



DEFENSE  
HEALTH AGENCY

**MB&RS**

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066

**CHANGE 164  
6010.57-M  
JUNE 17, 2016**

## **CORRECTED COPY**

### **PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

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

**CHANGE TITLE:** 2016 TRICARE OVERSEAS MANUAL UPDATE

**CONREQ:** 17634

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

**SUMMARY OF CHANGE(S):** This manual change incorporates the changes necessary to implement and execute the 2016 TRICARE Overseas Contract.

**EFFECTIVE DATE:** September 1, 2016.

**IMPLEMENTATION DATE:** September 1, 2016.

This change is made in conjunction with Feb 2008 TOM, Change No. 186, and Feb 2008 TRM, Change No. 130.

**FAZZINI.ANN**  
**NOREEN.119**  
**9802271**

Digitally signed by  
FAZZINI.ANN NOREEN 1199802271  
DN: c=US, o=U S. Government,  
ou=DoD, ou=PKI, ou=DHA,  
cn=FAZZINI.ANN NOREEN 1199802  
271  
Date: 2016.06.29 13:19:09 -06'00'

**Ann N. Fazzini  
Team Chief, Medical Benefits &  
Reimbursement Section (MB&RS)  
Defense Health Agency (DHA)**

**ATTACHMENT(S):** 53 PAGE(S)  
**DISTRIBUTION:** 6010.57-M

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

**CHANGE 164**  
**6010.57-M**  
**JUNE 17, 2016**

**REMOVE PAGE(S)**

**CHAPTER 9**

Section 2.1, pages 1 and 2  
Section 3.1, pages 1 - 3  
Section 4.1, pages 1 and 2  
Section 5.1, pages 1 and 2  
Section 14.1, pages 1 and 2  
Section 15.1, pages 5 - 23  
Section 17.1, pages 1 and 2

**CHAPTER 12**

Section 1.1, pages 1 - 4  
Section 1.2, pages 1 and 2  
Section 1.3, pages 1 - 4

**APPENDIX A**

pages 25 - 35

**INSERT PAGE(S)**

Section 2.1, pages 1 and 2  
Section 3.1, pages 1 - 3  
Section 4.1, pages 1 and 2  
Section 5.1, pages 1 and 2  
Section 14.1, pages 1 and 2  
Section 15.1, pages 5 - 23  
Section 17.1, pages 1 and 2

Section 1.1, pages 1 - 4  
Section 1.2, pages 1 and 2  
Section 1.3, pages 1 - 4

pages 25 - 35

## Eligibility - General

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(b\)](#), 10 USC 1079(g)

---

### 1.0 POLICY

**1.1** Extended Care Health Option (ECHO) benefits are available only to the following categories of TRICARE eligible beneficiaries with a qualifying condition:

**1.1.1** A spouse, dependent child, or unmarried person (as defined by 10 United States Code (USC) 1072(2)(I)) whose sponsor is an active duty member of one of the Uniformed Services of the United States, including members of the Reserve Component (RC) activated for a period of more than 30 days.

**1.1.2** A spouse, dependent child, or unmarried person (as defined by 10 USC 1072(2)(I)) whose sponsor is a former member of a Uniformed Service of the United States when such spouse, child, or unmarried person is the victim of physical or emotional abuse. (Benefits are limited to the period that the abused dependent is in receipt of transitional compensation under 10 USC 1059.)

**1.1.3** A Transitional Survivor as defined in 10 USC 1079(g)(2) and [Chapter 10, Section 7.1](#) of this Manual.

**1.1.4** A spouse, dependent child, or unmarried person who is receiving ECHO benefits at the time the sponsor dies and the sponsor was eligible at the time of death for receipt of hostile-fire pay or died as a result of a disease or injury incurred while eligible for such pay is entitled to retain the benefits under the ECHO for the greater of the period they qualify as a "Transitional Survivor" as defined by 10 USC 1079(g)(2) and [Chapter 10, Section 7.1](#) of this Manual or until the dependent reaches the age of 21.

**1.1.5** A spouse, dependent child, or unmarried person (as defined by 10 USC 1072(2)(I)) who is eligible for continued TRICARE medical benefits through the Transitional Assistance Management Program (TAMP). See [Chapter 10, Section 5.1](#).

**1.2** Eligibility for ECHO benefits ceases as of 12:01 a.m. of the day following the day of the earliest occurrence of the following events:

**1.2.1** The sponsor ceases to be an active duty member for any reason other than death; or

**1.2.2** Eligibility based upon the abused dependent provisions of [paragraph 1.1.2](#) expires; or

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 2.1

Eligibility - General

---

**1.2.3** Eligibility based on the deceased sponsor provisions of [paragraph 1.1.3](#) or [1.1.4](#) expires; or

**1.2.4** Eligibility based upon a beneficiary's participation in the TAMP program ends; or

**1.2.5** The Managed Care Support Contractor (MCSC) or the TRICARE **Overseas Program (TOP) contractor** determines that the beneficiary no longer has a ECHO qualifying condition.

**Note:** The **TOP contractor** shall advise the **appropriate TRICARE Area Office (TAO) Director** of all ECHO eligibility determinations.

**1.3** The MCSC or the TRICARE Overseas Program (TOP) contractor will notify the beneficiary in writing of the results of an eligibility determination.

**1.4** A determination that a TRICARE beneficiary is not eligible for the ECHO is considered a factual determination based on a requirement of the law or regulation and as such is not appealable. Denial of ECHO services and supplies to an ineligible beneficiary is not appealable.

## **2.0 EXCLUSION**

North Atlantic Treaty Organization (NATO) family members are not eligible for benefits through the ECHO.

## **3.0 EFFECTIVE DATE**

September 1, 2005.

- END -

## Chapter 9

## Section 3.1

# Registration

Issue Date: February 14, 2004

Authority: [32 CFR 199.5\(h\)\(2\)](#), 10 USC 1079(d)

---

### 1.0 ISSUE

Section 1079(d)(1) of Title 10 United States Code (USC) requires that TRICARE beneficiaries must be “registered” in order to receive the benefits provided under Section 1079(d)-(f) of Title 10, United States Code (USC). This registration policy will enhance the efforts to provide an integrated set of services and supplies to eligible TRICARE beneficiaries and insure effective utilization of program resources.

### 2.0 POLICY

**2.1** The active duty sponsor (or other authorized individual acting on behalf of the beneficiary) will submit the following to the Managed Care Support Contractor (MCSC) or TRICARE **Overseas Program (TOP) contractor** responsible for administering the Extended Care Health Option (ECHO) in the geographic area where the beneficiary resides:

**2.1.1** Evidence that the sponsor is an Active Duty Service Member (ADSM) in one of the Uniformed Services.

**2.1.2** Medical records, as determined necessary by the MCSC or **TOP contractor** which demonstrate that the Active Duty Family Member (ADFM) has a qualifying condition in accordance with [Sections 2.2](#) through [2.4](#), and who otherwise meets all applicable ECHO requirements.

**2.1.3** Evidence, as provided by the sponsor’s branch of service, that the family, or family member seeking ECHO registration, is enrolled in the Exceptional Family Member Program (EFMP) provided by the sponsor’s branch of service.

**2.1.3.1** This requirement is waived when either:

**2.1.3.1.1** The sponsor’s branch of service does not provide the EFMP; or

**2.1.3.1.2** The beneficiary seeks ECHO eligibility based on the “deceased sponsor” provisions listed in [Section 2.1](#), or

**2.1.3.1.3** Other circumstances exist that make enrollment in the EFMP unnecessary or inappropriate, such as when an individual resides with the custodial parent who is not the active duty sponsor.

**2.1.3.2** To avoid delaying receipt of ECHO services while completing the ECHO registration process, in particular awaiting completion of enrollment in the EFMP of the sponsor's service, the MCSC or TAO Director may grant otherwise ECHO-eligible beneficiaries a provisional eligibility status for a period of not more than 90 days during which ECHO benefits will be authorized and payable. This provisional status is portable across managed care support contract regions and, except for the ECHO Home Health Care (EHC) benefit, it applies to the TRICARE Overseas Program (TOP).

**Note:** The provisional status will terminate upon completion of the registration process or at the end of the 90 day period, whichever occurs first. The government liability for ECHO benefits will terminate at the end of the 90 day period. The government will not recoup claims paid for ECHO benefits provided during the provisional period.

**2.1.4** Such other information as may be required by the MCSC or TAO Director in order to determine whether or not the requesting beneficiary is eligible for the ECHO.

**2.1.5** In locations outside the 50 United States and the District of Columbia, the **TOP contractor** shall advise the **appropriate TRICARE Area Office (TAO) Director** of all ECHO eligibility determinations.

**2.2** Upon determination that an ADFM is eligible for the ECHO, the MCSC or the TOP contractor will use the Defense Online Enrollment System (DOES) to annotate the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) record to reflect ECHO eligibility.

**2.2.1** The MCSC or TOP contractor will provide the sponsor/beneficiary with written notification of the eligibility determination and that the beneficiary is registered in ECHO. Except as otherwise provided in [paragraph 2.1.3.2](#), the beneficiary is eligible to receive ECHO benefits as of the date of registration.

**Note:** Upon query through the Composite Health Care System (CHCS), the DEERS Eligibility Response will return the Health Care Delivery Plan (HCDP) code "400", which indicates the beneficiary is registered and eligible to receive ECHO benefits.

**2.2.2** Determination that a beneficiary is not eligible for the ECHO is factual, therefore, such determination can not be appealed.

**2.3** At the time of registration, the MCSC or TOP contractor will also provide the sponsor/beneficiary with informational materials that, at a minimum, emphasize the ECHO is an optional program for ADFMs only and has unique qualifying and cost-sharing requirements.

