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TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 102  
6010.56-M  
JULY 17, 2013

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

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

**CHANGE TITLE:** TRICARE OVERSEAS PROGRAM (TOP) COMBO 2013

**CONREQ:** 16454

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change corrects typographical errors, removes obsolete terms, clarifies existing requirements, and deletes the requirement for the TOP contractor to send the Philippines certified provider list electronically to the TRICARE Area Office (TAO) Pacific Director.

**EFFECTIVE DATE:** Upon direction of the Contracting Officer.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**This change is made in conjunction with Feb 2008 TPM, Change No. 94.**

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**Director, Operations Division**

**ATTACHMENT(S):** 43 PAGES  
**DISTRIBUTION:** 6010.56-M

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JULY 17, 2013**

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## Administration

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### 1.0 GENERAL

All TRICARE requirements regarding administration shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 1](#) for additional instructions regarding administration. Specific health care support services required for the performance of this contract are identified in this chapter, in the TPM, [Chapter 12](#), and the TOP contract.

### 2.0 CONTRACT ADMINISTRATION AND INSTRUCTIONS TO CONTRACTOR

**2.1** The provisions of [Chapter 1, Section 2](#) are applicable to the TOP. Additionally, the TOP contractor shall coordinate with the TRICARE Management Activity (TMA) Contracting Officer (CO), the appropriate TMA Contracting Officer Representative (COR), and the appropriate TRICARE Area Office (TAO) Director on any TOP policy or contractual issue that requires additional government **clarification or** assistance to resolve.

**2.2** The provisions of [Chapter 1, Section 2, paragraph 4.0](#) are superseded as described in [paragraphs 2.2.1](#) through [2.2.3](#).

**2.2.1** A 14 calendar day notice will be provided by the TMA Procurement Contracting Officer (PCO) for all meetings hosted by TMA.

**2.2.2** The TOP contractor shall provide annual representation at two contractor conferences (senior management level) and one Host Nation Provider Representative meeting at TMA. The contractor shall also provide up to four contractor representatives at up to four additional meetings at the direction of the CO per contract year.

**2.2.3** The TOP contractor shall provide representation at quarterly TOP roundtable meetings to be held at TMA-Falls Church with TAO representation.

### 3.0 TRICARE PROCESSING STANDARDS

**3.1** See [Chapter 1, Section 3](#) for instructions regarding TRICARE processing standards.

**3.2** The provisions of [Chapter 1, Section 3, paragraph 3.4.1](#) are not applicable to the TOP contract since there is no requirement in that contract for a dedicated Behavioral Health (BH) provider locator and assistance service.

## **4.0 MANAGEMENT**

The provisions of [Chapter 1, Section 4](#) are applicable to the TOP, except that the provisions of [Chapter 1, Section 4, paragraph 2.3](#) regarding zip code files are only applicable to Puerto Rico.

## **5.0 COMPLIANCE WITH FEDERAL STATUTES**

See [Chapter 1, Section 5](#) for instructions regarding compliance with Federal statutes.

## **6.0 LEGAL MATTERS**

See [Chapter 1, Section 6](#) for instructions regarding legal matters.

## **7.0 TRANSITIONS -- CONTRACT PHASE-IN**

### **7.1 Start-Up Plan**

The provisions of [Chapter 1, Section 7, paragraph 1.1](#) are applicable to the TOP, except that the contractor's comprehensive start-up plan shall be submitted with their contract proposal (instead of 10 calendar days following contract award). A revised start-up plan shall be submitted within 15 calendar days following the interface meetings.

### **7.2 Transition Specifications Meeting**

See [Chapter 1, Section 7, paragraph 1.2](#) for instructions regarding transition specification meeting(s). Separate meetings may be scheduled with each outgoing TOP contractor.

### **7.3 Interface Meetings**

The provisions of [Chapter 1, Section 7, paragraph 1.3](#) are applicable to the TOP, except that the requirement for interface meeting(s) with the outgoing Managed Care Support Contractor (MCSC) is replaced with a requirement for interface meetings with all outgoing overseas contractors. This includes the outgoing South Region MCSC (and its subcontractor for overseas claims processing), the outgoing TRICARE Global Remote Overseas (TGRO) contractor, the outgoing TRICARE Puerto Rico contractor, and all outgoing TAO regional enrollment/marketing contractors.

## **8.0 TRANSITIONS -- START-UP REQUIREMENTS**

**8.1** See [Chapter 1, Section 7, paragraphs 2.1, 2.2, and 2.3](#) for instructions regarding start-up requirements. For purposes of TOP implementation, all references to TRICARE Prime in [paragraph 2.2](#) shall apply to TOP Prime and TOP Prime Remote.

**8.2** Within 30 calendar days following contract award, all Military Treatment Facilities (MTFs) shall provide the TOP contractor with the names and addresses of host nation providers/facilities in the MTF's Preferred Provider Network (PPN). The TOP contractor is not required to duplicate existing networks.

## Financial Administration

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### 1.0 GENERAL

All TRICARE requirements regarding Financial Administration shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the [50](#) United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 3](#) for additional instructions.

### 2.0 PAYMENT POLICY

**2.1** Reimbursement of TOP beneficiary claims for overseas health care shall be based upon the lesser of billed charges, the negotiated reimbursement rate, or the government-[established](#) fee schedule. (See [Section 9](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 1, Sections 34](#) and [35](#) for additional guidelines). Puerto Rico claims shall be reimbursed following stateside reimbursement guidelines. Philippines and Panama claims shall be reimbursed following government-[established](#) fee schedules, unless the TOP contractor has negotiated a lesser rate with a host nation provider.

**2.2** Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. territories (Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands) shall be processed as routine foreign claims and shall be subject to the Prospective Payment System (PPS), as required under Medicare in accordance with the Social Security Act. These SNFs will be subject to the same rules as applied to SNFs in the U.S. (see the TRM, [Chapter 8](#)). SNF care is not available in other TOP locations.

**2.2.1** Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and TRICARE for Life (TFL) patients when TRICARE is the primary payer. The review required for the lower 18 Resource Utilization Groups (RUGs) for services prior to October 1, 2010, and the lower 14 RUGs for services on/after October 1, 2010, are a requirement for all TRICARE patients when TRICARE is primary (see TRM, [Chapter 8, Section 2, paragraph 4.3.16](#)). There will be no review for Standard or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

**2.2.2** Beneficiaries in the lower 18 or 14 RUGs depending on date of service do not automatically qualify for SNF coverage. These beneficiaries will be individually reviewed to determine whether they meet the criteria for skilled services and the need for skilled services (see the TRM, [Chapter 8, Section 2](#)). If these beneficiaries do not meet these criteria, the SNF PPS claim shall be denied.

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**2.2.3** The TOP contractor, at their own discretion, may collect Minimum Data Set (MDS) assessment data per the TRM, [Chapter 8, Section 2](#).

**2.3** The TOP contractor shall be responsible for entering into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

**2.3.1** The TOP contractor, at their own discretion, may conduct any data analysis to identify aberrant SNF PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG. The contractor shall also assist the TRICARE Area Office (TAO) Directors in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

**2.4** Balance billing provisions do not apply to TOP beneficiary claims for TOP overseas health care paid as billed, since there is no unpaid balance on these claims. Host nation network providers and participating providers are prohibited from balance billing.

**2.5** For health care rendered in Puerto Rico and in the U.S., reimbursement for all TOP beneficiary care shall follow the TRICARE payment policies except as outlined below.

**2.5.1** Non-participating provider claims for Active Duty Service Member (ADSM) health care received in the 50 United States and the District of Columbia shall be paid following TRICARE reimbursement rules for institutional and non-institutional care in that location. The TOP contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, first a rate within the 100% CHAMPUS Maximum Allowable Charge (CMAC) limitation and then second, a rate between 100 and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the TAO Director, as the designee of the Chief Operating Office (COO), TMA, to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the TAO Director before the negotiation can be concluded. The contractors shall ensure that the approval payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

**2.5.2** TOP ADSMs who have been required by the provider to make "up front" payment at the time services are rendered may submit a claim for reimbursement directly to the contractor. Normal TRICARE claims processing requirements apply (including any authorization requirements and the use of TRICARE-approved claims forms). If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

**2.5.3** In no case shall an ADSM be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve, they shall pend the file and forward the issue to the appropriate TAO Director. The appropriate TAO Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the TAO Director has requested and has been granted a waiver from the COO, TMA, or designee.

**2.5.4** Overseas drug claims shall be paid following the instructions in [Section 9](#) and the TRM, [Chapter 1, Section 15](#).

**2.5.5** Overseas ambulance service claims shall be paid following the instructions in [Section 7](#) and [Chapter 8, Section 1](#).

**2.5.6** Payment may be made for ambulance services provided by commercial transport (see [Section 7](#) for additional processing instructions for these claims).

**2.5.7** The provisions of [Chapter 3, Section 2, paragraph 2.2](#) are not applicable to the TOP. The TOP contractor may not require host nation providers who submit claims electronically to accept an electronic remittance advice and to receive payment by Electronic Funds Transfer (EFT). These electronic processes are optional for host nation providers since they may create a financial burden for the provider.

### **3.0 FINANCIAL ADMINISTRATION**

**3.1** The TOP contractor shall follow the Financial Administration non-financially underwritten funds requirements in [Chapter 3](#) with the following exceptions:

**3.1.1** Foreign overseas drafts (local currency) and checks (U.S. currency) shall also reflect "TRICARE Overseas Program".

**3.1.2** Foreign overseas drafts shall also reflect information that indicates the draft is valid for 190 days and if reissue is required/necessary, the draft must be returned to the overseas claims processing contractor with a request for reissuance. The contractor shall issue drafts/checks for Germany claims which look like local German drafts/checks.

