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TRICARE
MANAGEMENT ACTIVITY

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**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) UPDATES

CONREQ: 15378

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates existing procedures and policies; includes a requirement for proof of payment for all beneficiary-submitted claims, the utilization of the Military Medical Support Office (MMSO) for Reserve Component (RC) members in the United States Virgin Islands, and increased the total number of TRICARE Fundamentals Courses from six to nine per option period. The change also incorporates a new three-year timely filing deadline for all overseas claims as implemented in the 2012 National Defense Authorization Act (NDAA).

EFFECTIVE DATE: December 31, 2008: Chapter 24, Section 9, paragraph 3.0.
June 1, 2012: All other changes.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 62.


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Director, Operations Division

ATTACHMENT(S): 97 PAGES
DISTRIBUTION: 6010.56-M

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Administration

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regarding administration shall apply to the TRICARE Overseas Program (TOP) unless specifically **changed**, waived, or superseded by this section; **the TRICARE Policy Manual (TPM), Chapter 12**; or the TRICARE contract for health care support services outside the 50 United States and the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 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.

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8.3 See [Chapter 1, Section 7, paragraphs 2.4.1 and 2.4.2](#) for instructions regarding Memorandums of Understanding (MOUs). In addition to the MOU requirements in these referenced paragraphs, the TOP contractor shall also execute an MOU with each TAO Director No Later Than (NLT) 60 calendar days prior to the start of health care delivery, with copies to the PCO and the COR within 10 calendar days following MOU execution.

8.4 See [Chapter 1, Section 7, paragraphs 2.5 and 2.6](#) for instructions regarding phase-in of TRICARE enrollment and transfer of enrollment files. For purposes of TOP implementation, all references to TRICARE Prime in these paragraphs shall apply to TOP Prime and TOP Prime Remote.

8.5 The provisions of [Chapter 1, Section 7, paragraph 2.7](#) are not applicable to the TOP, since there are no enrollment fees associated with TOP Prime or TOP Prime Remote.

8.6 See [Chapter 1, Section 7, paragraph 2.8](#) for instructions regarding Health Care Finder (HCF) phase-in.

8.7 See [Chapter 1, Section 7, paragraph 2.9](#) for instructions regarding TRICARE Service Center (TSC) phase-in.

8.8 All claims that fall within the scope of the TOP contract received on or after the start of health care delivery on the TOP contract shall be processed by the TOP contractor.

Note: Normal claims filing deadlines apply. See [Chapter 8, Section 3](#) and [Section 9, paragraph 3.0](#).

8.9 The provisions of [Chapter 1, Section 7, paragraph 2.10](#) are applicable to the TOP, except that the provisions of [Chapter 1, Section 7, paragraph 2.10.4](#) are superseded by a requirement for the incoming contractor to cover non-obstetrical care for 90 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractor's existing practices and protocols, within the scope of the TRICARE program and applicable regulations or statutes. This transition period for prior authorizations and referrals is extended to one year for obstetrical care or any other condition for which a one-year authorization has been issued.

8.10 See [Chapter 1, Section 7, paragraph 2.11](#) for instructions regarding contractor weekly status reporting.

8.11 The provisions of [Chapter 1, Section 7, paragraph 2.12](#) are not applicable to the TOP. Instead, the TOP contractor shall prepare a mailing to the Resident Commissioners of Puerto Rico and the Northern Mariana Islands, and the Congressional representatives for American Samoa, Guam, and the U.S. Virgin Islands by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. This requirement supersedes the requirements outlined in [Chapter 1, Section 7, paragraph 2.12](#). The proposed mailing shall be submitted to the TMA CO, TMA COR, TAO Directors, and the TMA Program Integration Office for approval NLT 90 calendar days prior to the start of health care delivery. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

8.12 See [Chapter 1, Section 7, paragraphs 2.13 and 2.14](#) for instructions regarding web-based services and applications and TRICARE Handbook mailings.

9.0 TRANSITIONS -- INSTRUCTIONS FOR BENCHMARK TESTING

See [Chapter 1, Section 7, paragraph 3.0](#) for instructions regarding benchmark testing.

10.0 TRANSITIONS -- CONTRACT PHASE-OUT

The provisions of [Chapter 1, Section 7, paragraph 4.0](#) are applicable to the TOP, except that the requirement in [paragraph 4.4](#) for the outgoing contractor to process claims and adjustment for 120 days following cessation of health care delivery is waived for the TOP. The outgoing contractor is only required to process claims and adjustments received during it's period of service delivery. Processing of all claims shall be completed within 180 calendar days following the start of the incoming contractor's services delivery.

- END -

Records Management

1.0 GENERAL

All TRICARE requirements regarding records management 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 2** for additional instructions.

- END -

Financial Administration

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 fifty 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-directed reimbursement rate foreign 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-provided foreign 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 a uniformed service member 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 Retirees and their dependents living in a remote site health care claims 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 Retirees and their dependents living overseas claims 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 a electronic format to TMA, Attn: Finance and Accounting Branch, 16401 East Centretech 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)

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requesting reimbursement for the loss incurred. This payment will not be subject to the Prompt Payment Act (FAR 32.9) as amended, therefore, payment by TMA will usually be made within five working days of receipt of the invoice and the TRICARE Overseas Currency report.

- END -

Host Nation Providers

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 (ADFMs) 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.

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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

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multiple service locations. Upon TRICARE Area Office (TAO) Director request, the contractor shall provide copies of licensure/certification information for host nation providers.

4.5 The TOP contractor shall deny claims from non-certified host nation providers when TMA has directed that the country's host nation providers must be specially certified in order to receive TRICARE payments. See [Section 14](#) for additional certification requirements.

4.6 The provisions of [Chapter 5, Section 1, paragraph 1.3](#) regarding Telemental Health (TMH) are not applicable to the TOP contract.

- END -

TRICARE Overseas Program (TOP) Eligibility And Enrollment

1.0 GENERAL

All TRICARE requirements regarding eligibility, enrollments, re-enrollments, disenrollments, and transfers 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 6**; the TPM, **Chapter 10**; and the TRICARE Systems Manual (TSM) for additional instructions.

2.0 ELIGIBILITY

2.1 Eligibility for TRICARE is verified via the Defense Enrollment Eligibility Reporting System (DEERS). The DEERS record will indicate the dates of eligibility. Except for newborns, only those beneficiaries who are shown as eligible on DEERS will be enrolled or receive benefits under the TOP. If a beneficiary's date of birth is within 365 days of the contractor's query to DEERS, the contractor shall consider the newborn to be eligible for TRICARE benefits. In addition to DEERS eligibility, TOP Active Duty Family Members (ADFM) are required to demonstrate Command Sponsorship to be eligible for TOP Prime and TOP Prime Remote enrollment unless a specific exception exists. The TOP contractor shall verify DEERS eligibility (and Command Sponsorship, where required) prior to enrolling beneficiaries into TOP.

Note: Family members of the Armed Forces of foreign North Atlantic Treaty Organization (NATO) nations are not eligible for the TOP.

3.0 ENROLLMENT PROCESSING

3.1 TOP Prime and TOP Prime Remote are available to Active Duty Service Members (ADSM) and certain ADFM in overseas locations as described below. These programs are similar, but not identical, to TRICARE Prime and TRICARE Prime Remote (TPR)/TRICARE Prime Remote for ADFM (TPRADM) in the United States (**U.S.**). TOP Prime enrollees shall normally be enrolled to an Military Treatment Facility (MTF) Primary Care Manager (PCM), but enrollment to a host nation PCM may be authorized when MTF capacity is reached. TOP Prime enrollment procedures shall be established in the Memorandum Of Understanding (MOU) between the TOP contractor and the MTF Commander. TOP Prime Remote enrollees shall be enrolled to a remote Defense Medical Information System (DMIS) code with assignment to a host nation PCM or to the TOP contractor, according to the specific regional enrollment procedures established in the MOUs between the contractor and the TRICARE Area Office (TAO) Directors.

3.2 Unless a specific exception exists, enrollment to TOP Prime or TOP Prime Remote is available only to ADSM who are permanently assigned overseas, and to ADFM who are Command Sponsored and accompanying their sponsor on his/her overseas tour, or on orders in an overseas

location (see [paragraph 5.1](#) for additional information regarding Command Sponsorship). This includes activated Reserve Component (RC) ADSMs who are on orders to an overseas location for more than 30 days, and their Command Sponsored ADFMs who accompany the RC member on his/her overseas tour or are on orders in an overseas location.

3.3 Non-Command Sponsored ADFMs, retirees, and retiree family members are not eligible for TOP Prime or TOP Prime Remote enrollment in any overseas location. This long-standing limitation derives from the limited number and capacity of MTFs and staff in overseas locations, coupled with their mission-critical requirement to provide Prime coverage for ADSMs as their first priority, and to Command Sponsored ADFMs as their second priority. ADFMs who are not Command Sponsored or on military orders as described in this section will be covered by TOP Standard (see [Section 19](#)).

3.4 Enrollment may occur at any time after TOP eligibility has been established, and normally remains effective during the overseas tour of the sponsor. Annual re-enrollment is not required for TOP Prime or TOP Prime Remote. Once enrolled, **beneficiaries** remain enrolled in these programs until they disenroll; transfer enrollment to another TRICARE region/program; lose eligibility for TRICARE, TOP Prime, or TPR; or until the 61st calendar day following the end of the overseas tour (see [paragraph 12.5](#)).

3.5 The TOP contractor shall perform all enrollment-related activities for TOP Prime, TOP Prime Remote, TRICARE Plus, **TRICARE Young Adult (TYA)**, TRICARE Reserve Select (TRS), and **TRICARE Retired Reserve (TRR)** in overseas locations. These activities include validation of eligibility, enrollment, re-enrollment, disenrollment, transfers, updating information in DEERS, clearing enrollment discrepancies, assign or change PCM, collecting Other Health Insurance (OHI) information, and related enrollment functions. The contractor shall use the approved TRICARE Enrollment Application for enrollment activities and shall reproduce the form as necessary to ensure ready availability to all potential enrollees. **Enrollment shall be accomplished within five working days of receipt of a complete TRICARE Enrollment Application.**

Note: Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI.

3.6 Enrollments for TOP Prime or TOP Prime Remote are effective on the date the enrollment form is signed (and appropriate Command Sponsorship orders are received, when applicable), unless a retroactive enrollment has been authorized by the TAO Director or designee. For TOP emergency cases that should be placed under immediate case management, TOP MTF commanders and/or the TAO Directors may approve exceptions on a case-by-case basis for retroactive TOP enrollment. Except for administrative errors, the effective date for retroactive enrollments shall not be earlier than the first day of the month that the application is submitted (see the TPM, [Chapter 10, Section 2.1](#)).

- 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 Beneficiary Web Enrollment (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](#).