**2.4** The eligibility determination will remain in effect until such time as the MCSC or the **TOP contractor** determines the beneficiary is no longer eligible for the ECHO. This may result from a loss of TRICARE eligibility, remediation of the qualifying condition, or a determination that the beneficiary does not otherwise meet the eligibility requirements of the ECHO.

**2.5** TRICARE does not charge a fee for registering in the ECHO, however, the sponsor/beneficiary may incur costs associated with the determination of eligibility for the ECHO. For example, the sponsor of a beneficiary who uses TRICARE Standard or Extra to receive diagnostic services that result in a diagnosis that is an ECHO qualifying condition, is liable for all relevant cost-shares

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 3.1

Registration

---

associated with receipt of those diagnostic services through TRICARE Standard or Extra. Those cost-shares are not reimbursable under the ECHO. Additionally, TRICARE does not provide separate or additional reimbursement to providers for completion of forms, such as the DoD form DD 2792, **Exceptional Family Member Medical Summary**, or for reproducing, copying or transmitting records necessary to register in the ECHO. TRICARE will deny claims for such services.

**3.0 EFFECTIVE DATE**

September 1, 2005.

- END -



## Benefit Authorization

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(h\)\(3\)](#)

---

### 1.0 POLICY

**1.1** Except as provided in [paragraph 1.2](#), the Managed Care Support Contractor (MCSC) will provide the required authorization for requested services and items under the Extended Care Health Option (ECHO).

**1.2** In the case of beneficiaries residing outside the 50 United States and the District of Columbia, the TRICARE **Overseas Program (TOP) contractor** is responsible for authorizing ECHO benefits. The **TOP contractor** shall notify the **appropriate TRICARE Area Office (TAO) Director** of all ECHO benefit authorizations or authorization waivers.

**1.3** The authorization is based upon the following:

**1.3.1** The beneficiary is registered in the ECHO; and

**1.3.2** The requested service or item is allowable as a ECHO benefit; and

**1.3.3** The requested service or item meets the public facility use requirements when applicable.

**1.4** The authorization shall specify the services by type, scope, frequency, duration, dates, amounts, requirements, limitations, provider name and address, and all other information necessary to provide exact identification of approved benefits. Claims can not be adjudicated without this information.

**1.5** The authorization shall remain in effect until such time as the MCSC **or TOP contractor** determines that:

**1.5.1** The beneficiary is no longer eligible for the ECHO; or

**1.5.2** The authorized ECHO service or item is no longer appropriate or required by the beneficiary; or

**1.5.3** The authorized ECHO service or item becomes a benefit through the TRICARE Basic Program.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 4.1

Benefit Authorization

---

**1.6** The MCSC or **TOP contractor** may waive the required written authorization for rendered services and items that, except for the absence of the written authorization, would be allowable as an ECHO benefit.

**1.7** The MCSC or **TOP contractor** may waive the required public facility use certification when such waiver is appropriate. See [Section 5.1](#).

**2.0 EFFECTIVE DATE**

September 1, 2005.

- END -

## Public Facility Use Certification

Issue Date: August 4, 1988

Authority: [32 CFR 199.5\(h\)\(3\)\(v\)](#)

---

### 1.0 DEFINITION

The public facility use certification is a written confirmation that the requested Extended Care Health Option (ECHO) services or items are either not available from public facilities or are not adequate to meet the needs of the beneficiary's qualifying condition.

### 2.0 POLICY

**2.1** The ECHO requires that public facilities be used first for services and items related to training, rehabilitation, special education, assistive technology devices, institutional care in private nonprofit, public, and state institutions and facilities and, if appropriate, transportation to and from such institutions and facilities to the extent that they are available and adequate.

**2.2** Services available through state-administered plans for medical assistance under Title XIX of the Social Security Act (Medicaid) are not considered available and adequate facilities for the purpose of the ECHO.

**2.3** Services and items available through the ECHO Home Health Care (EHHC) or Respite Care benefits do not require a public facility use certification.

**2.4** The public facility use certification may be issued by the Commander of the local Military Treatment Facility (MTF) or an authorized administrator of the public facility.

**2.5** No public facility use certification is required for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act (IDEA) in accordance with the Individualized Family Service Plan (IFSP) and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

**2.6** For a beneficiary aged 3 to 21 who is enrolled in an education program, the local public education agency must certify that the services or items requested through the ECHO are not included on the beneficiary's Individualized Education Program (IEP), or if so, are not adequately available.

**2.7** A public facility use certification is valid until such time as the Managed Care Support Contractor (MCSC) or the TRICARE **Overseas Program (TOP) contractor** determines that a new certification is necessary in order to insure that public facilities are used to the extent available and adequate.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 5.1

Public Facility Use Certification

---

**2.8** The contractor will determine that services or items are not available from a specific public facility when the beneficiary provides a written statement that the facility refused to provide the required certification.

**2.9** A case-specific determination of public facility availability is conclusive and is not appealable

**3.0 EFFECTIVE DATE**

September 1, 2005.

- END -

## Durable Equipment (DE) Prior To January 30, 2015

Issue Date: December 29, 1982

Authority: [32 CFR 199.2\(b\)](#), [32 CFR 199.5\(c\)\(2\)](#), [\(d\)\(7\)](#), and [\(g\)\(2\)](#)

---

### 1.0 HCPCS CODES

All valid codes.

### 2.0 DESCRIPTION

Prior to January 30, 2015, Durable Equipment (DE) was defined in [32 CFR 199.2\(b\)](#) as a device or apparatus, which does not qualify as Durable Medical Equipment (DME) under the TRICARE Basic Program but which is essential to the efficient arrest or reduction of functional loss resulting from, or the disabling effects of a qualifying condition as provided in [Sections 2.2](#) through [2.4](#). Examples of DE, at the time, were special computer peripheral devices (keyboard, mouse, etc.) or software that makes a computer functional to an Extended Care Health Option (ECHO) beneficiary with a qualifying condition that would otherwise limit or prohibit the beneficiary's ability to use the computer; or an electrical/mechanical lifting device that raises an ECHO beneficiary in a wheelchair from ground level to first floor level of the beneficiary's residence.

### 3.0 POLICY

**3.1** DE may be cost-shared when:

**3.1.1** A physician has certified that the item is necessary for the treatment, habilitation, or rehabilitation of the beneficiary or to reduce the disabling effects of the qualifying condition.

**3.1.2** A written authorization to purchase the item has been issued by the appropriate Managed Care Support Contractor (MCSC) or TRICARE **Overseas Program (TOP) contractor** prior to the purchase.

**3.2** Customization of ECHO-authorized DE and any accessory or item of supply for any DE may be provided if such customization, accessory, or supply item is essential for:

**3.2.1** Achieving therapeutic benefit for the beneficiary; or

**3.2.2** Making the equipment usable; or

**3.2.3** Otherwise assuring the proper functioning of the equipment; and

**3.2.4** Is not otherwise excluded from coverage by regulation or policy.

**3.3** Installation of authorized DE may also be cost-shared through the ECHO, however, alterations, such as those made to living spaces or vehicles to accommodate installation of such equipment, **cannot** be cost-shared through the ECHO.

**3.4** A sponsor/beneficiary cost-share, as described in [Section 16.1](#), is required in the month in which the item is purchased.

**3.5** Reasonable repairs and maintenance on authorized beneficiary-owned DE may be cost-shared.

#### **4.0 EXCLUSIONS**

**4.1** Purchase or rental of DE is excluded when:

**4.1.1** The beneficiary is a patient in an institution or facility that ordinarily provides the same type of equipment to its patients at no additional charge in the usual course of providing services; or

**4.1.2** The item is available from a local Uniformed Service Medical Treatment Facility (USMTF); or

**4.1.3** The item has deluxe, luxury, immaterial or nonessential features that increase the cost to the Department relative to a similar item without those features; or

**4.1.4** When the item is duplicate equipment, as defined in [32 CFR 199.2](#). This does not preclude the purchase of a replacement for an item that is no longer usable.

**4.2** Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership, electronic devices used to locate or monitor the location of a beneficiary, and other similar charges or items are not considered DE.

**4.3** Rental of equipment is excluded unless it can be shown to be more cost-effective than purchase.

**4.4** DME that is available under the TRICARE Basic Program is not eligible to be cost-shared under this issuance.

#### **5.0 EFFECTIVE DATE**

September 1, 2005.

- END -

**6.1.5** Participating TRICARE-authorized HHA. A HHA that meets the requirements of [32 CFR 199.6\(b\)\(4\)\(xv\)](#) and has a valid participation agreement in effect at the time the EHC services are rendered.

## **6.2 Authorization**

All EHC services must be included in the beneficiary's POC and authorized by the Managed Care Support Contractor (MCSC) or TRICARE **Overseas Program (TOP) contractor** prior to those services being rendered.

## **6.3 Beneficiary Assessment**

**6.3.1** For the purpose of the EHC benefit, the beneficiary's attending physician or primary care manager is responsible for determining the required medically necessary skilled services. This includes, but is not limited to the scope, frequency and duration of such services, and is the basis for the POC.

**6.3.2** The EHC benefit is not subject to the HHA PPS, therefore, the MCSCs **and the TOP contractor** are not required to use the Outcome and Assessment Information Set (OASIS) nor the Centers for Medicare and Medicaid Services (CMS) Form 485 when developing the multidisciplinary POC.

