Chapter 3 Section 1.4

# DEERS Functions

**1.0** As the person-centric centralized data repository of Department of Defense (DoD) personnel and medical data and the National Enrollment Database (NED) for the portability of the Military Health System (MHS) worldwide TRICARE program, Defense Enrollment Eligibility Reporting System (DEERS) is designed to provide benefits eligibility and entitlements, TRICARE enrollments, and claims coverage processing.

This chapter will detail the events to verify eligibility, perform enrollments, perform a claims inquiry, and the associated updates of address information, enter fees, Catastrophic Cap And Deductible (CC&D) information, Other Health Insurance (OHI) and the Standard Insurance Table (SIT). The expected data stores for the contractor are illustrated in Figure 3.1.4-1 through Figure 3.1.4-4. Deviation from the intended concept of operations between the contractor and DEERS shown in the figure below is at the contractor's technical and financial risk.

## 1.1 Partial Match

A partial match response may be returned for any inquiry that does not use a DEERS ID or Patient ID. Eligibility may result in a partial match situation due to person ambiguity. There will be a separate listing for each person or family matching the requested Social Security Number (SSN). The listing includes the sponsor and family member identification information needed to determine the correct beneficiary or family including the DEERS ID, the Patient ID, or possibly both. The requesting organization must select which of the multiple listings is correct based on documents or information at hand. After this selection, the requesting organization would use the additional information returned (e.g., Date Of Birth (DOB), Name) "to resend the inquiry."

## 1.2 Health Care Delivery Program Eligibility and Enrollment

The rules for determining a beneficiary's entitlement to health care benefits are applied by rules-based software within DEERS. DEERS is the sole repository for these DoD rules, and no other eligibility determination outside of DEERS is considered valid. Whenever data about an individual sponsor or a family member changes, DEERS reapplies these rules. DEERS receives daily, weekly, and monthly updates to this data, which is why organizations must query DEERS for eligibility information before taking action. This ensures that the individual is still eligible to use the benefits and that the contractor has the most current information.

A beneficiary who is considered eligible for DoD benefits in accordance with DoD Instruction (DoDI) 1000.13 is not required to "sign up" for the TRICARE Standard benefits or any other DEERS assigned plan. If an authorized organization inquires about that beneficiary's eligibility, DEERS reflects if he or she is eligible to use the benefits. The effective and expiration dates for assigned plan coverage are derived from DoDI 1000.13 rules and supporting information.

### 1.2.1 Enrollment-Related Business Events

Enrollment related business events include:

- Eligibility for enrollment identifies current enrolled coverage plans and eligibility for enrollment into other coverage plans

- New enrollments are used for enrolling eligible sponsors and family members into a Health Care Delivery Program (HCDP) coverage plans or for adding family members to an existing family policy. Enrollments begin on the date specified by the enrolling organization and extend through the beneficiaries' end of eligibility for the HCDP. New enrollments may also perform the following functions:

  - PCM selection
  - Update address, email address and/or telephone number
  - Record that the enrollee has OHI

- Modifications of the current enrollment (updates) are used to change some information in the current enrollment plan. Modifications of the current enrollment include the following functions:

  - Change or cancel a Primary Care Manager (PCM) selection
  - Transfer enrollment (enrollment portability) or cancel a transfer
  - Change enrollment begin date
  - Cancel enrollment/disenrollment
  - Change prior enrollment end date
  - Change prior enrollment end reason
  - Request an enrollment card replacement
  - Add OHI information for an enrollee
  - Request a replacement letter for PCM change or disenrollment

- Individual fee waiver information is used to indicate that an enrollee is exempt from paying enrollment fees.

- Enrollment fee payments and enrollment fee waiver entitlements are used to indicate payment of, or exception from payment of, enrollment fees. The Fee/Catastrophic Cap and Deductible Database (CCDD) Web Research application is used to view this detailed information for a specified policy.

- Disenrollments are used to terminate the specified beneficiary's enrollment. Disenrollments are used for disenrolling a beneficiary only when he or she has lost eligibility, voluntarily disenrolls (e.g., chooses not to re-enroll) or involuntarily disenrolls (e.g., fails to pay enrollment fees).

- Defense Online Eligibility And Enrollment System (DOES) will display enrollment fees and enrollment fee waiver entitlement periods that apply to the policy.

The following figures show the data and process flow required by the government. Deviations from this diagram are at the contractor's technical and financial risk.

