the capability or the services to provide necessary treatment, and is accomplished after alternative sources of care and attendant costs have been explained to the patient or the sponsor.

P4.1.81. DISENROLLMENT. The process of termination of coverage. Voluntary termination would include a member quitting because he or she simply wants out. Involuntary termination would include leaving the plan because of

changing jobs. A rare and serious form of involuntary disenrollment occurs when the plan terminates a member's coverage against the member's will. This is usually only allowed (under State and Federal laws) for gross offenses such as fraud, abuse, nonpayment of premium or copayments, or a demonstrated inability to comply with recommended treatment plans.

P4.1.82. DISPENSARY. See: CLINIC.

P4.1.83. DISPOSITION, AMBULATORY. The end of an outpatient clinic encounter.

P4.1.84. DISPOSITION, CHAMPUS. The disposition or status of a patient at the end of the institutional facility's billing period covered by the claim submission.

P4.1.85. DISPOSITION, INPATIENT. The removal of a patient (including live births) from the census of a hospital by reason of discharge to duty, to home, transfer to another medical facility, death, or other termination of inpatient care.

P4.1.86. DO NOT RESUSCITATE (DNR). An order to withhold CPR on a patient following cardiac or pulmonary arrest. This must be given by an attending physician in line with the patient's desires. A physician in training (intern, resident) may convey the order of the attending.

P4.1.87. DoD-DESIGNATED MILITARY SPECIALIZED TREATMENT FACILITY. A military facility that has undergone review of its clinical outcomes for a particular type of care or diagnostic capability by the Department of Defense and has been designated by the DoD to provide that type of care or diagnostic procedure to DoD beneficiaries enrolled in the MHS coordinated care program.

P4.1.88. DoD-DESIGNATED NON-FEDERAL CIVILIAN SPECIALIZED TREATMENT FACILITY. A non-Federal civilian facility that has undergone review of its clinical outcomes for a particular type of care or diagnostic capability by the Department of Defense and has been designated by the DoD to provide that type of care or diagnostic procedure to DoD beneficiaries enrolled in the MHS coordinated care program.

P4.1.89. DoD-DESIGNATED OTHER FEDERAL SPECIALIZED TREATMENT FACILITY. A Federal civilian facility (usually a VA hospital or medical center) that has undergone review of its clinical outcomes for a particular type of care or diagnostic capability by the Department of Defense and has been designated by the DoD to provide that type of care or diagnostic procedure to DoD

beneficiaries enrolled in the MHS coordinated care program.

P4.1.90. DoD MEDICAL EXAMINATION REVIEW BOARD (DoDMERB).

A DoD Agency responsible for administering physical examinations for candidates to the Service academies and other high-cost Service scholarship programs to determine if the candidates meet required medical standards.

P4.1.91. DOMICILIARY CARE. The inpatient institutional care given to a beneficiary, not because it is medically necessary but because care in a home setting is either not available or is unsuitable, or the patient's family members will not provide the care. Institutionalization because of abandonment constitutes domiciliary care.

P4.1.92. DONOR. An individual who supplies his or her own body substances, tissues, or organs to be used in another body; for example, someone who furnishes a kidney for renal transplantation.

P4.1.93. DRG. See: DIAGNOSIS RELATED GROUP (DRG).

P4.1.94. DRG WEIGHT. An index number that reflects the relative resource consumption associated with each DRG.

P4.1.95. DURABLE MEDICAL EQUIPMENT (DME). Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. This is an area of increasing expense, particularly in conjunction with case management.

P5. PART 5
GLOSSARY E

P5.1. TERMINOLOGY

P5.1.1. ECONOMIC ANALYSIS (EA). A cost benefit analysis done to identify the relative cost-effectiveness of delivering healthcare to a projected beneficiary population under different MTF sizing scenarios.

P5.1.2. ELECTIVE CARE. Medical, surgical, or dental care that, in the opinion of professional authority, could be performed at another time or place without jeopardizing the patient's life, limb, health, or well-being. Examples are: surgery for cosmetic purposes, vitamins without a therapeutic basis, sterilization procedures, elective abortions, procedures for dental prosthesis, prosthetic appliances, and so on.

P5.1.3. ELIGIBLE BENEFICIARIES. For purposes of the managed care (TRICARE) program, eligible beneficiaries include: active duty personnel and their family members, Reserve component personnel when on active duty, family members of Reserve component personnel when their sponsor's active duty orders are for more than 30 days, retirees and their family members, and survivors from the seven Uniformed Services.

P5.1.4. EMERGENCY. A situation that requires immediate intervention to prevent the loss of life, limb, sight, or body tissue, or to prevent undue suffering.

P5.1.5. EMERGENCY MEDICAL TECHNICIAN (EMT). An individual trained to render immediate basic lifesaving support to ill and injured individuals, under the direction of a physician, and to safely transport them in a monitored environment to healthcare facilities.

P5.1.6. EMERGENCY PREPAREDNESS PLAN. A formal written plan of action for coordinating the response of a hospital staff in the event of a natural or technological disaster.

P5.1.7. EMERGENCY SERVICES. The resources, both personnel and facilities, that are available 24-hours-a-day to assess, treat, or refer for medical or dental treatment, an ill or injured person. The level of emergency service at a DoD Component Military Treatment Facility will be classified as level I, II, or III

following the JCAHO Accreditation Manual.

P5.1.7.1. LEVEL I EMERGENCY SERVICE. A level I emergency medical department or service offers comprehensive emergency care 24-hours-a-day, with at least one physician experienced in emergency care on duty in the emergency care area. There must be in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetrical, gynecological, pediatric, and anesthesiology services. When such coverage can be demonstrated to be met suitably through another mechanism, an equivalency will be considered to exist for purposes of compliance with the requirement. Other specialty consultation must be available within approximately 30 minutes. Initial consultation through two-way voice communication is acceptable. The hospital's scope of services must include in-house capabilities for managing physical and related emotional problems on a definitive basis.

P5.1.7.2. LEVEL II EMERGENCY SERVICE. A level II emergency department or service offers emergency care 24-hours-a-day, with at least one physician experienced in emergency care on duty in the emergency care area. There must be specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Initial consultation through two-way voice communication is acceptable. The hospital's scope of services must include in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another facility when needed.

P5.1.7.3. LEVEL III EMERGENCY SERVICE. A level III emergency department or service offers emergency care 24-hours-a-day, with at least one physician available to the emergency care area from within the hospital, who is available immediately through two-way voice communication. Specialty consultation must be available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

P5.1.8. ENCODER/GROUPER-GOVERNMENT (ENCODER/GROUPER-G). A medical AIS that supports users in encoding and Diagnosis-Related Group (DRG) recording of diagnosis and procedure codes for inpatient admissions (generates DRGs).

P5.1.9. ENCODER/GROUPER-PROPRIETARY (ENCODER/GROUPER-P). A proprietary medical AIS that supports users in encoding and Diagnosis-Related Group recording of diagnosis and procedure codes

for inpatient admissions (generates DRGs).

P5.1.10. ENCOUNTER. A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment.

P5.1.11. END STRENGTH. The number of personnel actually assigned as of the last day of the reporting period.

P5.1.12. ENROLLMENT. The process by which participation status in the MHS Managed Care Program (TRICARE) is established.

P5.1.13. ENROLLMENT-BASED CAPITATION (EBC). The allocation of DHP funds to the three Military Departments based on MTF TRICARE Prime enrollment vice the previous workload-based system. Implementation is slated to begin in FY 98. Three features of the EBC include:

P5.1.13.1. PER MEMBER PER MONTH PREMIUM (PMPM). PMPM will be earned by the MTF for each TRICARE Prime patient enrolled.

P5.1.13.2. ENROLLMENT-BASED CAPITATION ADDITIONAL REVENUES. Additional revenues can be earned by the MTF for providing care to external customers if the MTF's capacity permits.

P5.1.13.3. MTF TRICARE PRIME CARE. Prime care that is referred out by the Primary Care Manager (PCM) will be billed to the referring MTF. The earning of revenues and purchasing of care will be reconciled on a monthly basis at all levels of the MHS and could result in a transfer of DHP funds within and between the Military Departments.

P5.1.14. ENROLLMENT STATUS CODE. A code indicating whether a patient is enrolled with the Contractor (Prime) or not (not Prime), or the care was received under the Standard CHAMPUS Program, or the Continued Health Care Benefits Program.

P5.1.15. ENVIRONMENTAL SERVICES. Services such as housekeeping, laundry, maintenance, and liquid and solid waste control performed to ensure safe, sanitary and efficient hospital operation.

P5.1.16. EPISODE, CHAMPUS. All accumulated institutional claims corresponding to a patient hospitalization for the same beneficiary, same admission

date and same diagnosis. Depending on the database methodology, claims for professional services performed during a period prior to the hospitalization, while in the hospital, and/or a period after the hospitalization may or may not be included in the patient episode.

P5.1.17. EPISODE OF HOSPITAL CARE. One or more medical service(s) received by an individual during a period of continuous care by a hospital in relation to a particular medical problem or situation. A continuous episode of care may involve more than one hospital.

P5.1.18. EVACUATION. The process of moving any person who is wounded, injured or ill to and/or between medical treatment facilities. (See Joint Pub 4-02 reference (f).)

P5.1.19. EVACUATION POLICY. A command decision, indicating the length in days of the maximum period of noneffectiveness that patients may be held within the command for treatment. (Reference (f).)

P5.1.20. EXCEPTION (MANPOWER). Any one or combination of the following causes requiring a manpower change to a multi-location manpower standard: additive workload, excluded workload, or deviation.

P5.1.21. EXCESS MANNING. The manning assigned in excess of manpower spaces authorized.

P5.1.22. EXCLUSION (MANPOWER). These are work categories or tasks not required in one or more activities but commonly required in other like activities.

P5.1.23. EXISTED PRIOR TO SERVICE (EPTS). A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.

P5.1.24. EXECUTIVE COMMITTEE OF THE DENTAL STAFF. A committee of the treatment facility professional staff that provides a mechanism for dental staff involvement in the credentials review and privileging process.

P5.1.25. EXECUTIVE COMMITTEE OF THE MEDICAL STAFF. A committee of the treatment facility professional staff that provides a mechanism for medical staff involvement in the credentials review and privileging process.

P5.1.26. EXPLANATION OF BENEFITS (STATEMENT). A statement that is mailed to a member or covered insured explaining how and why a claim was or was not paid.

P5.1.27. EXPOSURE COUNT. The total number of exposures per exam, regardless of the number and size of x-ray films used. This number is listed in the standard operating procedures (SOP) and determined by the Chief, Department of Radiology, at each Military Treatment Facility.

P5.1.28. EXPOSURE X-RAY. When a plate (film) is utilized in x-ray exposure, each exposure on that plate is counted as one x-ray film exposed; that is, four exposures on the same plate is counted as four x-rays exposed. Ultrasound exposures are counted in the same manner. If instant film (Polaroid) is used, each exposure can be counted as one x-ray film exposed.

P5.1.29. EXTERNAL PARTNERSHIP PROVIDER. A written agreement enabling available military healthcare personnel to provide medical care to CHAMPUS beneficiaries in a civilian CHAMPUS-authorized professional services provider facility.

P6. PART 6

GLOSSARY F

P6.1. TERMINOLOGY

P6.1.1. FACILITY. A separate individual building, structure, utility system, or other item of real property improvement, each item of which is subject to separate reporting and recording, in accordance with DoD Instruction 4165.14 (reference (g)).

P6.1.2. FAMILY MEMBER PREFIX (FMP). A two-digit number used to identify a sponsor or prime beneficiary or the relationship of the patient to the sponsor.

P6.1.3. FAVORABLE SELECTION. Occurs when an MTF enrolls a higher percentage of healthy, low-risk members who do not utilize as much care as a similar age and sex of the population as a whole; also called proverse selection; the opposite of adverse selection.

P6.1.4. FEDERALLY QUALIFIED HMO. A health maintenance organization (HMO) that has been determined by the U.S. Department of Health and Human Services to meet standards in such areas as financial and administrative ability, quality, scope of services covered, and rate-setting practices. An employer who provides health insurance coverage to employees may be required to offer a Federally qualified HMO as an alternative to other health benefit plans offered.

P6.1.5. FEE-FOR-SERVICE. A traditional form of reimbursement in healthcare where payment is based on services rendered to the patient. Whether payment is based upon usual, customary, and reasonable charges, allowable costs, or variations on these formats, health care providers are used to receiving reimbursement at some level for doing “things” (tests, procedures, etc.) for patients. With payers moving toward prospective pricing methods, such as DRGs and Capitation, providers are adjusting to bearing greater risk and responsibility for appropriate resource allocation and usage.

P6.1.6. FELLOWSHIP. A Graduate Medical Education experience following residency, often not in continuity, which is formally structured and focused on a specialty area. It usually involves investigative commitment and achievement of specific technical or clinical skill. It can result in specified certification.

P6.1.7. FETAL DEATH. Death prior to the complete expulsion or extraction from its mother, in a hospital facility, of a product of conception, irrespective of the duration of pregnancy; death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

P6.1.8. FIELD MEDICAL CARD. A DD Form 1380 used to record basic patient identification data and to describe the problem requiring medical attention or care provided. This form is used by combat medics and aid stations in a non-fixed troop clinic environment.

P6.1.9. FINAL MEPRS EXPENSES. For MEPRS, reporting the final MEPRS expense is the final accumulation point for the cost pools, ancillary and support services MEPRS accounts after the MEPRS EAS performs the cost assignment of these expenses to provide calculated final expenses for the inpatient, outpatient, dental, special programs and readiness MEPRS work centers or accounts.