## **6.4 POC**

**6.4.1** Scope. A multidisciplinary POC will be developed by the beneficiary's attending physician, or designee, together with the assistance of the HHA. At a minimum, the plan must include:

**6.4.1.1** All pertinent diagnoses and qualifying condition(s), including the beneficiary's mental status;

**6.4.1.2** The type, frequency, and duration of services and supplies, including any medically necessary treatments;

**6.4.1.3** Assessment of the beneficiary's functional limitations and activities permitted;

**6.4.1.4** The potential for rehabilitation or prevention of deterioration of the beneficiary's condition;

**6.4.1.5** Nutritional requirements, including but not limited to enteral and parenteral nutritional therapy and other special dietary requirements and restrictions;

**6.4.1.6** Dosage and administration of all medications;

**6.4.1.7** Safety measures to protect the beneficiary and the provider against injury;

**6.4.1.8** Instructions for timely discharge or completion of a treatment and referral for other skilled services;

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 15.1

ECHO Home Health Care (EHC)

---

**6.4.1.9** Those services to be taught to the primary caregiver(s) as discussed in [paragraph 6.1.4](#).

**6.4.1.10** The professional level of provider expected to render the specified services;

**6.4.1.11** Although paid under the TRICARE Basic Program and not included in the EHC fiscal year benefit cap, the following shall also be included in the beneficiary's POC:

**6.4.1.11.1** Required Durable Equipment (DE) to be rented or purchased;

**6.4.1.11.2** U. S. Food and Drug Administration (FDA)-approved injectable drugs for osteoporosis;

**6.4.1.11.3** Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;

**6.4.1.11.4** Oral cancer drugs and antiemetics;

**6.4.1.11.5** Orthotics and prosthetics;

**6.4.1.11.6** Ambulance services operated by the HHA;

**6.4.1.11.7** Enteral and parenteral supplies and equipment; and

**6.4.1.11.8** Other drugs and biologicals administered by other than oral method.

**6.4.1.12** Although paid under the ECHO, the POC shall also include required Assistive Technology (AT) devices to be rented or purchased.

**6.4.1.13** Any other information the beneficiary's attending physician or primary care manager, the MCSC or TOP contractor case manager, and the HHA believe necessary in order to provide the beneficiary with the appropriate level of services.

**6.4.2** Plan Certification. Upon completion, the following certifications will be provided by signature on the POC:

**6.4.2.1** The beneficiary's attending physician or primary care manager will certify that:

**6.4.2.1.1** The beneficiary is homebound; and

**6.4.2.1.2** The beneficiary requires medically necessary skilled services that exceed the HHA PPS under the TRICARE Basic Program; and/or

**6.4.2.1.3** The beneficiary requires frequent interventions, as defined in [paragraph 6.1.4](#), such that respite care services are needed in order to allow the primary caregiver(s) the opportunity to rest or sleep; and

**6.4.2.1.4** The services are allowable TRICARE benefits through the ECHO.

**6.4.2.2** The HHA will certify that:

**6.4.2.2.1** The agency has an agreement to participate in the TRICARE program and will continue such agreement for the duration of the plan; and

**6.4.2.2.2** The agency agrees with the POC; and

**6.4.2.2.3** The agency has available, or will obtain, the appropriate professional level of providers who will render the services indicated in the POC; and

**6.4.2.2.4** Reimbursement for services provided by the HHA or its designee(s) will be in accordance with the TRICARE allowable amount or the rate(s) negotiated with the MCSC or TOP contractor.

**6.4.2.3** The MCSC or TOP contractor will certify that:

**6.4.2.3.1** The MCSC or TOP contractor accepts the POC, and

**6.4.2.3.2** The services are authorized effective on the date of such certification.

**Note:** If the MCSC or TOP contractor does not accept the POC, the beneficiary or provider, as appropriate, will be afforded appeal rights in accordance with the TRICARE Operations Manual (TOM), [Chapter 12](#).

**6.4.3** Responsible Party. The MCSC or TOP contractor has overall responsibility for development and review of the POC in accordance with the requirement that ECHO beneficiaries who need HHC are case-managed.

**6.4.4** Reassessment.

**6.4.4.1** The POC will be reviewed for appropriateness whenever the MCSC or TOP contractor is informed that the condition of the beneficiary has changed or there is otherwise a need to update the plan, but in all cases the beneficiary will be reassessed and the plan reviewed and updated at least every 90 days.

**6.4.4.2** If at any time the MCSC or TOP contractor determines that the required level of HHC services falls within the allowable level through the HHA PPS, the beneficiary will be referred to receive appropriate services under the HHA PPS.

**6.4.5** POC Revisions.

**6.4.5.1** Revisions to the POC that result from reassessment in accordance with [paragraph 6.4.4](#), will be signed by the attending physician and concurred with by the beneficiary's case manager. As with the initial POC, the case-manager's concurrence will constitute acceptance of the revision by the MCSC or TOP contractor and authorization for those services.

**6.4.5.2** When the supervising RN, or physical therapist, occupational therapist, or speech-language pathologist has reason to believe that services beyond those included in the POC are required, they are to immediately inform the beneficiary's case manager.

**6.4.5.2.1** Any increase in the frequency of services or addition of new services during an authorization period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

**6.4.5.2.2** If the beneficiary's attending physician agrees, the case manager will revise the POC, obtain the physician's and HHA's signatures, provide the required MCSC or TOP contractor concurrence and authorize the additional services.

**6.4.5.2.3** Records of telephone conversations and documents bearing physician orders and signatures that are/have been transmitted by facsimile will be maintained as supporting documentation to the POC and maintained by the case manager.

**6.4.6** For the sake of timeliness, the steps under paragraph 6.4.5 may be accomplished by telephone and/or by facsimile machine.

**6.4.7** Facsimile Signatures. The POC or oral order(s) may be transmitted by facsimile machine. Original signatures on the POC may be maintained by either the HHA or the MCSC/TOP contractor.

**6.4.8** Alternative Signatures. HHAs that maintain patient records by computer rather than hard copy may use electronic signatures.

**6.4.8.1** However, all such entries must be appropriately authenticated and dated.

**6.4.8.2** Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry.

**6.4.8.3** The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

## **6.5 Reasonable and Medically Necessary Care**

When provided in accordance with the POC, the following are considered reasonable and medically necessary care.

**6.5.1** Skilled Nursing Services. Application of professional nursing services and skills by an RN, LPN, or LVN, that are required to be performed at the direction of or under the general supervision of a TRICARE-authorized physician to ensure the safety of the patient and achieve management of the beneficiary's qualifying condition in accordance with accepted standards of practice.

**6.5.1.1** A skilled nursing service is a service that must be provided by a RN or a LPN or LVN under the supervision of a RN to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone, for example intravenous and intramuscular injections or insertion of catheters, if reasonable and medically necessary, would be covered on that basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

**6.5.1.2** A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. Where a service can be safely and effectively performed or administered by the average nonmedical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

**6.5.1.3** A service, which by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary for the management of the beneficiary's qualifying condition.

**6.5.1.4** The skilled nursing services must be in accordance with accepted standards of medical and nursing practice and consistent with the beneficiary's qualifying and overall medical condition.

**6.5.1.5** The beneficiary's qualifying condition should never be the sole factor in deciding that an EHC service the beneficiary needs is either skilled or not skilled.

**6.5.1.6** The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the qualifying condition of the patient when the services were ordered and what was, at the time, reasonably expected to be appropriate management of the beneficiary's qualifying condition throughout the certification period.

**6.5.1.7** Skilled nursing visits for management and evaluation of the patient's POC are reasonable and medically necessary where underlying conditions or complications require that only a RN can ensure that essential non-skilled care is achieving its purpose.

**6.5.1.8** Administration of Medications. The services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the management of the qualifying condition.

**6.5.1.8.1** Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.

**6.5.1.8.2** Vitamin B-12 Injections. Vitamin B-12 injections are considered specific therapy only for the following conditions:

**6.5.1.8.2.1** Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

**6.5.1.8.2.2** Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome;

**6.5.1.8.2.3** Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism;

**6.5.1.8.2.4** For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment.

**6.5.1.8.3** Insulin Injection. Insulin is customarily self-injected by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

**6.5.1.8.4** Oral Medications. The administration of oral medications by a nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the patient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The following are some examples of situations in which the administration of oral medications by a nurse would be considered reasonable or necessary skilled nursing care:

**Example 1:** A beneficiary with arteriosclerotic heart failure, in addition to their qualifying condition, requires observation by skilled nursing personnel for signs of decompensation or adverse effects from prescribed medication. Skilled observation is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the beneficiary's condition is stabilized.

**Example 2:** A beneficiary with glaucoma and a cardiac condition, in addition to their qualifying condition, has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmias. Skilled observation and monitoring of the drug actions is reasonable and necessary until the beneficiary's condition is stabilized.

**6.5.1.8.5** Eye Drops and Topical Ointments. The administration of eye drops and topical ointments does not require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service.

**6.5.1.8.6** Tube Feeding. Nasogastric tube, and percutaneous tube feeding (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services. However, the nutritional therapy products delivered by tube feeding will not be subject to the fiscal year EHC benefit cap, but will be reimbursed under the TRICARE Basic Program.

**6.5.1.8.7** Nasopharyngeal and Tracheostomy Aspiration. Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's illness or injury, would be covered as skilled nursing services.

**6.5.1.8.8** Catheters. Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter and in selected patients, urethral catheters, are considered be skilled nursing services.

**6.5.1.8.9** Wound Care. Care of wounds (including, but not limited to ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service.

**6.5.1.8.10** Ostomy Care. Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications.

**6.5.1.8.11** Heart Treatments. Heart treatments that have been specifically ordered by a physician as part of active treatment of an illness or injury and require observation by a licensed nurse to adequately evaluate the patient's progress would be considered skilled nursing services.

**6.5.1.8.12** Medical Gases. Initial phases of a regimen involving the administration of medical gases that are necessary to the treatment of the patient's illness or injury, would require skilled nursing care for skilled observation and evaluation of the patient's reaction to the gases, and to teach the patient and family when and how to properly manage the administration of the gases.

**6.5.1.8.13** Rehabilitation Nursing. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services.

**6.5.1.8.14** Venipuncture. Venipuncture, when the collection of the specimen is necessary to the diagnosis and treatment of the patient's illness or injury and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment in a SNF, is considered to be a skilled nursing service.