**3.2** The TRICARE Encounter Data (TED) for the overseas claims shall be reported on vouchers/batches according to the TRICARE Systems Manual (TSM), [Chapter 2](#) and as follows for remote sites:

**3.2.1** Active Duty Family Member (ADFM) and ADSM remote site claims, excluding health care claims for emergent/urgent care for Navy and Marine Corps ADSM who are either deployed and or deployed on liberty status in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten foreign bank account. They shall be submitted like all other claims currently processed from that account.

**3.2.2** Navy deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The Automated Standard Application for Payment (ASAP) account on the voucher header will identify the voucher as Navy.

**3.2.3** Marine Corps deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The ASAP account on the voucher header will identify the voucher as Marine Corps.

**3.2.4** **Claims for retirees and their eligible family members** living in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

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**3.2.4.1** Claims for care rendered in the United States or the District of Columbia to TOP ADSM, ADFM, retirees and their dependents living in a remote overseas site shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3** For other than remote site claims:

**3.3.1** TOP eligible ADSM and ADFM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.2** Claims for retirees and their eligible family members living overseas shall be submitted on vouchers and shall be paid from the current non-financially underwritten or TFL/accrual fund bank accounts. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.3** TOP Prime (ADSM and ADFM) and TOP Standard beneficiary stateside claims for health care shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.4** Overseas health care claims for stateside beneficiaries whose health care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States or the District of Columbia, who receive care while traveling or visiting abroad) shall be processed by the TOP contractor. Claims for these beneficiaries shall be paid from the current non-financially underwritten bank account. This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

**3.4** The TOP contractor shall:

**3.4.1** Provide TRICARE Overseas Currency reports identifying the gain or loss for the month reported to arrive by the 10th calendar day following the month reported. The reports for net gains/losses shall be sent in an electronic format to TMA, Attn: Finance and Accounting Branch, 16401 East Centretch Parkway, Aurora, CO 80011-9066.

**3.4.2** The TOP contractor shall calculate currency gains and losses resulting from payments made to host nations providers and/or beneficiaries in foreign countries. The gains and losses shall be computed based on the exchange rate in effect on the ending date of care. The difference between the cost of the foreign currency on the ending date of care and the contractor payment date shall be the gain or loss on the transaction. Payment shall be as follows for:

**3.4.2.1** Net Gain. For months that result in a net gain, the TOP contractor shall forward the report along with their check payable to the Department of Defense (DoD), TMA, for the gain from currency conversion.

**3.4.2.2** Net Loss. TMA will reimburse the TOP contractor for any losses incurred from currency conversion. The TRICARE Overseas Currency report shall be accompanied by a letter (invoice)

## Host Nation Providers

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### 1.0 GENERAL

TRICARE Overseas Program (TOP) health care services are provided by Military Treatment Facilities (MTFs) and host nation network and non-network providers and institutions. All TRICARE requirements regarding Provider Certification/Credentialing and Network Development shall apply to the TOP unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), Chapter 12; or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP Contract"). See Chapters 4 and 5 for additional instructions.

### 2.0 HOST NATION PROVIDER CERTIFICATION AND CREDENTIALING

2.1 The TOP contractor will be responsible for provider certification oversight, and monitoring of provider/institution quality. The contractor shall use Chapter 4, 32 CFR 199.6, and TPM, Chapter 11 to the maximum extent possible for the certification of host nation providers. The contractor is not required to follow TRICARE requirements for United States (U.S.) credentialing standards, except that services that are specifically linked to the Medicare program (e.g., home health, hospice, Skilled Nursing Facility (SNF) care) must be provided by a Medicare certified provider or facility. Also, Psychiatric Residential Treatment Centers (RTCs), Substance Use Disorder Rehabilitation Facilities (SUDRFs), and Psychiatric Partial Hospitalization Programs (PHPs) that are located in Puerto Rico require approval by the TRICARE Quality Monitoring Contractor (TQMC). Except for these services and facilities, the TOP contractor shall establish host nation provider certification processes based on the accepted licensure and credentialing requirements for the host nation.

**Note:** Medicare certification for organ transplant centers is only required for transplants performed in the U.S., the District of Columbia, and U.S. territories where Medicare is available. See TPM Chapter 12, Section 1.2.

2.2 Refer to Section 14 for additional certification requirements that have been established for host nation providers in the Philippines. TRICARE Management Activity (TMA) may expand these additional certification requirements to other locations in the future.

### 3.0 NETWORK DEVELOPMENT

3.1 The TRICARE Overseas health care support contractor (hereinafter referred to as the "TOP contractor") is responsible for developing and maintaining a complement of network and non-network host nation providers to augment the existing capacity of the Direct Care (DC) system for Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM) who are enrolled in TOP Prime, and to provide or arrange for primary and specialty care services for ADSMs and ADFMs who are enrolled in TOP Prime Remote.

**Note:** In remote overseas locations, the TOP contractor shall also establish dental provider networks for ADSMs in accordance with [Section 10](#).

**3.2** The TOP contractor shall establish signed provider agreements between network host nation providers and the contractor. Network provider agreements shall include language indicating that the provider agrees to participate on claims for authorized services for TOP enrollees on a cashless, claimless basis.

**Note:** "Cashless, claimless" is defined as a health care encounter that requires no up-front payment at the time of service, and the provider files the claim for the beneficiary.

**3.3** Networks will be sized to meet TOP-enrolled populations only. The TOP contractor may assist other beneficiaries (non-command sponsored ADFMs, retirees, retiree family members, etc.) upon request by identifying these host nation providers as they will be credentialed and familiar with TRICARE, but networks will not be developed to accommodate non-TOP enrollees.

**3.4** In TOP Prime locations, MTF commanders shall identify the specialties needed in the network and will communicate this information on an ongoing basis to the TOP contractor per the process identified in the Memorandum Of Understanding (MOU) (see [Section 16](#)).

**3.5** MTF capabilities and capacities may change frequently over the life of the contract without prior notice. The TOP contractor shall ensure that host nation provider services can be adjusted as necessary to compensate for changes in MTF capabilities and capacities, when and where they occur over the life of the contract, including short notice of unanticipated facility expansion, provider deployment, downsizing, and/or closures.

**3.6** Network providers shall be able to communicate in English, both orally and in writing, or provide translation services at the time of service.

**3.7** The TOP contractor shall be responsible to enter into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands per the provisions of [Section 3](#).

#### **4.0 CONTRACTOR REQUIREMENTS - HOST NATION PROVIDERS**

**4.1** Reimbursement rates for host nation providers may be negotiated by the contractor unless the government has designated specific reimbursement rates or methodologies. Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 34](#) for additional instructions.

**4.2** The contractor shall provide ongoing host nation provider education and support in accordance with [Section 11](#).

**4.3** The contractor shall have a Quality Oversight Plan for reviewing access and quality of care provided by host nation providers. This plan shall incorporate customer comments and feedback regarding care from host nation providers.

**4.4** The TOP contractor is required to assign provider numbers to host nation providers, identify providers as network or non-network, and create and submit TRICARE Encounter Provider (TEPRV) records. Each provider shall be identified by a single provider number, with a sub-identifier for

form (e.g., specific provider, gender or specialty preference). If the beneficiary's PCM preferences are incompatible with MTF enrollment/empanelment guidelines, the beneficiary shall be enrolled according to MTF guidelines. If the preferred PCM is not available (no capacity), the contractor will use the default PCM for that MTF. If there is no PCM capacity in the MTF, the contractor shall contact the MTF for instructions.

**8.5** A significant number of MTF PCMs rotate or move each year. This will require the TOP contractor to move the enrollment panels associated with those PCMs. Through a government-provided application, the contractor shall perform batch PCM reassignments based on the parameters established by the MTF. Those parameters include DMIS ID to DMIS ID, PCM ID to PCM ID, Health Care Delivery Plan (HCDP), sex of beneficiary, Unit Identification Code (UIC) (active duty only), age of beneficiary, sponsor Social Security Number (SSN) (for family moves) and name of beneficiary. The contractor will perform MTF PCM reassignment moves within three working days of the effective date of the PCM's reassignment. The contractor will also perform PCM reassignment, as necessary, in response to turnover in host nation PCMs.

**8.6** The TOP contractor shall enroll TOP Prime Remote beneficiaries to the appropriate enrollment DMIS ID based on beneficiary location. The contractor shall list the name of the assigned remote location/site or the host nation PCM, as appropriate.

## **9.0 ENROLLMENT PROCEDURES**

**9.1** No TRICARE-eligible beneficiary shall be denied enrollment or re-enrollment in, or be required to disenroll from, the TOP Prime/TOP Prime Remote program because of a prior or current medical condition.

**9.2** The TOP contractor shall be responsible for enrollment processing and for coordinating enrollment processing with the MTF, the appropriate TAO Director, and DEERS. The contractor shall enter enrollments into DEERS through the National Enrollment Database (NED) according to the provisions of the TSM, [Chapter 3](#). The contractor shall perform the following specific functions related to enrollment processing:

**9.2.1** The contractor shall collect TOP Prime enrollment applications at the TSCs or other sites mutually agreed to by the contractor, TAO Director, and the MTF Commander, or by mail or other secure means determined by the contractor. The contractor shall collect TOP Prime Remote service area applications by mail or other secure means determined by the contractor.