3.7 The contractor shall follow guidance from the TAO Directors and the MTFs regarding PCM assignment when enrolling beneficiaries into TOP Prime. The MTF enrollment area encompasses a 40-mile radius or a one-hour drive time from the MTF. TOP Prime Remote beneficiaries will be enrolled to the appropriate DMIS code for the beneficiary's remote overseas location. TOP Prime Remote enrollees in Canada will follow guidance applicable to the U.S. and Canada Reciprocal Health Care Agreement, and may be assigned to a Canadian Forces Health Facility for their primary care.

3.8 Newborns/adoptees are deemed to be enrolled for 60 days following birth/adoption when one other family member, to include the sponsor, is enrolled in TOP Prime/TOP Prime Remote. Parents of newborns/adoptees are required to take specific action to enroll the newborn/adoptee within 60 calendar days of birth/adoption. For newborns and newly adopted children who are deemed enrolled, Point of Service (POS) cost-sharing does not apply through the deemed enrollment period, or until an enrollment decision is made by a responsible representative, whichever is earlier. If the newborn/adoptee is not formally enrolled to TOP Prime or TOP Prime Remote during the 60-day period, the newborn/adoptee will revert to TRICARE Standard effective the 61st day, unless the deemed enrollment period has been waived. TAO Directors may extend the deemed enrollment period for newborns/adoptees up to 120 days on a case-by-case or regional basis. TAO Directors shall advise TRICARE Management Activity (TMA) Contracting Officer (CO) in writing when a region-wide enrollment waiver has been authorized. The TMA CO will notify the TOP contractor of any waivers to the 60-day deemed enrollment period in writing at the time the waiver is implemented, and this information shall be incorporated into the Memorandum of Understanding (MOU) between the contractor and the TAO Director(s).

Note: Newborns/adoptees of RC members who are called to active duty for more than 30 consecutive days are eligible for TOP/TRICARE benefits the same as other TRICARE eligible beneficiaries.

3.9 The provisions of [Chapter 6, Section 1](#) and the TPM, [Chapter 10, Section 2.1](#) regarding Prime enrollment fees shall not apply to TOP Prime or TOP Prime Remote. There are no enrollment fees associated with TOP Prime or TOP Prime Remote.

4.0 ENROLLMENT POLICY FOR ADSMs

4.1 Except as described in [paragraph 4.2](#), all ADSMs who are permanently assigned to an overseas duty location must be enrolled into the TOP program that is available in their area. This includes RC ADSMs who are called to active duty for more than 30 consecutive days with a final assignment to an overseas duty station.

4.2 ADSMs assigned to operational forces with assigned organic medical assets may be enrolled to an operational forces' DMIS ID affiliated with its "Parent" DMIS. This includes activated RC members on duty in combatant theaters of operation with existing or imbedded organic medical treatment and support capabilities for health care. Enrollment to a Service or Region-specific operational forces' DMIS for all ADSMs should occur prior to deployment.

5.0 ENROLLMENT POLICY FOR ADFMs

5.1 ADFMs who have Permanent Change of Station (PCS) orders to accompany the sponsor overseas or service-funded orders to relocate overseas without the sponsor are eligible for TOP

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Prime or TOP Prime Remote enrollment. In order to enroll in these programs, ADFMs must meet the definition of Command Sponsorship in the Joint Federal Travel Regulation (JFTR), Volume I, Appendix A (available at <https://secureapp2/hqda.pentagon.mil/perdiem/>) unless one of the following exceptions exists:

5.1.1 If the ADSM and his/her Command Sponsored ADFM(s) are enrolled in TOP Prime or TOP Prime Remote, and the sponsor is reassigned on unaccompanied PCS orders to a location that does not permit Command Sponsored family members, the family member(s) may retain their TOP enrollment for a period based on the length of the sponsor's unaccompanied orders (but not to exceed two years). In order to retain TOP enrollment in this situation, the family member(s) must continue to be Command Sponsored and may not relocate elsewhere during the sponsor's PCS move.

5.1.2 If the ADFM(s) are authorized to relocate to an overseas location per the sponsor's PCS orders in accordance with JFTR U5222, or per Noncombatant Evacuation Orders without the sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program consistent with their orders.

5.1.3 If the ADFM(s) resided in an overseas location prior to the activation/mobilization of a RC sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program based on the residential mailing address of the sponsor prior to activation/mobilization. The ADFM(s) must have had the same overseas residential address as the sponsor at the time of activation/mobilization.

5.1.4 If the ADFM(s) are currently enrolled in TOP Prime or TOP Prime Remote, and the family has a newborn or adopts a child, then the new family member will be eligible to enroll in the same TOP program.

5.1.5 If the ADFMs are eligible for Transitional Survivor benefits (see Enrollment Policy for Transitional Survivors below).

Note: Command Sponsorship is defined in the JFTR, Volume I, Appendix A at <https://secureapp2.hqda.pentagon.mil/perdiem/>.

5.2 ADFMs who choose to reside overseas but are not Command Sponsored as defined in the JFTR, and who do not meet any of the exceptions listed above, are not eligible for enrollment in TOP Prime or TOP Prime Remote. These ADFMs are eligible for TRICARE Standard, TRICARE Plus (where available) or MTF care on a space-available basis only.

5.3 Eligibility for TOP enrollment normally requires the family to be accompanied by the sponsor; therefore, a family member cannot relocate within the overseas region, relocate to another overseas region, or relocate from a overseas location to an overseas location and transfer enrollment except as specified under the exceptions in this section.

5.4 The TOP contractor shall verify that all of the above requirements are met (including DEERS eligibility check and validation of Command Sponsorship/military orders, if required) prior to enrolling an ADFM into TOP Prime or TOP Prime Remote.

5.5 The process for identifying ADFMs who are Command Sponsored may vary by Service. This is a Service personnel decision and as such, these processes may change over the life of the contract.

The TOP contractor may accept any current, valid method of identifying Command Sponsorship to meet the TOP enrollment requirements (e.g., Navy ADFMs who are not listed on the sponsor's orders, but who are in receipt of a letter from the Navy Personnel Services Division (PSD)).

6.0 ENROLLMENT POLICY FOR TRANSITIONAL SURVIVORS

The general provisions of TPM, [Chapter 10, Section 7.1](#) regarding Transitional Survivors shall apply to the TOP. Specific guidelines for Overseas Transitional Survivor benefits are listed below.

6.1 TOP Prime/TOP Prime Remote enrollment policy provisions which require command sponsorship shall not apply to Transitional Survivors whose sponsors died on or after October 7, 2001.

6.2 Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to remain in an overseas location are eligible for TOP Prime/TOP Prime Remote enrollment during the Transitional Survivor period, regardless of whether they remain at their original residence or relocate to another overseas location. These Transitional Survivors are also eligible for health care benefits under TRICARE Standard.

6.3 Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to return to the United States from an overseas location are eligible for TRICARE Prime (in TRICARE Prime service areas) or TPRADFM (in remote locations) during the Transitional Survivor benefit period. These Transitional Survivors are also eligible for health care benefits under TRICARE Standard/Extra.

6.4 Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to move from a stateside location to an overseas location are eligible for TOP Prime or TOP Prime Remote enrollment during the Transitional Survivor benefit period.

6.5 Transitional Survivors whose sponsors died on or after October 7, 2001 are eligible for enrollment and claims reprocessing per TPM, [Chapter 10, Section 7.1](#). Transitional Survivors are also eligible for enrollment fee refunds (if applicable) per TPM, [Chapter 10, Section 7.1](#).

6.6 If the Transitional Survivors are not enrolled in TOP Prime, the Transitional Survivor's priority for appointments at overseas MTFs will be the same as that of ADFMs who are not enrolled in TOP Prime.

6.7 At the end of the Transitional Survivor period, survivors lose their eligibility for enrollment in TOP Prime/TOP Prime Remote (in overseas locations) and TPRADFM (in remote locations) **in the 50 United States and the District of Columbia**.

7.0 ENROLLMENT PLAN

The TOP contractor, in consultation with the TAO Directors and MTF Commanders, shall develop and implement a TOP enrollment plan. The TOP enrollment plan shall establish enrollment goals and describe the methods to be used to accomplish these goals. The TOP enrollment plan shall be submitted through the TAO Directors to the TMA CO in accordance with the instructions in [Chapter 6, Section 1](#). The TOP enrollment plan shall be submitted not less than 90 calendar days prior to the start of each health care delivery period. At a minimum, the TOP enrollment plan shall

include the following:

7.1 A description of the contractor's process for informing beneficiaries about the availability of TOP enrollment options (TOP Prime and TOP Prime Remote).

7.2 A description of any unique conditions and resources which may impact enrollment activities by MTF area and TOP geographic region, along with a description of the contractor's plan for overcoming any potential barriers to effective and efficient enrollment of eligible beneficiaries.

7.3 A description of the contractor's process for verification of eligibility prior to enrollment (including verification of command sponsorship status, when required for enrollment).

7.4 A description of the contractor's process for enrollment of beneficiaries on the DEERS using an automated government-furnished systems application, including the contractor's process for ensuring that enrollment data remains up-to-date and accurate.

7.5 A description of the contractor's process for providing continuous open enrollment for TOP Prime and TOP Prime Remote, automatic re-enrollment, and disenrollment as described in the TPM, [Chapter 10, Sections 2.1 and 3.1](#). The contractor may propose multiple methods of enrollment; however the plan must include the opportunity for enrollment at TRICARE Service Centers (TSCs), at government-specified locations for arriving/deploying units (per [Section 11, paragraph 5.2](#)), via the TOP Point of Contact (POC) program, and by mail.

7.6 The TOP contractor shall provide TOP-enrolled beneficiaries with full and fair disclosure of any restrictions on freedom of choice that apply to TOP enrollees, including the POS option.

8.0 ASSIGNMENT OF PCM

8.1 TOP Prime enrollees will be assigned to a PCM in a local **Department of Defense (DoD)** MTF. TOP Prime enrollees may not select an MTF Partnership Provider or host nation network or non-network provider for a PCM.

8.2 The MTFs will maintain current PCM lists and will make these lists available to the TOP contractor on a regular basis as determined in the MOU. MTF PCM lists should contain sufficient detail to facilitate new enrollments or PCM reassignments until capacity is optimized per MTF guidance.

8.3 The TOP contractor shall assign TOP enrollees to a PCM at the time of enrollment via the Defense Online Eligibility and Enrollment System (DOES) per the MOU, access standards, and/or other specific government guidance. DOES will only display PCMs with available capacity. TOP Prime beneficiaries must enroll to an overseas DMIS with assignment to an MTF PCM. TOP Prime Remote beneficiaries must enroll to a civilian PCM, the contractor's call center(s), or a Canadian Forces Health Facility (in Canada). Appointments will be provided within the TRICARE Prime access standards.

8.4 MTF Commanders may establish specific MTF enrollment/empanelment guidelines for their facilities. The TOP contractor shall enroll TOP Prime beneficiaries and assign PCMs according to these MTF guidelines. Upon receipt of a completed TRICARE Enrollment Application, the contractor shall attempt to enroll the beneficiary according to the preferences indicated on the enrollment

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.