**6.5.1.9** Teaching and Training Activities.

**6.5.1.9.1** Teaching and training activities that require skilled nursing personnel to teach the beneficiary, the beneficiary's family or caregiver(s) how to manage the beneficiary's qualifying condition constitute skilled nursing services.

**6.5.1.9.2** When the teaching or training is reasonable and medically necessary to manage the beneficiary's qualifying condition, skilled nursing visits for teaching are covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered.

**6.5.1.9.3** Teaching and training activities that require the skills of a licensed nurse include, but are not limited to the following:

**6.5.1.9.3.1** Self-administration of an injectable medication or a complex range of medications;

**6.5.1.9.3.2** Diabetes management including how to prepare and administer insulin injections, prepare and follow a diabetic diet, to observe foot-care precautions, and to watch for and understand signs of hyperglycemia and hypoglycemia;

**6.5.1.9.3.3** Self-administration of medical gases;

**6.5.1.9.3.4** Wound care when the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

**6.5.1.9.3.5** Care for a recent ostomy or where reinforcement of ostomy care is needed;

**6.5.1.9.3.6** Self-catheterization;

**6.5.1.9.3.7** Self-administration of gastrostomy or enteral feedings;

**6.5.1.9.3.8** Care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

**6.5.1.9.3.9** Bowel or bladder training when bowel or bladder dysfunction exists;

**6.5.1.9.3.10** How to perform the activities of daily living when the patient or caregiver(s) must use special techniques and adaptive devices due to a loss of function;

**6.5.1.9.3.11** Transfer techniques, for example from bed to chair, that are needed for safe transfer;

**6.5.1.9.3.12** Proper body alignment and positioning, and timing techniques of a bed-bound patient;

**6.5.1.9.3.13** Ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

**6.5.1.9.3.14** Prosthesis care and gait training;

**6.5.1.9.3.15** Use and care of braces, splints and orthotics and associated skin care;

**6.5.1.9.3.16** Proper care and application of any specialized dressings or skin treatments, for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration from radiation treatment;

**6.5.1.9.3.17** Preparation and maintenance of a therapeutic (nutritional therapy) diet; and

**6.5.1.9.3.18** Proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

**6.5.2** Skilled Therapy Services.

**6.5.2.1** General Principles.

**6.5.2.1.1** The services of an occupational therapist, a physical therapist, and a speech-language pathologist are skilled therapy services if the inherent complexity of the service is such that it can be performed safely and effectively only by a skilled therapist.

**6.5.2.1.2** The skilled services must be reasonable and necessary for the management of the beneficiary's qualifying condition or for the restoration or maintenance of function affected by the beneficiary's qualifying condition. To be considered reasonable and necessary the services must be:

**6.5.2.1.2.1** Consistent with the nature and severity of the disabling effects of the beneficiary's qualifying condition, including the requirement that the type, frequency and duration of the services must be reasonable; and

**6.5.2.1.2.2** Reasonable in regards to the type, frequency, and duration of the services; and

**6.5.2.1.2.3** Considered to be specific, safe, and effective management of the beneficiary's qualifying condition; or

**6.5.2.1.2.4** Necessary for the establishment of a safe and effective maintenance program.

**Note:** Services involving activities for the general welfare of the beneficiary, for example, general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Those services can be performed by non-skilled individuals without the supervision of a therapist.

**6.5.2.1.3** The evaluation, development, and implementation of the beneficiary's POC constitute skilled therapy services when the beneficiary's condition requires the involvement of a skilled therapist to manage the beneficiary's qualifying condition and ensure medical safety.

**6.5.2.1.4** The services of a skilled therapist when needed to manage and periodically reevaluate the appropriateness of a maintenance program are covered, even if the therapist's services are not needed to carry out the activities performed as a part of the maintenance program.

**6.5.2.1.5** While the beneficiary's qualifying condition is a valid factor in deciding if skilled therapy services are needed, the qualifying condition should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to safely manage the beneficiary's qualifying condition or whether the services can be provided by non-skilled personnel.

**6.5.2.1.6** A service that is ordinarily considered non-skilled could be considered a skilled service in cases where there is clear documentation that, because of complications or possible complications, or the requirement to manage the beneficiary's qualifying condition, skilled rehabilitation personnel are required to perform or supervise the service or to observe the beneficiary. However, the importance of a particular service to a beneficiary or the frequency with which it must be performed does not, by itself, make a non-skilled service into a skilled service.

**6.5.2.1.7** Services of skilled therapists for the purpose of teaching the patient or the patient's family or caregivers necessary techniques, exercises or precautions are covered to the extent that they are reasonable and necessary to manage the beneficiary's qualifying condition. However, time spent by skilled therapists in a beneficiary's home for the purpose of training other HHA staff, home health aides for example, is not billable since the agency is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost for such time and services is an administrative cost to the agency.

**6.5.2.2** Application of the General Principles to Occupational Therapy Services.

**6.5.2.2.1** Assessment. The skills of an occupational therapist to assess and reassess a beneficiary's rehabilitation or maintenance of function needs and potential, or to develop and/or implement an occupational therapy program, are covered when they are reasonable and necessary because of the patient's condition.

**6.5.2.2.2** Planning, Implementing and Supervision of Therapeutic Programs. The planning, implementing and supervision of therapeutic programs including, but not limited to those listed below, are skilled occupational therapy services, and if reasonable and necessary to the management of the beneficiary's qualifying condition, are covered. The MCSC's or TOP contractor's medical review staff will be responsible for determining the reasonableness and necessity of therapeutic programs not listed under this paragraph.

**6.5.2.2.2.1** Selecting and teaching task oriented therapeutic activities designed to restore or maintain current level of physical function.

**6.5.2.2.2.2** Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

**6.5.2.2.2.3** Teaching compensatory techniques to improve the level of independence in the activities of daily living.

**6.5.2.2.2.4** The designing, fabricating and fitting of orthotics and allowable self-help devices.

**6.5.2.2.2.5** Vocational and prevocational assessment and training that is directed toward the restoration or maintenance of function with respect to the activities of daily living lost due to a qualifying condition are covered.

**6.5.2.3** Application of the General Principles to Physical Therapy Services.

**6.5.2.3.1** Assessment. The skills of a physical therapist to assess and periodically reassess a patient's needs, or to develop/implement a physical therapy program, are covered when reasonable and necessary because of the beneficiary's qualifying condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance or functional ability.

**6.5.2.3.2** Therapeutic Exercises. Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist to ensure the safety of the beneficiary and the

effectiveness of the treatment, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

**6.5.2.3.3** Gait Training. Gait evaluation and training, which require the skills of a qualified physical therapist, furnished to a beneficiary whose ability to walk has been impaired by the qualifying condition constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to either improve the beneficiary's ability to walk or maintain current level of ability to walk.

**6.5.2.3.3.1** Repetitive exercises to improve gait or to maintain strength and endurance and assistive walking are appropriately provided by non-skilled persons and ordinarily do not require the skills of a physical therapist.

**6.5.2.3.3.2** However, where such services are performed by a physical therapist as part of the initial design and establishment of a safe and effective maintenance program, the services would, to the extent that they are reasonable and necessary, be covered.

**6.5.2.3.4** Range of Motion. Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

**6.5.2.3.4.1** Range of motion exercises constitute skilled physical therapy only if they are part of the management of the qualifying condition that results in the loss of restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored).

**6.5.2.3.4.2** Range of motion exercises unrelated to the restoration of a specific loss of function often may be provided safely and effectively by non-skilled individuals. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by non-skilled persons do not constitute physical therapy.

**6.5.2.3.4.3** However, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, then the services would be covered.

**6.5.2.3.5** Maintenance Therapy. Where repetitive services that are required to maintain function involve the use of complex and sophisticated procedures, the judgement and skill of a physical therapist might be required for the safe and effective rendering of such services. If the judgement and skill of a physical therapist is required to safely and effectively render such services, they would be covered as physical therapy services. While a beneficiary is under a restorative physical therapy program, the physical therapist should regularly reevaluate the beneficiary's condition and adjust any exercise program the beneficiary is expected to carry out him/herself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session), the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

**6.5.2.3.6** Ultrasound, Shortwave, and Microwave Diathermy Treatments. These treatments must always be performed by or under the supervision of a qualified physical therapist and are considered skilled therapy.

**6.5.2.3.7** Hot Packs, Infrared Treatments, Paraffin Baths and Whirlpool Baths. Heat treatments and baths of this type ordinarily do not require the skills of qualified physical therapist. However, the skills, knowledge and judgement of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case; e.g., where the beneficiary's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complication.

**6.5.2.4** Application of the General Principles to Speech-Language Pathology Services.

**6.5.2.4.1** The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders) and rehabilitation potential. Reevaluation would only be considered reasonable and necessary if the beneficiary exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical condition that previously contraindicated speech-language pathology services. Where a beneficiary is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy.

**6.5.2.4.2** The services of a speech-language pathologist are covered if they are needed as a result of the qualifying condition and are directed towards specific speech/voice production.

**6.5.2.4.3** Speech-language pathology is covered when the service can only be provided by a speech-language pathologist and where it is reasonably expected that the service will materially improve the patient's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurable at a higher level of attainment than that attained prior to the initiation of the services. There must be an anticipated improvement in the patient's communicative ability in order for coverage to be extended under the home health benefit.

**6.5.2.4.4** The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cuing that directs a patient toward speech-language communication goals in the POC would be covered speech-language pathology.

**6.5.2.4.5** The services of a speech-language pathologist to train the beneficiary, the beneficiary's family or other caregivers to augment the speech-language services, or to establish an effective maintenance program are covered speech-language pathology services.

**6.5.2.4.6** The services of a speech-language pathologist to assist beneficiaries with aphasia resulting from the qualifying condition are covered.