**9.2.2** At the time of enrollment processing, the contractor shall access DEERS to verify eligibility of applicants and shall update the residential mailing address and any other fields for which they have update capability on DEERS. If the enrollment form does not contain a mailing address, the enrollment form should be developed for a mailing address. Enrollees may submit a temporary address (e.g., unit address) until a permanent address is established. Temporary addresses must be updated with the permanent address when provided to the contractor by the enrollee in accordance with the TSM, [Chapter 3, Section 1.4](#). The contractor shall not input temporary addresses not provided by the enrollee. If the DEERS record **does** not contain an address, or if the application contains information different from that contained on DEERS in fields for which the contractor does not have update capability, the contractor shall contact the beneficiary within five calendar days outlining the discrepant information and requesting that the beneficiary contact their military personnel information office for assistance in updating the DEERS record.

**9.2.3** Enrollment applications must be signed by the sponsor, spouse, or other legal guardian of the beneficiary. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#). A signature from an ADSM, although desired, is not required to complete Prime enrollment as enrollment in Prime is mandatory per TPM, [Chapter 10, Section 2.1, paragraph 1.1](#).

**9.3** All TOP enrollees shall be issued enrollment cards per TSM, [Chapter 3, Section 1.4](#).

**9.4** TOP Prime/TOP Prime Remote enrollment may occur at any time during the period of TOP eligibility and shall remain effective until the enrollee transfers enrollment to another region, disenrolls, or becomes ineligible for TOP Prime/TOP Prime Remote or the TRICARE program.

**9.5** TOP Prime/TOP Prime Remote enrollment may be on an individual or family basis. Single enrollment may be changed to family at any time during the TOP enrollment period. A new TOP enrollment period shall be established for the family.

**9.6** Enrollment fees are not required for TOP Prime/TOP Prime Remote.

**9.7** ADSMs and ADFMs on PCS assignment in Canada (not at the request of the Canadian government) may enroll in TOP, but must pay up front for all health care and file a claim with the TOP contractor for reimbursement.

## **10.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4**

**10.1** The provisions of [Chapter 6, Section 1](#) regarding enrollment of family members of E-1 through E-4 shall apply to the TOP, except that TOP Prime/TOP Prime Remote enrollment shall be effective on the date that the application is signed as long as it coincides with dates of eligibility.

**10.2** The provisions of [Chapter 6, Section 2](#) regarding enrollment portability shall apply to the TOP, except that stateside-enrolled retirees and retiree family members may not transfer Prime enrollment to an overseas location.

## **11.0 SPLIT ENROLLMENT**

The provisions of [Chapter 6, Section 3](#) regarding split enrollment shall apply to the TOP.

## **12.0 DISENROLLMENT**

**12.1** ADFMs shall be disenrolled from TOP Prime/TOP Prime Remote when:

- The enrollee requests disenrollment,
- The enrollee transfers enrollment to a new TRICARE region,
- The enrollee loses eligibility for TOP Prime or TOP Prime Remote,
- The enrollee loses TRICARE eligibility in DEERS, or
- The enrollee has not requested enrollment transfer/disenrollment within 60 calendar days following the end of the overseas tour.

## Medical Management

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### 1.0 GENERAL

All TRICARE requirements regarding Utilization Management (UM) and Quality Management (QM) shall apply to the TRICARE Overseas Program (TOP) unless specifically **changed**, waived, or superseded by the provisions of this section; **the TRICARE Policy Manual (TPM), Chapter 12**; or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See **Chapter 7** for additional instructions. Language in **Chapter 7** that has no direct application to the TOP contract does not apply (e.g., **Diagnosis** Related Group (DRG) validation reviews which are not applicable in any overseas location except Puerto Rico).

### 2.0 UTILIZATION MANAGEMENT

**2.1** The contractor shall establish a UM plan for care received by TRICARE beneficiaries.

**2.1.1** The contractor's UM plan shall recognize that the Military Treatment Facility (MTF) Primary Care Manager (PCM) retains clinical oversight for TOP Prime enrollees. As such, the enrolling MTF is responsible for issuing all authorizations for TOP Prime enrollees, and for providing UM/case management services for the MTF-enrolled population. The contractor is responsible for ensuring that MTF-issued authorizations are entered into all applicable contractor systems to ensure accurate, timely customer service and claims adjudication. The contractor is also responsible for providing notification of case to the MTF commander or designee whenever an MTF enrollee is admitted to an inpatient facility (including mental health admissions), regardless of location. Notification of case shall be accomplished No Later Than (NLT) 12 hours after the contractor becomes aware of the hospital admission.

**2.1.2** The contractor shall be responsible for review and authorization of specialty care for TOP Prime Remote enrollees and all Active Duty Service Members (ADSMs) who are on Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, or deployed/deployed on liberty in a remote overseas location. The contractor shall provide notification of cases to the appropriate TRICARE Area Office (TAO) for reviews involving remote ADSM requests for specialty care, and whenever hospital admissions have occurred for any beneficiary not enrolled to a TOP MTF (including mental health admissions), regardless of location. Notification of case shall be accomplished NLT 12 hours after the contractor becomes aware of the hospital admission.

**2.1.3** The contractor shall also be responsible for review and authorization of urgent specialty care for beneficiaries enrolled to a stateside Managed Care Support Contractor (MCSC) who are traveling outside of the 50 United States and the District of Columbia. Notification of case for inpatient admissions (including mental health admissions) for these beneficiaries shall be made to the appropriate regional TAO Director (based on the facility location) NLT 12 hours after the contractor becomes aware of the hospital admission.

**2.2** The UM plan shall recognize that host nation network providers (except for TOP Partnership Providers) are the responsibility of the TOP contractor and the contractor shall ensure that any adverse finding related to host nation provider care is forwarded within five calendar days of identification to the appropriate TAO.

**2.3** The UM plan shall include a process for identifying high utilization/high cost patients and locations.

**2.3.1** At a minimum, this process shall include the identification of patients exceeding **the frequency and/or cost thresholds established in the TOP contract**. These thresholds apply to all TOP beneficiaries, including TOP Prime, TOP Prime Remote, TOP Standard, and TOP TRICARE For Life (TFL).

**2.3.2** The TOP contractor shall review these claims for appropriateness of care, and shall propose interventions to reduce overutilization or contain costs whenever possible. Proposed interventions to cost and/or overutilization shall be forwarded to the government for review prior to contractor implementation.

**2.4** The UM plan shall integrate efforts to identify potential fraud/abuse. Any cases identified as possible fraud/abuse shall be referred directly and exclusively to the TRICARE Management Activity (TMA) Program Integrity (PI) Office in accordance with [Section 14](#).

**2.5** The TOP contractor shall provide case management services as outlined in the contract with TMA. Specific case management processes shall be addressed in the Memorandum of Understanding (MOU) between the contractor, Military Treatment Facility (MTF) commanders and the TAO Directors.

**2.6** The TOP contractor shall closely monitor requests for inpatient care or medical evacuation services to ensure that services are medically necessary and appropriate for the patient's condition. Beneficiaries will not be assigned to a particular facility or medically evacuated to a particular geographic location based solely on personal preference, but will be transported to the closest medical facility capable of providing appropriate stabilization and/or treatment.

**2.7** Inpatient stays that exceed the standard Length-Of-Stay (LOS) for a local area in a host nation country shall be identified and reviewed for medical necessity. Unless a different standard has been identified by the government, the contractor shall use best business practices to determine the standard LOS for a particular overseas location.

### **3.0 CONTRACTOR RELATIONSHIP WITH THE MILITARY HEALTH SYSTEM (MHS) TRICARE QUALITY MONITORING CONTRACTOR (TQMC)**

The provisions of [Chapter 7, Section 3](#) do not apply to the TOP.

### **4.0 CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)**

**4.1** The provisions of [Chapter 7, Section 4](#) are applicable to the TOP, except that the requirement for interface with the TQMC is waived for the TOP. The TQMC does not conduct regular, ongoing reviews to validate the appropriateness of the TOP contractor's quality of care and utilization

review decisions; however, the TQMC may provide such reviews on a limited basis upon government request.

**4.2** The TOP contractor shall monitor quality of care issues on a quarterly basis. Quality concerns shall be identified to the appropriate TAO Director; corrective action plans (when needed) shall be submitted to the appropriate TAO Director and the TMA Contracting Officer (CO).

## **5.0 REFERRAL/AUTHORIZATION/HEALTH CARE FINDER REQUIREMENTS**

**5.1** The TOP contractor shall develop procedures for processing referrals for TOP Prime and TOP Prime Remote enrollees in accordance with the TOP contract; [Chapter 8, Section 5](#); and this chapter. The TOP contractor shall conduct related authorization and Health Care Finder (HCF) activities. The MTF is responsible for conducting medical necessity reviews for TOP MTF enrollees and for determining that the requested care is not available in the MTF prior to forwarding the referral to the contractor.

**5.1.1** The contractor shall conduct covered benefit reviews to determine whether the referred care is a covered TRICARE benefit. Medical necessity notification to beneficiaries regarding covered benefit findings shall follow the provisions of [Chapter 8, Section 5](#). The contractor shall locate an appropriate network or non-network host nation provider for all authorized care and shall provide the provider information to the beneficiary. Upon beneficiary request, the contractor shall assist with scheduling an appointment for the beneficiary. The contractor shall also implement guarantee of payment or other business process to ensure that TOP Prime and TOP Prime Remote beneficiaries have access to authorized care on a cashless, claimless basis.

**Note:** Although a referral/authorization is never required for emergency care, TRICARE Prime/TRICARE Prime Remote (TPR) ADFMs who require emergency care (including emergency medical evacuation, if medically necessary and appropriate) while traveling outside the 50 United States and the District of Columbia will be provided with emergency care on a cashless, claimless basis upon notification to the TOP contractor before the services are rendered (see [Sections 7](#) and [9](#)).