P6.1.10. FINANCIAL ASSISTANCE PROGRAM (FAP). As prescribed under 10 U.S.C. 105 (reference (c)), the Financial Assistance Program was established for the purpose of obtaining health profession officers on active duty who are qualified in various critical specialties. Under the program, the Department of Defense pays an annual grant and monthly stipend for an individual to complete advanced medical specialized training at a civilian institution in exchange for an active duty commitment.

P6.1.11. FISCAL INTERMEDIARY (FI). An organization with which OCHAMPUS has entered into a contract for the adjudication and processing of CHAMPUS claims and the performance of related support activities.

P6.1.12. FI/CONTRACTOR NUMBER. The number used to identify each FI or Contractor submitting Provider File Records.

P6.1.13. FISCAL YEAR (FY). The 12-month accounting period used by the Federal Government (currently from 1 October to the next 30 September).

P6.1.14. FIXED CONTINGENCY MILITARY TREATMENT FACILITY (FCMTF). An inactive or partially inactive contingency MTF that is housed in a fixed structure such as a warehouse, hanger, excess hospital or other suitable building that is located in a required area of operation. Fixed CMTFs are equipped to provide medical treatment only during wartime, a major contingency, or an emergency. A fixed CMTF may be either U.S. owned or provided by a host nation.

P6.1.15. FIXED MILITARY TREATMENT FACILITY (FMTF). An established land-based medical center, hospital, clinic, or other facility that provides medical, surgical, or dental care and that does not fall within the definition of non-fixed Military Treatment Facility.

P6.1.16. FLEET HOSPITAL. A Navy pre-positioned, relocatable, modular, rapidly erectable medical and surgical facilities that provides definitive healthcare necessary to stabilize, treat, and rehabilitate theater casualties. It is located in the rear combat zone and communication zone.

P6.1.17. FORMULARY. A listing of drugs that a privileged healthcare provider may prescribe. The provider is requested or required to use only formulary drugs unless there is a valid medical reason to use a non-formulary drug.

P6.1.18. FORWARD AEROMEDICAL EVACUATION. That phase of evacuation that provides airlift for patients between points within the battlefield or theater of operations, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone.

P6.1.19. FULL-TIME EQUIVALENT (FTE). A work force equivalent of one individual working full-time for a specific period, which may be made up of several part-time individuals or one full-time individual.

P6.1.20. FULL TIME EQUIVALENT (FTE) WORK-MONTH. The amount of labor that would be available if one person had worked for one month in that work center. (The conversion factor: one FTE = total actual hours worked/168.)

P6.1.21. FUNCTIONING MILITARY TREATMENT FACILITY. A Military Treatment Facility that is partially or completely set up and ready to receive patients, as distinct from a nonfunctioning facility, which is one not set up and not ready to receive patients due to such conditions as being in training, in transit, staging, or held in tactical reserve.

P6.1.22. FUNDED POSITION. A manpower space as authorized in the Future Years Defense Program (FYDP).

P6.1.23. FUTURE YEARS DEFENSE PROGRAM (FYDP). The official program that summarizes the Secretary of Defense-approved plans and programs for the Department of Defense. The FYDP is published annually. The FYDP is also represented by a computer database that is updated regularly to reflect decisions.

P7. PART 7
GLOSSARY G

P7.1. TERMINOLOGY

P7.1.1. GATEKEEPER (PRIMARY CARE MANAGER). A primary care physician who is responsible (often financially and also clinically) for the care received by specific individuals in a managed care organization or other integrated health system. The primary care “gatekeeper” moves the person throughout the provider network, and patients cannot see specialist physician without a referral from their primary care gatekeeper. The term "gatekeeper" has come under attack in the past few years and the terms "primary care manager" or "care coordinator" are becoming popular alternatives.

P7.1.2. GLOBAL PATIENT MOVEMENT REQUIREMENTS CENTER (GPMRC). The primary role of the GPMRC is to coordinate with supporting resource providers (e.g., DoD MTFs, DoD Regional Lead Agents, USACOM, TACC, VA, USPHS) to identify assets that can be designated for use by the supported Theater Patient Medical Requirements Centers (TPMRCs). The GPMRC merged the patient regulating and Aeromedical Evacuation (AE) scheduling functions previously performed by the Armed Services Medical Regulating Office (ASMRO) and the CONUS Aeromedical Evacuation Coordination Center (AECC). (See Joint Pub 4-02 reference (f).)

P7.1.3. GOVERNING BODY. The individual, group, or Agency that has ultimate authority and responsibility for the overall operation of the organization.

P7.1.4. GRADUATE MEDICAL EDUCATION (GME). Full-time, structured, medically-related training, accredited by a national body (e.g., the Accreditation Council for Graduate Medical Education), approved by the commissioner of education, and obtained after receipt of the appropriate doctoral degree.

P7.1.5. GRADUATE MEDICAL EDUCATION (GME) TEACHING FACILITY. A hospital that conducts residency training programs.

P8. PART 8
GLOSSARY H

P8.1. TERMINOLOGY

P8.1.1. HCFA-1500R. A claims form (Health Care Financing Administration) used by professionals to bill for services. It is required by Medicare and generally used by private insurance companies and managed care plans.

P8.1.2. HCFA COMMON PROCEDURAL CODING SYSTEM (HCPCS). A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes, but also has codes for services not included in CPT, such as ambulance. While HCPCS is nationally defined, there is provision for local use of certain codes.

P8.1.3. HEALTH BENEFITS ADVISOR (HBA). An individual at a Military Treatment Facility who is responsible for providing information about the Uniformed Services Health Benefits Program and who assists beneficiaries to obtain healthcare benefits.

P8.1.4. HEALTHCARE FINANCING ADMINISTRATION (HCFA). The Federal Agency that oversees all aspects of health financing for Medicare and also oversees the Office of Prepaid Health Care Operations and Oversight (OPHCOO).

P8.1.5. HEALTHCARE FINDER (HCF) PROGRAM. A program coordinated by the local Military Treatment Facility or Managed Care support Contractor to help eligible beneficiaries find quality, accessible, and affordable health care in the MTF of civilian community under the provisions of the TRICARE Program.

P8.1.6. HEALTHCARE PROFESSIONAL. An individual who has received special training or education in a health-related field. This may include administration, direct provision of patient care, or ancillary services. Such a professional may be licensed, certified, or registered by a Government Agency or professional organization to provide specific health services in that field as an independent practitioner or employee of a healthcare facility.

P8.1.7. HEALTHCARE PROVIDER. A healthcare professional who provides health services to patients; examples include a physician, dentist, nurse, or allied

health professional.

P8.1.8. HEALTHCARE SERVICES RECORD (HCSR). An OCHAMPUS data record containing CHAMPUS beneficiary health care information.

P8.1.9. HEALTH FAIR. An approach to offering health promotion services for self-referred participants who are encouraged to select the information and services of personal interest. It often includes health information and education opportunities and some diagnostic screening, lifestyle assessment and counseling services directed at preventing disease and promoting health. It is usually is community-based and may be targeted to a specific segment of the population.

P8.1.10. HEALTH MAINTENANCE ORGANIZATION (HMO). An organization that has management responsibility for providing comprehensive healthcare services on a prepayment basis to voluntarily enrolled persons within a designated population.

P8.1.11. HEALTH PROMOTION. Any combination of health information, education, diagnostic screening and healthcare interventions designed to facilitate behavioral alterations that will improve or protect health. It includes those activities intended to influence and support individual lifestyle modification and self-care.

P8.1.12. HEALTH-RELATED SERVICES. The services (other than the provision of medical care) intended to directly or indirectly contribute to the physical or mental health and well-being of patients.

P8.1.13. HEALTH RECORD. A document that records the provision of health services to an individual patient. Health records include both outpatient treatment and dental record of a military member. It excludes the inpatient treatment record but may contain a summary of inpatient care.

P8.1.14. HEALTH RESOURCES. The available manpower, facilities, revenue, equipment, and supplies used to produce healthcare and service.

P8.1.15. HEALTH SERVICE SUPPORT. All services performed, provided or arranged by the Services to promote, improve, conserve or restore the mental or physical well-being of personnel. (See Joint Pub 4-02 reference (f).)

P8.1.16. HEALTH SERVICES. The services intended to directly or indirectly contribute to the health and well-being of patients.

P8.1.17. HEMOCARE PROGRAM. A program through which a blend of health and social services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or of minimizing the effects of illness and disability.

P8.1.18. HOSPICE PROGRAM. A program providing physical care and psychological support to terminally ill patients and their families or significant others, in both the home and inpatient setting.

P8.1.19. HOSPITAL. A health treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the fields of general medicine and surgery and preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.

P8.1.20. HOSPITAL, ACCREDITED. A hospital recognized upon inspection by the Joint Commission on Accreditation of Healthcare Organizations as meeting its standards for quality of care, for the safety and maintenance of the physical plant, and for organization, administration, and governance.

P8.1.21. HOSPITAL DAY. An overnight stay at a hospital. Normally, if the patient is discharged in less than 24 hours, it will not be considered an inpatient stay unless the patient was admitted and assigned to a bed and the intent of the hospital was to keep the patient overnight. For hospital stays exceeding 24 hours, the day of admission is considered a hospital day; the day of discharge is not.

P8.1.22. HOSPITAL SHIP. A mobile, flexible, rapidly responsive afloat Military Treatment Facility. It provides acute medical and surgical care in support of forward deployed troops in areas of hostility.

P8.1.23. HOSTILE CASUALTY. A person who is the victim of a terrorist activity or who becomes a casualty "in action." (See Joint Pub 4-02 reference (f).)

P8.1.24. HOURS OR MINUTES OF SERVICE OR TREATMENT. The elapsed time between commencement of service or treatment and termination of service or treatment. For a detailed discussion, see DoD 6010.13-M (reference (a)).

P8.1.25. HOUSE STAFF. Individuals serving in hospitals who are appointed to graduate medical education programs in those hospitals.

P8.1.26. HUMANITARIAN AND CIVIL AFFAIRS. Assistance to the local populace provided by predominantly U.S. forces in conjunction with military operations and exercises. (See Joint Pub 4-02.1 reference (f).)

P9. PART 9

GLOSSARY I

P9.1. TERMINOLOGY

P9.1.1. IMMEDIATE NON-EMERGENCY CARE. The medical, surgical, or dental care for other than an emergency condition, which is necessary at the time and place for the health and well being of the member.

P9.1.2. IMMUNIZATION. The protection of susceptible individuals from communicable diseases by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.

P9.1.3. IMMUNIZATION PROCEDURE. The process of injecting a single dose of an immunizing substance. For a detailed discussion on counting immunization procedures, see DoD 6010.13-M (reference (a)).

P9.1.4. INCENTIVE SPECIAL PAY (ISP). ISP may be paid to qualified medical officers, not undergoing internship or initial residency training and certified registered nurse anesthetists. ISP is an annual lump sum bonus and eligible officers must sign a written agreement to remain on active duty for one full year. The purpose of ISP, as a retention incentive, is to close the civilian-military pay gap, and amounts vary with specialty. Certain Reservists may be eligible, in accordance with Section 302f of 37 U.S.C. (reference b)).

P9.1.5. INCIDENCE. An expression of the rate of which a certain event occurs, such as the number of new cases of a specific disease occurring during a certain period.

P9.1.6. INDIRECT COST POOL. One or more intermediate operating expense accounts that collect indirect operating expenses for purposes of reassignment to work center accounts and ultimately to the final operating expense accounts.

P9.1.7. INCAPACITATING ILLNESS OR INJURY (III). A classification for hospitalized patients who are not seriously ill (SI) or very seriously ill (VSI) but whose illness or injury renders the patient physically or mentally incapable of communicating with his or her next of kin (NOK), involves serious disfigurement, causes major diminution of sight or hearing, or results in a loss of a major extremity.

P9.1.8. INDEPENDENT PRACTICE ASSOCIATION (IPA). An IPA is a corporation formed by physicians who maintain their independent practices but participate in the IPA to secure managed care business. IPAs accept financial risk for their members through capitation or discounted fees. The group is spread out geographically and is less formal than a group of staff model HMO. The only association between IPA providers is an individual contract between the physicians and the insurance company.

P9.1.9. INFECTION CONTROL PROGRAM. The policies and procedures followed by a medical or dental treatment facility to minimize the risk of infection to patients and staff.

P9.1.10. INFECTION CONTROL COMMITTEE. A military Treatment Facility committee composed of medical, dental, nursing, laboratory, and administrative staff members (and occasionally others, such as dietary or housekeeping staff members) whose purpose is to oversee infection control activities.

P9.1.11. INFORMED CONSENT. A legal principle requiring that the patient must be informed of all proposed medical or surgical procedures, the material risks of these procedures, alternative courses of action, and the material risks attendant to the alternatives prior to consenting to the receipt of the recommended treatment.

P9.1.12. INFRASTRUCTURE. Infrastructure is related to an underlying base or foundation for an organization. It includes the basic facilities, equipment, and installation needed for the functioning of any system.

P9.1.13. INITIAL OPERATING CAPABILITY (IOC). The first attainment of the capability to effectively employ a weapon, item of equipment, or system of approved specific characteristics, and which is manned or operated by an adequately trained, equipped, and supported military unit or force.

P9.1.14. INITIAL OPERATING CAPABILITY DATE (IOCD). The date on which an initial operational capability is attained.

P9.1.15. INJURY. A condition caused by trauma, such as a fracture, wound, sprain, dislocation, or concussion. An injury also includes conditions resulting from extremes of or prolonged exposure to temperature and acute poisoning resulting from exposure to a toxic substance. Poisoning due to contaminated food is not considered an injury.

P9.1.16. INLIERS. The actual weight for cases falling within the short and long stay trim points of a DRG. These cases receive the full relative weight assigned by year of disposition of the patient to the patient's DRG by the CHAMPUS or HCFA system.