**FIGURE 3.1.4-1 DEERS ENROLLMENT AND CLAIMS INTERACTION - MANAGED CARE SUPPORT CONTRACTOR (MCSC)**

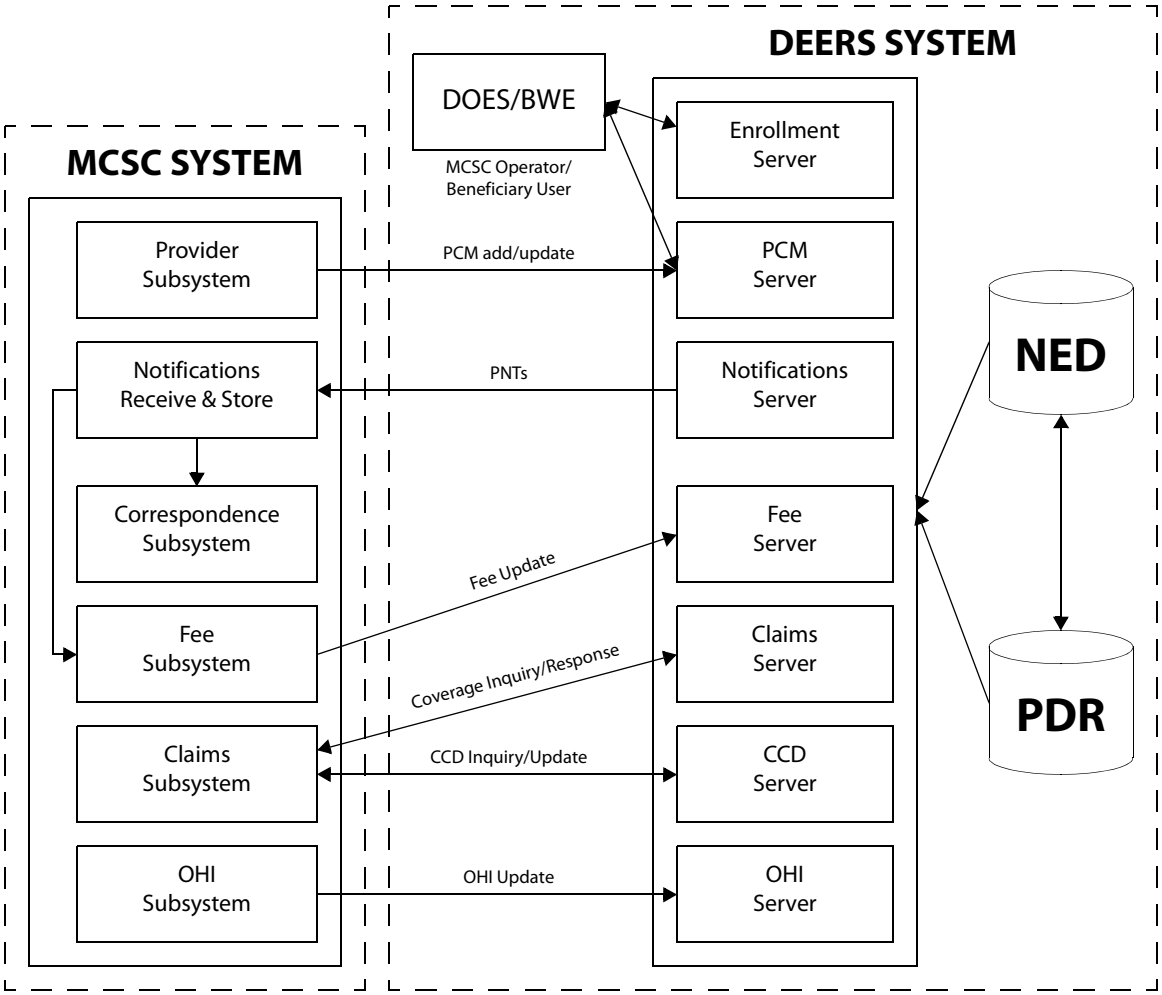


**FIGURE 3.1.4-2 DEERS ENROLLMENT AND CLAIMS INTERACTION - UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)**

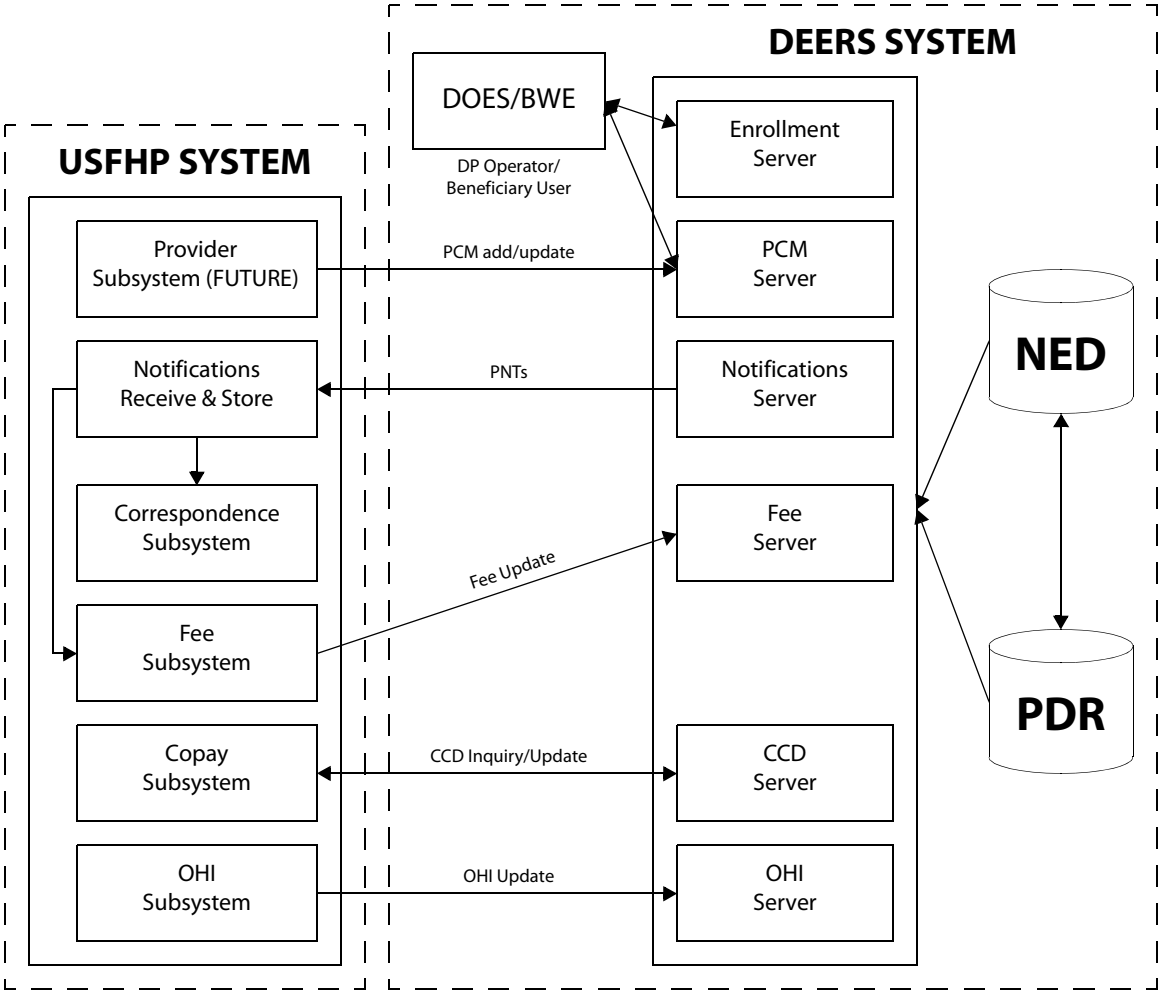


**FIGURE 3.1.4-3 DEERS ENROLLMENT AND CLAIMS INTERACTION - TRICARE DUAL ELIGIBLE FISCAL INTERMEDIARY CONTRACTOR (TDEFIC)**