12.2 ADSMs shall be disenrolled from TOP Prime/TOP Prime Remote when:

- The enrollee transfers enrollment to a new TRICARE region,
- 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.

12.3 ADFMs who are enrolled in TOP Prime/TOP Prime Remote may disenroll at any time. They will not be permitted to make another enrollment until after a 12-month period if they have already changed their enrollment status from enrolled to disenrolled twice during the enrollment year (October 1 to September 30) for any reason. ADFMs with sponsors E-1 through E-4 are exempt from these enrollment lock-out provisions. See Chapter 6, Section 1 for guidance regarding enrollment lock-outs.

12.4 ADSMs cannot voluntarily disenroll from TOP Prime or TOP Prime Remote if they remain on permanent assignment in an overseas location where these programs are offered. ADSM enrollment in TOP Prime or TOP Prime Remote continues until they transfer enrollment to another TRICARE region/program or lose eligibility for TOP/TRICARE.

12.5 TOP Prime/TOP Prime Remote enrollees must either transfer enrollment or disenroll within 60 calendar days of the end of the overseas tour when the ADSM departs to a new area of assignment. The TOP contractor shall provide continuing coverage until (1) the enrollment has been transferred to the new location, (2) the enrollee disenrolls, or (3) when enrollment transfer or disenrollment has not been requested by the TOP Prime/TPR enrollee by the 60th day. The TOP contractor will automatically disenroll the beneficiary on the 61st calendar day following the end date of the overseas tour. The ADFM TOP Prime/TPR beneficiary will revert to TRICARE Standard.

13.0 TRICARE ELIGIBILITY CHANGES

13.1 Refer to the TPM, Chapter 10, Section 3.1 for information on changes in eligibility.

13.2 The TOP contractor shall include full and complete information about the effects of changes in eligibility and sponsor rank in beneficiary materials and briefings.

- END -

Medical Management

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.

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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 \$5,000 total paid claims for non-institutional care (per fiscal year) and \$10,000 total paid claims for institutional care (per fiscal year). This process shall also identify patients with more than 10 paid claims per fiscal year for the same diagnosis or related diagnoses, and patients with more than 10 total inpatient days per fiscal year. 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 Electronic Non-Availability Statement (E-NAS).

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 for enrolled ADFM (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 -

Ambulance/Aeromedical Evacuation Services

1.0 GENERAL

All TRICARE requirements regarding ambulance/aeromedical evacuation services 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 **32 CFR 199.4** and the TPM, **Chapter 8, Section 1.1** for additional instruction.

2.0 CONTRACTOR RESPONSIBILITIES

2.1 The TOP contractor shall arrange for medically necessary ambulance/aeromedical evacuation services for TRICARE Overseas Program (TOP) Prime/TOP Prime Remote enrollees, Active Duty Service Members (ADSMs) who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location, and all Prime enrolled Active Duty Family Members (ADFMs) (regardless of enrollment location) who require ambulance/aeromedical evacuation services while traveling outside of the 50 United States and the District of Columbia (including ADFMs enrolled in TOP Prime, TOP Prime Remote, TRICARE Prime, or TRICARE Prime Remote (**TPR**) for ADFMs) according to the processes identified in the TOP contract.

2.1.1 When arranging for ambulance/aeromedical evacuation for the beneficiaries identified in **paragraph 2.1**, the contractor shall establish medical necessity, identify the most appropriate method of evacuation, schedule the evacuation with the most appropriate resource, authorize the services, arrange for medical records to accompany the patient, and coordinate the transfer with the receiving institution or provider.

2.1.2 For ADSM emergency medical evacuations (including ADSMs who are on temporary duty, in an authorized leave status, or deployed/deployed on liberty), the TOP contractor shall ensure that the ADSM's unit is aware of the medical evacuation. The TRICARE Area Office (TAO) shall be contacted for assistance if the member's unit information cannot be determined by the contractor.

2.1.3 Except for normal TRICARE cost-shares, these beneficiaries shall not be responsible for any up-front payments for emergency ambulance service (to include aeromedical evacuation, when medically necessary and appropriate). The contractor shall establish business processes (e.g., Guarantee of Payment to host nation ambulance provider) to ensure that these beneficiaries are not subjected to up-front payments in excess of normal TRICARE cost-shares.

Note: "Medical necessity" is defined in **32 CFR 199.2**.

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2.2 Upon request, the TOP contractor shall facilitate medically necessary ambulance/aeromedical evacuation services for all TRICARE-eligible beneficiaries not identified in [paragraph 2.1](#) (regardless of enrollment location or residence) according to the processes identified in the TOP contract. When facilitating ambulance/aeromedical evacuation for these beneficiaries, the contractor shall identify ambulance/aeromedical evacuation resources that service the patient's location; however, the contractor is not required to schedule the evacuation, coordinate with the receiving institution or provider, obtain medical records, or establish business processes (e.g., Guarantee of Payment) to limit up-front payments for these beneficiaries.

2.3 Since medical evacuations may involve transfers between TRICARE regions, the TOP contractor shall establish processes for coordinating medical evacuations with the stateside Managed Care Support Contractors (MCSCs). The TOP contractor shall also work cooperatively with the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor to provide customer service support, and to facilitate the medically necessary evacuation of TRICARE dual-eligible beneficiaries back to the United States.

2.4 The TOP contractor shall ensure that ambulance/aeromedical evacuation services can be accomplished in an expeditious manner that is appropriate and responsive to the beneficiary's medical condition. The contractor may establish a dedicated unit for responding to such requests, or may augment existing service units. Contractor staff must be available for ambulance/aeromedical evacuation assistance 24 hours per day, seven days per week, 365 days per year. Ambulance/aeromedical evacuation telephone assistance must be available without toll charges to the beneficiary, regardless of their location.

2.5 The TOP contractor shall maximize the use of military medical transport services before considering other options. If military medical transport services are not available (or if services cannot be provided in a timely manner that is appropriate for the patient's medical condition), the contractor shall attempt to arrange services through the most economical commercial resource that is capable of providing appropriate services within the required time frame. Private, chartered evacuation services will only be used as a last resort when all other options have been exhausted. The contractor shall document their rationale and selection process for any commercial and/or private, chartered evacuation services. If multiple resources are identified that are capable of providing the needed services, the contractor shall select the resource that represents the best value to the government. Upon request, the contractor shall provide TRICARE Management Activity (TMA) with documentation supporting their rationale and selection process.

2.6 Upon transfer to a facility for stabilization and care, the TOP contractor shall coordinate with the appropriate MTF (for TOP Prime enrollees) or TAO (for TOP Prime Remote enrollees) to advise of the patient's transfer and to provide further assistance as appropriate.

2.7 The TOP contractor is required to comply with the provisions of TPM, [Chapter 8, Section 1.1](#), except that the TOP contractor shall utilize the coding requirements identified for ambulance charges but is not required to develop claims for diagnosis or transfer information for ambulance services received overseas. The TOP contractor shall utilize the diagnosis if provided, or may use available in-house methods such as claims history when processing the claim. **If a diagnosis is not provided and there are no claim attachments or other claims for the Episode of Care (EOC) from which a diagnosis can be determined, the claim shall be processed using an unlisted diagnosis.**

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2.8 Medical evacuation charges that are determined to be a TRICARE benefit may be bundled on one claim and coded appropriately as a medical evacuation charge. If this simplified billing approach is adopted, all related documentation (including, but not limited to original invoices, supporting documents, and Explanation of Benefits (EOB)) related to the evacuation must be made available to the Government upon request for further review.

- END -

Clinical Preventive Services (Prime/Standard)

1.0 GENERAL

All TRICARE requirements regarding clinical preventive services 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 the TPM, **Chapter 7, Sections 2.1 and 2.2** and **Chapter 12, Section 1.2** for additional instructions.

- END -

Claims Processing Procedures

1.0 GENERAL

1.1 All TRICARE requirements regarding claims processing 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 8 for additional instructions.

1.2 The provisions of Chapter 8, Section 1, paragraph 1.0 are applicable to the TOP.

1.3 The provisions of Chapter 8, Section 1, paragraph 2.1 are applicable to the TOP. Additionally, a designated TOP Point of Contact (POC) may submit claims in accordance with Section 12.

1.4 The provisions of Chapter 8, Section 1, paragraph 2.2 are not applicable to the TOP, except in U.S. territories where Medicaid is available.

1.5 The provisions of Chapter 8, Section 1, paragraph 2.3 are applicable the TOP; however, region or country-specific requirements regarding third party payments or payment addresses may be established by TRICARE Management Activity (TMA) at any time to prevent or reduce fraud.

Note: Benefit payment checks and Explanation Of Benefits (EOB) to Philippine providers (and other nation's providers as determined by the government) shall be mailed to the place of service identified on the claim. This policy applies even if the provider uses a Third Party Administrator (TPA). No provider payments may be sent to any other address. The government may discontinue TPA payments to other countries or specific agencies if it is determined that significant fraud is occurring on a regular basis.

1.6 The TOP contractor shall comply with the provisions of Chapter 8, Section 1, paragraph 3.1 regarding acceptable claims forms, **unless a different process has been authorized by the TMA Contracting Officer (CO).**

1.7 The provisions of Chapter 8, Section 1, paragraph 4.0 are applicable to the TOP.

1.8 The contractor's claims processing procedures shall integrate efforts to prevent and identify fraud/abuse.

2.0 JURISDICTION

2.1 In the early stages of TOP claims review, the TOP contractor shall determine whether claims received are within its contractual jurisdiction using the criteria below. TOP jurisdiction for health

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care and remote Active Duty Service Member (ADSM) dental care is identified in the TOP contract with TMA.

2.2 Services rendered onboard a commercial ship while outside U.S. territorial waters are the responsibility of the TOP contractor. Claims for services provided on a commercial ship that is outside the territorial waters of the United States (U.S.) are to be processed as foreign claims regardless of the provider's home address. If the provider is certified within the U.S., reimbursement for the claim is to be based on the provider's home address. If the provider is not certified within the U.S., reimbursement will follow the procedures for foreign claims. This does not include health care for enrolled ADSM on a ship at sea or on a ship at home port.

2.3 The provisions of [Chapter 8, Section 2, paragraphs 1.0](#) and [2.0](#) are superseded as described in [paragraphs 2.3.1](#) through [2.3.9](#).

2.3.1 When a beneficiary is enrolled in TOP Prime or TOP Prime Remote, the TOP contractor shall process all health care claims for the enrollee, regardless of where the enrollee receives services. The contractor shall also process dental care claims for remote overseas ADSMs per the provisions of [Section 10](#). Referral/authorization rules apply.

2.3.2 Claims for Active Duty Family Members (ADFM) (including Reserve Component (RC) ADFMs whose sponsors have been activated for more than 30 days), retirees, and retiree family members whose 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 and the District of Columbia) who receive **Civilian Health Care (CHC)** while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled. Referral/authorization and Point Of Service (POS) rules apply for TRICARE Prime/TRICARE Prime Remote (TPR) enrollees.