**5.2** The TOP contractor shall develop procedures for the identification and tracking of TOP enrollee claims submitted by either a TOP host nation designated or non-designated overseas host nation provider or a beneficiary without preauthorization/authorization.

**5.3** The TOP contractor is required to educate beneficiaries of preauthorization/authorization requirements and of the procedures for requesting preauthorization/authorization. In MTF locations, these beneficiary education efforts may be conducted in conjunction with MTF staff. Although beneficiaries are required to obtain authorization for care prior to receiving payment for the care requiring TOP preauthorization/authorization, retroactive authorization may be requested following the care from the appropriate authority for issuing authorizations. The contractor shall document preauthorization/authorizations according to current contract requirements.

**5.4** If medical review is required to determine medical necessity of a service rendered, the TOP contractor shall follow the requirements outlined in [Chapter 7, Section 1](#) related to medical review staff qualifications and review processes.

**5.5** The TOP preauthorization/authorization must be submitted with the claim or be available via **internal contractor systems designated to interface with the claims processing system.**

**5.6** The TOP contractor must maintain a preauthorization/authorization file.

**5.7** When necessary, clarification of discrepancies between authorization data and data on the claims shall be made by the TOP contractor with the appropriate authorizing authority.

**5.8** Except for obstetrical care or other long-term/chronic care authorizations, the TOP contractor shall consider authorizations valid for 90 days (i.e., date of service must be within 90 days of issue date). Authorizations may be granted for 365 days for obstetrical care, or for any other long-term/chronic conditions for which an extended care period is medically necessary and appropriate. Only services that are applicable to the care authorization shall be covered under the authorization (i.e., a care authorization for obstetrical care cannot be extended to cover specialty care that is unrelated to the pregnancy). The contractor shall consider retroactive and chronic authorizations valid for the specific date/care authorized.

**5.9** Procedures for preauthorizations/authorizations for TOP beneficiaries for inpatient mental health care rendered in the 50 United States or the District of Columbia shall be developed between the TOP contractor (and the mental health subcontractor, if applicable) and the overseas TAO Directors in coordination with the appropriate TMA Contracting Officer's Representative (COR). The TOP contractor is responsible for authorizing/reviewing all stateside non-emergency inpatient mental health care (i.e., Residential Treatment Center (RTC), Substance Use Disorder Rehabilitation Facility (SUDRF), etc.) and outpatient mental health care sessions nine and above per fiscal year for TOP Prime/TOP Prime Remote ADFMs, regardless of where the care is rendered. To perform this requirement, the contractor shall at a minimum provide three 24-hour telephone lines: one stateside toll free, one commercial and one fax for overseas inpatient mental health review requirement, sample forms for use by the referring physician when requesting preauthorization/authorization for care, and a system for notification of the contractor when care has been authorized. Additionally, the TOP contractor shall:

**5.9.1** Inform the beneficiary/provider if a desired facility is not a TRICARE authorized facility and offer the beneficiary/provider a choice of alternative facilities and assist with identifying stateside facilities for referring providers.

**5.9.2** Upon request, either telephonically or by fax, from a referring provider, the contractor will initiate preauthorization prior to admission for non-emergency inpatient care, including TRC, SUDRF, Partial Hospitalization Program (PHP), etc. (Essentially, all admissions defined by TPM, [Chapter 1, Section 7.1](#), as requiring preauthorization). The TOP contractor will arrange ongoing utilization review, as indicated, for overseas beneficiaries admitted to any level of inpatient mental health care.

**5.9.3** The review determination must conclude in either authorization or denial of care. Review results must be faxed to the beneficiary/provider within 24 hours of the request. The review and denial process will follow, as applicable the processes outlined in [Chapter 7](#).

**5.9.4** The TOP contractor will provide an opportunity to discuss the proposed initial denial determination with the patient's attending physician AND referring physician (if different providers). The purpose of this discussion is to allow further explanation of the nature of the beneficiary's need for health care support services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care. This is important in those beneficiaries designated to return overseas, where supporting alternative level of care is limited, as

well as support for intensive outpatient treatment. If the referring provider does not agree with the denial determination, then the contractor will contact the appropriate overseas TAO Director to discuss the case. The TAO Director will provide the schedule and contact information for all overseas TAO mental health advisors. The final decision on whether or not to issue a denial will be made by the TOP contractor.

**5.9.5** The TOP contractor will notify the referring provider if the patient is returning to ensure coordination of appropriate after-care arrangements, as well as facilitate discussion with the attending provider to ensure continuity of care is considered with the proposed after-care treatment plan.

**5.9.6** The TOP contractor will adhere to the appeals process outlined in [Section 13](#).

**5.10** The required data elements for MTF referrals prescribed in [Chapter 8, Section 5, paragraph 6.1](#) may be altered to accommodate the delivery of health care overseas with the permission of the government.

**Note:** Any alteration to the referral data elements prescribed in [Chapter 8, Section 5, paragraph 6.1](#) must be approved in writing by the TMA CO prior to implementation.

## **6.0 CASE MANAGEMENT**

The TOP contractor shall establish and operate a case management program to identify and manage the health care of individuals with high-cost conditions or with specific diseases or conditions for which evidence-based clinical management. This program shall be available to all TOP beneficiaries (both enrolled and non-enrolled) except TRICARE-Medicare dual eligible beneficiaries who receive care in the Commonwealth of Puerto Rico, Guam, American Samoa, the Northern Marianas, and the U.S. Virgin Islands. MTFs retain primary responsibility for case management for MTF enrollees; however, the contractor shall assist the MTF by identifying MTF enrollees who might benefit from case management, and by coordinating care for these individuals with the MTF clinical staff as well as the host nation civilian provider staff. The contractor shall submit a Case Management Program and patient selection criteria and shall provide annual updates in accordance with the provisions of the TOP contract.

## **7.0 DISEASE MANAGEMENT**

The TOP contractor shall establish and operate a disease management program for TOP Prime Remote enrollees. Disease management conditions will be asthma, diabetes, cancer screening, depression and anxiety disorders, and hypertension. The contractor shall submit a Disease Management Program Plan describing the contractor's guidelines, protocols, and interventions and shall provide annual reports in accordance with the provisions of the TOP contract.

- END -



**5.6** Refer to [Section 10](#) for referral/preauthorization/authorization requirements for ADSM dental care in remote overseas locations.

## **6.0 CLAIM DEVELOPMENT**

**6.1** Development of missing information shall be kept to a minimum. The TOP contractor shall use available in-house methods, contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS), etc., to obtain incomplete or discrepant information. If this is unsuccessful, the contractor may return the claims to sender with a letter which indicates that the claims are being returned, the reason for return and requesting the required missing documentation. The contractor's system must identify the claim as returned, not denied. The government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits. The contractor shall review all claims to ensure TOP required information is provided prior to payment. **For the Philippines, claims requiring development of missing or discrepant information, or those being developed for medical documentation, shall be pended for 90 days and are excluded from the claims processing standard.**

**6.2** Claims may be filed by eligible TRICARE beneficiaries, TOP host nation providers, TOP POCs, and TRICARE authorized providers in the 50 United States and the District of Columbia as allowed under TRICARE (see [Chapter 8, Section 1](#)). Providers may submit claims by fax if the TOP contractor provides a secure fax for claims receipt by the contractor.

**6.3** Confidentiality requirements for TOP are identical to TRICARE requirements outlined in [Chapter 8](#).

**6.4** As a guideline, all overseas claims shall be sent to the microcopy area, transferred to microcopy format, and returned to the contractor's claims processing unit No Later Than (NLT) the close of business the following working day of submission.

**6.5** The provisions of [Chapter 8, Section 9](#) are applicable to TOP.

**6.6** The following minimal information is required on each overseas claim prior to payment:

### **6.6.1 Signatures**

Beneficiary and host nation provider signatures.

### **6.6.2 Name and Address**

**6.6.2.1** Complete beneficiary and host nation provider name and address.

**6.6.2.2** If an address is not available on the claim, obtain the address either from previously submitted claims, directly from the beneficiary/host nation provider via phone, fax or e-mail, DEERS per [paragraph 6.11](#), or notify the TAO Director as appropriate.

**Note:** The TOP contractor shall accept APO/FPO for the beneficiary address.

### 6.6.3 Diagnosis(es)

**6.6.3.1** A valid payable diagnosis. Prior to returning a claim that is missing a diagnosis, the TOP contractor shall research the patient's history and determine whether a diagnosis from a related claim can be applied.

**6.6.3.2** Claims received for dates of service for outpatient services or dates of discharge for inpatient services prior to International Classification of Diseases, 10th Revision (ICD-10) implementation, with ICD-10 codes shall be converted to International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) codes by the TOP contractor. Claims received for dates of service for outpatient services or dates of discharge for inpatient services on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**, with International Classification of Diseases, 9th Revision (ICD-9) or ICD-9-CM codes shall be converted to International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM) codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraphs 4.0 and 5.0](#) regarding the use of ICD-9-CM **V** codes (factors influencing health status and contact with health services) and ICD-10-CM **Z** codes (factors influencing health status and contact with health services).

### 6.6.4 Procedures/Services/Supply/DME

Identification of the procedure/service/supply/DME ordered, performed or prescribed, including the date ordered performed or prescribed. The TOP contractor may use the date the claim form was signed as the specific date of service, if the service/purchase date/order date is not on the bill.