**6.5.2.4.7** The services of a speech-language pathologist to assist beneficiaries with voice disorders resulting from the qualifying condition to develop proper control of the vocal and respiratory systems for correct voice production are covered.

**6.5.3** Home Health Aide Services.

**6.5.3.1** Home health aide services are covered when

**6.5.3.1.1** The beneficiary meets the eligibility requirements in [paragraph 5.1](#);

**6.5.3.1.2** The services are medically necessary and reasonable for the management of the beneficiary's qualifying condition;

**6.5.3.1.3** The services are included in the physician-approved POC; and

**6.5.3.1.4** The services meet the definition of home health aide services.

**6.5.3.2** The reason for the visits by the home health aide must be to provide hands-on personal care of the beneficiary or services needed to maintain the beneficiary's health or to facilitate management of the beneficiary's ECHO-qualifying condition.

**6.5.3.3** Home health aide services may include, but are not limited to:

**6.5.3.3.1** Personal Care. Personal care means:

**6.5.3.3.1.1** Bathing, dressing, grooming, caring for hair, nails and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care and ear care;

**6.5.3.3.1.2** Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition), routine catheter care and routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers;

**6.5.3.3.1.3** Simple dressing changes that do not require the skills of a licensed nurse;

**6.5.3.3.1.4** Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively;

**6.5.3.3.1.5** Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services; and

**6.5.3.3.1.6** Routine care of prosthetic and orthotic devices.

**6.5.3.3.2** Other Services. When a home health aide visits a beneficiary to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service, for example light cleaning, preparation of a meal, taking out the trash, shopping, etc. However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

**6.5.4** Medical Social Services. Medical social services that are provided by a qualified Medical Social Worker (MSW) or a social work assistant under the supervision of a qualified MSW may be

covered as home health services when the beneficiary meets the eligibility requirements in [paragraph 5.1](#); and

**6.5.4.1** The services of these professionals are necessary to resolve social or emotional problems that are, or are expected to be, an impediment to the effective management of the beneficiary's qualifying condition; and

**6.5.4.2** The POC indicates how the required services necessitate the skills of a qualified MSW or a social work assistant under the supervision of a qualified MSW in order to be performed safely and effectively.

**6.5.4.3** When both of these requirements for coverage are met, services of these professionals that may be covered include, but are not limited to:

**6.5.4.3.1** Assessment of the social and emotional factors related to the beneficiary's qualifying condition, need for care, response to care and adjustment to care;

**6.5.4.3.2** Assessment of the relationship of the beneficiary's medical and nursing requirements to the beneficiary's home situation, financial resources and availability of community resources;

**6.5.4.3.3** Appropriate action to obtain available community resources to assist in resolving the beneficiary's patient's problem;

**6.5.4.3.4** Counseling services that are required by the beneficiary; and

**6.5.4.3.5** Medical social services furnished to the patient's family member(s) or caregiver(s) on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a MSW is necessary to remove a clear and direct impediment to the effective management of the beneficiary's qualifying condition or to his or her rate of recovery, are covered. To be considered "clear and direct," the behavior or actions of the family member(s) or caregiver(s) must plainly obstruct, contravene, or prevent appropriate management of the beneficiary's qualifying condition. Medical social services to address general problems that do not clearly and directly impede management of the beneficiary's qualifying condition, as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

**6.5.4.3.6** Participating in the development of the POC, preparing clinical and progress notes, participating in planning and in-service programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the HHA.

**6.5.5** Medical Supplies.

**6.5.5.1** Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential to enabling HHA personnel to carry out effectively the care the physician has ordered for the management of the beneficiary's qualifying condition.

**6.5.5.2** Routine supplies are generally consumable, that is, they can not withstand prolonged or repeated use, and are customarily used during the course of HHC visits. They are generally not designated for a specific patient.

**6.5.5.3** Non-routine supplies, which may or may not be consumable, are those supplies that are specifically ordered by the physician and are essential in order for HHA personnel to provide the services indicated in the POC.

**6.5.5.3.1** Non-routine medical supplies will be indicated in the beneficiary's POC with specific justification that demonstrates why the supply item(s) is needed and why it is not considered a routine supply item.

**6.5.5.3.2** Except as otherwise provided in [paragraph 6.7.10](#), medical supplies will not be billed separately, that is, the cost for such will be included in the allowable charge or the hourly rate negotiated between the MCSC or TOP contractor and the HHA.

**6.5.5.4** Items that generally serve a routine hygienic purpose, for example soaps and shampoos, and items that generally serve as skin conditioners such as baby lotion, baby oil, skin softeners, powders, and other skin care lotions, are not considered medical supplies unless the particular item is recognized as serving a specific purpose in the physician's prescribed management of the beneficiary's qualifying condition.

**6.5.5.5** Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the beneficiary or other caregiver. These items must be part of the POC in which the home health staff is actively involved. For example, in the case of a beneficiary who requires a nutritional therapy enteral or parenteral feeding when HHA personnel are not present, it would be appropriate for the agency to leave reasonable quantities of the nutritional therapy product in the beneficiary's home for administration by other caregivers. Items such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

**6.5.6** AT Devices. As defined in [32 CFR 199.2](#), AT devices are equipment that generally does not treat an underlying injury, illness, disease or their symptoms. AT devices are authorized only under the ECHO. AT devices help an ECHO beneficiary overcome or remove a disability and are used to increase, maintain, or improve the functional capabilities of an individual. AT devices may include non-medical devices (e.g., computer peripheral devices, keyboard, mouse, etc., or software that makes a computer functional to an ECHO beneficiary with a qualifying condition that would otherwise limit or prohibit the beneficiary's ability to use the computer) but do not include any structural alterations (e.g., permanent structure of wheelchair ramps or alterations to street curbs), service animals (e.g., Seeing Eye dogs, hearing/handicapped assistance animals, etc.), or specialized equipment and devices whose primary purpose is to enable the individual to engage in sports or recreational events. AT devices are authorized only under coverage criteria determined by the Director, Defense Health Agency (DHA) (formerly TRICARE Management Activity (TMA)) to assist in the reduction of the disabling effects of a qualifying condition for individuals eligible to receive benefits under the ECHO program, as provided in [32 CFR 199.5](#). For AT devices coverage criteria, see [Section 14.2](#).

**6.5.7** DE. Durable Medical Equipment (DME) (a subset of DE), although included in the POC and provided by a HHA, is not part of the EHC benefit; it will be cost-shared only through the TRICARE Basic Program.

## 6.6 Authorized Providers

**6.6.1** All EHC and respite care services will be provided only by TRICARE-authorized HHAs who have in effect at the time of services a valid agreement to participate in the TRICARE program;

**6.6.1.1** In order to receive payment for HHC services provided in accordance with this issuance, HHAs must be Medicare or Medicaid certified and meet all applicable Medicare or Medicaid conditions of participation.

**6.6.1.2** HHAs for which Medicare or Medicaid certification is not available due to the specialized categories of individuals they serve, for example, individuals that are under the age of 18 or who are receiving maternity care, must meet the qualifying conditions for corporate services provider status as specified in [Chapter 11, Section 12.1](#).

**6.6.2** HHAs, whether or not they are Medicare or Medicaid certified, will be responsible for assuring that all individuals rendering EHC services and respite care services meet all applicable qualification standards. The MCSCs or TOP contractor are not responsible for certification of individuals employed by or contracted with a HHA.

**6.6.3** Reimbursement for all EHC services provided by Medicare or Medicaid certified and non-Medicare or non-Medicaid certified HHAs will be as discussed in [paragraph 6.7](#) and [6.8](#).

## 6.7 Claims

**6.7.1** Billing. HHAs will use itemized billing for EHC services, including those items that will be cost-shared under the TRICARE Basic Program, that are identified on the beneficiary's POC

**6.7.2** Primary Agency. When necessary, multiple HHAs may be involved in providing the services indicated in the beneficiary's POC. When such is the case, the MCSC or TOP contractor will designate one such agency as the Primary Agency. In addition to being responsible for providing the services in the plan, the primary agency is also responsible for:

**6.7.2.1** Negotiating the reimbursement rate with the MCSC or TOP contractor having jurisdiction where the beneficiary lives;

**6.7.2.2** Arranging for the services to be provided by other HHAs;

**6.7.2.3** Insuring the qualifications of the other HHAs;

**6.7.2.4** Insuring that services provided by other HHAs are in accordance with the POC; and

**6.7.2.5** Reimbursing the other HHAs that provide services.

**6.7.3** The MCSCs and TOP contractor will deny claims from other than the primary agency for services and items provided as described herein.

**6.7.4** The EHC and respite care benefits will not use the "Requests for Anticipated Payment."

**6.7.5** All claims for EHC services or items will be submitted only after such services or items are provided.

**6.7.6** EHC and respite care services will be coded using the appropriate procedure codes shown in [paragraph 1.0](#).

**6.7.7** The EHC and respite care benefits will operate on the platform of existing TRICARE claims processing systems.

**6.7.8** Hours of services provided in accordance with the beneficiary's POC will become the unit of reimbursement and tracking in the claims processing systems. The EHC and respite care benefits require that services be recorded in one hour increments.

**6.7.9** HHAs providing EHC services will submit claims using the CMS 1500 Claim Form, either in paper form or electronic version.

**6.7.9.1** Frequency of submitting claims is at the discretion of the MCSC or TOP contractor, that is, the HHA may be required by the MCSC or TOP contractor to submit claims weekly, monthly, or at such other intervals as the MCSC or TOP contractor determines is appropriate.

**6.7.9.2** The monthly (or other billing period as specified by the MCSC or TOP contractor) claim will indicate the total hours for each type of service, that is, skilled services, skilled therapy services, home health aide services, and medical social services, will be grouped according to the professional level of the individuals providing such services. The totals will be entered on separate lines of the CMS 1500 Claim Form.