Note: This provision does not apply to beneficiaries who are enrolled in 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.

2.3.3 Claims for ADSMs residing in the 50 United States and the District of Columbia (including RC ADSMs activated for more than 30 days) who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in an overseas location shall be processed by the TOP contractor, regardless of where the ADSMs resides or is enrolled. Referral/authorization rules apply.

2.3.4 Claims for TOP-enrolled ADSMs (including RC ADSMs activated for more than 30 days) on a ship or with an overseas home port shall not be processed by the member's military unit. These claims shall be processed by the TOP contractor.

2.3.5 **Initial and follow-on Line Of Duty (LOD)** claims for RC ADSMs on orders for 30 consecutive days or less, who are injured while traveling to or from annual training or while performing their annual training who receive civilian medical care overseas, shall have their claims processed by the TOP contractor in coordination with the Military Medical Support Office (MMSO) **or the TRICARE Area Office (TAO) Medical Director. MMSO will Coordinate LOD care in the U.S. Virgin Islands.**

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2.3.6 Claims for Durable Medical Equipment (DME) (otherwise coverable by TRICARE) that is purchased/ordered by TOP-eligible beneficiaries in an overseas area from a stateside provider (i.e., internet, etc.) shall be processed by the TOP contractor.

2.3.7 For inpatient claims that are paid under the **Diagnosis** Related Group (DRG)-based payment system, the TOP contractor, on the date of admission, shall process and pay the entire DRG claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outlier cases, and for professional claims that are date-driven, the contractor shall process and pay the claims.

2.3.8 When a beneficiary's enrollment changes from one TRICARE region to another during a hospital stay that will be paid under the DRG-based payment system, the contractor with jurisdiction on the date of admission shall process and pay the entire DRG claim, including cost outliers.

2.3.9 For information on portability claims for relocating TOP Prime/TOP Prime Remote enrollees, refer to [Chapter 6, Section 2](#).

2.4 The provisions of [Chapter 8, Section 2, paragraphs 6.0, 6.1, 6.2, and 6.3](#) are applicable to the TOP.

2.5 The provisions of [Chapter 8, Section 2, paragraph 6.4](#) and [Chapter 19, Section 4](#) are applicable to the TOP for U.S. citizens who are practicing outside the U.S.

2.6 The provisions of [Chapter 8, Section 2, paragraphs 6.5, 6.6, 6.7, 7.1, 7.2, 8.1, 8.2, and 8.3](#) are applicable to the TOP.

2.7 Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4, paragraph 5.0](#) for jurisdictional guidance regarding health care claims for work-related illness or injury which is covered under a Worker's Compensation Program.

2.8 The provisions of [Chapter 8, Section 2, paragraph 5.0](#) are applicable to the TOP in those locations where the TRICARE Pharmacy (TPharm) contractor has established services (the U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). The TOP contractor cannot process pharmacy claims from these locations except for pharmacy that is part of an emergency room visit or inpatient treatment. Any prescriptions from this care that are not provided at time of treatment for inpatient/emergency care, shall be required to be submitted through the TPharm contractor. Copays will apply.

2.9 The TOP contractor shall forward all retail pharmacy claims to the TPharm contractor within 72 hours of identifying it as being out-of-jurisdiction. In all other overseas locations, the contractor shall process claims from host nation retail pharmacies and providers.

2.10 If an enrolled ADFM beneficiary in Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, or Northern Mariana Islands utilizes a non-network pharmacy, POS charges including deductibles and cost-shares will apply.

2.11 Non-enrolled ADFMs (Standard), retirees or their family members residing overseas obtaining prescription from an overseas host nation pharmacy shall submit their claims to the TOP contractor. TRICARE Standard cost-share provisions will apply.

2.12 Claims for DME purchased/ordered by TOP eligible beneficiaries in an overseas area from a stateside provider shall be processed by the TOP contractor.

3.0 CLAIMS FILING DEADLINE

The provisions of [Chapter 8, Section 3](#) are applicable to the TOP **except that claims for services provided outside the 50 United States or the District of Columbia, the Commonwealth of Puerto Rico, or the possessions of the United States are considered to be filed in a timely manner if they are filed No Later Than (NLT) three years after the date the services were provided or three years from the date of discharge for an inpatient admission. The TOP contractor shall search their claims system and reprocess any such claims that denied for lack of timely filing, retroactive to December 30, 2008.** The TOP contractor shall notify the Contracting Officer's Representative (COR) if they become aware of country-specific claims filing processes that are in conflict with **this** timely filing deadlines. **All other claims must be filed within one year according to the requirements listed in Chapter 8, Section 3, unless an exception to the filing deadline has been granted.** See [Chapter 1, Section 2, paragraph 5.0](#) for the timely filing waiver process.

4.0 SIGNATURE REQUIREMENTS

4.1 The provisions of [Chapter 8, Section 4](#) are applicable to the TOP unless a different process has been directed by the TMA CO.

4.2 The TOP contractor may, at its discretion, accept a thumbprint in lieu of a signature on a claim form, unless otherwise directed by the government.

4.3 When directed by the TMA CO, the TOP contractor may not use signature on file and may not accept facsimile or thumbprint signatures on claims.

5.0 REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

The provisions of [Chapter 8, Section 5](#) are **altered** for the TOP by the requirements listed below.

5.1 Referral/Preauthorization/Authorization Requirements for TOP Prime and TOP Prime Remote Enrollees

5.1.1 Unless otherwise directed by the government, referrals/preauthorizations/authorizations are not required for emergency care, clinical preventive services, ancillary services, radiological diagnostics (excluding Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans), drugs, and services provided by a TOP Partnership Provider. Additionally, TOP Prime/TOP Prime Remote ADFMs may receive the first eight outpatient mental health sessions in a fiscal year without preauthorization. All other care that is provided to a TOP Prime/TOP Prime Remote-enrolled ADSM or ADFM by anyone other than their Primary Care Manager (PCM) requires authorization, regardless of where the care is rendered.

5.1.2 Claims for ADSM care not authorized by the TOP contractor shall be pended for a review to make a determination regarding authorization. If the care is retroactively authorized, then the contractor shall enter the authorization and process the claim for payment. If the contractor determines that the care was not authorized, the contractor shall deny the claim. Refer to [Section 26](#) for additional information.

5.1.3 TOP ADSM claims for non-emergent care obtained in the 50 United States and the District of Columbia shall only be paid when accompanied by the appropriate payment authorization forms (SF 1034 or NAVMED 6320/10) or a **referral with justification statement from the ADSM's Primary Care Manager (PCM) or designee.**

5.1.4 Claims for **self-referred, non-emergency care for TOP Prime and TPR enrolled ADFMs** shall process with POS deductibles and cost-shares **if not authorized by the TOP contractor or Military Treatment Facility (MTF)** (see [paragraph 5.4](#)).

5.2 Referral/Preauthorization/Authorization Requirements for all other TOP Beneficiaries

5.2.1 TRICARE-eligible beneficiaries residing in an overseas location who are not enrolled in TOP Prime/TOP Prime Remote typically do not need to obtain preauthorization/authorization for care. However, preauthorization reviews shall be performed for all care and procedures listed in [Chapter 7, Section 2](#).

5.2.2 The TOP contractor may propose additional authorization reviews for non-enrolled TOP beneficiaries to the government.

5.3 Referral/Preauthorization/Authorization Requirements for Beneficiaries Who Reside in the 50 United States and the District of Columbia

5.3.1 TRICARE beneficiaries whose health care is normally provided under one of the three regional MCSCs who require care while traveling in an overseas location shall request any necessary preauthorizations/authorizations through the TOP contractor, regardless of where the beneficiary resides or is enrolled.

Note: This process does not apply to beneficiaries enrolled to the USFHP or the CHCBP.

5.3.2 Effective for dates of service June 1, 2010, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for Medicare/TRICARE dual eligible beneficiaries. The dual eligible contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer.

5.4 Point of Service (POS) Provisions

5.4.1 Unless specifically excluded by this section, all self-referred, non-emergency care provided to TOP Prime/TOP Prime Remote-enrolled ADFMs which is not either provided/referred by the beneficiary's PCM or specifically authorized shall be reimbursed under the POS option. This provision applies regardless of where the care is rendered. POS provisions also apply to the following stateside beneficiaries when traveling overseas: ADFMs, retirees, and retiree family members who are enrolled in TRICARE Prime, and ADFMs enrolled in TPR for ADFMs.

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5.4.2 POS cost-sharing only applies to TRICARE-covered services. Claims for services that are not a covered TRICARE benefit shall be denied.

5.4.3 The TOP contractor shall adjust POS deductibles and cost-shares when TOP PCMs or Health Care Finders (HCFs) do not follow established referral/authorization procedures. For example, if the contractor processes a claim under the POS option because there was no evidence of a referral and/or an authorization, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim and reverse the POS charges. The contractor need not identify past claims that may be eligible for POS adjustment; however, the contractor shall adjust these claims as they are brought to their attention.

5.4.4 On a case-by-case basis, following stabilization of the patient, the TAO Director or MTF Commander may require an enrolled beneficiary to transfer to a TOP network facility or an MTF. The TAO Director or 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 beneficiary who is subject to TOP POS provisions elects to remain in the non-network facility after such notification, POS cost-sharing provisions will apply beginning 24 hours following the receipt of the written notice. Neither the TOP Director nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

5.4.5 The following deductible and cost-sharing amounts apply to all TOP POS claims for health care support services:

- Enrollment year deductible for outpatient claims: \$300 per individual; \$600 per family. No deductible applies to inpatient services.
- 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).
- POS deductible and cost-share amounts are not creditable to the enrollment/Fiscal Year (FY) catastrophic cap and they are not limited by the cap.
- POS deductible and cost-share amounts do not apply to claims for care received by newborns and newly adopted children who are deemed enrolled in TOP Prime or TOP Prime Remote.

5.4.6 POS deductible and cost-share amounts do not apply if a TOP enrollee has Other Health Insurance (OHI) that provides primary coverage (i.e., the OHI must be primary under the provisions of the TRM, [Chapter 4, Section 1](#)). Evidence of OHI claims processing (including the exact amount paid on the claim) must be submitted with the TOP claim.

5.4.7 EOB shall clearly indicate that a claim has been processed under the POS Option.

5.4.8 POS is not applicable to ADSMs or to TOP non-enrollees.

5.5 Extended Care Health Option (ECHO) benefits in overseas locations must be authorized by the TAO Director or designee. Refer to [Section 23](#) and the TPM, [Chapter 9](#) for additional guidance.

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.

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 Beneficiary and host nation provider signatures.

6.6.2 Complete beneficiary and host nation provider name and address.

6.6.3 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, or notify the TAO Director as appropriate.

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

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

6.6.5 Identification of the 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.

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6.6.6 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 with International Classification of Diseases, 10th Revision (ICD-10) codes shall be converted to International Classification of Diseases, 9th Revision (ICD-9) codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of "V" codes.