**6.6.5** Claims received with a narrative description of services provided shall be coded by the TOP contractor with as accurate-coding as possible based upon the level of detail provided in the narrative description or as directed by the TMA CO. The provisions of [paragraph 6.1](#) apply for narrative claims that cannot be accurately coded due to insufficient or vague information. Claims received for dates of service for outpatient services or dates of discharge for inpatient services prior to ICD-10 implementation, with International Classification of Diseases, 10th Revision (ICD-10) codes shall be converted to ICD-9 codes by the TOP contractor. Claims received for dates of discharge for inpatient services on or after the date specified by the CMS in the Final Rule as published in the **Federal Register**, with ICD-9 codes shall be converted to ICD-10 codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of **V** and **Z** codes.

#### 6.6.5.1 Inpatient Institutional Procedures

Inpatient institutional (i.e., hospital) claims received for claims received for dates of discharge for inpatient services prior to ICD-10 implementation, shall have the procedure narratives coded by the TOP contractor using ICD-9-CM, Volume 3 procedure codes. Inpatient institutional (i.e., hospital) claims received for dates of discharge for inpatient services on or after the date specified by the CMS in the Final Rule as published in the **Federal Register**, shall have the procedure narratives coded by the TOP contractor using ICD-10-Procedure Classification System (ICD-10-PCS) procedure codes.

**9.2** The TOP contractor shall ensure that business processes are established which require appropriate system and/or supervisory controls to prevent erroneous manual overrides when reviewing potential duplicate payments.

## **10.0 DOUBLE COVERAGE**

**10.1** TOP claims require double coverage review as outlined in the TRM, [Chapter 4](#).

**10.2** Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TAO Director for resolution with the contractor.

**10.3** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. National Health Insurance (NHI) plans do not always provide EOBs to assist in the adjudication of TRICARE claims. If a beneficiary has attempted unsuccessfully to obtain an EOB from their NHI plan, they may submit a beneficiary attestation and an itemized claim checklist (approved by TMA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the TMA-approved **document**.

**Note:** If the Japanese insurance points are not clearly indicated on the claim/bill, the TOP contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim.

## **11.0 THIRD PARTY LIABILITY (TPL)**

The TOP contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the [Chapter 10](#).

## **12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS**

When processing TOP claims, the TOP contractor shall follow the reimbursement payment guidelines outlined in the TRM, [Chapter 1, Section 34](#) and the cost-sharing and deductible policies outlined in the TRM, [Chapter 2, Section 1](#), and shall:

**12.1** Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, **or the manner in which services are rendered and considered the standard of care in a host nation country, such as rehabilitation services received in an inpatient setting**.

**12.2** Reimburse claims at the lesser of the billed amount, the negotiated reimbursement rate, or the government established fee schedules (TRM, [Chapter 1, Sections 34 and 35](#)), unless a different reimbursement rate has been established as described in TPM, [Chapter 12, Section 1.3](#).

**12.3** Not reimburse for host nation care/services specifically excluded under TRICARE.

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**12.4** Not reimburse for host nation care/services provided in the Philippines unless all of the certification requirements listed in [Section 14](#) have been met.

**12.5** Not reimburse for administrative charges billed separately on claims, except for individual administrative charges as determined by the government. The contractor shall reimburse these charges only in instances when the fee is billed concurrently with the corresponding health care services. If a bill is received for these charges without a corresponding health care service, the charges should be denied.

**12.6** Determine exchange rates as follow:

**12.6.1** Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the TOP contractor shall use the exchange rate of the primary insurer, not the rate based on the last date of service to determine the TOP payment amount, and/or;

**12.6.2** Use the ending dates of the last service to determine exchange rates for multiple services.

**12.6.3** Use the exchange rate in [paragraph 12.6.1](#) to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

**12.6.4** Overseas drafts/checks and EOBs. Upon completion of processing, checks (payable in U.S. dollars) shall be created by the TOP contractor within 48 hours, after Contract Resource Management (CRM) approval. Drafts (payable in foreign currency units) shall be created by the TOP contractor within 96 hours following CRM approval, unless a different process has been authorized by TMA. Payments that need to be converted to a foreign currency shall be calculated based on the exchange rate in effect on the last date of service listed on the EOB. Drafts/checks shall be matched with the appropriate EOB, and mailed to the beneficiary/sponsor/host nation provider/POC as applicable.

**Note:** Drafts for certain foreign currency units may require purchase from a bank location other than the one normally used by the TOP contractor (out of state or out of country). Currency units that must be purchased from an alternate bank (out of state or out of country) may take up to 10 business days for the draft to be returned and matched up with the EOB.

**12.7** The TOP contractor shall convert lump sum payments instead of line items to minimize conversion problems.

**12.8** Provider claims for all overseas locations (excluding claims from Korean providers) will be paid by foreign currency/drafts. Drafts may not be changed to a U.S. dollar check after the contractor has issued a foreign draft. Claims from Korean providers will be paid in U.S. dollars.

**12.9** Foreign overseas drafts (in local currency) are good for 190 days and may be cashed at any time, unless a different process has been established by TMA. U.S. dollar checks are good for 120 days unless a different process has been established by TMA. The provisions of [Chapter 3, Section 4](#) regarding staledated, voided, or returned checks/Electronic Funds Transfers (EFTs) are applicable to the TOP.

**12.10** TOP claims submitted by a beneficiary shall be paid in U.S. dollars, unless there is a beneficiary request on the claim at the time of submission for payment in a foreign currency. The

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TOP contractor may reissue the payment in U.S. dollars if a request is subsequently received from the beneficiary and the foreign draft is included in the request or the payment has staledated.

**12.11** Payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxemburg, Netherlands, Austria, Portugal, Spain, Cyprus, and Malta shall be made in Euros. As other countries transition to Euro, the TOP contractor shall also switch to Euros.

**12.12** The contractor shall issue drafts/checks for German claims which look like German drafts/checks.

**Note:** In order for TRICARE drafts/checks to look like German drafts/checks, a German address must be used. The TOP contractor may use a corporate address in Germany or the TAO Eurasia-Africa address for this purpose.

**12.13** U.S. licensed Partnership providers claims for treating patients shall be paid based upon signed agreements. Refer to [Section 29](#) for additional information related to the Partnership Program.

**12.14** Pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

**12.15** Professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. These services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as PCMs) may refer TOP enrollees to host nation providers, these claims shall be processed per TOP policy and procedures.

**12.16** Claims for drugs or diagnostic/ancillary services purchased overseas shall be reimbursed by the TOP contractor following applicable deductible/cost-share policies.

**12.17** Not honor any draft request for currency change, except as outlined in [paragraph 12.10](#) or when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor.

**12.18** Shall mail the drafts/checks and EOB to host nation providers unless the claim indicates payment should be made to the beneficiary. In conformity with banking requirements, the drafts/checks shall contain the contractor's address. Drafts and EOBs shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

**12.19** Benefit payment checks and EOBs to Philippine providers, and other nations' providers as directed by the TMA CO, shall be mailed to the place of service identified on the claim. No provider checks or EOBs for Philippine providers, and other nations' providers as directed by the TMA CO may be sent to any other address.

**12.20** Inpatient and outpatient claims for TRICARE overseas eligible beneficiaries, including ADSM claims, are to be processed/paid as indicated below:

**12.20.1** The TPharm contractor shall allow TOP ADSM to use the TPharm retail pharmacy network under the same contract requirements as other Military Health System (MHS) eligible beneficiaries (see TPM, [Chapter 8, Section 9.1](#)).

**12.20.2** The TPharm contractor shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see TPM, [Chapter 8, Section 9.1](#)).

**12.20.3** The TOP contractor shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside MCSC's region following the guidelines outlined in this chapter. Payment shall be made from applicable bank accounts and shall be based on billed charges unless a lower reimbursement rate has been established by the government or the contractor.

**12.21** EFT payments. Upon host nation provider request, the TRICARE Overseas health care support contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider. **Upon beneficiary request, EFT payments to a U.S. bank may be provided. Bank charges associated with beneficiary EFT payments shall be the responsibility of the beneficiary.**

**12.22** The TOP contractor shall process 85% of all retained and adjustment TOP claims to completion within 21 calendar days from the date of receipt. Claims pending per government direction are excluded from this standard. However, the number of excluded claims must be reported on the Overseas Weekly/Monthly Workload/Cycletime Aging report. 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days from the date of receipt, unless the CO specifically directs the contractor to continue pending a claim or group of claims.

**12.23** Correspondence pended due to stop payment orders, check tracers on foreign banks and conversion on currency. This correspondence is excluded from the routine 45 calendar day correspondence standard and the priority 10 calendar day correspondence standard. However, the number of excluded routine and priority correspondence must be reported on the Overseas Monthly Workload/Cycletime Aging report.

**12.24** The TOP contractor is authorized to pay Value Added Tax (VAT) included on German health care claims for all beneficiary categories.

**12.25** Fees for transplant donor searches in Germany may be reimbursed on a global flat fee basis since the German government does not permit health care facilities to itemize such charges.

**12.26** Itemized fees for supplies that are related or incidental to inpatient treatment (e.g., hospital gowns) may be reimbursed if similar supplies would be covered under reimbursement methodologies used within the U.S. The TOP contractor shall implement internal management controls to ensure that payments are reasonable and customary for the location.

### **13.0 CLAIMS ADJUSTMENT AND RECOUPMENT**

**13.1** The TOP contractor shall follow the adjustment requirements in [Chapter 10](#) except for the requirements related to financially underwritten funds.