**6.7.10** The following, although required to be included in the POC and when provided by the HHA, will be itemized billed separately from the allowed HHC services and will be cost-shared through the TRICARE Basic Program or the ECHO as appropriate. The amount reimbursed for these items do not accrue to the EHC fiscal year benefit cap established under [paragraph 6.8](#).

- Rental or purchase of AT devices and DE;
- FDA-approved injectable drugs for osteoporosis;
- Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;
- Oral cancer drugs and antiemetics;
- Orthotics and prosthetics;
- Ambulance services operated by the HHA;
- Enteral and parenteral supplies and equipment; and
- Other drugs and biologicals administered by other than oral method.

## **6.8 Reimbursement**

Reimbursement for the services described in this issuance will be made on the basis of allowable charges or negotiated rates between the MCSCs or TOP contractor and the HHAs.

**6.8.1** Benefit cap. Coverage for the EHC benefit is capped on a fiscal year basis.

**6.8.2** Basis of the cap. The purpose of the EHC benefit is to assist eligible beneficiaries in remaining at their primary residence rather than being confined to institutional facilities, such as a

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 15.1

ECHO Home Health Care (EHC)

---

SNF or other acute care facility. Therefore, TRICARE has determined that the appropriate EHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a SNF.

**6.8.2.1** Annually, the MCSCs and TOP contractor will calculate the EHC cap for each beneficiary's area of primary residence as follows:

**6.8.2.1.1** Obtain the annual notice, published in the **Federal Register**, of the CMS PPS and Consolidated Billing for SNFs--Update for the upcoming fiscal year. (From time to time the update notice may be known by another name but will contain the same information.)

**Note:** Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHC cap for the fiscal year beginning on that date.

**6.8.2.1.2** From the "RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component", determine the highest cost RUG-IV category;

**6.8.2.1.3** Multiply the labor component obtained in [paragraph 6.8.2.1.2](#) by the "FY 2016 Wage Index for Urban Areas Based on CBSA Labor Market Areas" value corresponding to the beneficiary's location;

**6.8.2.1.4** Sum the non-labor component from [paragraph 6.8.2.1.2](#) and the adjusted labor component from [paragraph 6.8.2.1.3](#); the result is the beneficiary's EHC per diem in that location;

**6.8.2.1.5** Multiply the per diem obtained in [paragraph 6.8.2.1.4](#) by 365 (366 in leap year); the result is the beneficiary's fiscal year cap for EHC in that location.

**6.8.2.1.6** For beneficiaries residing in rural areas, use "RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component" and "FY 2016 Wage Index Based on CBSA Labor Market Areas for Rural Areas" and adjust similarly to [paragraphs 6.8.2.1.3](#) through [6.8.2.1.5](#) to determine the EHC cap for beneficiaries residing in rural areas.

**6.8.2.2** Beneficiaries who seek EHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

**6.8.2.3** The maximum amount reimbursed in any month for EHC services is the amount authorized in accordance with the approved POC and based on the actual number of hours of HHC provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHC exceed one-twelfth (1/12) of the annual fiscal year cap established under [paragraph 6.8.2.1](#) and as adjusted for the actual number of days in the month during which the services were provided.

**6.8.2.4** Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHC services will reflect the re-calculated EHC cap.

**6.8.2.5** The cost for EHC services does not accrue to the maximum monthly or fiscal year Government cost-shares indicated in [Section 16.1](#).

**6.8.3** The sponsor's cost-share for EHC services will be as indicated in [Section 16.1](#).

## **7.0 EXCLUSIONS**

**7.1** Basic program and the ECHO Respite Care benefit (see [Section 12.1](#)).

**7.2** EHC services will not be provided outside the beneficiary's primary residence.

**7.3** EHC services and EHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education. Except for those excluded activities, this exclusion does not otherwise restrict or prohibit the primary caregiver(s) from engaging in other activities they choose, including those outside the beneficiary's primary residence.

**7.4** EHC services and supplies can be provided only to the eligible beneficiary, that is, such services will not be provided to or on behalf of other members of the beneficiary's family nor other individuals who reside in or are visiting in the beneficiary's primary residence.

**7.5** EHC services and supplies are excluded from those who are being provided continuing coverage of HHC as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

## **8.0 EFFECTIVE DATE**

September 1, 2005.

- END -



## Chapter 9

## Section 17.1

### Providers

Issue Date: August 4, 1988

Authority: [32 CFR 199.6\(e\)](#)

---

#### 1.0 POLICY

**1.1** Services and items cost-shared through the Extended Care Health Option (ECHO) must be rendered by TRICARE authorized providers.

**1.2** ECHO inpatient care providers: A provider of residential institutional care authorized under the ECHO must:

**1.2.1** Be a not-for-profit organization which primarily provides services to the disabled, OR

**1.2.2** Be a facility operated by the state or under state contract, AND

**1.2.3** Meet all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider is located.

**1.3** ECHO outpatient care providers. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

**1.3.1** An authorized provider of services as defined in [32 CFR 199.6](#), or

**1.3.2** An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as a ECHO benefit and not otherwise allowable as a benefit of [32 CFR 199.4](#), that meets all applicable licensing or other regulatory requirements that are extant in the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered.

**1.4** Individual professional providers authorized by [32 CFR 199.6](#) for the Basic Program are also authorized providers for the ECHO. Individual professional providers who can be authorized only under the ECHO must meet all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or, in the absence of such licensing or regulatory requirements, as determined by the Director, [Defense Health Agency \(DHA\)](#) or designee.

**1.5** For the purpose of services rendered in conjunction with Applied Behavior Analysis (ABA) (see Section 9.1), TRICARE-authorized providers are those that:

**1.5.1** Have a current State license to provide ABA services; or

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 17.1

Providers

---

**1.5.2** Are currently state-certified as an Applied Behavior Analyst; or

**1.5.3** Where such state license or certification is not available, are certified by the Behavior Analyst Certification Board (BACB) as either a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) when providing services under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration; and

**1.5.4** Otherwise meet all applicable requirements of TRICARE-authorized providers.

**1.6** ECHO vendor. A provider of an allowable ECHO item, supply, equipment, orthotic, or device shall be deemed to be an authorized vendor for the provision of the specific item, supply, equipment, orthotic, or device when the vendor supplies such information as the Managed Care Support Contractor (MCSC) or TRICARE **Overseas Program (TOP) contractor** determines necessary to adjudicate a specific claim.

**1.7** Provider requirements for the DoD Enhanced Access to Autism Services Demonstration are indicated in the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#).

**2.0 EFFECTIVE DATE**

September 1, 2005.

- END -

## Chapter 12

## Section 1.1

# TRICARE Overseas Program (TOP)

Issue Date:

Authority: [32 CFR 199.17\(u\)](#)

---

### 1.0 GENERAL

**1.1** The TRICARE Overseas Program (TOP) is the Department of Defense's (DoD's) program for the delivery of health care support services overseas (all locations outside of the 50 United States and the District of Columbia). The delivery of health care services overseas represents a unique situation that cannot be effectively addressed by applying all of the standards that apply in the 50 United States and the District of Columbia. TOP blends many of the features of the TRICARE program in the United States (U.S.) while allowing for significant cultural differences unique to health care practices and services in **overseas locations**.

**1.2** TOP provides health care coverage for all overseas beneficiaries, including Active Duty Service Members (ADSMs), eligible Reserve Component (RC) personnel, Active Duty Family Members (ADFMs) (including family members of eligible RC personnel), retired military and their respective family members, and transitional survivors. This coverage applies regardless of where the services are received. TOP also provides health care coverage for stateside beneficiaries residing in the 50 United States or the District of Columbia (excluding beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP)) who receive health care in an overseas location. TOP coverage includes **all** dental care for ADSMs permanently assigned to, **and receiving dental care in, a** remote overseas location. **TOP coverage also includes** urgent and emergency dental care for ADSMs who are Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, deployed or deployed on liberty in remote overseas locations. Specific TOP program eligibility and health care coverage is based upon beneficiary status, location, and enrollment elections. All beneficiaries must be eligible for TRICARE as verified via the Defense Enrollment Eligibility Reporting System (DEERS).

**Note:** USFHP enrollees must be authorized to receive care by their USFHP Primary Care Manager (PCM), regardless of where the care is rendered. Claims for overseas care rendered to USFHP enrollees shall be sent to the USFHP for processing and payment. Claims for overseas care rendered to CHCBP enrollees shall be sent to the CHCBP contractor for processing and payment.

**1.3** TOP health care services are provided by Military Treatment Facilities (MTFs), MTF Partnership Providers, and a complement of network- and non-network **purchased care sector** providers and institutions.

**1.4** Three geographic regions have been identified for the oversight of health care delivery overseas: TRICARE Eurasia-Africa (including the European continent, the Middle East, and Africa), TRICARE Pacific (including Asia, Australia, and the islands of the Pacific and Indian Oceans), and

# TRICARE Policy Manual 6010.57-M, February 1, 2008

## Chapter 12, Section 1.1

### TRICARE Overseas Program (TOP)

---

TRICARE Latin America and Canada (TLAC) (including Puerto Rico, the Caribbean basin, Latin America, South America, and Canada). Three TRICARE Area Offices (TAOs) have been established for these geographic regions to provide management and oversight of TOP health care delivery for eligible TRICARE beneficiaries. The TAO Directors, working in concert with the MTFs and their respective services, are responsible for organizing and managing health care delivery for beneficiaries in their respective region. A single TRICARE Overseas health care support contractor (hereinafter referred to as the "TOP contractor") supports the TAOs, MTFs, services, beneficiaries, and purchased care sector providers by providing or arranging for the delivery of health care services, claims processing services, and a variety of health care administrative services.