P9.1.17. INPATIENT. An individual, other than a transient patient, who is admitted (placed under treatment or observation) to a bed in a MTF that has authorized or designated beds for inpatient medical or dental care. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital or does not actually use a hospital bed overnight. This does not include a patient administratively admitted to the hospital for the purposes of a same day surgery procedure.

P9.1.18. INPATIENT CARE. The examination, diagnosis, treatment, and disposition of inpatients appropriate to the specialty and/or subspecialty under which the patient is being cared for as an inpatient to a hospital.

P9.1.19. INPATIENT PROFESSIONAL SERVICES. See: VISIT. These professional services are labeled and filed separately from Outpatient (Ambulatory) Professional Services in the CHAMPUS databases, although their data format is the same. If kept separate in the database, users should be notified in order to choose whether to report these services separate from ambulatory professional services, or to combine the two together.

P9.1.20. INPATIENT TREATMENT RECORD. The medical record that is used by hospitals to document inpatient medical or dental care. The inpatient treatment record is initiated on admission and completed at the end of hospitalization. This record applies to all beneficiaries.

P9.1.21. INPATIENT VISIT. See: VISIT.

P9.1.22. INTEGRATED DELIVERY SYSTEMS (IDS). An IDS is a seamless consolidation of providers (hospitals, physicians, etc.) that focuses on the coordination, delivery, and management of care to a defined population.

P9.1.23. INTENSIVE CARE. The constant, complex, detailed healthcare as provided in various acute, life-threatening conditions. Special training is necessary to provide intensive care.

P9.1.24. INTENSIVE CARE UNIT (ICU). A hospital unit in which patients requiring close monitoring and intensive care are housed for as long as needed. An ICU contains highly technical and sophisticated monitoring devices and equipment, and the staff in the unit is educated to give critical care as needed by the patients. Types of ICUs are the Medical ICU (MICU), Surgical ICU (SICU), Neonatal ICU (NICU) and Pediatric ICU (PICU).

P9.1.25. INTERMEDIATE CARE. That care rendered to patients whose physiological and psychological status is such that they require observation and nursing care for the presence of real or potential life-threatening disease or injury. The acuity of care may range from those requiring constant observation and care to those patients able to ambulate and begin assuming responsibility for their own care. These patients may require monitoring devices, ventilator support, IV therapy, frequent suctioning, dressing changes or reinforcements, and ambulation.

P9.1.26. INTERNATIONAL CLASSIFICATION OF DISEASES, 9th REVISION, CLINICAL MODIFICATION (ICD-9-CM). A coding system for classifying diseases and operations to facilitate collection of uniform and comparable health information.

P9.1.27. INTERN. A person with formal training in a profession who undergoes a period of practical experience under the supervision and/or direction of a person experienced in that profession.

P9.1.28. INTERNAL PARTNERSHIP PROVIDER. A written agreement enabling civilian healthcare personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a MTF.

P9.1.29. INTERTHEATER EVACUATION. The evacuation of patients between the originating theater and points outside the theater, to include the continental United States and other theaters. En route care is provided by trained medical personnel. (See Joint Pub 4-02 reference (f).)

P9.1.30. INTRATHEATER EVACUATION. The evacuation of patients between points within the theater. En route care is provided by trained medical personnel. (See reference (f).)

P9.1.31. INTRAVENOUS CONSCIOUS SEDATION. The sedation for which there is a reasonable expectation that the sedation may result in the loss of protective reflexes in a significant percentage of patients.

P9.1.32. INVESTMENT EQUIPMENT. That equipment are major end items of equipment. These are items of such importance to the operating readiness of operating units that they are subject to continuing, centralized, individual item management and asset control throughout all command and support echelons, and through their active life, from acquisition through use until wearing out and disposal. Typically, such items are long-lived in use, of high-dollar unit value, repairable, and the subject of a control report routinely submitted by the final user to the cognizant inventory manager. See: DEPRECIATION for investment equipment recording in MEPRS.

P10. PART 10

GLOSSARY J

P10.1. TERMINOLOGY

P10.1.1. JOINT BLOOD PROGRAM OFFICE (JBPO). A tri-Service staffed office responsible for joint blood product management in a unified command theater of operations.

P10.1.2. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO). A private, not-for-profit organization composed of representatives of the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and American Dental Association whose purpose is to establish standards for the operation of health facilities and services, conduct surveys, and determine accreditation status of Military Treatment Facilitiesmedical treatment facilities.

P10.1.3. JOINT FORCE. A general term applied to a force composed of significant elements, assigned or attached, of the Army, the Navy or the Marine Corps and the Air Force, or two or more of these Services, operating under a single commander authorized to exercise operational control. (See Joint Pub 4-02 reference (f).)

P10.1.4. JOINT FORCE COMMANDER. A general term applied to a commander authorized to exercise combatant (command authority) or operational control over a joint force. (See Joint Pub 4-02 reference (f).)

P10.1.5. JOINT FORCE SURGEON. A general term applied to an individual appointed by the joint force commander to serve as the theater or joint task force special staff officer responsible for establishing, monitoring or evaluating joint force health service support.

P10.1.6. JOINT STANDARD. A standard that is common to all of the DoD Components.

P11. PART 11

GLOSSARY K

P11.1. TERMINOLOGY

P11.1.1. KILLED IN ACTION (KIA). A battle casualty who is killed outright or who dies as a result of wounds or other comba-related injuries before reaching a Military Treatment Facility. KIA does not include DOW or WIA. Civilian battle deaths are not classified as KIA.

P12. PART 12

GLOSSARY L

P12.1. TERMINOLOGY

P12.1.1. LABOR ROOM. A hospital room regularly maintained for maternity patients who are in active labor.

P12.1.2. LEAD AGENT. The office responsible for administering a TRICARE Health Service Region. The Lead Agent may also be the commander of a major medical facility located in the area. The office functions as the focal point for health services and collaborates with the other military treatment facility commanders within the region to develop an integrated plan for the delivery of healthcare for beneficiaries.

P12.1.3. LENGTH OF PATIENT STAY (LOS). The number of occupied bed days accumulated from the date of admission and the date of disposition.

P12.1.4. LENGTH OF STAY, AVERAGE. See: AVERAGE LENGTH OF STAY (ALOS).

P12.1.5. LEVEL OF EFFORT (LOE). The historic baseline -- adjusted to FY96 -- for the amount of space-available care that an MTF provides to Medicare dual-eligibles (patients over age 65 or with special qualifiers, i.e., disability) for MTF outpatient, inpatient, and UTF care; a region must provide the same amount of LOE care in the first year of the demonstration as it did during the baseline calculation year, before its enrolling MTFs are able to receive any added HCFA revenue for enrolled patients (final definition pending negotiations and legislation; see also: SPACE-AVAILABLE CARE).

P12.1.6. LICENSED INDEPENDENT PRACTITIONER (LIP). Practitioner-granted clinical privileges to independently diagnose, initiate, alter or terminate healthcare treatment regimens within the scope of his or her license, certification or registration.

P12.1.7. LICENSED PRACTICAL NURSE (LPN). A person who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of practical nursing and whose qualifications have been examined by a State board of nursing, and who has been legally authorized to practice as a licensed

practical nurse (LPN).

P12.1.8. LICENSED VOCATIONAL NURSE (LVN). A person who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of vocational nursing and whose qualifications have been examined by a State board of nursing, and who has been legally authorized to practice as a licensed vocational nurse (LVN).

P12.1.9. LICENSURE. The granting of permission by an official agency of a State, the District of Columbia, or a Commonwealth, territory, or possession of the United States to provide healthcare independently in a specified discipline in that jurisdiction. It includes, in the case of such care furnished in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide healthcare independently in a specified discipline.

P12.1.10. LIFE SAFETY CODE. A standard developed and updated regularly by the National Fire Protection Association that specifies construction and operational conditions to minimize fire hazards and provide a system of safety in case of fire.

P12.1.11. LITTER. A device (such as a stretcher) for the transport of a sick or injured person.

P12.1.12. LITTER PATIENT. A patient requiring litter accommodations while in transit.

P12.1.13. LINE OF DUTY (LOD) INVESTIGATION. An inquiry into the circumstances surrounding the injury or disease of an active duty member. It is also used to determine the status of an active duty member for indemnity and compensation purposes.

P12.1.14. LIVE BIRTH. The complete expulsion or extraction from a mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life such as heartbeat, umbilical cord pulsation, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions. Respirations are to be distinguished from fleeting respiratory efforts or gasps. For counting purposes, live births are those born in the reporting Military Treatment Facility.

P12.1.15. LIVING-IN UNIT. See: ROOMING-IN.

P12.1.16. LOANED LABOR. Staff personnel whose services are temporarily made unavailable to the Military Treatment Facility because of emergency and contingency needs or because of the necessity to provide temporary medical support to other facilities or worksites. For specific guidance on reporting, see DoD 6010.13-M (reference (a)).

P12.1.17. LONG-TERM CARE. That routine help with everyday activities such as eating, bathing and dressing necessitated because of chronic illness, disability or frailty. Long-term care is provided to individuals in their homes, in community settings or nursing homes; a part of the continuum of care.

P13. PART 13

GLOSSARY M

P13.1. TERMINOLOGY

P13.1.1. MAGNETIC RESONANCE IMAGING (MRI). A system that produces images of the body by using a strong magnetic field and computers. The imaging system is capable of showing the differences between gray and white matter in the brain and also is able to show other soft tissue structures that cannot be demonstrated with x-ray technologies.

P13.1.2. MAINTENANCE. The recurring day-to-day, periodic, or scheduled work required to preserve or restore a facility to such condition that it may effectively be used for its designated purpose. It includes work undertaken to prevent damage to a facility that otherwise would be more costly to restore.

P13.1.3. MAJOR DIAGNOSTIC CATEGORY (MDC). One of 25 subdivisions to which all of the codes of ICD-9-CM have been assigned on the basis of organ system whenever possible.

P13.1.4. MANAGED CARE. A system in which the patient's health care is managed by a single provider or group of providers. Primary care managers act as patient advocates, monitoring all care, avoiding needless care and referring patients to economical care sources. Such systems negotiate discount fees with providers, and stress keeping people healthy through health promotion and preventive medicine.

P13.1.5. MANAGED CARE ORGANIZATIONS (MCOs). A form of health insurance coverage where enrollee utilization patterns and provider service patterns are monitored before (prospectively), during (concurrently), and after (retrospectively) the actual delivery of services. The insurer or other assigned intermediary engages in evaluation of providers to contain costs and ensure appropriate health service utilization by its members. Traditional indemnity insurance usually covered whatever the healthcare professional decided to do for the individual. However, managed care has the insurer playing a much more active role in determining what is done for a beneficiary, where it will be done, who will do it, and what they are willing to pay for it. Most businesses have determined managed care to be the best mechanism in controlling their healthcare costs. Managed care entities can be designated as PPOs, HMOs, IPAs or other alternative delivery systems.

P13.1.6. MANAGED CARE SUPPORT CONTRACTS. A fixed price, at risk contract, supporting the DoD TRICARE program. These contracts support Lead Agents by combining civilian managed care networks with fiscal and administrative support, and compliment the majority of services provided in the MTFs.

P13.1.7. MANAGEMENT ENGINEERING. That discipline that combines the exactness of science with the art of judgment to develop managerial tools, techniques, procedures, and methods that, when applied by a manager, will help achieve more effective operations. Management engineering also refers to the application of engineering principles to all phases of planning, organizing, directing, controlling, and coordinating a project or enterprise.

P13.1.8. MAN-DAY. A unit of work equal to the productive effort of one person working one 8-hour workday.

P13.1.9. MAN-HOUR. A unit of measuring work. It is equivalent to one person working at a normal pace for 60 minutes, two people working at a normal pace for 30 minutes, or a similar combination of people working at normal pace for a period of time equal to 60 minutes.

P13.1.10. MAN-HOUR AVAILABILITY FACTOR (MAF). The average number of man-hours per month that an assigned individual is available to perform primary duties. Monthly required man-hours are divided by the MAF to determine the manpower requirements.

P13.1.11. MAN-YEAR. A unit of work equal to the productive effort of one person working 8 hours per day, 5 days per week for a period of one year, adjusted to include paid leave.

P13.1.12. MANNING. The specific inventory of people currently assigned to an activity in terms of numbers, grades, and occupational groups.

P13.1.13. MANPOWER ANALYSIS AND PLANNING SYSTEM (MAPS). A medical AIS that is used to improve decision-making capabilities and resource management at all levels within the DoD healthcare community. Processes include workload data capture, acuity data capture, population data capture, and personnel staffing analysis.

P13.1.14. MANPOWER AUTHORIZATION. The authority to staff a military or civilian space based on an official table of organization or unit manning document,

issued by a higher headquarters.

P13.1.15. MANPOWER REQUIREMENT. The human resources needed to accomplish the specified workloads of an organization.

P13.1.16. MANPOWER STANDARD. A quantitative expression that represents a work center's manpower requirements in response to varying levels of workload. A standard also includes a description of work center tasks and associated conditions on which the standard is built.

P13.1.17. MANPOWER VALIDATION. The process of establishing the validity of stated military and civilian manpower requirements through on-site manpower utilization studies.

P13.1.18. MARKETING, HOSPITAL. An analysis of community healthcare needs and institutional needs and circumstances, and subsequent planning, implementation, and evaluation of activities to meet identified needs.

P13.1.19. MASS CASUALTIES (MASCAL). Any numbers of casualties produced in a relatively short period of time, which exceed normal day-to-day logistical support capabilities.