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**13.2** The TOP contractor shall follow the recoupment requirements in [Chapter 10](#) for non-financially underwritten funds, except for providers. The contractor shall use the following procedures for host nation provider recoupments. Recoupment actions shall be conducted in a manner that is considered culturally appropriate for the host nation provider's country. The contractor shall:

**13.2.1** Send an initial demand letter.

**13.2.2** Send a second demand letter at 90 days.

**13.2.3** Send a final demand letter at 120 days.

**13.2.4** Refer the case to TMA at 240 days, if the case is over \$600.00, and if under \$600.00 the case shall remain open for an additional four months and then shall be written off at 360 days.

**13.3** Recoupment letters (i.e., the initial letter, the 90 day second request and the 120 day final demand letter) shall be modified to delete references to U.S. law. Invoice numbers shall be provided on all recoupment letters. The TOP contractor shall include language in the recoupment letter requesting that refunds be returned/provided in the exact amount requested.

**13.4** Provider recoupment letters sent to Germany, Italy, and Spain, shall be written in the respective language.

**13.5** The TOP contractor may hand write the dollar amount and the host nation provider's name and address, on all recoupment letters.

**13.6** If the recoupment action is the result of an inappropriately processed claim by the TOP contractor, recoupment is the responsibility of the contractor, not the beneficiary/provider.

**13.7** The TOP contractor shall have a TOP bank account capable of receiving/accepting wire transfers from TRICARE Eurasia-Africa overseas for host nation provider recoupment/overpayment returns. The TOP contractor shall accept the amount received as payment against the amount owed. Any fees associated with the wire transfer will be the responsibility of the payer/provider.

**14.0 DUPLICATE PAYMENT PREVENTION**

The provisions of [Chapter 8, Section 9](#) are applicable to the TOP.

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## Program Integrity

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### 1.0 GENERAL

All TRICARE requirements regarding program integrity shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 13](#) for additional instructions.

**1.1** In addition to the requirements outlined in [Chapter 13](#), the Government may implement additional requirements as necessary to prevent or detect fraud in overseas locations.

**Note:** TRICARE guidance regarding anti-fraud programs at Military Treatment Facilities (MTFs) is contained in Department of Defense Instruction (DoDI) 5505.12 (October 19, 2006). This instruction is located at: <http://www.dtic.mil/whs/directives/corres/rtf/550512x.rtf>.

**1.2** The TRICARE Area Office (TAO) Directors shall report possible fraudulent or abuse practices by a TOP beneficiary/host nation provider to the TOP contractor, the appropriate TRICARE Management Activity (TMA) Contracting Officer's Representative (COR), and the TMA, Chief, Program Integrity Branch, including requests for the contractor to flag or watch providers suspected of fraud and abuse.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** The TOP contractor is required to notify the TMA Program Integrity Office (PI) in writing of any new or ongoing fraud and abuse issues.

**2.2** In cases involving check fraud, the TOP contractor is not required to reissue checks until the investigation is finalized, fraud has been determined, and the contractor has received the money back from the investigating bank.

**2.3** The TOP contractor is responsible for performing on-site verification and provider certification in the Philippines. At a minimum, this on-site verification shall confirm the physical existence of a facility/provider office, verify the credentials/licensure of the facility/provider, verify the adequacy of the facility/provider office, and verify the capability of the facility/provider office for providing the expected level and type of care. This requirement may be expanded to other locations upon Contracting Officer (CO) direction.

**2.3.1** The TOP contractor shall provide beneficiaries with easy access to both the approved Philippines demonstration provider listing and the certified provider listing via a user-friendly searchable World Wide Web (WWW) site and any other means established at the contractor's discretion. Information on the WWW site and any other electronic lists shall be current within the

last 30 calendar days. At a minimum, the data base shall be searchable by provider location, provider name, and provider specialty (if available).

**2.3.2** If a claim is received for care rendered by a non-certified provider in the Philippines, the TOP contractor shall pend the claim and initiate on-site verification/provider certification action. Claims pended for this reason are excluded from normal claims processing cycle time standards. If the on-site verification/certification action is not completed within 90 calendar days, the TOP contractor shall deny claims based on lack of provider certification.

**2.3.3** The TOP contractor shall use the following guidelines for prioritizing certification of Philippine providers as follows:

**2.3.3.1** Reviewing new providers.

**2.3.3.2** Reviewing the TOP contractor's current certified provider files.

**2.3.3.3** Reviewing non-certified providers on claims which have been denied by the TOP contractor and the beneficiary/provider has followed-up on why the claim was denied.

**2.3.3.4** Reviewing non-certified providers on claims which have been denied by the TOP contractor and the beneficiary/provider has NOT followed-up on why the claim was denied.

**2.3.4** Recertification of Philippine providers shall be performed by the TOP contractor every three years and shall follow the above process. TMA shall, as necessary, require the contractor to add additional overseas countries for host-nation provider certification. Upon direction by the government, the contractor shall follow the process above outline for Philippines, to include prioritization of certification of new country providers.

**2.3.5** The TOP contractor shall deny claims submitted from non-certified or non-confirmed host nation providers from the Philippines, advising the provider to contact the contractor for procedures on becoming certified (see [paragraph 2.3.12](#)).

**2.3.6** For the Philippines, Panama, and Costa Rica, the TOP contractor shall review billings on a monthly basis to determine if providers in these areas have exceeded the \$3,000 per year billing cap for the previous 12 month period for pharmacy services. High volume providers (determined by total pharmacy services billings exceeding \$3,000 in the previous 12 months) identified shall be sent the provider notification letter (see [Section 30, Figure 24.30-1](#)) advising them of the TOP NDC submission requirements and payment for drugs as required in this section. The electronic report shall arrive NLT the 15th of the month in which it is due. TMA may expand this requirement to other countries during the life of the contract. As other countries are added, the report shall include these countries.

**2.3.7** For those providers identified as high volume providers (determined by total pharmacy services billings exceeding \$3,000 in the previous 12 months), the TOP contractor shall be required to submit a report by country and provider, which tracks the number of claims, dollar amounts billed vs. paid before the above process was implemented and compares it to the number of claims, dollar amounts billed vs. paid after the above process was implemented. The report shall arrive NLT the 15th of the month in which it is due. TMA may expand this requirement to other countries

during the life of the contract. As other countries are added, the report shall include these countries.

**2.3.8** The TOP contractor shall provide an electronic report, annually (by fiscal year), identifying all high volume overseas pharmacy providers that have exceeded the \$3,000 per year billing cap for pharmacy services to the appropriate TMA COR. The reports shall identify the provider, the provider total billed amount, the total amount paid to the provider, and the total amount paid by the government. Upon receipt, the government shall review the report and may notify the contractor to issue a provider notification letter (see [Section 30, Figure 24.30-1](#)) to TMA identified overseas pharmacy providers in other countries than the Philippines, Panama, and Costa Rica that have exceeded the \$3,000 per year billing cap on pharmacy services. The report shall arrive by the 15th of October for the preceding fiscal year (October 1 through September 30). TMA may expand this requirement to other countries during the life of the contract. As other countries are added, the report shall include these countries.

**2.3.9** For the Philippines, Panama, and Costa Rica, providers exceeding the \$3,000 per year billing cap for pharmacy service are required to submit claims using National Drug Coding (NDC).

**2.3.10** For the Philippines and other nations as may later be determined by TMA, the TOP contractor shall quarterly determine the top 10% of institutional and individual professional providers based on claims volume. The contractor shall return a copy of all claims received from these providers to the provider's practice address requesting the providers signature on the attestation at [Section 30, Figure 24.30-3](#). Only the original signature of the provider is acceptable. For institutional providers, the signature shall be that of the institution's chief executive. Claims shall be pended for 35 calendar days following the mailing of the attestation and a copy of the claim. If no response is received within 35 calendar days, the contractor shall deny the claim.

**2.3.11** Upon direction from TMA, the contractor shall discontinue payments to Third Party Administrators (TPAs) in countries or specific agencies where significant fraud is occurring on a regular basis.

**2.3.12** For the Philippines, prescription drugs may be cost-shared when dispensed by a certified retail pharmacy or hospital based pharmacy. The TOP contractor shall deny claims for prescription drugs obtained from a physician's office.

- END -



## TRICARE Area Office (TAO) Director/Military Treatment Facility (MTF) And Contractor Interfaces

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### 1.0 GENERAL

All TRICARE requirements regarding government/contractor interfaces shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 15](#) for additional instructions.

### 2.0 GOVERNMENT/CONTRACTOR RESPONSIBILITIES

**2.1** The Memorandum of Understanding (MOU) requirements outlined in [Chapter 15, Section 1](#) are applicable to the TOP. The TOP contractor shall enter into a MOU with each TRICARE Area Office (TAO) Director to address region-specific issues and procedures, and with each Military Treatment Facility (MTF) commander to address local issues and procedures. MTFs with oversight/control of subordinate military clinics (a parent/child Defense Medical Information System (DMIS) relationship) shall be addressed in a single MOU between the parent MTF and the contractor. The model MOU in [Chapter 15, Addendum A](#) may be used as a guide for the development of TOP MOUs, or any other MOU format may be adopted as long as all required components are addressed and the format is mutually acceptable to the Government and the TOP contractor.

**Note:** MOUs must be re-executed and approved annually ([Chapter 15, Section 1](#)). Beginning with Option Period 2, MOUs may be re-executed by the development of a cover sheet which identifies any changes in processes/staff since the previous MOU was signed. This cover sheet (with appropriate signatures) along with any updated/revised attachments, will be accepted as a properly re-executed MOU when submitted with the original MOU in accordance with the submission time lines established in [Chapter 15, Section 1](#).

### 2.2

**2.3** MOUs shall identify MTF hours/days of operation, to include any holiday or training days, and other unique issues regarding MTF operation (e.g., inclement weather procedures). The MTFs shall ensure that the MOU is updated as changes occur.