6.6.7 Care authorizations (when required).

6.6.8 Itemization of total charges. (Itemization of hospital room rates are not required on institutional claims).

6.6.9 Proof of payment is required for all beneficiary submitted claims if the claim indicates that the beneficiary made payment to the provider or facility. The overseas claims processor shall use best business practices when determining if the documentation provided is acceptable for the country where the services were rendered.

6.7 The TOP contractor shall return all claims for overseas pharmacy services submitted by high volume overseas providers without National Drug Code (NDC) coding (where required), unless the provider has been granted a waiver by the TMA CO as outlined below.

6.8 Non-prescription (Over-The-Counter (OTC)) drugs are to be denied. This includes drugs that are considered OTC by U.S. standards, even when they require a prescription in a foreign country.

6.9 The TOP contractor shall use a schedule of allowable charges based on the Average Wholesale Price (AWP) as a reference source for processing drug related TRICARE overseas claims.

6.10 Claims for medications prescribed by a host-nation physician, and commonly used in the host-nation country, may be cost-shared.

6.11 The TOP contractor shall use \$3,000 as the overseas pharmacy service drug tolerance. A limited waiver to the NDC coding and payment requirements (where required) may be granted for overseas claims for pharmaceuticals submitted from low volume/small overseas pharmacy providers or TRICARE eligible beneficiaries from the Philippines, Panama, and Costa Rica and any other country designated by TMA, when it would create an undue hardship on a beneficiary. High volume providers who provide pharmaceuticals in the Philippines, Panama, and Costa Rica (and any other country designated by TMA) would not qualify for the limited waiver. See [Section 14](#) for specific NDC coding and payment requirements.

6.12 For the Philippines, prescription drugs may only be cost-shared when dispensed by a certified retail pharmacy or hospital-based pharmacy. The TOP contractor shall deny claims for prescription drugs dispensed by a physician's office. Certification requirements outlined in [Section 14](#) apply.

Note: This does not apply to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

6.13 Claims for DME involving lease/purchase shall always be developed for missing information.

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6.14 The TOP contractor shall use ECHO claims processing procedures outlined in TPM, [Chapter 9, Section 18.1](#), when processing ECHO overseas claims.

6.15 The TOP contractor shall deny claims from non-certified or non-confirmed host nation providers when the TMA CO has directed contractor certification/confirmation of the host nation provider prior to payment.

6.16 Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary in TRICARE [Eurasia-Africa](#) Region, the contractor shall include a special insert in German, Italian and Spanish which indicates what missing information is required to process the claim and includes the contractor's address for returning requested information.

6.17 If the TOP contractor elects to develop for additional/missing information, and the request for additional information is not received/returned within 45 days, the contractor shall deny the claim.

6.18 If the TOP contractor has no record of referral/authorization prior to denial/payment of the claim, the contractor will follow the TOP POS rules, if the service would otherwise be covered under TOP.

6.19 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 without preauthorization/authorization. Upon receipt of a claim for a TOP-enrolled ADFM submitted by a TOP host nation designated or non-designated overseas host nation provider without preauthorization/authorization, the contractor shall process the claims following POS payment procedures. For ADSM claims submitted by a TOP host nation provider without preauthorization/authorization, the contractor shall pend the claim for review prior to denying the claim.

6.20 The TOP contractor must have an automated data system for eligibility, deductible and claims history data and must maintain on the automated data system all the necessary TOP data elements to ensure the ability to reproduce both TRICARE Encounter Data (TED) and EOB as outlined in [Chapter 8, Section 8](#), except for requiring overseas providers to use Health Care Procedure Coding System (HCPCS) to bill outpatient rehabilitation services, issue provider's the Form 1099 and suppression of checks/drafts for less than \$1.00. The contractor is allowed to split claims to accommodate multiple invoice numbers in order to reference invoice numbers on EOB when necessary. Refer to [Chapter 8, Section 6](#) for additional requirements related to claims splitting.

6.21 The TOP contractor shall not pay for pharmacy services obtained through the internet.

6.22 The TOP contractor shall pay all non-emergency and emergency civilian/medical surgical and dental claims for TRICARE [Eurasia-Africa](#), TLAC, and Pacific ADSM health care even when not a TRICARE covered benefit when the claim is:

6.22.1 Submitted by the MTF or other military command personnel, or by a designated POC; and

6.22.2 Accompanied by a completed and signed TRICARE claim form; and

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6.22.3 Accompanied by either a Standard Form (SF) 1034, a Standard Form 1035 continuation sheet, a Naval Medical (NAVMED) Form 6320/10 (these forms shall be considered an authorization for payment), or a **referral from the ADSM's PCM or designee**; and

6.22.4 DEERS verification indicates the TRICARE **Eurasia-Africa**, TLAC, and Pacific ADSM was on Active Duty (AD) at the time the services were rendered.

Note: The SF 1034, SF 1035 continuation sheet or NAVMED 6320/10 must be signed by the submitting military command. If a patient signature is not present on the claim form, the military command must submit a letter of explanation with the unsigned claim form prior to payment.

6.23 Upon payment for a TOP enrolled ADSM overseas claim, a copy of the EOB and, when applicable, the SF 1034 or SF 1035 or NAVMED 6320/10 shall also be manually submitted to the MTF, or MTF command personnel, or a designated POC.

6.24 Emergency submitted non-remote ADSM claims for health care received overseas/stateside not meeting TPM, [Chapter 2, Section 4.1](#) policy on emergency department services shall be denied explaining the reason of denial and advising resubmission with proper forms by the appropriate MTF, etc.

6.25 The TOP contractor shall deny non-remote TRICARE **Eurasia-Africa**, TLAC, and Pacific ADSM claims for health care received overseas when any one of the administrative items are missing. Upon denial, the contractor shall instruct the non-remote TRICARE **Eurasia-Africa**, TLAC, and TRICARE Pacific ADSM/host nation provider to contact the local MTF or other military command personnel, for assistance in proper claim submission and in obtaining missing documentation. Copies of EOB and claims denied as DEERS ineligible or not submitted by an MTF shall be electronically forwarded to the appropriate overseas TAO Director for further action.

6.26 The TOP contractor shall pay all TOP ADSM stateside claims as outlined in [Section 26](#).

6.27 All claims must be submitted in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. Refer to [Section 28](#) for more information on HIPAA requirements.

6.28 Electronic claims not accepted by the TOP contractor's Electronic Data Information (EDI) system/program shall be rejected.

6.29 For all overseas claims, the TOP contractor shall create and submit TEDs following current guidelines in the TRICARE Systems Manual (TSM) for TED development and submission. Claim information will be able to be accessed through the TRICARE Patient Encounter Processing and Reporting (PEPR) Purchased Care Detail Information System (PCDIS).

6.30 The TOP contractor shall establish Utilization Management (UM) high dollar/frequency thresholds in accordance with [Section 6](#).

6.31 Claims either denied as "beneficiary not eligible" or "found to be not eligible on DEERS" may be processed as a "good faith payment" when received from the TMA Beneficiary and Provider Services (BPS). The TAO Director shall work with the TOP contractor on claims issues related to good faith payment documentation (e.g., a completed claim form and other documentation as required by [Chapter 10, Sections 3 and 4](#)).

6.32 The provisions of [Chapter 8, Section 6, paragraph 10.0](#) shall apply to the TOP.

6.33 The Claims Auditing Software requirements outlined in the TRM, [Chapter 1, Section 3](#) do not apply to TOP claims; however, the TOP contractor shall implement an internal process for identifying upcoding, unbundling, etc. on coded claims.

7.0 APPLICATION OF DEDUCTIBLE AND COST-SHARING

Application of TOP deductible and cost-sharing procedures shall follow the guidelines outlined in [Chapter 8, Section 7](#).

8.0 EOB VOUCHERS

8.1 The TOP contractor shall follow the EOB voucher requirements in [Chapter 8, Section 8](#), where applicable, with the following exceptions and additional requirements:

8.1.1 The letterhead on all TOP EOB shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or Standard.

8.1.2 TOP EOB may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".

8.1.3 TOP EOB shall include the toll-free number for beneficiary and provider assistance.

8.1.4 TOP EOB for overseas enrolled ADSM claims shall be annotated "ACTIVE DUTY"

8.1.5 For Point of Sale or Vendor pharmacy overseas claims, TOP EOB must have the name of the provider of service on the claim.

8.1.6 For beneficiary submitted pharmacy claims, TOP EOB shall contain the name of the provider of service, if the information is available. If the information is not available, the EOB shall contain "your pharmacy" as the provider of service.

8.1.7 The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOBs, if available.

8.1.8 The following EOB message shall be used on overseas claims rendered by non-network host nation providers who are required to be certified, but have not been certified by the TOP contractor - "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider".

8.1.9 When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

9.0 DUPLICATE PAYMENT PREVENTION.

9.1 The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

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 documentation.**

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, etc.

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.

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.

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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 payment may not be changed to U.S. dollars after the foreign draft has been issued.

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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 when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor and the draft has been returned with the request.

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 EOB 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 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](#)).

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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 Provider requests for EFT payment. 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.

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 pended 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.

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

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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.

- END -

Active Duty Dental Care In Remote Overseas Locations

1.0 GENERAL

All TRICARE requirements regarding active duty dental care 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").

2.0 CONTRACTOR RESPONSIBILITIES

2.1 The TOP contractor shall arrange and provide access to dental care on a cashless, claimless basis to TOP Prime Remote enrolled Active Duty Service Members (ADSMs), except for ADSMs located in U.S. territories (including Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). This includes routine, urgent, and emergent dental care services, including dental transportation/evacuation when medically necessary and appropriate. The contractor shall also arrange and provide access to urgent and emergent dental care services (including dental transportation/evacuation when medically necessary and appropriate) to non-enrolled ADSMs who require urgent or emergent dental care services while on Temporary Additional Duty /Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in a remote overseas location.

Note: "Cashless, claimless" refers to an encounter with a provider who collects only normal TRICARE copayments at the time of service and agrees to file the claim for the beneficiary.

2.2 The TOP contractor shall establish a network of host nation dental providers who have been evaluated and determined to meet international hygiene and clinical practice standards. Upon beneficiary request, the contractor will also provide information to any TRICARE beneficiary regarding dental network providers; however, the contractor is not required to establish dental networks to support Active Duty Family Members (ADFM), retirees, or retiree family members.

2.3 The TOP contractor's Call Center(s) shall provide assistance regarding ADSM dental care 24 hours per day, seven days per week, 365 days per year.

2.4 ADSMs in remote overseas locations shall contact the TOP contractor's Call Center to schedule routine care under **\$750**. Treatment plans that exceed **\$750** per episode or **\$1,500** per calendar year require prior authorization and approval from the appropriate TRICARE Area Office (TAO) Dental Director (or designee) even if the dental visits are considered "routine care". The contractor shall assist ADSMs in submitting treatment plans for TAO review.