P13.1.20. MAXIMUM HOSPITAL BENEFIT. The point during hospitalization when the patient's progress appears to have stabilized and it can be anticipated that additional hospitalization cannot directly contribute to any further substantial or more rapid recovery.

P13.1.21. MEAL. All of the food sent on a tray to an inpatient or served to a dining room patient or patron at traditional meal hours; e.g., breakfast, mid-day (lunch and/or dinner), evening (supper and/or dinner) or night meal. Between meal nourishments do not count as a meal. If a diner goes through the dining room serving line a second (or more) time(s), the food items are counted as "seconds," not as an additional meal. The total of all meals shall equal meals served.

P13.1.22. MEDICAID. Those medical benefits that are authorized under Title XIX of the Social Security Act, as amended, and are provided to welfare recipients and the medically indigent through programs administered by the various States.

P13.1.23. MEDICAL. Pertaining to or dealing with the art of healing and the science of medicine, which includes services related to the prevention, diagnosis, and treatment of illness, injury, pregnancy, and mental disorders.

P13.1.24. MEDICAL CENTER. A large hospital that has been so designated and is appropriately staffed and equipped to provide a broad range of healthcare services. Serves as a referral center with specialized and consultative support for facilities within the geographic area of responsibility; conducts, as a minimum, a surgical graduate medical education program.

P13.1.25. MEDICAL CLINIC. A freestanding healthcare treatment facility appropriately staffed and equipped to provide outpatient medical care that may include a wide range of clinical specialties.

P13.1.26. MEDICAL DIAGNOSTIC IMAGING SYSTEM (MDIS). A Picture Archiving and Communications System (PACS) with teleradiology capabilities. It is a fully integrated digital imaging system that digitally receives, stores, retrieves, displays and transmits radiological images. MDIS is currently deployed worldwide in a limited number of MTFs as PACS or teleradiology systems.

P13.1.27. MEDICAL DIRECTOR. A physician, usually employed by a hospital, who serves in a medical and administrative capacity as liaison for the medical staff with the administration and governing body.

P13.1.28. MEDICAL EVACUEES. Those personnel who are wounded, injured, or ill and must be moved to or between medical facilities.

P13.1.29. MEDICAL EVALUATION BOARD (MEB). A medical report about the current state of health and physical status of a member of the Armed Forces that includes recommendations about further evaluation and treatment and that, as appropriate, may render opinion concerning future health status and related needs.

P13.1.30. MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM FOR FIXED MILITARY MEDICAL AND DENTAL TREATMENT FACILITIES (MEPRS). A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions, and requirements for accounting and reporting of expense, manpower, and performance data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. (The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.)

P13.1.31. MEDICAL EXPENSE AND PERFORMANCE REPORTING

SYSTEM-EXPENSE ASSIGNMENT SYSTEM II (MEPRS-EAS II). A medical AIS that provides automated functions to standardize the expense data collection, processing, and reporting and workload practices of the DoD medical departments at each MTF.

P13.1.32. MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM-EXPENSE ASSIGNMENT SYSTEM III (MEPRS-EAS III). A medical AIS that provides automated functions to standardize the expense and workload data collection, processing, and reporting practices of the DoD medical departments at each MTF. It provides monthly reports and will replace MEPRS-EAS II.

P13.1.33. MEDICAL INTELLIGENCE. That category of intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information that is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors. (See Joint Pub 4-02 reference (f).)

P13.1.34. MEDICAL OFFICER. A physician with officer rank.

P13.1.35. MEDICAL RECORDS. Paper or electronic versions of inpatient treatment records, outpatient treatment records, health records, dental records, civilian employee medical records, x-ray film, DD Forms 602, "Patient Evacuation Tag," and DD Forms 1380, "U.S. Field Medical Card," alcohol and drug abuse prevention and control program outpatient records, and consultation service case files.

P13.1.36. MEDICAL RECORDS ADMINISTRATOR. An individual who has successfully passed an appropriate examination conducted by the American Health Information Management Association, or who has the equivalent of such education and training.

P13.1.37. MEDICAL REGULATING. The actions and coordination necessary to arrange for the movement of patients through the levels of care. (See Joint Pub 4-02 reference (f).)

P13.1.38. MEDICAL SERVICES. Activities related to medical care performed by physicians and/or other healthcare provided under the direction of a physician.

P13.1.39. MEDICAL STAFF. An organized body of fully licensed physicians and other licensed individuals permitted by law and by the Military Treatment

Facility to provide patient care services independently in the facility. All members have delineated clinical privileges. The members are subject to medical staff and departmental bylaws, rules, and regulations and are subject to review as part of the hospital quality assurance program. As a staff, they have overall responsibility for the quality of the professional services provided by individuals with clinical privileges and are accountable for this to the governing board.

P13.1.40. MEDICAL STAFF BYLAWS. Creates a contractual agreement between the governing body and medical staff by establishing a framework for self-governance of medical staff activities and accountability to the governing body.

P13.1.41. MEDICAL STUDENT. A person who is enrolled in a program of study to fulfill requirements for a degree in medicine or osteopathy.

P13.1.42. MEDICAL THREAT. A collective term used to designate all potential or continuing enemy actions and environmental situations that could possibly adversely affect the combat effectiveness of friendly forces, to include wounding, injuries or sickness incurred while engaged in a joint operation. (See Joint Pub 4-02 reference (f).)

P13.1.43. MEDICALLY ISOLATED FACILITY. An MTF located in an area where within a 40-mile driving radius, there are less than 100 acute care beds and/or insufficient healthcare manpower in the civilian community to provide for the healthcare needs of the military member and his family members.

P13.1.44. MEDICALLY NECESSARY. The level of services and supplies (that is, frequency, extent, and kinds) required for the proper diagnosis and treatment of illness or injury (including maternity care). Medically necessary includes the concept of essential medical care.

P13.1.45. MEDICARE. A national program of health insurance that is operated by the Health Care Financing Administration (HCFA) on behalf of the Federal Government. The program provides health insurance benefits primarily to persons over the age of 65 and others who are eligible for Social Security benefits. Coverage includes the cost of hospitalization, medical care, and some related services; Part A includes inpatient costs and Part B includes outpatient costs.

P13.1.46. MEDICARE-ELIGIBLE BENEFICIARIES. Beneficiaries not eligible for CHAMPUS by virtue of their eligibility for Part A of Medicare. (There are a few exceptional circumstances when an individual is eligible for both.)

P13.1.47. MEMORANDUM OF UNDERSTANDING (MOU). A written record or communication; a statement outlining terms of an agreement, transaction, or contract.

P13.1.48. MENTAL INCAPACITATION. A condition resulting from temporary or permanent mental instability as a result of injury, disease, or other mental condition. It is determined by an administrative or judicial determination of a member's ability to manage his or her personal affairs.

P13.1.49. MENTAL INCOMPETENCE. An administrative or judicial determination of impaired judgment secondary to psychiatric disorder(s) or other condition, especially if the question of impaired judgment is raised incident to pending trial, administrative separation, or disciplinary action.

P13.1.50. MILITARY CONSTRUCTION (MILCON). In accordance with Section 2801 of reference (c): "The term "military construction"... includes "any construction, development, conversion, or extension of any kind carried out with respect to a military installation." The term is also used as a category of funds appropriated for military construction projects.

P13.1.51. MILITARY CONSTRUCTION (MILCON) PROJECT. In accordance with Section 2801 of reference (c): "A military construction project includes all military construction work, or any contribution authorized by this chapter, necessary to produce a complete and usable facility or a complete and usable improvement to an existing facility (or to produce such portion of a complete and usable facility or improvement as is specifically authorized by law)."

P13.1.52. MILITARY HEALTH CARE ADVISORY COUNCIL (MHCAC). An external, civilian board of healthcare advisors, to the ASD(HA). It was chartered in May 1995 after the Persian Gulf War and originally existed to help and advise ASD(HA) with TRICARE operations. It advises DoD on medical operations within the peacetime/TRICARE and wartime continuum.

P13.1.53. MILITARY HEALTH CARE MANAGEMENT INFORMATION SYSTEM (MHCNIS). A medical AIS that will automate the MTF, Service, and higher command-levels' collection, processing, and reporting of data crucial to planning, organizing, and controlling healthcare delivery. Areas supported will include administrative reports, management reports, patient records, and workload analysis .

P13.1.54. MILITARY HEALTH SYSTEM (MHS). The Military Health System incorporates all aspects of health services for the Department of Defense.

P13.1.55. MILITARY HEALTH SYSTEM 2020. An MHS strategic planning process complementing the five-to-seven year horizon of the MHS Strategic Plan by engaging national and international healthcare experts, both public and private sector, to envision the practice and delivery of healthcare in the year 2020. Forecasts changes in clinical and non-clinical technologies and allows the MHS to synthesize future healthcare directions to promote a seamless integration from individual fitness to war zone operations.

P13.1.56. MILITARY PERSONNEL. Persons on active duty or active duty for training in the U.S. Armed Forces, including cadets and midshipmen of the Armed Forces academies.

P13.1.57. MILITARY SERVICES. The Army, the Navy, the Marine Corps, and the Air Force. It includes the Coast Guard when it is operating as a Service of the Navy. This definition includes all personnel serving on active duty, active duty for training, inactive duty for training, and retained beyond active duty for training.

P13.1.58. MILITARY TREATMENT FACILITY (MTF). A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

P13.1.59. MILITARY TREATMENT FACILITY (MTF) AFLOAT. A facility established aboard ship or other afloat structure for the purpose of furnishing medical and/or dental care to eligible personnel within the limits of its staff and equipment and that meets the description provided in the General Specifications for Ships of the Navy (GENSPECS).

P13.1.60. MINIMAL CARE. That care rendered to patients who are ambulatory and partially self-sufficient who require limited therapeutic and diagnostic services and are in the final stages of recovery. The focus of nursing management is on maintenance of a therapeutic environment that enhances recovery. The complexity of care includes administering medications and treatments that cannot be done by the patients and providing instruction in self-care and post-hospitalization health maintenance.

P13.1.61. MINUTES. A record of business introduced, transactions and reports made, conclusions reached, and recommendations made.

P13.1.62. MISSING IN ACTION (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the individual is not known to be in a status of unauthorized absence.

P13.1.63. MODERNIZATION AND REPLACEMENT EQUIPMENT. That equipment required to replace worn out, uneconomically repairable, and/or obsolete equipment in medical and dental facilities; and that equipment that is acquired as the result of new technology wherein no existent equipment is replaced.

P13.1.64. MORBIDITY. The incidence of disease; condition of being diseased; sick rate; the ratio of sick to well persons in a community.

P13.1.65. MORTALITY. The rate of death.

P13.1.66. MULTI-YEAR SPECIAL PAY (MSP). A qualified medical officer who executes a written agreement to remain on active duty for two, three, or four years after completion of any other active duty service commitment, may be paid an annual MSP bonus. The purpose of MSP is to increase retention in critical specialties and amounts vary, depending on clinical specialty and length or service agreement.

P14. PART 14

GLOSSARY N

P14.1. TERMINOLOGY

P14.1.1. NARRATIVE SUMMARY. A medical report dictated prior to a patient's discharge from an inpatient facility and ultimately included in the active duty member's health record or in the non-active duty patient's outpatient treatment record.

P14.1.2. NATO MEMBER. A military member of an armed force of a North Atlantic Treaty Organization nation who is on active duty.

P14.1.3. NEEDS ASSESSMENT. An evaluation of the requirements or demands for health services by a population or community.

P14.1.4. NEONATAL INTENSIVE CARE UNIT (NICU). An intensive care unit for high risk neonates, directed by a board-certified pediatrician with subspecialty certification in neonatal medicine. Refer to the American Academy of Pediatrics, "Guidelines For Perinatal Care," 1988 (reference (h)).

P14.1.5. NEONATE. An infant from birth to 4 weeks (28 days) of age.

P14.1.6. NETWORK. The combination of the MTF and other providers (individual and group practitioners, other Federal and non-Federal hospitals, clinics, etc.) who have agreed to accept DoD and Uniformed Services beneficiaries enrolled in the MHS Managed Care (TRICARE) Program, provide care at negotiated rates, adhere to quality assurance and utilization management procedures and follow other requirements of the TRICARE Program.

P14.1.7. NEXT OF KIN (NOK). An individual authorized as a primary point of contact for an individual. A NOK may participate in decision making regarding medical treatment and/or disposition of remains.

P14.1.8. NONAVAILABILITY STATEMENT (NAS). The certification by a commander (or a designee) of a Military Treatment Facility, and recorded on DD Form 1251, "Uniformed Services Military Treatment Facility Nonavailability Statement (NAS)," stating that medical care required by a CHAMPUS beneficiary does not exist or cannot be provided in a timely manner at the facility concerned.

P14.1.9. NONAVAILABLE TIME. Those hours expended in support of activities unrelated to the healthcare mission. These activities include, but are not limited to, official leave, PCS processing, medical visits or treatments, change of quarters, parades, formations, details, and non-healthcare-related training.

P14.1.10. NONBATTLE CASUALTY. A person who is not a battle casualty, but who is lost to his organization by reason of disease or injury, including persons dying from disease or injury, or by reason of being missing where the absence does not appear to be voluntary or due to enemy action or to being interned.

P14.1.11. NONEFFECTIVE RATE. The average daily number of active duty personnel noneffective for medical reasons per 1,000 average strength. It is computed by dividing (the number of sick days lost by active duty personnel on hospital census during the period x 1,000) by (the average active duty strength during the period x the number of days in the period).

P14.1.12. NONFIXED MILITARY TREATMENT FACILITY. Medical facilities for field service, such as aid stations, clearing stations, and division, field and force combat support and evacuation hospitals; medical facilities afloat, such as hospital ships and sick bays aboard ships; and tactical casualty staging facilities and medical advance base components contained within mobile-type units.