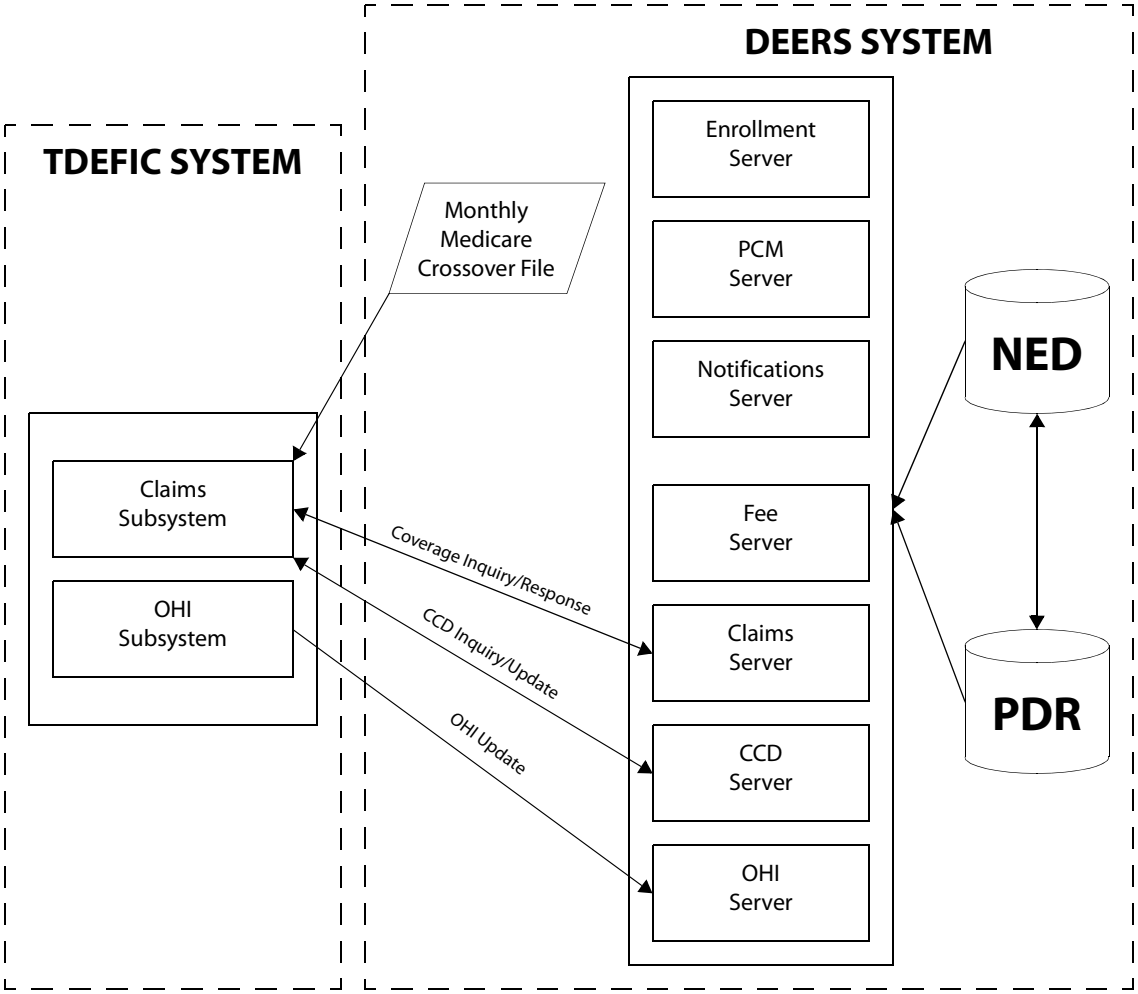


**FIGURE 3.1.4-4 DEERS ENROLLMENT AND CLAIMS INTERACTION - PHARMACY**

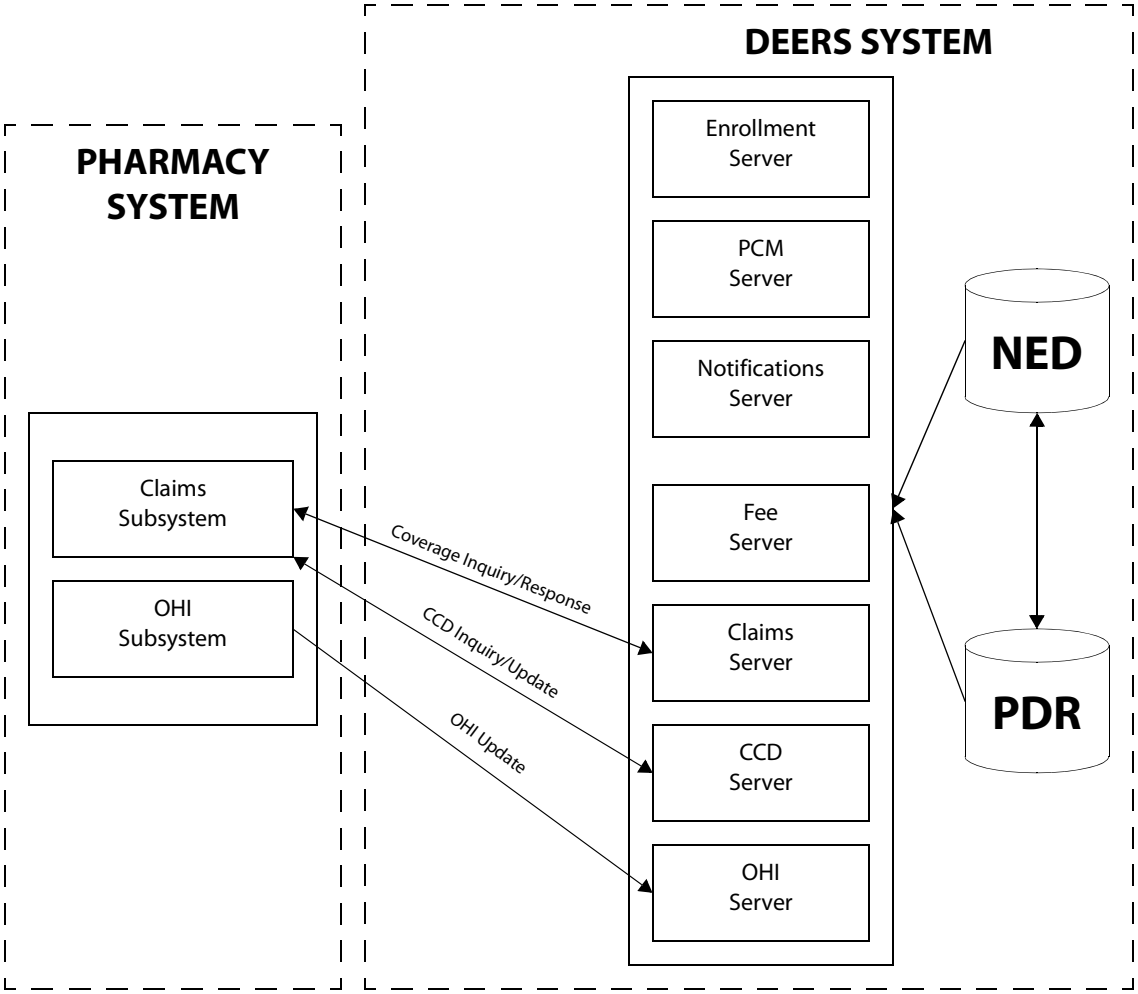
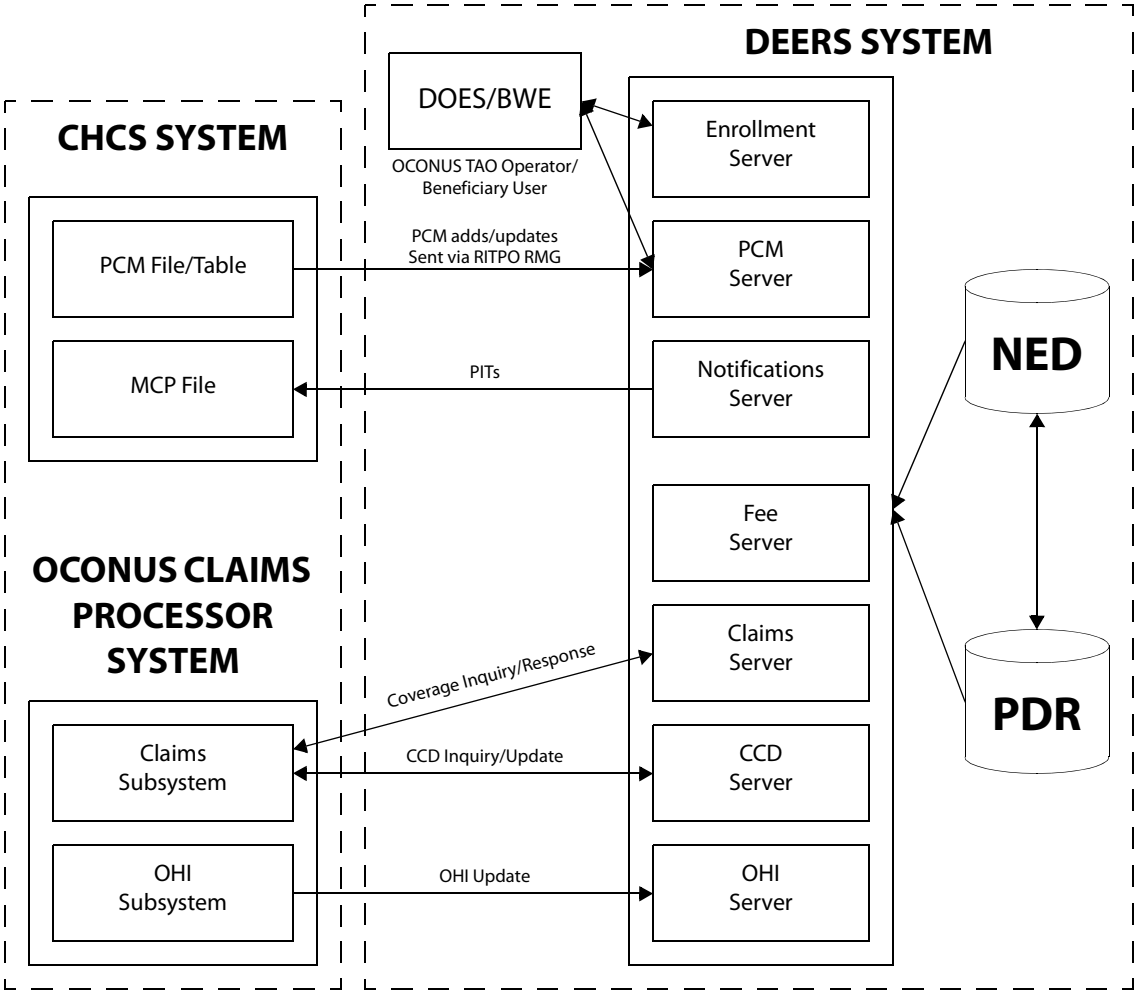