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2.5 The TOP contractor shall ensure that the following documentation is provided to the TAO for all pre-authorization reviews: radiographs and diagnosis, treatment plan, estimated time required for care, probable cost, and projected length of tour of duty at the patient's present duty station.

2.6 All ADSM orthodontic service requests shall be forwarded to the appropriate TAO Dental Director for review and authorization, regardless of treatment cost.

2.7 ADSMs who seek dental service without coordinating their care through the TOP contractor may be required to pay up-front at the time services are rendered. The ADSM shall be responsible for submitting claims for reimbursement. Dental care claims that lack proper authorization (where required) shall be denied. The TAO Dental Director (or designee) may provide a retroactive authorization for dental care services when appropriate.

2.8 The contractor will accept electronic or paper referrals and authorizations from the TAOs.

2.9 Prior authorizations are not required for emergency dental care services. However, ADSMs shall be encouraged to contact the contractor's Call Center for assistance with obtaining emergency dental care whenever possible. This shall ensure that services can be provided on a cashless, claimless basis for covered services from a qualified dental provider.

2.10 Dental claims may be submitted by TOP Points of Contact (POCs) on behalf of remote ADSMs in accordance with [Section 12](#).

2.11 Some POC-submitted claims will require payment even though Defense Enrollment Eligibility Reporting System (DEERS) does not report eligibility.

2.12 Reserve component members who are on orders for less than 30 days may not appear eligible in DEERS. Claims submitted for these beneficiaries must be accompanied by proof of eligibility in order to adjudicate the claim.

2.13 Claims will be accepted without Current Dental Terminology (CDT) procedure codes and will be manually coded by the TOP contractor based on narratives provided.

2.14 Host nation dental providers will not be required to indicate dental readiness classification on the claim form.

2.15 Payment for remote overseas active duty dental care shall be at billed charges, unless a different process has been identified by the government.

2.16 Normal TRICARE foreign currency rules apply.

2.17 Upon beneficiary request, the TOP contractor shall assist the ADSM in locating an appropriate dental provider and making dental appointments.

2.18 The government will provide the TOP contractor with a Dental Overseas Benefit Brochure/ Handout explaining local requirements. This material shall be incorporated into all applicable beneficiary education briefings and mailings.

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2.19 At the discretion of the TOP contractor, dental emergencies that cannot be adequately addressed through the contractor's dental network may be treated as medical cases and shall interface with the medical management program (e.g., if an ADSM resides in a remote area where there are no dental providers, they may be referred to a host nation medical provider for pain management pending travel to an area with a qualified dentist).

2.20 The TOP contractor shall prepare and submit a quarterly report for TOP ADSM dental care per [Section 15](#).

- END -

Beneficiary And Provider Services (BPS)

1.0 GENERAL

1.1 All TRICARE requirements regarding Beneficiary and Provider Services (BPS) 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 11** for additional instructions.

1.2 Per Department of Defense Instruction (DoDI 6010.21 ("TRICARE Marketing Policy") dated December 18, 2001, TRICARE marketing materials developed by contractors must be coordinated with appropriate **Regional Director (RD)** and approved by TRICARE Management Activity (TMA). For the TOP contract, this coordination includes the **TRICARE Area Office (TAO)** Directors. Coordination of local administrative changes is at the local discretion of Military Treatment Facilities (MTFs).

2.0 TRICARE SERVICE CENTERS (TSCs)

2.1 The provisions of **Chapter 11, Section 3** are applicable to the TOP, except that TOP TSCs are jointly staffed by MTF personnel and TOP contractor personnel.

2.2 **The requirement for full-time staffing as described in Chapter 11, Section 3, paragraph 1.0 is applicable to the Beneficiary Service Representatives (BSRs) in the TSCs. The TOP contractor shall implement appropriate business processes to provide full-time TSC coverage if the assigned BSR(s) are unavailable due to planned or unplanned absences (e.g., illness, leave, personal emergencies, etc.) for more than two consecutive business days. Local processes for managing short-term BSR absences (up to two consecutive business days) shall be addressed in the Memorandum of Understanding (MOU) between the affected MTF commander(s) and the TOP contractor.**

3.0 HEALTH CARE FINDER (HCF) SERVICES

3.1 TOP HCF functions are performed by TOP contractor personnel located in the TSCs or in contractor-operated call center(s). The contractor shall offer call center operations to support HCF services via toll-free lines 24 hours per day, seven days per week, 365 days per year.

Note: The contractor must also offer claims assistance via toll-free lines seven days per week, 365 days per year, between the hours of 2:00 AM and 7:00 PM Central Standard Time (CST). These service hours for claims assistance apply even if claims assistance is provided via the contractor's call center(s).

3.1.1 HCFs (including MTF/contractor personnel and call centers) are responsible for facilitating access to host nation provider care (including, but not limited to primary care, specialty care, mental health care, ancillary services, Durable Medical Equipment (DME), and pharmacy

services), and for authorizing certain health care services. Additionally, HCFs shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of host nation TOP network/non-network providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments and the sharing of medical records. TOP HCFs will serve all Military Health System (MHS) beneficiaries in the region, regardless of their enrollment status. This includes dual-eligible beneficiaries and beneficiaries residing or enrolled in the 50 United States and the District of Columbia who may require assistance when accessing care in an overseas location.

3.1.2 For MTF enrollees, the specialty care referral process includes a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). The contractor shall also provide information to MTF personnel regarding the status of specialty care referrals and shall work cooperatively with the MTF to assist in obtaining consult results from host nation providers; however, the contractor is not responsible for tracking receipt of consult results.

3.1.3 For TOP Prime Remote enrollees, the specialty care referral process includes a medical necessity review; a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). This process is also applicable to Active Duty Service Members (ADSMs) who are on Temporary Additional Duty/ Temporary Duty (TAD/TDY), in an authorized leave status, or deployed/deployed on liberty in a remote overseas location, and to TRICARE Prime/TRICARE Prime Remote (TPR) enrollees who require urgent specialty care while traveling outside the 50 United States and the District of Columbia.

3.1.4 Beneficiaries enrolled to the **Uniformed Services** Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP) must follow the requirements of those programs when obtaining overseas care.

3.2 The TOP HCF is responsible for the following functions:

3.2.1 Referral Assistance for TOP Beneficiaries

The TOP contractor (working in concert with the MTF Commander) is required to ensure optimal use of MTFs and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTF. The TOP HCF is the primary mechanism for achieving these objectives. The referral services of the TOP HCF are primarily to ensure access to care for enrolled beneficiaries, but the TOP HCF is also available to assist non-enrollees in finding network/non-network host nation providers. For TOP Prime/TOP Prime Remote enrollees, the referral is generally initiated by the beneficiary's Primary Care Manager (PCM). The PCM or beneficiary contacts the TOP HCF for assistance in locating an appropriate host nation provider and to obtain authorization for the care (see [Sections 17](#) and [18](#) for additional information on HCF referral assistance).

3.2.2 Referral Assistance for Beneficiaries Enrolled or Residing in the 50 United States and the District of Columbia

The TOP contractor shall provide referral assistance for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. These referrals will generally be initiated by the beneficiary, a host nation provider, or an overseas MTF provider. Emergency care never requires preauthorization; however, ADFMs enrolled to TRICARE Prime/TPR may receive **urgent and** emergency health care services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation per Section 7) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor. The TOP contractor shall implement guarantee of payment or other business processes to ensure that ADFMs enrolled to TRICARE Prime/TPR may receive **urgent or** emergency medical services on a cashless, claimless basis upon beneficiary request.

3.2.3 Authorizations

The TOP HCF will authorize care for TPR enrollees; for ADSMs who are on TAD/TDY, in an authorized leave status, or deployed, deployed on liberty in a remote overseas location, and for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. The contractor shall also ensure that MTF-issued authorizations are entered into all applicable contractor systems. Non-emergent specialty health care received from a host nation provider must be authorized if benefits are to be paid as TOP Prime/TPR.

3.2.4 Care subject to a PCM referral/authorization/Non-Availability Statement (NAS) may receive a clinical review and authorization by the HCF or other designee. An NAS is needed for non-emergency inpatient mental health care when the beneficiary resides within an overseas MTF enrollment area (defined as a 40-mile radius or a one hour drive time from the MTF).

3.2.5 If an ADFM TOP Prime/TOP Prime Remote enrollee receives care that was not authorized, the care may be covered under the TOP Point of Service (POS) option, with POS deductibles and cost-shares. POS provisions also apply to TRICARE Prime/TPR enrollees who receive non-emergency care outside the 50 United States and the District of Columbia without obtaining prior authorization from the TOP contractor. The care must also be otherwise coverable under TRICARE or the claim shall be denied.

3.2.6 ADSM care that was not referred and authorized may be denied unless it is retroactively authorized by the appropriate service or TAO personnel. POS does not apply to ADSMs.

4.0 CUSTOMER SERVICE RESPONSIBILITIES

TOP customer support shall be provided to TOP RD and TAO staffs, TOP host nation providers, TOP beneficiaries, designated Point of Contacts (POCs), TOP MTF staffs including Health Benefit Advisors (HBAs)/Beneficiary Counseling and Assistance Coordinators (BCACs)/Debt Collection Assistance Officers (DCAOs), stateside TRICARE Regional Offices (**TROs**), stateside **Managed Care Support Contractors** (MCSCs), stateside TRICARE beneficiaries traveling overseas, claims processing

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contractors, and TMA. TOP contractor customer support service shall include the following:

4.1 The TOP contractor shall secure at a minimum one dedicated post office box for the receipt of all claims and correspondence from foreign locations per overseas region.

4.2 The TOP contractor shall identify a specific individual and an alternate to assist the TOP RD, TAO Directors, TMA, BCACs and stateside claims processing contractors with the resolution of TOP issues. Issues which cannot be successfully resolved shall be referred to the TOP Contracting Officer's Representative (COR).

4.3 The TOP contractor shall identify a specific individual and an alternate to assist DCAOs with the resolution of TOP beneficiary debt collection issues.

4.4 The TOP contractor shall be responsible for establishing and operating a dedicated TRICARE overseas claims/correspondence processing department with a dedicated staff. This department and staff shall be under the direction of a supervisor, who shall function as the contractor's POC for TRICARE overseas claims and related operational and support services. The contractor's department for TRICARE overseas claims shall include at a minimum the following functions/requirements:

4.4.1 The TOP contractor shall provide toll-free telephone service for claims assistance to TOP beneficiaries and providers seven days a week, 365 days a year, between the hours of 2:00 AM and 7:00 PM CST. Toll-free services must be available from any stateside or overseas location.

4.4.2 The TOP contractor shall have the ability to translate claims submitted in a foreign language and write in German, Italian, Japanese, Korean, Tagalog (Filipino) and Spanish, or shall have the ability to obtain such translation or writing.

4.4.3 The TOP contractor shall provide on-line read only access to their claims processing system to the TOP RD, each TOP TAO Director, and the TMA technical representative for TOP claims.