P14.1.13. NONHOSTILE CASUALTY. A person who becomes a casualty due to circumstances not directly attributable to hostile action or terrorist activity. (See Joint Pub 4-02 reference (f).)

P14.1.14. NON-NETWORK CARE AUTHORIZATIONS. The authorization for enrolled beneficiaries to go out of the coordinated care network to obtain certified medically necessary care when that care is not available in the network.

P14.1.15. NONREPORTABLE TIME. Those hours not accounted for by a MTF of assignment because another facility has reporting responsibility or such hours are already excluded by the use of 168 hours as the standard work month used by MEPRS, such as, regularly scheduled days off, holidays not worked, meal and other breaks, etc.

P14.1.16. NOSOCOMIAL. Pertaining to or originating in a hospital.

P14.1.17. NUMBER OF PROFESSIONAL SERVICES. The number of rendered services reported on a professional services claim for a particular procedure,

based on the CPT-4 procedure coding system.

P14.1.18. NUMBER OF PROFESSIONAL SERVICES VISITS. The number of visits reported on a claim for a particular procedure, based on the CPT-4 procedure coding system. It usually refers to Evaluation and Management CPT-4 codes (99XXX), when the number of services are coded as zero.

P14.1.19. NURSE MIDWIFE, CERTIFIED (CNM). An individual educated in the two disciplines of nursing and midwifery who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives (ACNM).

P14.1.20. NURSE MIDWIFERY. The independent management of care of essentially normal newborns and women (i.e., antepartal, intrapartal, postpartal, and/or gynecological) occurring within a healthcare system that provides for medical consultation, collaborative management, or referral, and in accordance with standards for nurse midwifery practice as defined by the ACNM (American College of Nurse-Midwives).

P14.1.21. NURSE OFFICER. A registered nurse with officer rank.

P14.1.22. NURSE PRACTITIONER. A registered nurse who is prepared through a formal organized education program to determine, start, alter or suspend defined regimens of medical and/or nursing treatment provided to a patient, either on a routine or occasional basis, in the specialties of obstetrics/gynecology, pediatrics, primary care, family practice, and mental health/psychiatric care.

P14.1.23. NURSE, REGISTERED. A person who is specifically prepared in the scientific basis of nursing; is a graduate of an approved school of nursing; has successfully completed the National Council Licensure Examination for Registered Nurses, and has a current, valid license to practice as a registered nurse in the United States, Guam, or the U.S. Virgin Islands.

P14.1.24. NURSING. The provision of services by or under the direction of a nurse to patients requiring assistance in recovering or maintaining their physical or mental health.

P14.1.25. NURSING SERVICE ADMINISTRATOR. A registered nurse responsible for the overall administration and management of nursing activities accomplished in a healthcare setting.

P14.1.26. NURSING SERVICES. The activities related to nursing care performed by nurses and other professional and technical personnel under the supervision of a registered nurse.

P14.1.27. NURSING STUDENT. A person who is enrolled in a program of study to fulfill the requirements for a degree or diploma in nursing.

P14.1.28. NUTRITION CARE SERVICES. Those activities related to the provision of comprehensive nutritional care to include: nutritional assessment and medical nutrition therapy of beneficiaries, nutrition education and health promotion, administration and operation of a hospital food service, and applied research.

P14.1.29. NUTRITION MANAGEMENT INFORMATION SYSTEM (NMIS). A clinical AIS supporting the dietary staff at MTFs worldwide for activities that are repetitive, calculation intense, and require memory of data for later analysis. Supports the Nutrition Care mission of providing preventive and therapeutic medical nutrition therapy and medical food management. It replaces TRIFOOD and includes all TRIFOOD functionality such as automated inventory, menu planning, and accounting. NMIS includes additional functionality such as automated inventory, menu planning, and accounting, nutrition clinical outcomes measurement, standardized patient treatment support, patient monitoring, automated patient menus, therapeutic and regular menu planning, cost analysis of nutrition operations, a la carte fixed price dining, interface to CHCS, and inventory electronic data interchange.

P15. PART 15

GLOSSARY O

P15.1. TERMINOLOGY

P15.1.1. OCCASION OF SERVICE. A specific identifiable act or service involved in the medical care of a patient that does not require the assessment of the patient's condition nor the exercising of independent judgment as to the patient's care, such as a technician drawing blood, taking an x-ray, administering an immunization, issuance of medical supplies and equipment; i.e., colostomy bags, hearing aid batteries, wheel chairs or hemodialysis supplies, applying or removing a cast and issuing orthotics. Pharmacy, pathology, radiology, and special procedures services are also occasions of service and not counted as visits.

P15.1.2. OCCUPANCY RATE. The ratio of average daily census to the average number of authorized operating beds maintained during the reporting period.

P15.1.3. OCCUPATIONAL ILLNESSES. The abnormal acute or chronic conditions, other than injury, that are due to exposure (inhalation, absorption, ingestion, or direct contact) to physical, chemical, or biological agents found at the work place.

P15.1.4. OCCUPATIONAL MEDICAL EXAMINATION. Those medical examinations conducted for civilian employees and military members that are prescribed by regulation, directive of law. Occupational medical examinations include periodic medical examinations, tests, and services including screening examinations for occupational hazards; and pre-employment, termination, enlistment, and separation medical examinations conducted in occupational medical clinics.

P15.1.5. OCCUPATIONAL THERAPIST. An individual qualified by graduation from an accredited school of occupational therapy with either a baccalaureate or masters degree who has passed a national certification examination given by the American Occupational Therapy Certification Board, Inc. In many States, a license to practice is also required.

P15.1.6. OCCUPATIONAL THERAPY SERVICES. A preventive and restorative treatment process designed to improve physical, psychosocial and developmental ability; enhance knowledge and skill; and engineer motivation to achieve independence in self care, a vocation and work.

P15.1.7. OCCUPIED BED. A hospital bed assigned to a patient.

P15.1.8. OCCUPIED BED DAY. See: DAYS, CENSUS, BED DAYS (CBD).

P15.1.9. OCCUPIED BED DAYS PER DISPOSITION (OBDD). See: CENSUS, BED DAYS PER DISPOSITION (CBDD).

P15.1.10. OFFICE OF WORKERS' COMPENSATION (OWC) PROGRAMS BENEFICIARY. A civilian employee of the U.S. Government who is injured or incurs a disease in the performance of duty and is designated as a beneficiary by the Office.

P15.1.11. OPEN ENROLLMENT PERIOD. The period when an employee may change health plans; usually occurs once per year. A general rule is that most managed care plans will have around half their membership up for open enrollment in the fall for an effective date of January 1. A special form of open enrollment is still law in some States. This yearly open enrollment requires an HMO to accept any individual applicant (i.e., one not coming in through an employer group) for coverage, regardless of health status. Such special open enrollments usually occur for 1 month each year. Many Blue Cross and Blue Shield plans have similar open enrollments for indemnity products.

P15.1.12. OPEN PANEL. A managed care plan that contracts (either directly or indirectly) with private physicians to deliver care in their own offices. Examples would include a direct contract HMO and an IPA.

P15.1.13. OPERATING BED. See: BED, OPERATING.

P15.1.14. OPERATING EXPENSES. The value, measured in dollars, of the transactions and events of work centers. Each work center accumulates operating expenses with a specific definition provided for the function(s) included in each operating expense account. Operating expenses may be "final" or "intermediate," depending on whether or not the account is the final expense accumulation point (inpatient, ambulatory, dental, or special programs) in the system, or is further assigned (ancillary or support) to a final operating expense account. Operating expenses may also be classified as "direct" or "indirect."

P15.1.15. OPERATING EXPENSE ACCOUNT. The record of transactions and events in monetary terms for the functions and activities (i.e., work center(s)) of a

Military Treatment Facility. For specific guidance on reporting, see DoD 6010.13-M (reference (a)).

P15.1.16. OPERATING ROOM. An area of a hospital equipped and staffed to provide facilities and personnel services for the performance of surgical procedures.

P15.1.17. OPERATING ROOM MINUTES OF SERVICE. The elapsed time of an operation performed in the operating room multiplied by the number of hospital personnel participating in each operation. For specific guidance on reporting, see reference (a).

P15.1.18. OPTIMUM HOSPITAL BENEFIT. The point during hospitalization when the patient's medical fitness for further active service can be determined and further treatment for a reasonable period of time will not result in any material change in the patient's condition that would alter the ultimate type of disposition or the amount of separation.

P15.1.19. OPTOMETRIST. A person qualified by graduation from an accredited school of optometry and licensed to provide independent primary eye care in the United States, District of Columbia, Guam, Puerto Rico, or the U.S. Virgin Islands.

P15.1.20. ORGANIZATIONAL MEDICAL ASSETS. Those personnel and materiel allocated for specific tasks regarding input of patients into the contingency medical treatment facility system. Tasks include, but are not limited to: casualty collection functions, emergency care, triage, beginning resuscitation, and preparation of patients for evacuation. These assets are designated to meet Service-specific demands.

P15.1.21. OUTCOME INDICATORS. The specified outcomes of care that are identified and subject to trend analysis. Examples include: neonatal death rate, mortality following coronary artery bypass surgery, readmission rate following discharge, nosocomial infection rate, and wound evisceration or dehiscence rate.

P15.1.22. OUTLIERS. Those cases that differ from average cases within a DRG by either unusually long or short lengths of stay or unusually high or low resource consumption.

P15.1.23. OUTLIERS, LONG STAY. Those cases with the length of stay longer than the long stay trim point. These cases will receive the full DRG relative weight plus a designated percentage of the DRG per diem weight for each bed or

bassinets day of stay in excess of the long stay trim point.

P15.1.24. OUTLIERS, SHORT STAY. Those cases with the length of stay shorter than the short stay trim point. These cases are credited on a per diem basis at 200 percent of the DRG per diem weight for each day of hospital stay, not to exceed the full DRG weight. CHAMPUS uses the 200 percent factor, while Medicare does not recognize short stay outliers.

P15.1.25. OUT-OF-CATCHMENT AREA (NON-CATCHMENT AREA). Those areas outside of predefined catchment areas (see: CATCHMENT AREA). The responsibility for healthcare treatment and/or payment for healthcare for a beneficiary residing in a non-catchment area reverts back to the Health Service regions and the sponsor's branch of Service.

P15.1.26. OUTPATIENT. An individual receiving healthcare services for an actual or potential disease, injury, or life style-related problem that does not require admission to a medical treatment facility for inpatient care.

P15.1.27. OUTPATIENT PROFESSIONAL SERVICES. Ambulatory professional services. See discussion on Inpatient Professional Services.

P15.1.28. OUTPATIENT SERVICE. A care center providing treatment to patients who do not require admission as inpatients.

P15.1.29. OUTPATIENT VISIT. See: VISIT.

P16. PART 16

GLOSSARY P

P16.1. TERMINOLOGY

P16.1.1. PARAMEDIC. A person who is certified by a State agency to perform advanced cardiac life support procedures and other emergency medical treatment under the direction of a physician.

P16.1.2. PARAPROFESSIONAL. A trained aide who assists a professional person.

P16.1.3. PARTIALLY RELOCATABLE CONTINGENCY MEDICAL TREATMENT FACILITY (CMTF). Contingency medical treatment facilities are designed to use the mobile core functions of the relocatable CMTF, such as surgery, x-ray, and laboratory. Ancillary and operating support functions, such as wards, laundry, and food service, shall be satisfied by the use of fixed structures.

P16.1.4. PARTNERSHIP PROVIDER. A relationship based upon a written agreement between a MTF commander and a CHAMPUS-authorized civilian health care provider.

P16.1.5. PATIENT. A sick, injured, wounded, or other person requiring medical or dental care or treatment.

P16.1.6. PATIENT ACCOUNTING & REPORTING REALTIME TRACKING SYSTEM (PARRTS). A medical AIS that electronically collects contingency and special category patient information from field and fixed MTFs. The information is consolidated into a centralized database, edited and released to those having a need to know.

P16.1.7. PATIENT ACUITY. The measurement of the intensity of care required for a patient accomplished by a registered nurse. There are six categories ranging from minimal care (I) to intensive care (VI).

P16.1.8. PATIENT, AMBULATORY. A patient who is able to walk or ambulate in a wheelchair as opposed to one requiring confinement to a bed.

P16.1.9. PATIENT, BED. Patient who is not ambulatory.

P16.1.10. PATIENT CATEGORY. See: BENEFICIARY CATEGORY.

P16.1.11. PATIENT DIVE. A patient dive is recorded for each patient while in a compressed air chamber for treatment. A single chamber compression that includes several patients would be credited with a patient dive for each patient. The patient dive minutes of service is the total dive time (from start of compression to the completion of the dive) times the number of patients treated.

P16.1.12. PATIENT, EMERGENCY. A patient with a potentially disabling or life-threatening condition who receives initial evaluation and medical, dental, or other health-related service.

P16.1.13. PATIENT MOVEMENT. The process of transporting an inpatient from one medical treatment facility (military or civilian) to another.

P16.1.14. PATIENT MOVEMENT ITEM (PMI). The medical equipment and supplies to support the patient during evacuation.

P16.1.15. PHARMACOECONOMIC CENTER (PEC). The PEC is established to promote the cost effective use of pharmaceuticals throughout DoD. The Army is designated by the ASD(HA) as the Executive Agent for the DoD PEC. The PEC's roles include functional proponentcy for pharmacy operational policy and Business Process Improvements.

P16.1.16. PEER REVIEW. An assessment of professional performance by professionally-equivalent military or civilian providers.

P16.1.17. PERFORMANCE FACTOR. A measure of work produced by a function, such as visits, procedures, occupied bed days, etc. For specific guidance on reporting, see DoD 6010.13-M (reference (a)).