## 2.0 TRICARE PROGRAMS/SERVICES IN OVERSEAS LOCATIONS

**2.1** The following TRICARE programs or services are available under the TOP contract: TOP Prime, TOP Prime Remote, TOP Standard, TOP TRICARE for Life (TFL), TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Plus, the Extended Care Health Option (ECHO), TRICARE Young Adult (TYA), and the Transitional Assistance Management Program (TAMP).

**2.2** The following TRICARE programs or services may be available in certain overseas locations, but are not administered under the TOP contract: TRICARE Dental Program (TDP), TRICARE Retiree Dental Program (TRDP), TFL, TRICARE Pharmacy (TPharm) Program, TRICARE Active Duty Dental Program (ADDP), and the CHCBP.

**2.3** TRICARE Extra is not available outside the 50 United States and the District of Columbia.

## 3.0 TOP BENEFIT POLICY

**3.1** TOP benefit policy applies to the scope of services and items which may be considered for coverage by TRICARE within the intent of 32 CFR 199.4 and 32 CFR 199.5. Specifically, TRICARE may cost-share a procedure that is determined to be appropriate medical care, is medically or psychologically necessary, is not unproven as defined in 32 CFR 199.2, and the service or supply is not specifically limited in coverage or explicitly excluded by statute, regulation, or policy.

**3.2** While "appropriate medical care" references the norm for medical practice in the U.S., TOP gives consideration to the significant cultural differences unique to foreign countries. The TOP contractor shall exercise reasonable judgment to accommodate cultural differences relevant to the practices and delivery of host nation health care services. Services and supplies which otherwise fall within the range of TRICARE benefits (including, but not limited to, clinical preventive services, prescription drugs, and Durable Equipment (DE)/Durable Medical Equipment (DME)) may be eligible for coverage under TOP when the diagnosis or description of illness supports the reasonableness of the procedure, service, or supply and is commonly accepted practice in an overseas location. Services and supplies, which are specifically excluded from TRICARE coverage cannot be covered under TOP simply because of cultural differences. A specific waiver is required if the service or supply would not normally be considered a TRICARE benefit. Refer to Section 1.2 for a list of authorized benefit variations for TOP.

**3.3** Cultural differences may apply to things like location of care (provider comes to the patient's home) or the manner in which care is provided (services commonly done by a provider class in the U.S. may be performed by a provider assistant or physician overseas, depending on the country). Cultural differences may also apply to the manner in which claims are submitted to TRICARE. For

example, certain countries may require a separate delineation of charges for health care delivery and administrative practices that are attendant to the delivery of health care. These charges may be payable under TRICARE if they are determined to be reasonable and customary for a particular overseas location. Also, due to cultural differences, **purchased care sector** providers may, and frequently do submit claims containing narrative summaries in lieu of diagnostic and/or procedural codes. These claims may be payable under TRICARE; however, the TOP contractor shall establish processes to ensure that narrative claims are converted to codes that accurately describe the services rendered and billed by the host nation provider. 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. Itemized fees for supplies that are related or incidental to inpatient treatment in Japanese hospitals (e.g., hospital gowns) may be reimbursed if similar supplies would be covered under reimbursement methodologies used within the U.S. **In some countries, multi-specialty group practices may submit claims that do not identify the name of the provider who actually rendered the care, the individual's professional status, or the provider number. Such cultural differences in billing practices shall be accommodated for foreign multi-specialty group practices (subject to all provider licensure/certification requirement in the contract).** The TOP contractor shall implement internal management controls to ensure that payments are reasonable and customary for the location.

**3.4** The TOP benefit package includes pharmacy services through the TOP contractor for drugs dispensed by **purchased care sector** pharmacies, institutions, and providers. TOP beneficiaries may also receive limited services through the TPharm contract, to include retail network pharmacy services (in U.S. territories) and mail order pharmacy (MOP) services. The TPharm MOP may be used by all TOP beneficiaries provided certain criteria are met, such as a U.S. credentialed provider to write the prescription and a U.S. zip coded address to ship to (Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Pouch Mail). Additionally, ADSMs or ADFMs assigned to U.S. Embassies/ State Departments may also use TPharm MOP services. TOP beneficiaries who are covered by Other Health Insurance (OHI) with a prescription drug benefit may not use TPharm MOP services unless the OHI plan does not cover the medication needed, or the OHI coverage limit has been met. The TPharm MOP cannot ship drugs which must be refrigerated (e.g., insulin) to an address outside the 50 United States and the District of Columbia.

**Note:** The TPharm retail network pharmacy benefit is available in the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

#### **4.0 APPLICABILITY OF TRICARE REQUIREMENTS**

**4.1** All TRICARE requirements set forth in the TPM, the TRICARE Reimbursement Manual (TRM), TRICARE Operations Manual (TOM), and the TRICARE Systems Manual (TSM) apply to the TOP, unless specifically waived or superseded by the TOP contract, this chapter, or the TOM, [Chapter 24](#).

**4.2** For purposes of TOP implementation, any applicable manual language that refers to "TRICARE Prime" and "TRICARE Prime Remote" shall apply to TOP Prime and TOP Prime Remote, language that refers to "Regional Directors" shall apply to TAO Directors, language that refers to "TRICARE Standard" shall apply to TOP Standard, and language that refers to "Managed Care Support Contractor(s)" (MCSC(s)) shall apply to the TOP contractor.

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Chapter 12, Section 1.1

#### TRICARE Overseas Program (TOP)

---

**4.3** Waiver of rigid application of the requirements for processing/review of claims has been granted by the Defense Health Agency (DHA) Director to overcome variations between U.S. standards of health care practice and standards of health care practice in foreign countries. Examples of these variations are:

- TOP **purchased care sector** providers (**both** network and non-network) are not required to meet all TRICARE provider certification requirements to become a TOP host nation authorized provider; or
- Charges for taxi companies for driving physicians to accidents or private residences.

#### **5.0 CONTRACTOR RESPONSIBILITIES**

The TOP contractor shall support the best value in the coordination and delivery of health care services in overseas locations for ADSM, ADFMs, and other TRICARE-eligible beneficiaries. This includes all health care services provided in an overseas location, regardless of the beneficiary's enrollment location or residence address. Contractor responsibilities under this contract include (but are not limited to) enrollment processing, **purchased care sector** provider certification, network development and maintenance, Beneficiary and Provider Services (BPS) (including education and marketing), MTF optimization, medical management, fraud and abuse prevention and detection, medically-necessary patient evacuations and transfers, active duty dental care in remote overseas locations (except for U.S. territories), and claims processing. The contractor shall provide a designated Point of Contact (POC) to assist the TAO Directors or designee(s). Additionally, every stateside regional MCSC shall offer traveling TOP beneficiaries use of existing toll free Health Care Finders (HCFs) numbers/services to locate a stateside TRICARE network provider. Specific contractor responsibilities are addressed in the TRICARE Manuals and in the TRICARE Overseas health care support contract. Refer to the TOM, [Chapter 24](#) for additional TOP program instructions.

- END -

## TRICARE Overseas Program (TOP) Medical Benefit Variations

Issue Date:

Authority: [32 CFR 199.17\(u\)](#)

---

### 1.0 GENERAL

**1.1** TRICARE Overseas Program (TOP) medical benefits are based upon the scope of services and items which may be considered for coverage by TRICARE within the intent of [32 CFR 199.4](#) and [32 CFR 199.5](#). Specifically, TRICARE may cost-share a procedure that is determined to be appropriate medical care, is medically or psychologically necessary, is not unproven as defined in [32 CFR 199.2](#), and the TRICARE Policy Manual (TPM) does not explicitly exclude or limit coverage of the service or supply.

**1.2** Unique health care issues and challenges may arise in locations outside of the 50 United States and the District of Columbia. In some situations, TRICARE may authorize coverage for a specific service or supply under the TOP, even though the service or supply would normally be excluded from coverage by TRICARE. Such situations are expected to be rare and must be approved by the government.

### 2.0 AUTHORIZED TOP MEDICAL BENEFIT VARIATIONS

#### 2.1 Tick Borne Encephalitis (TBE) Vaccine

Cost-sharing of the TBE vaccine is authorized in endemic areas of Europe and Asia when an at-risk Active Duty Family Member (ADFM), retiree, or retiree family member receives the vaccine from a TRICARE authorized provider. When covered, the TBE vaccine shall be cost-shared as a clinical preventive service. See [Chapter 7, Sections 2.1 and 2.2](#).

#### 2.2 Medicare Certification of Organ Transplant Facilities

Medicare certification for organ transplant centers is only required for transplants performed in the 50 United States, the District of Columbia, and U.S. territories where Medicare is available. Organ transplantation is within the range of TRICARE covered benefits and is covered in overseas locations when it is medically necessary, reasonable, and commonly accepted practice in the country where the transplant is performed.

#### 2.3 Non-U.S. Food and Drug Administration (FDA) Approved Drugs

Non-FDA approved prescription drugs may be cost-shared **in foreign countries** if the TOP contractor has substantiated that the drug is commonly used for the intended purpose in the host nation. The TOP contractor shall substantiate that the drug is commonly used in the host nation

based on past claims/country experience or by a web search on the drug in question. If a claim for a non-FDA approved drug is submitted by a provider that is required to comply the National Drug Coding (NDC) requirements as outlined in TRICARE Operations Manual (TOM), [Chapter 24, Section 14](#), the TOP contractor shall contact [Defense Health Agency \(DHA\)](#) for assistance prior to processing the claim.

**Note:** FDA approval is required for all prescription drugs in U.S. commonwealths and territories.

## **2.4 Therapeutic Mud Baths**

Therapeutic mud baths (a form of balneotherapy which is used in some foreign countries to treat back pain, arthritis, or other medical conditions) is not a covered TRICARE benefit unless it can be established that pharmacological or other non-pharmacological treatments are unavailable in that particular country. Such cases are expected to be very rare and will require government review and approval prior to payment.