4.4.4 The TOP contractor shall provide a secure, user-friendly internet portal for receipt of customer claims status inquiries and access to claims status information (to include the ability to view and print Explanation of Benefits (EOBs)).

4.4.5 The TOP contractor is required to provide, upon TMA or TAO Director request, documentation of claims for auditing purposes.

4.5 The TOP contractor is required to assist traveling TOP beneficiaries to ensure beneficiary access/receipt of urgent or emergent care in the 50 United States and the District of Columbia. The contractor shall also assist beneficiaries residing or enrolled in the United States or the District of Columbia who require urgent or emergent care while traveling overseas. ADFMs who are enrolled to TRICARE Prime or TPR may receive emergency medical services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor.

4.6 The contractor shall refer beneficiary, provider, HBAs, and congressional inquiries not related to claims status to TMA Chief, BPS Office.

5.0 BENEFICIARY SERVICES

5.1 The TOP contractor shall achieve the highest level of beneficiary satisfaction possible in the overseas environment. This shall be accomplished by developing qualified host nation provider networks (complemented by non-network host nation providers as necessary), ensuring timely access to host nation care, providing TOP information/education/training to beneficiaries and host nation providers, and processing claims in a timely, accurate manner.

5.2 In addition to the beneficiary education requirements outlined in [Chapter 11, Sections 1 and 2](#), the TOP contractor may be required to conduct beneficiary education/enrollment activities for arriving/deploying units in accordance with the enrollment protocols established in the Memorandum of Understanding (MOU) between the TOP contractor and the MTFs.

5.3 In addition to the requirements outlined in [Chapter 11, Section 2](#), all beneficiary satisfaction activities (including beneficiary surveys conducted in accordance with [Chapter 11, Section 2](#)) shall be coordinated with the three TAOs to achieve a coordinated, uniform approach to Department of Defense (DoD) customer services overseas.

5.4 The TOP contractor shall maintain up-to-date lists of host nation network providers, and shall make this information available at all TOP TSCs and via web-based access. Web-based network provider listings shall include information regarding authorization requirements that are applicable to TOP enrollees.

5.5 The TOP contractor's beneficiary education plan shall address their process for educating TOP beneficiaries regarding care received in the 50 United States and the District of Columbia. At a minimum, this process shall include information regarding referrals/authorizations while stateside, TOP POS policy, and the recommended process for accessing care while stateside. TOP beneficiaries traveling stateside shall be encouraged to utilize MTF care whenever possible. If MTF care is not available, beneficiaries should be encouraged to seek care from a network provider before obtaining care from a non-network provider.

5.6 The requirement for a quarterly three-day TRICARE training course, as outlined in [Chapter 11, Section 2, paragraph 1.1](#), is superseded for the TOP contractor by a requirement for a total of **nine** three-day TRICARE training courses per contract option period (two per option period within the TRICARE Eurasia-Africa area; two within the TRICARE Pacific area; two within the TRICARE Latin America/Canada (TLAC) area; **and three additional courses that may occur in any stateside or overseas location at the direction of the Contracting Officer (CO)**).

Note: Only the frequency requirements of [Chapter 11, Section 2, paragraph 1.1](#) are superseded; all other requirements of the referenced paragraph apply to the TOP contractor.

5.7 The requirement for mailing TRICARE handbooks, as outlined in [Chapter 11, Section 1, paragraph 4.1](#), is superseded for the TOP contractor by a requirement for "on-demand" processes for distributing TRICARE handbooks upon beneficiary request (including, at a minimum, web-based requests, telephone requests, and on-site requests at a TSC).

6.0 PROVIDER SERVICES

6.1 The TOP contractor shall ensure that all host nation network providers and their support staff have sufficient understanding of the applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner that promotes beneficiary satisfaction.

6.2 The TOP contractor shall have the responsibility for developing and delivering TRICARE Program information to host nation providers. The contractor shall determine the requirements for printed products and will develop and deliver these products after obtaining approval from the government. The information in these products will generally be determined by the contractor based on their understanding of the needs of their network providers; however, the government may mandate the inclusion of certain topics or information.

6.3 Provider education materials shall include information regarding claims processing procedures, claims submission deadlines, and normal claims processing time lines.

6.4 The government shall ensure provider satisfaction with contractor-provided information by conducting random satisfaction surveys of select network providers.

7.0 GRIEVANCES AND GRIEVANCE PROCESSING

The TOP contractor shall process all grievances related to contractor personnel or contractor actions. The contractor shall also process all grievances related to network or non-network host nation providers or institutions, with a copy provided to the TMA COR and the appropriate TAO.

- END -

Appeals And Hearings

1.0 GENERAL

All TRICARE requirements regarding appeals and hearings 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 the TPM, Chapter 1, Section 4.1; 32 CFR 199.10; 32 CFR 199.15; and Chapter 12, Sections 1 through 6 for additional instructions.**

2.0 CONTRACTOR RESPONSIBILITIES

2.1 Denial of Authorization of Payment for Treatment for Active Duty Family Members (ADFM), Retirees, and Retiree Family Members

The TOP contractor shall perform initial determinations. Initial denial determinations shall be appealed/directed to the TOP contractor. The contractor shall perform the reconsideration review, to include research and consideration of any host nation practice patterns or other cultural differences that are relevant to the case (see [paragraph 2.3](#)). If the TOP contractor upholds the denial in whole or in part, the contractor shall notify the beneficiary in writing of further appeal rights.

2.2 Denial of Authorization of Payment for Treatment for Active Duty Service Members (ADSMs)

The TOP contractor shall perform initial determinations. When authorization or payment is denied by the TOP contractor, the ADSM or their appointed representative may appeal the denial to the designated Service Point of Contact (SPOC). The TOP contractor shall furnish the ADSM with clear guidance, in writing, for filing an appeal with the SPOC. If the SPOC upholds the denial in whole or in part, the SPOC will notify the ADSM of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SPOC will notify the TOP contractor and the ADSM of the results. The TOP contractor is required to maintain a log by TRICARE Area Office (TAO) region of overturned denials.

2.3 Consideration of Cultural Differences During Reconsideration Process

Prior to issuing a reconsideration determination, the TOP contractor shall conduct research to determine whether there are unique host nation practice patterns or other cultural differences unique to foreign health care that may be relevant to the beneficiary's case. The TOP contractor shall document any relevant practice patterns or cultural differences and shall consider the potential impact of these issues during the reconsideration process. This documentation shall be

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included in the file documentation identified in [Chapter 12, Section 3](#).

- END -

Program Integrity

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 a current file of all certified Philippines providers via electronic format to the TAO Pacific Director No Later Than (NLT) 60 calendar days prior to the start of health care delivery. The contractor is required to ensure these providers are designated on their provider file as certified/authorized overseas host nation providers and shall assign each provider a

unique number following current contract requirements and shall provide that number to the appropriate TAO Director.

2.3.2 Updates/reconciliations of Philippine providers who have been certified or disapproved shall be provided by the TOP contractor to the Contracting Officer's Representative (COR) and the TAO Pacific Director. Separate reports shall be submitted for network and non-network providers. For new non-network providers, the contractor shall submit a cumulative report in an Excel format which includes those providers which are approved or denied, including copies of current licenses/credentials and the providers name, business address and billing address, including telephone and fax numbers, if available, date of certification/denial, and provider specialty if available. This report shall be submitted semiweekly. TMA may expand this process to other countries in the future.

2.3.3 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 45 calendar days, the TOP contractor shall deny claims based on lack of provider certification.

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

2.3.4.1 Reviewing new providers.

2.3.4.2 Reviewing the TOP contractor's current certified provider files.

2.3.4.3 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.

2.3.4.4 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.

2.3.5 The TOP contractor shall forward new provider certification requests to the TAO Pacific Director two times per week, on Mondays and Wednesdays. If these days fall on a United States national holiday, the reports will be provided the next business day.

2.3.6 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.

2.3.7 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 2.3.14](#)).

2.3.8 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

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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.

2.3.9 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.

2.3.10 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.

2.3.11 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).

2.3.12 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.

2.3.13 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.

2.3.14 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 -

Audits, Inspections, Reports, And Plans

1.0 GENERAL

All TRICARE requirements regarding audits, inspections, reports, and plans 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 14** for additional instructions.

2.0 AUDITS AND INSPECTIONS

2.1 The TOP contractor shall comply with the provisions of **Chapter 14, Section 1** regarding audits and inspections.

2.2 The TRICARE Overseas Currency reports, and the claims supporting them, are subject to audit by TRICARE Management Activity (TMA) or other authorized Government auditors as part of any financial audit.

2.3 The claims auditing software requirements outlined in the TRICARE Reimbursement Manual (TRM), **Chapter 1, Section 3** do not apply to TOP claims.

3.0 REPORTS AND PLANS

3.1 All TOP reports and plans shall be submitted to TMA in accordance with the process identified in **Chapter 14, Section 2**, unless a different method of submission is identified in the Contract Data Requirement Lists (CDRLs), DD Forms 1423, incorporated into the contract.

3.2 Reports must be sortable by all fields and by TOP Region/TRICARE Area Office (TAO) Director unless a different format is specified by the government.

3.3 All reports and plans shall be titled as listed in the TOP contract CDRLs.

3.4 All TRICARE requirements regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy of **Individually Identifiable Health Information (IIHI)** shall apply to TOP reports and plans.

- END -

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

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.

2.2 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.

2.3 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.).

2.4 The provisions of **Chapter 15, Sections 2 and 3** are not applicable to the TOP.

2.5 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

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. The TOP contractor shall accept an electronic care authorization issued under the Electronic Non-Availability Statement (E-NAS) function or a locally produced document that contains HCF/PCM referral/approval. 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.

Note: The E-NAS function is currently used in all overseas regions.

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

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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.

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) Standard

1.0 GENERAL

1.1 All TRICARE requirements regarding TRICARE Standard 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").

1.2 TOP Standard is identical to TRICARE Standard in the United States with benefits, deductibles, and cost-shares unchanged. Beneficiaries residing overseas may be required to pay up front and file a claim for reimbursement.

1.3 TRICARE requirements regarding TRICARE Extra are not applicable to the TOP contract. TRICARE Extra is not available overseas.

2.0 ELIGIBILITY

TRICARE-eligible Active Duty Family Members (ADFM)s, retirees, and retiree family members are eligible for TOP Standard in all overseas locations. The TOP contractor shall verify beneficiary eligibility via the Defense Enrollment Eligibility Reporting System (DEERS) in accordance with the provisions of [Section 5](#).

3.0 CONTRACTOR RESPONSIBILITIES

3.1 The TOP contractor shall process claims and provide claims assistance for TRICARE Standard beneficiaries who reside in an overseas location (regardless of where the care was rendered), and for TRICARE Standard beneficiaries residing in the United States and the District of Columbia who receive health care services in an overseas location. This includes claims for prescriptions unless these claims are otherwise covered under the TRICARE Pharmacy (TPharm) contract.