P16.1.18. PERMANENT DISABILITY RETIRED LIST (PDRL). If, as a result of a periodic examination or upon final determination, it is determined that a member's physical disability is of a permanent nature and if he or she has at least 20 years of service or is rated at least 30 percent disabled by the Department of Veterans Affairs, the member's name shall be removed from the TDRL and he or she shall be retired.

P16.1.19. PHYSICAL EVALUATION BOARD (PEB). The PEB provides three stages of review (a documentary review, a due process hearing upon demand,

and appeal by petition) for a Service member whose physical conditions have been referred to it by a medical board of an MTF that believes that the member's physical condition raises questions about his ability to perform the duties of his or her office, grade, rank or rating.

P16.1.20. PHYSICAL EXAMINATION, COUNT OF COMPLETE. The total number of physical examinations (except flight physical examinations, which are counted separately); e.g., annual, enlistment, reenlistment, appointment, and promotion. Visits made to various clinics incident to the physical examination are counted as visits in addition to this selective reporting.

P16.1.21. PHYSICAL EXAMINATION, COUNT OF FLIGHT. The total number of physical examinations performed by aerospace medical or aeromedical services that require the examination to be completed by a flight surgeon.

P16.1.22. PHYSICAL THERAPIST. An individual qualified by graduation from an accredited school of physical therapy with either a baccalaureate or masters degree and licensed by a State licensing board to practice physical therapy.

P16.1.23. PHYSICAL THERAPY SERVICES. The activities related to primary care evaluation and treatment of patients with neuromusculoskeletal complaints; evaluation and planning or implementation of physical rehabilitation programs for patients with medical or surgical conditions, who may have been referred by either physicians or dentists; and consultation in injury prevention and health promotion.

P16.1.24. PHYSICIAN. A person possessing a degree in medicine (MD) or osteopathy (DO).

P16.1.25. PHYSICIAN, ATTENDING. See: ATTENDING PHYSICIAN.

P16.1.26. PHYSICIAN, CONTRACT. A physician who, under a full-time or part-time contract, provides care in the hospital and whose payment as defined in the contract may be an institutional responsibility, on a fee basis, or on another agreed-on basis.

P16.1.27. PHYSICIAN ASSISTANT. A person who has successfully completed an accredited Physician Assistant education program, and is granted privileges to determine, start, alter or suspend regimens of medical care under the supervision of a licensed physician.

P16.1.28. PLAN OF SUPERVISION. A command-approved plan of supervision, specific to a practitioner, that includes the following elements: scope of care permitted, level of supervision, identity of supervisor, evaluation criteria and frequency of evaluations.

P16.1.29. PLANT EQUIPMENT. The personal property of a capital nature (consisting of machinery, furniture, equipment, vehicles, machine tools, accessory and auxiliary items, but excluding special tooling) used or capable of use in the manufacture of supplies or in the performance of services or for any administrative or general plant purpose. It excludes minor plant equipment.

P16.1.30. PLANT PROPERTY. All real and personal property for which the medical facility has accountability and is defined to include all owned real property, and that realty that is not owned but for which accountability is a responsibility. Also included is personal property of a capital nature. It does not include property of a capital nature held in a financial inventory account (such as WRM prepositioned war reserve), nor does it include equipment designated as "minor plant equipment" (property with a unit cost for which the Service does not require individual in-use accounting). Plant property for management, financial and technical control purposes includes land; buildings, structures and utilities; plant equipment (other than production equipment) and production equipment.

P16.1.31. POINT OF ATTACHMENT. A term used in the discussion of catastrophic risk protection and insurance for the MTF; also called "cut-off point" or ";stop-loss threshold" the level over which the insurance for catastrophic care begins to cover added claims loss from the risk pool; a DoD risk pool is being considered for Medicare Demonstration and a Military Department risk pool is being considered for revised financing in Regions 1, 2, and 5.

P16.1.32. POINT OF SERVICE PLAN (POS). Point of Service Plans are based upon an HMO format. They demand the selection of a primary care physician, but allow for opting out of the network (called self-referring) at a substantially reduced benefit. The POS premiums generally are priced to be competitive with an HMO. They have to associate utilization management mechanisms, but also provide out-of-network flexibility, although generally at a significant financial expense to the physician member.

P16.1.33. POTENTIALLY COMPENSABLE EVENT (PCE). An injury caused by healthcare management, with or without legal fault. More broadly, it is

any adverse event or outcome in which the patient experiences any unintended or unexpected negative result.

P16.1.34. PRACTICE PRIVILEGES. See: PRIVILEGES.

P16.1.35. PREADMISSION PROCESS. The formal acceptance by a hospital of a patient for preliminary tests on an outpatient basis prior to admission as an inpatient.

P16.1.36. PRAUTHORIZATION. The authorization given prior to the provision of healthcare that allows reimbursement for inpatient care, designated outpatient procedures, or specialized care. This authorization is based on the determination that the care or procedure being considered is medically necessary, and the proposed location for delivery of that care is appropriate. Preauthorization does not prevent the possibility that a later review of the medical record will result in a determination that the care was not medically necessary or was not provided in the appropriate setting.

P16.1.37. PREFERRED PROVIDER NETWORK (PPN). A group of civilian practitioners organized by a TRICARE Contractor to supplement military direct care in TRICARE Prime and Extra. In exchange for Contractor's referrals, PPN members discount fees (to the CHAMPUS allowable or less) for TRICARE users, and file patient's claims.

P16.1.38. PREFERRED PROVIDER ORGANIZATION (PPO). A term applied to a variety of direct contractual relationships between hospitals, physicians, insurers, employers, or third-party administrators in which providers negotiate with group purchasers to provide health services for a defined population, and which typically share three characteristics: a negotiated system for payment for services that may include discounts from usual charges or ceilings imposed on a charge, per diem, or per discharge basis; financial incentives for individual subscribers (insured) to use contracting providers, usually in the form of reduced copayments and deductibles, broader coverage of services, or simplified claims processing; and an extensive utilization review program.

P16.1.39. PRESIDENT OF THE MEDICAL STAFF. A member of a hospital medical staff who is elected or appointed by the medical staff to serve as its administrative head for a designated time.

P16.1.40. PRESUMPTION OF FITNESS. In the Disability Separation

System, a presumption of fitness refers to the important concept that active duty members who serve with disabilities are “presumed fit” by fact of that Service and are therefore ineligible for disability compensation from the Armed Forces (but may seek compensation from the Veterans Administration).

P16.1.41. PREVALENCE. The total number of cases of a disease in existence at a certain time in a designated area.

P16.1.42. PRIMARY MEDICAL CARE FOR THE UNIFORMED SERVICES (PRIMUS). A contract, satellite primary care center that provides primary healthcare for a specified catchment area. These clinics provide medical services to the user population in a setting outside the hospital.

P16.1.43. PRIMARY CARE MANAGER (PCM). An individual (military or civilian) primary care provider, a group of providers, or an institution (clinic, hospital, or other site) who or which is responsible for assessing the health needs of a patient, and scheduling the patient for appropriate appointments (example: pediatric, family practice, ob-gyn) with a primary healthcare provider within the local MHS network.

P16.1.44. PRIMARY CARE PHYSICIAN (PCP). A term that generally applies to internists, pediatricians, family physicians, and general practitioners and occasionally to obstetrician/gynecologists.

P16.1.45. PRIMARY CAUSE OF ADMISSION. The immediate condition that caused the patient's admission to the MTF for the current, uninterrupted period of hospitalization. When several related conditions simultaneously cause admission, the condition that is the first in the chain of etiology will be designated as the primary cause. When unrelated conditions simultaneously cause admission, the most serious condition will be recorded as the primary cause of admission.

P16.1.46. PRIME VENDOR. The primary distribution channel (single distributor) for procurement and delivery of a full range of commercial brand-specific pharmaceuticals and medical and surgical supplies to a group of MTFs in a given geographical region.

P16.1.47. PRINCIPAL DIAGNOSIS. The condition established after study to be chiefly responsible for the patient's admission. This should be coded as the first diagnosis in the completed record.

P16.1.48. PRINCIPAL PROCEDURE. The procedure that was therapeutic

rather than diagnostic, most related to the principal diagnosis, or necessary to take care of a complication. This should be coded as the first procedure in the completed record.

P16.1.49. PRIVACY ACT STATEMENT. DD Form 2005, "Privacy Act Statement," used to inform individuals of the purpose, routine uses, and authority for collecting personal information.

P16.1.50. PRIVILEGES. A term used for permission to provide specified medical, dental and other patient care services in the granting facility, within defined limits, based on the individual's education, professional license, experience, competence, ability, health and judgment. The three types of privileges include:

P16.1.50.1. PRIVILEGES, REGULAR. Granting permission to independently provide medical and other patient care services in the facility within defined limits, based on the individual's education, professional license, experience, competence, ability, health and judgment. Regular privileges shall not be granted for periods exceeding 24 months.

P16.1.50.2 PRIVILEGES, SUPERVISED. Identifies the status of non-licensed/non-certified providers who, according to JCAHO standards, may neither be appointed to the medical staff nor practice independently. Supervised privileges shall not be granted for periods exceeding 24 months.

P16.1.50.3. PRIVILEGES, TEMPORARY. Granted in situations when time constraints will not allow full credentials review. All temporary privileges must be time-limited. Granting of temporary privileges shall be relatively rare and then only to fulfill pressing patient care needs. Temporary privileges may be granted with or without a temporary appointment to the medical staff.

P16.1.51. PRODUCTION EQUIPMENT. Those items of plant equipment located within a manufacturing, processing, assembling, or service establishment and used for cutting, abrading, grinding, shaping, forming, joining, measuring, testing, heating, or treating production materials or work-in-process. Only such items initially costing over \$1,000 each shall be considered to be production equipment, and those costing less shall be classified as "other plant equipment."

P16.1.52. PROFESSIONAL SERVICES. Any service or care rendered to an individual to include an office visit, x-ray, laboratory services, physical or occupational therapy, medical transportation, etc. It is also any procedure or service

that is definable as an authorized procedure from the CPT-4 coding system or the OCHAMPUS manuals.

P16.1.53. PROSPECTIVE PAYMENT SYSTEM (PPS). A generic term applied to a reimbursement system that pays prospectively rather than on the basis of charges. Generally, it is used only to refer to hospital reimbursement and applied only to DRGs, but it may encompass other methodologies as well.

P16.1.54. PROTOCOL. A written procedure providing basic guidelines for the management (diagnosis and treatment) of specific types of medical or dental patient care in specified circumstances.

P16.1.55. PROVIDER. A healthcare professional or facility or group of healthcare professionals or facilities that provide healthcare services to patients.

P16.1.56. PROVIDER ID. An identification code for the source of care professional services provider. The code is usually a 9-digit IRS taxpayer number or the social security number issued to a provider or facility.

P16.1.57. PROVIDER ID SUBIDENTIFIER. An identification code that uniquely identifies multiple professional services providers who are using the same Taxpayer Identification Number, such as for Group Practice providers.

P16.1.58. PROVIDER MAJOR SPECIALTY CODE (PMSC). An identification code that identifies the general categories of practice for professional services providers. Types of practice specialties can be General Practice, Allergy, Psychiatry, Nurses (RN), etc. A provider may use different specialty codes on different claims, depending upon which services were provided and reported on a claim.

P16.1.59. PURIFICATION. A MEPRS term used to describe the cost assignment of a MEPRS cost pool account expense and FTEs.

P17. PART 17

GLOSSARY Q

P17.1. TERMINOLOGY

P17.1.1. QUICK RESPONSE DETAIL (RECORD COMMON) FIELDS (QRDF). The OCHAMPUS data record containing CHAMPUS beneficiary healthcare information. These data records are abbreviated versions of the HCSR data records.

P17.1.2. QUALIFIED. Formally recognized by an appropriate Agency or organization as meeting certain standards of performance related to the professional competence of an individual or the eligibility of an institution to participate in a Government program.

P17.1.3. QUALITY ASSURANCE (QA). The formal and systematic monitoring and reviewing of medical care delivery and outcome; designing activities to improve healthcare and overcome identified deficiencies in providers, facilities, or support systems; and carrying out follow-up steps or procedures to ensure that actions have been effective and no new problems have been introduced.

P17.1.4. QUALITY IMPROVEMENT PROGRAM. Any activity carried out by or for the Department of Defense to monitor, assess, and improve quality of healthcare. This includes activities conducted by individuals, military medical and/or dental treatment facility committees, contractors, military medical departments, or DoD Agencies responsible for quality assurance, credentials review and clinical privileging, infection control, patient care assessment including review of treatment procedures, blood use, medication use, review of healthcare records, health resources management review, and risk management reviews.

P17.1.5. QUANTUM. Quantum is an Executive Information System for healthcare management managed by the Corporate Executive Information System Program Office. It integrates information from throughout the healthcare enterprise and the marketplace to give executives a perspective on indicators and trends that affect their business.

P17.1.6. QUARTERS PATIENT. An active duty Uniformed Service member receiving medical or dental treatment for a disease or injury that is of such a nature that, on the basis of sound professional judgment, inpatient care is not required.

Absent sick patients may be placed in quarters by a nonmilitary physician. The quarters patient is treated on an outpatient basis and normally will be returned to duty within a seventy-two hour period. The quarters patient is excused from duty past 2400 hours of the current day while under medical or dental care and is permitted to remain at home, in quarters or in clinic observation beds.

P18. PART 18

GLOSSARY R

P18.1. TERMINOLOGY

P18.1.1. RADIOLOGY FILMS EXPOSED. The number of x-ray films exposed, regardless of the number of exposures per film or the procedures involved. For specific guidance, see DoD 6010.13-M (reference (a)).