**2.4** MOUs shall include a process for ongoing, regular communication between TAOs, MTFs, and the contractor regarding anticipated changes that may affect health care delivery for TOP beneficiaries (e.g., deployments, increase/decrease in MTF capacity and capabilities, change in troop strength/number of command sponsored family member billets, etc.).

**2.5** The provisions of [Chapter 15, Sections 2](#) and [3](#) are not applicable to the TOP.

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Chapter 24, Section 16

TRICARE Area Office (TAO) Director/Military Treatment Facility (MTF) And Contractor Interfaces

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**2.6** The TOP contractor shall immediately notify the TAO Directors and TRICARE Management Activity (TMA) of any changes to telephone and fax numbers.

- END -

## TRICARE Overseas Program (TOP) Prime Program

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### 1.0 GENERAL

**1.1** TRICARE Overseas Program (TOP) Prime is available to Active Duty Service Members (ADSMs) (including Reserve Component (RC) members activated for more than 30 days) who are on permanent assignment overseas in a location serviced by a Military Treatment Facility (MTF), Command-Sponsored Active Duty Family Members (ADFM), accompanying the sponsor or on service orders, and certain transitional survivors and Transitional Assistance Management Program (TAMP)-eligible beneficiaries according to the eligibility and enrollment provisions of [Section 5](#). TOP Prime offers enrollees access to a Primary Care Manager (PCM), clinical preventative services, and specialty services.

**Note:** Command Sponsorship is defined in the Joint Federal Travel Regulations (JFTR), Volume I, Appendix A at <https://secureapp2.hqda.pentagon.mil/perdiem/>.

**1.2** TOP Prime has no enrollment fees, and deductibles and cost-shares are waived except for TOP Prime ADFMs who receive care under the Point of Service (POC) option, or who obtain pharmacy services in the 50 United States, the District of Columbia, or United States (U.S.) territories where the TRICARE Pharmacy (TPharm) contractor has established a retail pharmacy network. Waiver of copayment and deductibles under TOP Prime is subject to review/updating based on enrollment status.

**1.3** Under TOP Prime, annual catastrophic caps are calculated on fiscal years. The enrollment year shall coincide with the fiscal year. Since deductibles and cost-shares are waived for TOP Prime enrollees, this policy will apply only to TOP Prime enrollees who incur out-of-pocket expenses as described above.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** TOP Prime enrollees shall select or have assigned to them PCMs according to guidelines established by the MTF Commander, TRICARE Area Office (TAO) Director, or designee. TOP Prime enrollment to a host nation PCM may only occur when all available capacity in the MTF has been reached. The TOP PCM:

**2.1.1** May be an individual professional provider (not a Partnership Provider) in an overseas MTF, other military treatment site, or other health care delivery arrangement that is part of the MTF. MTF PCMs may be organized into teams for the purpose of ensuring patient continuity and accountability in the event that the individual's assigned PCM is absent or unavailable.

**2.1.2** May be a host nation primary care provider (internist, family practitioner, pediatrician, general practitioner, obstetrician/gynecologist, physician assistant, nurse practitioner, or certified nurse midwife) when determined by the TOP contractor to meet governing country rules and

licensure requirements. See [Section 14](#) for additional provider certification requirements in the Philippines.

**2.1.3** May also act as a Health Care Finder (HCF), when dual responsibility is necessary, as determined by the MTF commander or TAO Director.

**2.2** A TOP Prime enrollee must seek all his or her primary health care from the TOP PCM with the exception of care listed in [Section 8](#). If the TOP PCM is unable to provide the care, the TOP PCM is responsible for referring the enrollee to another primary care provider.

**2.3** TOP Prime enrollees must obtain appropriate referral/authorization for any non-emergency care rendered by anyone other than the beneficiary's PCM or another MTF provider. This provision applies regardless of where the care is rendered. TAO Directors and MTF commanders (or their designees) may direct retroactive authorizations on a case-by-case basis. TOP Prime enrollees who need urgent care while traveling stateside may contact the TOP contractor's call center(s) for appropriate authorization. Routine care is generally not authorized while a TOP Prime enrollee is traveling out of their enrollment region; however, exceptions may be made for unusual circumstances on a case-by-case basis with PCM referral and appropriate justification. Emergency care does not require prior authorization; however, the beneficiary should contact their PCM and the TOP contractor as soon as possible to arrange any necessary follow-up care.

**2.4** Failure to obtain a TOP PCM referral/authorization when one is required for care may result in the service being paid under TOP Point of Service (POS) procedures for an Active Duty Family Member (ADFM) with a deductible and cost-shares for outpatient services and cost-shares for inpatient services.

**2.5** The TOP PCM is responsible for notifying the TOP HCF that a referral is being made/requested. The TOP HCF will assist the TOP Prime enrollee and other beneficiaries in locating an MTF or host nation TOP network or non-network provider to provide the care, and to assist in scheduling an appointment upon request. The HCF will conduct a benefit determination review and provide authorization for service for which the referral was made. If the contractor has no record of referral/authorization, prior to denial/payment, the contractor will follow the TOP POS rules, assuming the service would otherwise be covered under the provisions of TRICARE Standard.

**2.6** TOP MTF PCMs may be delegated authority by the TOP MTF Commander to authorize referrals within the MTF. All referrals/authorizations to civilian host nation providers and all referrals/authorization made by a TOP designated host nation PCM must be made through the TOP HCF and must receive an authorization.

**2.7** The TOP contractor shall ensure that all authorized services for TOP Prime enrollees are provided on a cashless, claimless basis. The contractor shall implement guarantee of payment or other business arrangements to ensure that TOP Prime enrollees are not required to pay up front at the time services are rendered by a host nation provider.

**2.8** Cashless, claimless provisions do not apply to self-referred care that would normally require authorization.

**2.9** MTFs have right of first refusal for any specialty care provided to TOP Prime enrollees.

**2.10** For TOP Prime enrollees who are traveling in the 50 United States or the District of Columbia, the TOP contractor and the TAO Directors will encourage TOP beneficiaries to utilize stateside MTFs and TRICARE network providers whenever possible.

### **3.0 POS OPTION**

**3.1** TOP Prime-enrolled ADFMs are required to follow established referral/authorization procedures prior to obtaining specialty care to avoid the application of POS cost-shares and deductibles. This includes all self-referred, non-emergency outpatient specialty medical services (including outpatient mental health services) and all inpatient care (including inpatient mental health care), except for ancillary services, drugs, services provided by a TOP Partnership Provider, and the first eight outpatient mental health visits in a fiscal year. TOP Prime ADFMs who self-refer to a civilian provider other than their PCM shall have their claims processed as POS.

**3.2** POS cost-shares and deductibles shall not apply to claims for care received by newborns/adoptees during the deemed enrollment period.

**3.3** There are no NAS requirements for TOP Prime enrollees. This requirement is replaced by a care authorization from the PCM.

**3.4** Self-referred, non-emergency, specialty, or inpatient care provided to a TOP Prime enrollee by a network or non-network host nation provider, which is not either provided/referred by the beneficiary's PCM or specifically authorized may be reimbursed only under the TOP Prime POS option if it is a benefit under TRICARE Standard. Services which are not a TRICARE benefit shall be denied.

**3.5** POS cost-sharing and deductible amounts do not apply if a TOP Prime enrollee has Other Health Insurance (OHI) that provides primary coverage. The OHI must be primary under the provisions of the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 1](#), and documentation that the other insurance processed the claim and the exact amount paid must be submitted with the TOP claim. TRICARE OHI provisions apply for this type of claim.

**3.6** The POS option does not apply to ADSM overseas/stateside care.

**3.7** The TOP contractor shall adjust TOP Prime copayments when TOP PCMs or HCFs do not follow established referral/authorization procedures. For example, if the contractor processes a claim without evidence of an authorization and/or a referral under POS provisions, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the overseas claims processing contractor shall adjust the claim under TOP Prime provisions. The contractor need not identify past claims, however, the contractor shall adjust these claims as they are brought to their attention.

**3.8** On a case-by-case basis, following stabilization of the patient, the MTF Commander may require a TOP Prime beneficiary to transfer to a TOP network facility or the MTF. The MTF Commander shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a TOP Prime-enrolled ADFM elects to remain in a non-network facility following notification of an impending transfer to another facility, TOP POS cost-sharing will begin 24 hours following receipt of the written notice. The MTF Commander may not require a transfer until such time as the transfer is deemed medically safe.

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Chapter 24, Section 17

TRICARE Overseas Program (TOP) Prime Program

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**3.9** The following deductible and cost-share amounts apply to all TOP Prime POS claims for health care services:

**3.9.1** Enrollment year deductible for outpatient claims (no deductible applies to inpatient services): \$300 per individual; \$600 per family.

**3.9.2** Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).

**3.9.3** POS deductible and cost-share amounts are NOT creditable to the enrollment/fiscal year catastrophic cap and they are not limited by the cap.

**3.9.4** POS deductible and cost-sharing do not apply to the claims for care received by certain newborn and newly adopted children during the deemed enrollment period. See [Section 6](#) for additional guidance regarding deemed enrollment for newborns/adoptees.

- END -

## TRICARE Overseas Program (TOP) Prime Remote Program

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### 1.0 GENERAL

**1.1** TRICARE Overseas Program (TOP) Prime Remote is available to Active Duty Service Members (ADSMs) (including Reserve Component (RC) members activated for more than 30 days) on permanent assignment to a remote overseas location, Command-Sponsored Active Duty Family Members (ADFMs) accompanying their sponsor in the remote location or on Service orders, and certain transitional survivors according to the eligibility and enrollment provisions of [Section 5](#). TOP Prime Remote offers enrollees access to a Primary Care Manager (PCM), clinical preventative services, and specialty services. The TOP contractor, working in concert with host nation providers and the TRICARE Area Offices (TAOs), has primary responsibility for ensuring that TOP Prime Remote enrollees receive appropriate services and support to facilitate access to the TOP benefit in remote overseas locations.