**FIGURE 3.1.4-5 DEERS ENROLLMENT AND CLAIMS INTERACTION - OUTSIDE THE CONTINENTAL UNITED STATES (OCONUS)**




### 1.2.2 Defense Online Eligibility And Enrollment System (DOES)

DOES is a full function Government Furnished Equipment (GFE) application developed by Defense Manpower Data Center (DMDC) to support enrollment-related activity. DOES interacts with both the main DEERS database and the NED satellite database to provide enrolling organizations with eligibility and enrollment information, as well as the capability to update the NED with new enrollments and modifications to existing enrollments. The Managed Care Support Contractors (MCSCs), the Uniformed Services Family Health Plan (USFHP), and the TRICARE Area Offices (TAOs) are required to perform enrollment related functions through DOES, including:

- Enrollment
- Disenrollment
- PCM Change
- PCM Cancellation and Transfer Cancellation
- Transfer

- Enrollment Period Change
- Enrollment End Reason Code Change
- Enrollment/Disenrollment Cancellation
- Enrollment Fee Payment
- Beneficiary Update
- OHI Add
- Confirm Enrollment/PCM change (to support beneficiary web enrollment)
- Request new or replacement enrollment ID card
- Request PCM letter

DOES will display enrollment fees for the last Fiscal Year (FY) that DEERS has fees applied to the policy.

The DOES application meets the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines for a direct data entry application, and is data-content compliant for enrollment and disenrollment functions.

### 1.2.3 Beneficiary Self-Service Enrollment

Beneficiary Web Enrollment (BWE) serves all TRICARE eligible beneficiaries and will support most enrollment programs. BWE will interface with the contractor systems for the purposes of accommodating on-line payment of initial enrollment fees. See the BWE Enrollment Fee Gateway Technical Specification for more details.

DEERS will pre-populate data elements where possible. The beneficiary can perform the following enrollment events:

- Enrollment
- PCM change
- Address update
- Transfer of enrollment (as a result of address update)
- Disenrollment
- Limited cancellation events
- Submit an initial enrollment application
- Add limited OHI
- Request replacement enrollment card

The web application contains checks for beneficiary eligibility and hard edits requiring the beneficiary to fulfill established DEERS business rules and enrollment criteria. Upon completion of the web process, the beneficiary is informed that the enrollment actions will be reviewed by the appropriate contractor for accuracy and compliance with established Regional requirements, and that they will be contacted if additional information is needed. DEERS will send the contractor a Policy Notification Transaction (PNT), informing the contractor that a pending enrollment exists for the beneficiary. The contractor shall apply all PNTs for pending enrollments and/or PCMs and use the pending status to create workload reports. Using DOES, the contractor shall review or modify all pending enrollment-related activities within six calendar days of submission to DEERS, including any necessary contact with the beneficiary. DEERS will perform a daily process to finalize enrollment actions after six calendar days. DEERS will send a policy notification indicating the approval. If the enrollment is not accepted, the contractor shall cancel the enrollment using DOES,

and send the beneficiary an explanatory letter within five calendar days. The contractors shall consider beneficiary provided data from BWE as having the same validity as beneficiary provided data on paper enrollment forms. DEERS will not provide support or interfaces to contractor web applications that perform any enrollment-related functions.

### 1.2.4 Eligibility For Enrollment

The DoD provides assigned health care delivery programs and plans when a person joins the DoD. DEERS determines coverage plans for which a beneficiary is eligible to enroll by using the DoD-assigned coverage in conjunction with additional eligibility information. The Eligibility for Enrollment Inquiry in DOES is used to view a person's or family's eligibility to enroll. [NOTE: The Eligibility For Enrollment Inquiry in DOES should not be used for other eligibility determinations. For example, USFHP providers should use Government Inquiry of DEERS (GIQD) and not DOES to determine if a person is eligible for a hospital admission.]

DEERS provides coverage plan information identifying the period of eligibility and/or enrollment for the coverage plan. A beneficiary can only be enrolled into the coverage plans that have an "eligible for" status. When a sponsor and family member are first added into DEERS, DEERS determines basic eligibility for health care benefits in accordance with DoDI 1000.13 and establishes an assigned HCDP coverage plan together with coverage dates.

For example, when an active duty sponsor and family members are added to DEERS:

- A sponsor is assigned TRICARE Prime for Active Duty Service Members (ADSMs), No PCM Selected in which he or she is the subscriber and the insured. The dates on the coverage represent the dates determined by the eligibility rules.

- A sponsor with family members is listed as the subscriber under the TRICARE Standard for Active Duty Family Members (ADFMs) assigned plan. The sponsor is not insured under this coverage plan.

- Eligible family members are assigned TRICARE Standard for ADFMs plan as insured with both Direct Care (DC) and Civilian Health Care (CHC) coverage. The coverage plan dates are determined by the eligibility rules. There are no enrollment dates, since this option requires no enrollment.