P18.1.2. RATE. The regular fee charged to all persons of the same patient category for the same service or care.

P18.1.3. READMISSION, PATIENT. The subsequent admission of a patient to the hospital for treatment of a condition related to or deriving from the one initially requiring admission. Usually the time period will be specified.

P18.1.4. REAL PROPERTY INSTALLED EQUIPMENT. All equipment affixed and built into the facility as an integral part of the facility.

P18.1.5. RECOVERY ROOM. A room for temporarily monitoring and treating post-anesthesia patients.

P18.1.6. RECOVERY ROOM MINUTES OF SERVICE. The period of time beginning when the patient enters the recovery room and ending when the patient leaves the recovery room.

P18.1.7. REFERRAL. The practice of sending a patient to another program or practitioner for services or advice that the referring source is not prepared or qualified to provide.

P18.1.8. REFERRAL CENTERS. The designated MTFs, usually STFs, with authority to issue Non-availability Statements (where TRICARE has not been implemented) or Non-Network Care Authorizations (where TRICARE has been implemented) for specialized healthcare.

P18.1.9. REGION (HEALTH SERVICE REGIONS). A breakdown of the MHS into subsets managed by Lead Agents to coordinate care worldwide.

P18.1.10. REGISTER NUMBER. A unique number assigned in each hospital

to each patient: admitted (inpatient), or for whom the facility has administrative responsibility for completing an inpatient record (i.e., absent sick status), or whose record is carded for record only (CRO).

P18.1.11. RELOCATABLE CONTINGENCY MEDICAL TREATMENT FACILITY (CMTF). A CMTF designed specifically for mobility. Mobility is a quality or capability that permits these CMTFs to move from place to place while retaining the ability to fulfill their primary mission for the Military Services.

P18.1.12. REPAIR. The restoration of a facility to such condition that it may be used effectively for its designated purpose by overhaul, reprocessing, or replacement of constituent parts or materials that have deteriorated or have been damaged by action of the elements or usage, and that may have not been corrected through maintenance. Included is Real Property Fixed Equipment and nonfixed equipment within a facility.

P18.1.13. REPORTABLE TIME. See: AVAILABLE TIME and NONAVAILABLE TIME.

P18.1.14. RESIDENCY. A multi-year, specialty-specific, graduate medical education experience designed to prepare the candidate in a particular specialty. Upon completion, the graduate is prepared to take the certification examination for that specialty.

P18.1.15. RESIDENT. A person engaged in residency training.

P18.1.16. RESOURCE ANALYSIS AND PLANNING SYSTEM (RAPS). A medical AIS that supports military healthcare analysts in assessing the impact of various factors on the peacetime healthcare delivery system. Capabilities include modeling various peacetime healthcare scenarios, distributing cost and workload data (direct care facilities and CHAMPUS), and forecasting resource requirement scenarios at the MTF, Service, and DoD levels of organization.

P18.1.17. RESOURCE SHARING. An agreement between contractor and an individual MTF commander to provide or share equipment, supplies, facilities, or staff who are under contract or employed by the contractor for work in the MTF for the purpose of enhancing the capabilities of the MTF to provide needed patient care to beneficiaries.

P18.1.18. RETIREE. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay and other benefits based on duty in a Uniformed Service.

P18.1.19. RETROSPECTIVE CASE MIX ANALYSIS SYSTEM-OPEN SYSTEMS ENVIRONMENT (RCMAS-OSE). A medical AIS that supports all levels of management to perform inpatient utilization and cost analyses. It shows where and how beneficiaries are seeking and receiving care within MHS by improving access to useful clinical management information at the MTF and at the central management level. Contains patient-level disposition data (direct care and CHAMPUS), civilian and military normative data, and provides management reports. It replaces RCMAS-P.

P18.1.20. REVISED FINANCING. The fiscal environment in which the Military Treatment Facility (MTF) receives a capitated funding for all TRICARE enrollees (active duty and CHAMPUS eligible), which is designed to cover their MTF and/or TRICARE Managed Care Support Contractor network care costs for the fiscal year; the MTF assumes financial responsibility to perform all care requirements of enrollees in return for receipt of the capitated payment from the respective Military Department.

P18.1.21. RISK CONTRACT. A contract involving medical claims risk on a prepayment basis between two entities, such as HCFA and a Federally-qualified HMO (in this case the DoD). The Medicare risk contract specifies the medical services to be included, together with the associated reimbursement structure of monthly AAPCC; if claims run above projections, it is the responsibility of the DoD (that bears risk under the contract) to pay those excess costs, whereas any savings is similarly given to the party bearing risk.

P18.1.22. RISK MANAGEMENT (RM). A function of planning, organizing, implementing, and directing a comprehensive program of activities to identify, evaluate, and take corrective action against risks that may lead to patient, visitor, or employee injury and property loss or damage with resulting financial loss or legal liability.

P18.1.23. RISK MANAGER. A person who coordinates all aspects of risk identification, evaluation, and treatment within the Military Treatment Facility in order to reduce the frequency and severity of events that may result in injury to patients, visitors, and employees and in property loss or damage or legal liability.

P18.1.24. ROOMING-IN. A method of organizing obstetric facilities and services whereby mothers share accommodations with and assume the care of newborn infants under the supervision of nursing personnel.

P19. PART 19

GLOSSARY S

P19.1. TERMINOLOGY

P19.1.1. SAFETY COMMITTEE. A committee composed of medical, dental, nursing, engineering, administrative, and other staff members whose purpose is to oversee safety practice.

P19.1.2. SAME-DAY SURGERY PROGRAM (SDS). A hospital program for the performance of elective surgical procedures on patients who are admitted to and discharged from the hospital on the day of surgery.

P19.1.3. SATELLITE. An associated or subsidiary enterprise.

P19.1.4. SELF-CARE. A patient performance for himself or herself of healthcare activities of limited scope, such as the self-administration of oral medication.

P19.1.5. SERIOUSLY ILL (SI). A patient is seriously ill when his or her illness is of such severity that there is cause for immediate concern but there is no imminent danger to life.

P19.1.6. SERVICE. A term used to indicate a functional division of the hospital or of the medical staff. It also used to indicate the delivery of care. In addition, it is commonly used to refer to the three Military Departments.

P19.1.7. SERVICE BLOOD PROGRAM OFFICE (SBPO). A Service-staffed office responsible for coordination and management of that Service's blood program.

P19.1.8. SICK DAYS. The total number of days from the date of admission to the date of disposition. The day of admission is counted as a Sick Day and the day of disposition is not counted. (Exception: see ADMISSION and/or DISCHARGE on the same day in the OCCUPIED BED DAY definitions).

P19.1.9. SPACE-AVAILABLE CARE. Any outpatient or inpatient care provided by an MTF for a Medicare dual-eligible beneficiary, who is not enrolled in TRICARE Prime; also called fee-for-service care in the private sector (pending negotiations or legislation, "credit" will not be given to MTFs by the Health Care

Financing Administration (HCFA) for pharmacy prescriptions to be considered as space-available care, within the parameters of the Medicare Demonstration for DoD).

P19.1.10. SPECIAL CARE UNIT (SCU). A medical care unit in which there is appropriate equipment and a concentration of physicians, nurses, and others who have special skills and experience to provide optimal care to critically ill patients. This excludes a close observation room (COR).

P19.1.11. SPECIALIST. A physician, dentist, or other healthcare professional, usually with special advanced education and training.

P19.1.12. SPECIALIZED TREATMENT SERVICES (STS). For certain high technology or high cost procedures, Health Affairs will establish STS on a multi-regional or national level. These centers may be designated military or civilian facilities. The designation of an STS will be based on readiness, access, quality and cost considerations. Lead agents may designate regional STSs as a component of their Regional Health Services Plan. Using provisions of the CHAMPUS regulation and in accordance with its procedures, an MTF commander can withhold a non-availability statement based on the availability of care at designated STS facilities. Should a beneficiary choose not to use a specialized service when one is designated and available, the beneficiary will be responsible for the full cost of the care. Waivers may be granted in consideration of medical appropriateness or personal hardship. However, for all other beneficiary services, the 40-mile catchment area rule remains in effect, even in overlapping catchment areas.

P19.1.13. SPECIALTY CARE. The provision by a specialist of specialized healthcare services.

P19.1.14. SPONSOR. The prime beneficiary who derives his or her eligibility based on individual status rather than dependence of another person.

P19.1.15. STANDARD INPATIENT DATA RECORD (SIDR). The standardized record for reporting biomedical data by the Army, Navy, and Air Force medical treatment facilities. The record uses the same format, codes, and definitions.

P19.1.16. STEPDOWN. A term used in MEPRS to describe the cost assignment of MEPRS expenses.

P19.1.17. STILL BIRTH. The delivery of a fetus, irrespective of its gestational age, that after complete expulsion or extraction shows no evidence of life; i.e., no heart beats or respirations. Heart beats are to be distinguished from transient

cardiac contractions. Respirations are to be distinguished from fleeting respiratory efforts or gasps.

P19.1.18. STRATEGIC PLANNING. A 5- to 7-year look towards the future that identifies the mission, vision and goals of an organization and action steps necessary to achieve the vision.

P19.1.19. SUBSISTING OUT. The non-leave status of an inpatient who is no longer assigned a bed. These days are not counted as occupied bed days but are counted as sick days. Inpatients authorized to subsist out are not medically able to return to duty but their continuing treatment does not require a bed assignment.

P19.1.20. SUPPLEMENTAL CARE. A non-elective specialized inpatient and/or outpatient treatment, procedures, consultation, tests, supplies, or equipment in a non-Military Treatment Facility while an inpatient or outpatient of a military facility. This care is required to augment the course of care being provided by the Military Treatment Facility.

P19.1.21. SUPPORT SERVICES. Those services other than medical, dental, nursing, and ancillary services that provide support in the delivery of clinical services for patient care, including laundry service, housekeeping, purchasing, maintenance, central supply, materials management, and security.

P19.1.22. SYSTEMS ANALYSIS. The analysis of a sequence of activities or management operations to determine which activities or operations are necessary and how they can best be accomplished.

P20. PART 20

GLOSSARY T

P20.1. TERMINOLOGY

P20.1.1. TASK ANALYSIS. A detailed examination of the observable activities associated with the execution or completion of a required function or unit of work.

P20.1.2. TELEMEDICINE. An umbrella term that encompasses various technologies as part of a coherent health service information resource management program. Telemedicine is the capture, display, storage and retrieval of medical images and data towards the creation of a computerized patient record and managed care. Advantages include: move information, not patients or providers; enter data ONCE in a healthcare network; network quality specialty healthcare to isolated locations; and build from hands-on experience.

P20.1.3. TOTAL HEALTH CARE SUPPORT RESOURCE REQUIREMENTS ALLOCATION PLAN (THCSRR). A plan that identifies those personnel required to meet the day-to-day operational support to the Navy and Marine Corps mission, the wartime mission and those personnel required for sustainment.

P20.1.4. TEMPORARY DISABILITY RETIRED LIST (TDRL). A list of officers and enlisted persons released from active service because of disability, the degree of which has not been permanently established, who will be monitored via mandatory periodic reexaminations, every 18 months or less, to determine whether their disability has stabilized. Once their disability has stabilized or after five years on the TDRL, whichever is less, they will be either assigned a permanent disability or offered to return to active duty. During their period on the TDRL, they will receive at least 50 percent retired pay.

P20.1.5. TERMINALLY ILL. A situation in which there is no reasonable medical possibility that the patient's condition will not continue to degenerate and result in death.

P20.1.6. TERTIARY CARE. A provision by a large medical center, usually serving a region or State and having sophisticated technological and support facilities, of highly specialized medical and surgical care for unusual and complex

medical problems.

P20.1.7. THEATER DEFENSE BLOOD STANDARD SYSTEM (T-DBSS). T-DBSS, an offspring of DBSS, is a totally self-contained patient management system that provides all the functional capabilities DBSS provides in a theater environment.

P20.1.8. THEATER MEDICAL INFORMATION PROGRAM (TMIP). TMIP provides a seamless, global medical information system linking information data bases and integration centers that are accessible to the warfighter, anywhere, anytime, in any mission.

P20.1.9. THEATER PATIENT MOVEMENT REQUIREMENTS CENTER (TPMRC). The TPMRC is responsible for theater-wide patient movement, and coordinates with theater MTFs to allocate the proper treatment assets required to support its role. The primary role of the TPMRC is to devise theater plans and schedules and then monitor their execution in concert with the GPMRC.

P20.1.10. THIRD PARTY OUTPATIENT COLLECTION SYSTEM (TPOCS). The TPOCS compiles outpatient visit information from Ambulatory Data System (ADS), and ancillary testing or services information from the Composite Health Care System (CHCS). Using rate tables for billing services from the DoD Comptroller, the system generates a billing for accounts receivable, refunds, or other healthcare insurance purposes.

P20.1.11. TRAINING AND CONTINUING EDUCATION OF NONSTUDENT PERSONNEL. Training of assigned nonstudent personnel of all ranks and specialties is designed to improve and maintain proficiency in military and medical skills, which is a necessary cost to any military medical unit. This type of training can be subdivided into continuing education, military contingency, and day-to-day proficiency training.

P20.1.12. TRANSCOM REGULATING AND COMMAND & CONTROL EVACUATION SYSTEM (TRAC2ES). A decision support system for regulation and evacuation of patients.

P20.1.13. TRANSFER. Each movement of an inpatient from one Treatment Facility (civilian or military) to another.

P20.1.14. TRANSIENT PATIENT. A patient enroute from one Military Treatment Facility to another Military Treatment Facility.

P20.1.15. TRENDPATH. An Executive Information System for healthcare management managed by the CEIS Program Office.