## **2.5 Private Hospital Room Charges**

Effective [September 1, 2016](#), Active Duty Service Members (ADSMs) in [locations designated in the TOP contract](#) are authorized to receive private accommodations in a hospital or other authorized institution, regardless of whether semiprivate accommodations are available.

## **2.6 Sub-Acute Care**

**2.6.1** Medically necessary and appropriate skilled nursing services and other medically necessary services, such as Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST), which are otherwise covered benefits under Title 10 United States Code (USC) Chapter 55, rendered to covered beneficiaries overseas who are receiving sub-acute inpatient care may be covered. Payment for any facility charges and other non-covered services related to the inpatient care, whether rendered at an inappropriate inpatient level or in a non-Medicare certified Skilled Nursing Facility (SNF) or similar institution, shall be denied.

**2.6.2** Part-time or intermittent Home Health Care (HHC) and hospice services may only be provided in the same manner and under the same conditions as Medicare (e.g. provided in a Medicare certified facility) and thus are not available overseas; however, coverage may still be extended for otherwise covered services and supplies provided to eligible homebound and hospice beneficiaries overseas.

**2.6.3** Payment shall be based upon the lesser of billed charges or the negotiated reimbursement rate in accordance with the TRICARE Manuals and the overseas contract. Covered services must be provided by individuals who would otherwise meet the requirements to be a TRICARE authorized individual professional provider. The contractor shall provide copies of all requested records to assist the Government in the annual retrospective review of these claims to ensure appropriate reimbursement and to identify any potential issues related to these services and the reimbursement amounts associated with these services.

- END -

## Outside The 50 United States And The District Of Columbia Locality-Based Reimbursement Rate Waiver

Issue Date: April 7, 2008

Authority: [32 CFR 199.14\(n\)](#) and [\(o\)](#)

---

### 1.0 APPLICABILITY

**1.1** This policy is mandatory for waiver of TRICARE established reimbursement schedules for professional providers outside the 50 United States and the District of Columbia locations. Reimbursement rate waivers are available to TRICARE eligible beneficiaries in specified locations outside the 50 United States and the District of Columbia where the government has established reimbursement rate schedules. Please reference the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 35](#).

**1.2** Except for medical evacuations, care in the U.S. commonwealths and territories adheres to reimbursement rates used for the 50 United States and the District of Columbia (which align with Medicare's prospective payment systems) (see [TRM, Chapter 1, Section 35, paragraph 1.0](#)). Please refer the TRM, [Chapter 5, Section 2](#) for the applicable [CHAMPUS Maximum Allowable Charge \(CMAC\)](#) waiver process for [these locations](#).

### 2.0 POLICY

**2.1** Under this reimbursement rate waiver process, a locality-based waivers may be submitted for consideration in the waiver of professional providers receiving TRICARE established reimbursement rates:

**2.1.1** If it is determined that access to specific health care services is impaired, higher payment rates may be authorized or established, by the Director, [Defense Health Agency \(DHA\)](#), for specific services that are covered under TRICARE. For specified areas outside the 50 United States and the District of Columbia, locality waivers are defined geographically as a city or country.

**2.1.2** When the Director, [DHA](#), or designee, determines beneficiary access to health care services in a locality is impaired, the Director, [DHA](#), or designee, may establish rates, as deemed appropriate and cost efficient by the following methodologies to assure adequate access to health care services.

**2.1.2.1** A percent factor may be applied or added to the allowed and established by TRICARE under the TRM, [Chapter 1, Section 35](#).

**TRICARE Policy Manual 6010.57-M, February 1, 2008**  
Chapter 12, Section 1.3  
Outside The 50 United States And The District Of Columbia Locality-  
Based Reimbursement Rate Waiver

---

**2.1.2.2** A prevailing charge for a specified location outside the 50 United States and the District of Columbia may be applied. TRICARE may use any appropriate methodology to substantiate and establish prevailing charges.

**2.1.2.3** Other appropriate payment schedules, if applicable.

**2.2** All waiver requests for specified locations outside the 50 United States and the District of Columbia shall be submitted to the **appropriate Regional** Director, TRICARE Area Offices (TAOs), to ensure that the TAO agrees with such request and that all available evidence in support of the locality-based waiver request has been submitted for consideration.

**2.3** The procedure to be followed for specified locations outside the 50 United States and the District of Columbia is as follows:

**2.3.1** The Director, TAO shall validate that the access to care is impaired in localities where the government has established reimbursement schedules.

**2.3.2** Who can apply:

- Director, TAO.
- Providers in the affected specified localities outside the 50 United States and the District of Columbia.
- **TRICARE Overseas Program (TOP)** contractor.
- TRICARE beneficiaries in the locality.

**2.3.3** How to apply:

**2.3.3.1** Applicant must submit a written waiver request to the Director, TAO. The request must specify the type of waiver the application is for and justify that access to health care services is impaired due to low TRICARE reimbursement rates.

**2.3.3.2** Justification for the waiver must include at the minimum:

**2.3.3.2.1** Total number of providers (primary care, specialty, or other) in a designated locality.

**2.3.3.2.2** Mix of primary/specialty providers needed to meet patient access standards (refer to the Department of Defense (DoD) access standards. Example, DoD access standards require one Primary Care Physician (PCP) per 1,000 beneficiaries).

**2.3.3.2.3** Current number of providers who accept or work with TRICARE.

**2.3.3.2.4** Number of eligible beneficiaries in the locality.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 12, Section 1.3

Outside The 50 United States And The District Of Columbia Locality-  
Based Reimbursement Rate Waiver

---

**2.3.3.2.5** A description of any efforts that have been attempted to locate alternative providers of service, as well as the results of those efforts.

**2.3.3.2.6** Availability of Military Treatment Facilities (MTFs) and MTF providers, if applicable.

**2.3.3.2.7** Geographic characteristics or other unique characteristics.

**2.3.3.2.8** Applicable defined cultural issues.

**2.3.3.2.9** Cost effectiveness of granting a waiver.

**2.3.3.2.10** Provider letters of intent.

**2.3.3.2.11** Evidence of the existence and/or evidence of provider acceptance of country specific prevailing fees, usual and customary fees, or commercial fee schedules.

**2.3.3.2.12** Other relevant factors, unique to the specified location outside the 50 United States and the District of Columbia.

**2.3.3.2.13** Medical Readiness issues.

**2.4** Exceptions.

**2.4.1** A provider request for beneficiary payment “up front” for health care services or beneficiary payment for higher cost share amounts in specified locations outside the 50 United States and the District of Columbia, shall not be considered as a basis for requesting a locality-based waiver.

**2.4.2** Any provider who has been placed on Program Integrity Watch by **DHA's** Chief, Program Integrity Office, or designee, or the overseas claims processor is not eligible for a reimbursement fee waiver until removed from Program Integrity Watch status.

**2.5** The Director, TAO or designated staff shall conduct a thorough analysis of the information submitted and supply any missing information to the waiver request. The Director, TAO shall review and forward their recommendations with a preliminary cost estimate to the **Chief**, TRICARE Overseas Program **Office** (TOPO). The **Chief**, TOPO will indicate agreement, document the receipt of the waiver and track the waiver request. The Director, TOP, will subsequently forward the waiver request to the **DHA** Contracting Officer (CO) and to **DHA** Medical Benefits and Reimbursement **Section** (MB&RS). Should the **Chief**, TOPO, disagree with the TAO waiver request it shall be returned to the TAO and the request shall be canceled. In processing waivers, the appropriate TRICARE Contracting staff (CO, Contracting Officer's Representative (COR), etc.) along with **DHA** MB&RS will confer with other TRICARE analysts, other Subject Matter Experts, obtain an Independent Government Cost Estimate (IGCE), and/or perform additional analysis to ensure that the requested increase in reimbursement shall alleviate access problems.

**2.6** Disapprovals by the Director, TAO, will be forwarded to the **Chief**, TOPO, for recording purposes, but will not be forwarded for additional action or waiver process completion.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 12, Section 1.3

Outside The 50 United States And The District Of Columbia Locality-  
Based Reimbursement Rate Waiver

---

**2.7** Final Authority. The Director, **DHA**, or designee is the final approval authority. A decision by the Director, **DHA**, or designee to authorize, not authorize, terminate, or modify the authorization of higher payment amounts is not subject to appeal or hearing procedures. The Director, **DHA**, or designee has the discretion to review at unspecified intervals any previously enforced decision for fee schedule modifications, revisions, reversals, or other actions as he/she deems appropriate.

**2.8** Implementation of waivers in specified areas outside the 50 United States and the District of Columbia. If the Director, **DHA**, or designee approves a higher payment rate for certain services in a locality, reimbursement rates for those procedure codes in those locations would be adjusted by the overseas claims processor, in order to improve the access to services.

- END -

TRICARE Policy Manual 6010.57-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

---

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
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
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
PII	Personally Identifiable Information
PIN	Personnel Identification Number
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
<b>PMRC</b>	<b>Patient Movement Requirement Center</b>
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

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
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
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
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
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

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
QABA	Qualified Applied Behavior Analysis
QASP	Qualified Autism Services Practitioner
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
RARC	Remittance Advice Remark Code
RBT	Registered Behavior Technician
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
Rddb	Reportable Disease Database

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHA	Records Holding Area
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RIA	Radioimmunoassay
RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation Specified Authorization Staff (formerly Service Point of Contact (SPOC))
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SME	Subject Matter Expert
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
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

# TRICARE Policy Manual 6010.57-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

SOR	Statement of Reasons <b>Statement of Responsibilities</b> System of Records
SORN	System of Records Notice
SP	Special Publication
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUD	Substance Use Disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVP	State Vaccine Program State Vaccine Program entity
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

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

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TN	Termination Notice
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
TP	Treatment Plan
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

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
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
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
USCYBERCOM	United States Cyber Command

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

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 Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WDR	Written Determination Report
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

- END -