### 1.2.5 Enrollment

The assigned plans provide the foundation for enrollment into various coverage plans. Enrollment plans are mandatory for ADSMs and include:

- TRICARE Prime for ADSMs. This plan requires the assignment of a PCM.

- TRICARE Prime Remote (TPR) for ADSMs. This plan requires a PCM if one is available.

- TRICARE Overseas Prime for ADSMs. This plan requires a PCM to be assigned.

- TRICARE Global Remote Overseas (TGRO) Prime for ADSMs. This plan requires a PCM if one is available.

For other beneficiary categories, such as ADFMs and retirees and their family members, enrollment is optional.

Enrollments are at the individual or family level, depending on the number of family members wishing to enroll. DEERS creates a policy that encompasses all enrollments for a family and a HCDP. DEERS automatically switches enrollment policies from individual to family or family to individual when required. It is the contractor's responsibility to correct the fees based on the policy notification of the plan change. Some HCDP's, such as TRICARE Plus, only offer enrollment on an individual basis. For these plans, DEERS does not limit the number of individual policies that a family may have.

The contractors are required to enter the following information into DOES in order to complete an enrollment. Required data elements vary by plan. For instance, TRICARE Prime for ADFMs requires the following data elements:

- Coverage plan
- Enrollment begin date (if different than DOES default)
- Address verification
  - PCM assignment
  - PCM Network Provider Type Code (if not defaulted by DOES)
  - PCM Enrolling Division (if more than one is available for the coverage plan and PCM Network Provider Type Code)
  - Individual PCM selection

Enrollments may be backdated up to 18 months.

Enrollment policies for all enrollees shall be on a FY basis, i.e., October 1 through September 30. To accomplish this, the contractor shall establish the policy and prorate the enrollment fees as described below. At the end of that FY, the contractor shall renew the policy for the next FY.

For enrollees that pay fees on an annual basis, the contractor shall collect the entire prorated fee covering the period through September 30 of the current FY.

For enrollees that pay fees on a quarterly basis, the contractor shall collect a prorated fee covering the period until the next FY quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30 of the current FY. For enrollees that pay fees on a monthly basis (by Electronic Funds Transfer (EFT) or monthly allotments), contractors must collect and post an amount equal to three months of fees at the time of enrollment with monthly EFT or allotments beginning on the first day of the fourth month following the enrollment anniversary date. If the first three month payment crosses into the next FY, the contractor shall send DEERS the three month payment amount, indicating the applicable paid through date and a payment plan type of "Request to begin allotment". DEERS will apply one or two months of the three month payment (whichever is applicable) to the enrollment ending in the current FY and the remaining one or two months of fees to the beginning of the new enrollment beginning on October 1 of the next FY.

#### 1.2.5.1 Prime Enrollment Fees

##### 1.2.5.1.1 Enrollment Year To FY Alignment

By statute, Prime enrollees are entitled to both an enrollment year and a FY for the purposes of enrollment fees and catastrophic cap amounts. Tracking two sets of amounts for each enrollee is cumbersome, confusing, expensive, and can lead to inaccurate totals as well as negatively affecting enrollment portability. To ease portability and resolve problems, enrollment anniversary dates for all enrollees are on a FY basis, i.e., October 1 through September 30. For new enrollments, the policy end date will be set to the end of the FY. Enrollment fees and catastrophic cap amounts are prorated accordingly.

##### 1.2.5.1.2 Prorated Enrollment Fees

For new Prime enrollments that do not begin on October 1, DEERS will establish abbreviated (less than 12 months) policies ending September 30 and the contractor shall prorate the enrollment fees on a monthly basis. The monthly prorated enrollment fee for individual policies is 1/12 of the annual individual enrollment fee (currently $230/year). For family policies, the monthly prorated enrollment fee shall be 1/12 of the annual family enrollment fee (currently $460/year). The contractor shall apply any fee overage from the abbreviated enrollment year to the next FY enrollment policy and shall set the paid through dates in accordance with those amounts. At the end of the abbreviated enrollment (end of the current FY), the contractor shall renew the policy for the next FY with an begin date of October 1 and resume collecting the full enrollment fees.

##### 1.2.5.1.3 Prorated Catastrophic Cap Amounts

TRICARE Prime enrollees who are other than Active Duty (AD) or ADFM, (e.g., Retirees and Retiree Family Members), are entitled to an enrollment year catastrophic cap, currently $3,000. As with enrollment fees, catastrophic cap amounts must also be prorated in order to complete the enrollment year to FY alignment. In order to align the enrollment year to the FY, a one time prorated catastrophic cap credit will be applied to each new enrollment for each month that the beneficiary was not enrolled during the current FY. The monthly prorated catastrophic cap credit for non-AD and non-ADFMs will be 1/12 of the annual catastrophic cap limit (currently $250 per month).