P20.1.16. TRENDSTAR. A decision support system that gives healthcare managers the information vehicle they need to manage across new geographic and cultural barriers. TRENDSTAR's single source of integrated management information provides views of both clinical and financial information that span network entities. TRENDSTAR is managed by the CEIS Program Office.

P20.1.17. TRIAGE. The evaluation and classification of casualties for purposes of treatment and evacuation. It consists of sorting patients according to type and seriousness of injury and the establishment of priority for treatment and evacuation. (See Joint Pub 4-02 reference (f).)

P20.1.18. TRICARE. A tri-Service managed care program that provides all healthcare for DoD beneficiaries within a DoD geographical region. The program utilizes capitation budget management. It integrates MTF direct care and CHAMPUS civilian provider resources by forming partnerships with military medical personnel and civilian contractors.

P20.1.19. TRICARE-ACTIVE DUTY FAMILY MEMBER DENTAL PLAN. A dental plan offered by DoD through the TRICARE Support Office.

P20.1.20. TRICARE EXECUTIVE COMMITTEE (TEC). The TEC serves as the executive-level committee responsible for reviewing and integrating a broad spectrum of issues ensuring a fully capable military healthcare system ready to support the continuum of military operations and the Military Health System (MHS).

P20.1.21. TRICARE EXTRA. The civilian preferred provider network organized by the contractor. To join the network, doctors and other providers agree to charge lower fees and to handle all claims-filing. To use TRICARE Extra and to benefit from the lower fees and claims-filing, a beneficiary needs only to make an appointment with a network member. There is no enrollment or registration requirement, nor is there any commitment to use the network again in the future. Seeing network providers will save beneficiaries money. One reason is because the network providers charge lower fees. Another reason is, TRICARE sets the patient's share of the cost for TRICARE Extra services at a level five percentage points lower than for TRICARE Standard. Patients are still responsible to pay annual CHAMPUS deductibles.

P20.1.22. TRICARE PRIME. Operates like a civilian health maintenance organization or HMO. It offers the most comprehensive coverage at the lowest cost to the beneficiary. TRICARE Prime provides healthcare primarily at the Military Treatment Facility, augmented by the contractor's network. Beneficiaries are assigned to primary care managers who may be an individual provider, such as a Family Practice, Internal Medicine or General Practitioner; or it may be a clinic or panel of practitioners and, where possible, those primary care managers will be part of the MTF. However, some beneficiaries may be assigned network providers as their primary-care managers. Beneficiaries must enroll for TRICARE Prime. They are committed to it for one year, then they may choose another option. Beneficiaries must agree to follow the plan for obtaining healthcare. If they do not, they may be liable for large deductibles and up to 50 percent of the cost of services they obtain from outside the plan on their own.

P20.1.23. TRICARE READINESS COMMITTEE (TRC). The TRC serves as the executive-level committee responsible for reviewing and integrating a broad spectrum of issues ensuring a fully capable military healthcare system ready to support continuum of military operations for readiness-related issues.

P20.1.24. TRICARE STANDARD. Operates in the same way as the basic CHAMPUS program. As such, it is the most expensive option for beneficiaries because it gives the greatest freedom of choice in selecting civilian providers. An annual deductible is paid for each individual with a maximum paid per family before TRICARE pays anything in the same manner as Standard CHAMPUS. In addition to the deductible, active duty family members' cost shares or co-payments--the portion paid by patients themselves--are 20-percent of the CHAMPUS allowed charge. Retirees and their families' co-payments are 25-percent. Another potential cost under TRICARE standard--patients may be responsible for paying the difference between a provider's billed charges and the CHAMPUS allowable rate--known as balanced billing--and, beneficiaries may have to file their own claims.

P20.1.25. TRICARE SUPPORT OFFICE (TSO). Formerly known as OCHAMPUS. The TSO administers an integral part of TRICARE and the Military Health System, a quality civilian health benefits program for the Uniformed Services families and acts as the primary health services activity for the Department of Defense.

P20.1.26. TRIPLE OPTION PLANS (TOP). These types of insurance plans typically contain three levels of benefits, each with various levels of flexibility to the

insured. As the level of flexibility increases, so does the amount the insured must pay out-of-pocket. These types of programs are also called step-down benefit plans.

P20.1.27. TUMOR REGISTRY. A repository of data drawn from medical records on the incidence of cancer and the personal characteristics, treatment, and treatment outcomes of cancer patients.

P20.1.28. TYPE OF FACILITY CODE/PLACE OF SERVICE. The codes indicating the location and/or type of facility that provided healthcare; i.e., inpatient hospital, doctor's office, patient's home, nursing home, etc.

P21. PART 21

GLOSSARY U

P21.1. TERMINOLOGY

P21.1.1. UB-92. The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-92, requiring the hospitals to send additional itemized bills. The UB-92 replaced the UB-82 in 1993.

P21.1.2. UNIFIED BIOSTATISTICAL UTILITY (UBU). The part of CEIS responsible for capturing and standardizing biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses, and algorithms across the MHS.

P21.1.3. UCR. Usual, customary, or reasonable. A method of profiling prevailing fees in an area and reimbursing providers on the basis of that profile. One common technology is to average all fees and choose the 80th or 90th percentile, although a plan may use other technologies to determine what is reasonable. Sometimes this term is used synonymously with a fee allowance schedule when that schedule is set relatively high.

P21.1.4. UNAUTHORIZED ABSENTEE PATIENT. A patient who is either in an unauthorized absentee status, in the case of active duty, or the non-active duty patient who has left without permission.

P21.1.5. UNBUNDLING. The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressing and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments.

P21.1.6. UNIFORM REPORTING. The reporting of financial and service data in conformance with prescribed standard definitions to permit comparisons among hospitals.

P21.1.7. UNIFORMED SERVICE. The term includes personnel serving in the Army, the Navy, the Marine Corps, and the Air Force; the Coast Guard when operating as a Service of the Navy; the Commissioned Corps of the National Oceanic

and Atmospheric Administration; and the Commissioned Corps of the Public Health Service.

P21.1.8. UNIFORMED SERVICES TREATMENT FACILITIES (USTF). The nine hospitals, previously referred to as U.S. Public Health Service hospitals, are now owned and operated by civilian industry. In addition to their normal civilian business, under the Jackson Amendment they have a charter to provide the TRICARE benefit package plus preventive medicine services to DoD beneficiaries. DoD beneficiaries may obtain care from a USTF just as they would from any DoD MTF. Beneficiaries must be enrolled in the USTF, and while enrolled must receive all care from the USTF. USTFs have an approximate 40-mile catchment area.

P21.1.9. UNIFORMED SERVICES TREATMENT FACILITY SYSTEM (USTFS). A medical AIS that provides automated support to the DoD in capturing, processing, and reporting USTF-specific beneficiary services supplied during designated periods. It supports data collections, data integration, data validation, data analysis, and reporting of data collected by USTFSs.

P21.1.10. UNIT. An organizational entity or functional division or facility.

P21.1.11. UTILIZATION REVIEW ACCREDITATION COMMISSION (URAC). A not-for-profit organization that performs reviews on external utilization review agencies (freestanding companies, utilization management departments of insurance companies, or utilization management departments of managed care plans). Its sole focus is managed indemnity and PPOs, not HMOs or similar types of plans. States often require certification by URAC for utilization management organization to operate.

P21.1.12. USEFUL LIFE OF DEPRECIABLE ASSETS. The normal operating or service life in terms of utility to the medical treatment facility.

P21.1.13. UTILIZED HOURS. The total hours (available and non-available) contributing to the completion of required work center functions. These may include work hours from assigned, detached, detailed, borrowed, contracted, or volunteer personnel.

P22. PART 22

GLOSSARY V

P22.1. TERMINOLOGY

P22.1.1. VA/DoD SHARING. A program established by Public Law 97-174 "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," May 4, 1982, to ensure maximum use of DoD and VA facilities and services within the same geographic area.

P22.1.2. VARIABLE SPECIAL PAY (VSP). Qualified medical officers below the grade of O-7 are entitled to receive VSP in monthly payments that vary with years of creditable service. The purpose of VSP is to provide an increase in compensation for all medical officers on active duty, regardless of specialty or training status. Certain Reservists may be eligible, in accordance with Section 302f of 37 U.S.C. (reference (b)).

P22.1.3. VERY SERIOUSLY ILL (VSI). When illness is of such severity that life is imminently endangered.

P22.1.4. VETERAN. A person who served on active duty in the Armed Forces and was discharged or released therefrom under conditions other than dishonorable.

P22.1.5. VETERANS AFFAIRS (VA) BENEFICIARY. A person who is entitled to certain medical care in a VA hospital, or who may be provided healthcare in a Military Treatment Facility at the expense of Veterans Affairs.

P22.1.6. VETERANS BENEFITS. Those medical benefits, authorized under 38 U.S.C. 17 (reference (i)), available to military veterans who have a Service-connected illness or injury through programs administered by the VA.

P22.1.7. VISION AND OPTICAL READINESS. The current visual and optical ability of a person or force to deploy and perform a mission. There are four specific categories (degrees) of vision and optical readiness from full deployable to non-deployable.

P22.1.8. VISIT. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.

P23. PART 23

GLOSSARY W

P23.1. TERMINOLOGY

P23.1.1. WARD. A hospital room designed and equipped to house more than four inpatients.

P23.1.2. WEIGHTED RATIONS. A ration value in which the number of meals is weighted by a predetermined percentage to balance the cost and attendance variances between the meals. The number of weighted rations is figured by multiplying the number of breakfast, lunch and dinner meals served by the weighted ration factor percentages of 20, 40, and 40 percent respectively, and totaling the results. The average number of daily weighted rations served is equal to the number of occupied-bed days.

P23.1.3. WITHHOLD POOL. A withhold pool is projected to insure against potential losses of catastrophic care loss; also called risk pool or catastrophic pool (see also CATASTROPHIC RISK and POINT OF ATTACHMENT).

P23.1.4. WOMEN'S HEALTH NURSE PRACTITIONER. Nurse Practitioner who specializes in women's health issues. Formerly designated as OB/GYN Nurse Practitioner.

P23.1.5. WORK. The activity of a body or mind that can be measured against standards in time, quantity, quality, or outcome product.

P23.1.6. WORK AREA. The functional field or physical location in which work is accomplished.

P23.1.7. WORK CENTER. A discrete function or subdivision of an organization for which provision is made to accumulate and measure its expense and determine its workload performance. The minimum work centers for a Military Treatment Facility are established by the prescribed operating expense accounts. For specific guidance, see DoD 6010.13-M (reference (a)).

P23.1.8. WORK CENTER DESCRIPTION (WCD). A format that shows work center responsibilities structured for easy measurement of work categories, tasks, and subtasks.

P23.1.9. WORKDAY. A day on which full-time work is performed.

P23.1.10. WORKLOAD. An expression of the amount of work, identified by the number of work units or volume of a workload factor, that a work center has on hand at any given time or performs during a specified period of time.

P23.1.11. WORKLOAD ASSIGNMENT MODULE. A module in CHCS that allows authorized users to generate MEPRS EAS and for the Navy the Standard Accounting and Reporting System/Field Level (STARS/FL) workload data, generate EAS and STARS/FL workload reports, manage CHCS workload data with approval processes and creates EAS and STARS/FL workload American Standard Code for Information Interchange (ASCII) files for interfacing with the EAS and STARS/FL. It also provides a centralized CHCS menu of MEPRS related reports.

P23.1.12. WORKLOAD FACTOR. An index or unit of measure that is consistently expressive of, or reliable to, the manpower required to accomplish the quantitatively- and qualitatively-defined responsibilities for a work center. Also, an end product (or a combination of products) that represents the work done in the work center. It may be either something physically produced in the work center (referred to as a production-type workload factor) or something that is external to, but served by, the work center (referred to as a work generator-type workload factor).

P23.1.13. WORKLOAD INDICATOR. A broad index sometimes used as a guide in establishing relationships between workload and manpower requirements.

P23.1.14. WORKLOAD MANAGEMENT SYSTEM FOR NURSING (WMSN). A factor evaluation patient classification system that classifies inpatients into one of six categories of acuity according to required nursing care. Hours of nursing care for each category are then translated into the appropriate number and mix of personnel needed to provide care for the patient workload. This system has both a direct and indirect care component. Users have the option to use either the manual or automated version.

P23.1.15. WORKLOAD MANAGEMENT SYSTEM FOR NURSING-DOD (WMSN-D). A medical AIS that captures nursing workload based on patient acuity and provides guidelines for effective and efficient allocation and utilization of personnel and generates personnel staffing requirements.

P23.1.16. WORK MEASUREMENT. A technique for the collection of data on man-hours and production by work units, so that the relationship between work

performed and man-hours expended can be calculated and used as the basis for manpower planning, scheduling, production, budget justification, performance evaluation, and cost control.

P23.1.17. WORK UNIT. The basic identification of work accomplished or services performed. Work units should be easy to identify, convenient for obtaining productive count, and usable for scheduling, planning, and costing.

P23.1.18. WOUNDED IN ACTION (WIA). Battle casualties, other than the individuals "killed in action," who have incurred trauma or an injury due to external agent or cause. The term encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetrating or perforating wound, or none, as in a contused wound; all fractures, burns, blast concussions, all effects of gases and like chemical warfare agents; and the effect of exposure to radioactive substances. Civilian battle casualties are not classified as WIA.

P24. PART 24

GLOSSARY X

P24.1. TERMINOLOGY

NO ENTRIES

P25. PART 25

GLOSSARY Y

P25.1. TERMINOLOGY

NO ENTRIES

P26. PART 26

GLOSSARY Z

P26.1. TERMINOLOGY

NO ENTRIES