**Note:** Command Sponsorship is defined in the Joint Federal Travel Regulations (JFTR), Volume I, Appendix A at <https://secureapp2.hqda.pentagon.mil/perdiem/>.

**1.2** TOP Prime Remote has no enrollment fees, and deductibles and cost-shares are waived except for TOP Prime Remote ADFMs who receive care under the Point of Service (POS) option, or who obtain pharmacy services in the 50 United States, the District of Columbia, and United States (U.S.) territories where the TRICARE Pharmacy (TPharm) has established a retail pharmacy network. Waiver of copayment and deductibles under TOP Prime Remote is subject to review/updating based on enrollment status.

**1.3** Under TOP Prime Remote, annual catastrophic caps are calculated on fiscal years. The enrollment year shall coincide with the fiscal year. Since deductibles and cost-shares are waived for TOP Prime Remote enrollees, this policy will apply only to TOP Prime Remote enrollees who incur out-of-pocket expenses as described above.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** TOP Prime Remote enrollees shall select or have assigned to them Primary Care Managers (PCMs) according to guidelines established by the TAO Director, or designee. The TOP PCM:

**2.1.1** PCMs may be an individual professional provider (not a Partnership Provider), an overseas treatment site, or other health care delivery arrangement. For the purposes of referral management and authorization for TOP Prime Remote episodes of care, the TOP contractor's call center(s) are considered PCMs.

**2.1.2** May be an internist, family practitioner, pediatrician, general practitioner, obstetrician/gynecologist, physician assistant, nurse practitioner, or certified nurse midwives when determined by the TOP contractor to meet governing country rules and licensure.

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### Chapter 24, Section 18

#### TRICARE Overseas Program (TOP) Prime Remote Program

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**2.1.3** May also act as a Health Care Finder (HCF), when dual responsibility is necessary, as determined by the TAO Director.

**2.2** A TOP Prime Remote enrollee must seek all his or her primary health care from the TOP PCM with the exception of care listed in [Section 8](#). If the TOP PCM is unable to provide the care, the TOP PCM is responsible for referring the enrollee to another primary care provider.

**2.3** TOP Prime Remote enrollees must obtain appropriate referral/authorization for any non-emergency care rendered by anyone other than the beneficiary's PCM. This provision applies regardless of where the care is rendered. TAO Directors (or designees) may direct retroactive authorizations on a case-by-case basis. TOP Prime Remote enrollees who need urgent care while traveling stateside should contact the TOP contractor's call center(s) for appropriate authorization. Routine care is generally not authorized while a TOP Prime Remote enrollee is traveling out of their enrollment region. Emergency care does not require prior authorization; however, the beneficiary should contact their PCM and the contractor as soon as possible to obtain authorization for any necessary follow-up care.

**2.4** Failure to obtain a TOP PCM referral/authorization when one is required for care may result in the service being paid under TOP POS procedures for an Active Duty Family Member (ADFM) with a deductible and cost-shares for outpatient services and cost-shares for inpatient services.

**2.5** The TOP PCM is responsible for notifying the TOP HCF that a referral is being made/requested. The TOP HCF will assist the TOP Prime Remote enrollee and other beneficiaries in locating an Military Treatment Facility (MTF) or host nation TOP network or non-network provider to provide the care, and will assist in scheduling an appointment upon request. The HCF will conduct a benefit determination review and provide authorization for service for which the referral was made. If the contractor has no record of referral/authorization, prior to denial/payment, the claims processing contractor will follow the TOP POS rules, assuming the service would otherwise be covered under the provisions of TRICARE Standard.

**2.6** All referrals made by a TOP designated host nation PCM must be made through the TOP HCF and must receive an authorization.

**2.7** The TOP contractor shall ensure that all authorized services for TOP Prime Remote enrollees are provided on a cashless, claimless basis. The contractor shall implement guarantee of payment or other business arrangements to ensure that TOP Prime Remote enrollees are not required to pay up front at the time services are rendered by a host nation provider.

**2.8** Cashless, claimless provisions do not apply to self-referred care that would normally require an authorization.

**2.9** For TOP Prime Remote enrollees who are traveling stateside, the TOP contractor and the TAO Directors will encourage TOP beneficiaries to utilize stateside MTFs and network providers whenever possible.

### **3.0 POINT OF SERVICE (POS) OPTION**

**3.1** TOP Prime Remote-enrolled ADFMs are required to follow established referral/authorization procedures prior to obtaining specialty care to avoid the application of POS cost-shares and

deductibles. This includes all self-referred, non-emergency outpatient specialty medical services (including outpatient mental health services) and all inpatient care (including inpatient mental health care), except for ancillary services, drugs, services provided by a TOP Partnership Provider, and the first eight outpatient mental health visits in a fiscal year. TOP Prime Remote ADFMs who self-refer to a civilian provider other than their PCM shall have their claims processed as POS.

**3.2** POS cost-shares and deductibles shall not apply to claims for care received by newborns/adoptees during the deemed enrollment period.

**3.3** There are no Non-Availability Statement (NAS) requirements for TOP Prime Remote enrollees. This requirement is replaced by a care authorization from the TOP contractor or other appropriate authority.

**3.4** Self-referred, non-emergency, specialty, or inpatient care provided to a TOP Prime Remote ADFM enrollee by a network or non-network host nation provider, which is not either provided/referred by the beneficiary's PCM or specifically authorized may be reimbursed only under the TOP Prime Remote POS option if it is a benefit under TRICARE. Services which are not a TRICARE benefit shall be denied.

**3.5** POS cost-sharing and deductible amounts do not apply if a TOP Prime Remote ADFM enrollee has Other Health Insurance (OHI) that provides primary coverage. The OHI must be primary under the provisions of the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 1](#), and documentation that the other insurance processed the claim and the exact amount paid must be submitted with the TOP claim. TRICARE OHI provisions apply for this type of claim.

**3.6** The POS option does not apply to ADSM overseas/stateside care.

**3.7** The TOP contractor shall adjust TOP Prime Remote copayments when TOP PCMs or HCFs do not follow established referral/authorization procedures. For example, if the contractor processes a claim without evidence of an authorization and/or a referral under POS provisions, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the overseas claims processing contractor shall adjust the claim under TOP Prime Remote provisions. The contractor need not identify past claims, however, the contractor shall adjust these claims as they are brought to their attention.

**3.8** On a case-by-case basis, following stabilization of the patient, the TAO Director may require a TOP Prime Remote beneficiary to transfer to a TOP network facility or the MTF. The TOP TAO Director shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a TOP Prime Remote-enrolled ADFM elects to remain in a non-network facility after being notified of an impending transfer to another facility, TOP POS cost-sharing will begin 24-hours following receipt of the written notice. The TAO Director may not require a transfer until such time as the transfer is deemed medically safe.

**3.9** The following deductible and cost-share amounts apply to all TOP Prime Remote POS claims for health care services:

**3.9.1** Enrollment year deductible for outpatient claims (no deductible applies to inpatient services): \$300 per individual; \$600 per family.

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**3.9.2** Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).

**3.9.3** POS deductible and cost-share amounts are NOT creditable to the enrollment/fiscal year catastrophic cap and they are not limited by the cap.

**3.9.4** POS deductible and cost-sharing do not apply to the claims for care received by certain newborn and newly adopted children during the deemed enrollment period. See [Section 5](#) for additional guidance regarding deemed enrollment for newborns/adoptees.

- END -

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 24, Section 26

#### Civilian Health Care (CHC) Of Uniformed Service Members

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**2.5.2** For ADSMs leaving remote TOP assignments from all overseas areas other than Puerto Rico, ADSMs in those locations should request medical records from the host nation provider(s) who provided health care services during the ADSM's tour of duty. **These ADSMs may also request copies of medical care documentation (specialty care visits and discharge summaries) on an ongoing, EOC basis.**

**2.5.3** Records provided by host nation providers in languages other than English may be submitted to the TOP contractor for translation into English according to the terms of the contract.

**2.5.4** Network host nation providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Non-network host nation providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges unless the government has directed a lower reimbursement rate. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out-of-pocket expenses. All providers and/or ADSMs must submit a claim form, with the charges clearly identified, to the contractor for reimbursement.

**Note:** The purpose of copying medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to a host nation provider who photocopies medical records to support the adjudication of a claim.

## **2.6 Provision of Respite Care For The Benefit of Seriously Ill or Injured Active Duty Members**

**2.6.1** The provisions of [Chapter 17, Section 3](#) and the TRICARE Systems Manual (TSM), [Chapter 2, Sections 2.8](#) and [6.4](#) regarding respite care for seriously ill or injured ADSMs are applicable in locations outside the 50 United States and the District of Columbia where TRICARE-authorized Home Health Agencies (HHAs) have been established.

**2.6.2** The respite care benefit is applicable to ADSMs enrolled to TOP Prime, TOP Prime Remote, and to any ADSM referred by an overseas MTF or TAO.

**2.6.3** All normal ADSM authorization and case management requirements for the TOP apply to the ADSM respite care benefit.

- END -



## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
<b>RIA</b>	<b>Radioimmunoassay</b>
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile

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#### Acronyms And Abbreviations

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SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office

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TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy

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TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions

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TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence

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USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web

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X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

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