3.2 The TOP contractor is not required to develop host nation provider networks to support the TOP Standard beneficiary population.

3.3 The TOP contractor is not required to provide health care services on a cashless, claimless basis for TOP Standard beneficiaries, or for TRICARE Standard beneficiaries residing in the United States and the District of Columbia who receive health care services in an overseas location.

3.4 The TOP contractor is not required to make appointments with host nation providers for TOP Standard beneficiaries, or for TRICARE Standard beneficiaries residing in the United States and the District of Columbia who receive health care services in an overseas location. However, upon beneficiary request, the contractor shall provide the name, telephone number, and address of host

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nation network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic area.

- END -

TRICARE Reserve Select (TRS)

1.0 GENERAL

All TRICARE requirements regarding TRICARE Reserve Select (TRS) 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 22, Section 1** for additional instructions. For purposes of TOP implementation, all references to TRICARE Prime in this section shall apply to TOP Prime and TOP Prime Remote, and all references to TRICARE Regional Offices (TROs) shall apply to TRICARE Area Offices (TAOs).

2.0 ELIGIBILITY

2.1 The TOP contractor shall provide TRS information and enrollment/disenrollment assistance to Reserve Component (RC) members residing in overseas locations outside the 50 United States and the District of Columbia.

3.0 ENROLLMENT

3.1 The TOP contractor shall process TRS enrollment applications and collect premium payments for TRS enrollment.

3.2 TRS enrollees will receive a TRS member card reflecting their overseas region of enrollment (TRICARE **Eurasia-Africa**, TRICARE Pacific, or TRICARE Latin America/Canada (TLAC)).

3.3 The TOP contractor shall process claims for TRS members enrolled overseas (regardless of where the care was rendered), and for TRS members enrolled in the 50 United States and the District of Columbia who receive health care services in an overseas location. This includes claims for prescriptions unless these claims are otherwise covered by the TRICARE Pharmacy (TPharm) contract. TOP TRS claims shall be processed as TOP Standard since TRS members are not eligible for TOP Prime or TOP Prime Remote.

3.4 The TOP contractor is not required to develop host nation provider networks to support the TRS beneficiary population.

3.5 The TOP contractor is not required to provide Guarantee of Payment to host nation providers or institutions for TRS enrollees.

3.6 The TOP contractor is not required to make appointments with host nation providers for TRS enrollees. However, upon beneficiary request, the contractor shall provide the TRS enrollee with

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TRICARE Reserve Select (TRS)

the name, telephone number, and address of host nation network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic area.

- END -

TRICARE Plus

1.0 GENERAL

1.1 TRICARE Plus is a service-directed primary care enrollment program that is available at selected Military Treatment Facilities (MTFs). Local MTF commanders determine whether TRICARE Plus shall be offered based on their facility's capacities, capabilities, and mission.

1.2 All TRICARE requirements regarding TRICARE Plus 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 6, Section 4** for additional instructions.

2.0 ELIGIBILITY

Active Duty Family Members (ADFM) in overseas locations may enroll in TRICARE Plus (where available) regardless of whether they are Command Sponsored. See **Chapter 6, Section 4** for additional instructions regarding TRICARE Plus eligibility.

3.0 ENROLLMENT

3.1 All beneficiary inquiries regarding TRICARE Plus enrollment/disenrollment shall be directed to the TOP contractor's toll-free number or, based on the Memorandum of Understanding (MOU) with each MTF Commander, to the designated MTF Point of Contact (POC) for TRICARE Plus. This shall include questions about TRICARE Plus, general questions about enrollment/disenrollment, providing enrollment/disenrollment forms, providing information about the availability of TRICARE Plus at a particular MTF, the extent of coverage available and not available through TRICARE Plus, the selection of individual primary care coordinators, or confirmation of enrollment/disenrollment.

3.2 MTFs are responsible for approving or disapproving requests for TRICARE Plus enrollment and for managing Primary Care Clinic capacity for TRICARE Plus enrollment. The MTF is responsible for ensuring that TRICARE Plus enrollment forms are complete with validated eligibility through the Defense Enrollment Eligibility Reporting System (DEERS). The MTFs shall send all completed and approved TRICARE Plus enrollment/disenrollment forms to the TOP contractor no less frequently than weekly.

3.3 The TOP contractor is responsible for ensuring that all TRICARE Plus enrollments are entered through the Defense Online Enrollment System (DOES). The contractor shall return incomplete forms or any application for which enrollment/disenrollment cannot be effected, for any reason other than internal contractor systems or process problems, to the MTF for completion/correction. The contractor shall make no effort to correct or complete any TRICARE Plus enrollment/disenrollment application.

3.4 TOP Prime and TOP Prime Remote cannot be used in conjunction with TRICARE Plus. Enrollment in TRICARE Plus will necessitate disenrollment from TOP Prime or TOP Prime Remote.

3.5 TRICARE Plus enrollment to an overseas MTF is effective on the date the enrollment application is approved by the MTF.

4.0 DISENROLLMENT

4.1 All beneficiary inquiries regarding TRICARE Plus disenrollment shall be directed to the appropriate location in accordance with [paragraph 3.1](#). Beneficiaries may disenroll from TRICARE Plus at any time. TRICARE Plus disenrollment is effective on the date the disenrollment application is approved by the MTF. Disenrollment forms will be sent to the TOP contractor no less frequently than weekly. The contractor shall process disenrollments in accordance with [paragraph 3.3](#).

5.0 HOST NATION PROVIDER SERVICES

5.1 TRICARE Plus is an MTF primary care access program, not a health plan. TRICARE Plus has no impact on care received from civilian providers. Claims for care rendered to TRICARE Plus enrollees by civilian providers will be processed as TRICARE Standard. This includes care rendered by host nation providers overseas or civilian providers in the United States and the District of Columbia.

5.2 The TOP contractor is not required to develop host nation provider networks to support the TRICARE Plus beneficiary population.

5.3 The TOP contractor is not required to provide Guarantee of Payment to host nation providers or institutions for TRICARE Plus enrollees.

5.4 The TOP contractor is not required to make appointments with host nation providers for TRICARE Plus enrollees. However, upon beneficiary request, the contractor shall provide the beneficiary with the name, telephone number, and address of host nation network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic location.

- END -

Extended Care Health Option (ECHO)

1.0 GENERAL

All TRICARE requirements regarding the Extended Care Health Option (ECHO) 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 the TPM, **Chapter 9** for additional instructions.

- END -

Transitional Assistance Management Program (TAMP)

1.0 GENERAL

All TRICARE requirements regarding the Transitional Assistance Management Program (TAMP) 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 the TPM, **Chapter 10, Section 5.1** for additional instructions.

2.0 ELIGIBILITY

2.1 TAMP eligible beneficiaries are eligible for the TOP per the enrollment provisions described below.

2.2 The TOP contractor is responsible for determination of TRICARE eligibility during the TAMP period based on eligibility in the Defense Enrollment Eligibility Reporting System (DEERS).

2.3 The military services are responsible for eligibility entries/updates in DEERS.

3.0 ENROLLMENT

3.1 The provisions of TPM, **Chapter 10, Section 5.1** regarding the "twentieth of the month rule" for enrollment are waived for the TOP. New enrollments for TOP Prime are normally effective on the date the application is signed. Refer to **Section 5** for additional guidance.

3.2 TAMP eligibles who were enrolled in TOP Prime immediately prior to their change in status may continue their enrollment in TOP Prime with no break in coverage. A reenrollment application must be completed prior to the TAMP expiration period in order to continue with TOP Prime. The effective date shall be the date the sponsor separated from active duty, as the intent is to ensure that TOP Prime coverage is seamless.

3.3 10 USC 1145 authorized Military Treatment Facility (MTF) and Civilian Health Care (CHC) for certain Reserve Component (RC) personnel "in the same manner" and "subject to the same rates and conditions" as a dependent of an Active Duty Service Member (ADSM) during the TAMP eligibility period. Transitioning RC personnel who were ordered to active duty under Executive Order 13223, 10 USC 12302, 10 USC 12301(d), or 32 USC 502(f) may either continue in TOP Prime or enroll during the TAMP period per the provisions of 10 USC 1145.

3.4 RC family members who were eligible for TOP Prime during the member's activation may either continue in TOP Prime or enroll during the TAMP period per the provisions of the TRICARE Reserve Family Demonstration Project.

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3.5 RC family members who were not eligible for TOP Prime enrollment during the member's activation (e.g., the member was not ordered to active duty for more than 30 days, or the dependents were not Command Sponsored to accompany the member in their overseas assignment) are not eligible to enroll in TOP Prime during the TAMP period.

3.6 TAMP-eligible members and family members who are not eligible for TOP Prime, or who choose not to enroll in TOP Prime upon change in status, will have eligibility under TOP Standard.

3.7 TAMP beneficiaries may not enroll in TOP Prime Remote.

- END -

Demonstrations

1.0 GENERAL

All TRICARE requirements regarding demonstrations 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 18** for additional instructions.

- END -

Health Insurance Portability and Accountability Act (HIPAA) of 1996

1.0 GENERAL

All TRICARE requirements regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards and privacy of individually identifiable health information 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 19** for additional instructions.

- END -

EXECUTIVE SUMMARY (CONT'D)

Summary of Cost Options:	Partnership	Network/Local	TDY
Cost First Year (Start-Up & Recurring)	-	-	-
Cost Second Year (Recurring)	-	-	-
Savings (Partnership vs. Network/Local)	-		
Savings (Partnership vs. TDY)	-		

Providers Assigned:	
Primary Care Providers (including assigned Partnership)	0.0
Specialty/Allied/Nurse (including assigned Partnership)	0.0

Other Benefits:

MTF Commander Certification:

I certify that:

- Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing MTF resources.
- Use of the Partnership Program is consistent with the mission of the MTF.
- Use of the Partnership Program is consistent with the high standards of quality health care established for MTFs.

II. NARRATIVE:

ELIGIBLE POPULATION

This section should identify your eligible population. The source for the eligible population data is M2, CHCS, or the TRICARE Eurasia-Africa web site.

<http://www.tricare.osd.mil/tma/EurasiaAfrica/>

Active Duty Service Members	
Active Duty Family Members 0-18	
Active Duty Family Members 19+	
Retirees under age 65	
Retirees Age 65 or over	
Data Source(s): <input type="text"/>	Total: <input type="text"/>

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Acronyms And Abbreviations

IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service

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Acronyms And Abbreviations

IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee ⁷
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer

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Acronyms And Abbreviations

LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set

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Acronyms And Abbreviations

MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer

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Acronyms And Abbreviations

MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health

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Acronyms And Abbreviations

NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights

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Acronyms And Abbreviations

OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System

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PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number

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PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
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

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Acronyms And Abbreviations

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
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
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System

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Acronyms And Abbreviations

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
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
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
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
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

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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
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

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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
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
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
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

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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
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

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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)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
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
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
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

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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
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)

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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
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
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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