#### 1.2.5.2 PCM Assignment Within The DOES Application

DEERS has a centralized PCM file containing both the PCMs for the DC facilities and all MCSC civilian network PCMs. The DOES application accesses the central PCM file to perform provider assignments. The DEERS PCM Repository will accept additions, terminations, and modifications of civilian network PCMs in real time to support enrollment activities. All PCM additions, terminations, or modifications shall be transmitted to DEERS no less than daily. To deactivate or delete a PCM, contractors shall send DEERS a modification where the PCM's effective date is equal to the PCM's end date, and DEERS will deactivate the PCM from the central file. DEERS will only delete PCMs from the central file if there have been no assignments to that provider. DEERS will not allow subsequent assignments to a deactivated PCM. Contractors are responsible for the quality of the PCM data transmitted to DEERS. Contractors cannot reuse PCM IDs that are deactivated or were assigned to PCMs deleted from their provider system. Contractors will not submit inaccurate data.

#### 1.2.5.2.1 DC PCM Assignment

The contractor shall perform DC PCM assignment at the time of enrollment in the DOES application. The contractor shall use the PCM preference indicated on the enrollment form in addition to guidance contained in any MOU agreement or other government-provided direction, if available. For ADSMs, if the enrollment form has a Unit Identification Code (UIC) specified and the Military Treatment Facility (MTF) has established a default provider for the UIC, the contractor should use the default. If the enrollment form contains a specialty or gender preference, the contractor shall use the preference filters available in DOES to select a PCM. In the case where a beneficiary has not indicated a preference and there is not precise direction in an Memorandum Of Understanding (MOU) or other government direction, the contractor shall use the search criteria in DOES to select a PCM. DOES and BWE will only display PCMs with available capacity in the selected Defense Medical Information System (DMIS)-ID. The contractor is responsible for determining the appropriate DMIS-ID based on MOUs, access standards, and any specific guidance from the government. If there is no capacity at a DC facility, the contractor shall contact the MTF to confirm that enrollment is closed; MTFs must respond to such requests within two business days or the contractor may enroll the beneficiary to their civilian network.

#### 1.2.5.2.2 Civilian PCM Assignment

The contractor shall perform Civilian PCM assignment at the time of enrollment in the DOES application. The contractor shall use the PCM preference indicated on the enrollment form. If the enrollment form contains a specialty or gender preference, the contractor shall use the preference filters available in DOES to select a PCM.

### 1.2.6 Disenrollment

Once actively enrolled in a coverage plan, an individual or family may voluntarily disenroll or be involuntarily disenrolled. Voluntary disenrollment is self-elected. Involuntary disenrollment occurs from failure to pay enrollment fees or from loss of eligibility. Upon disenrollment, DEERS will notify the beneficiary of the change in or loss of coverage. If disenrollment occurs at other than the renewal date, the beneficiary incurs a 12 month lockout. Contractors must set the lockout manually, and may cancel the lock and disenrollment in accordance with established administrative procedures.

#### 1.2.6.1 Disenrollment - Loss Of Eligibility

A loss of eligibility refers to any loss or change in eligibility for DoD health care benefits in accordance with the current DoDI 1000.13 or additional legislation authorizing benefits or for a specific health coverage plan. At the time of enrollment, DEERS provides the end of eligibility date to the contractors via the notification. If that end date does not change, DEERS will provide no additional notifications. If the end date changes, DEERS will provide another notification with the new end date. DEERS also cancels any future actions for that beneficiary, including future enrollments, PCM changes, etc.

#### 1.2.6.2 Retroactive Eligibility/Enrollment Maintenance

There may be instances where DEERS receives notice of a loss of eligibility from the Uniformed Services, only to later be informed of the immediate reinstatement. Upon the receipt of

the initial loss of eligibility, DEERS terminates the enrollment. Upon receipt of the notice of reinstatement, DEERS reinstates the eligibility and enrollment as long as there are no gaps in eligibility. DEERS will reinstate eligibility and enrollments only if DEERS receives new personnel information reinstating eligibility within 90 days of the initial loss of eligibility and only if the plan does not require fee payment.

#### 1.2.6.3 Disenrollment - Voluntary

An enrollee may choose to terminate his or her current enrollment prior to the end date, or choose not to re-enroll into the current coverage plan. This transaction is performed in DOES. DEERS then terminates the enrolled coverage plan for the beneficiary and reverts to the DEERS assigned coverage, starting on the day after the termination of the enrollment. If additional systems need notification of the disenrollment, DEERS sends disenrollment notifications as necessary, notifying them of the termination of coverage benefits.

#### 1.2.6.4 Disenrollment - Involuntary

The enrollee may fail to pay enrollment fees. In this case, the enrolling organization performs a disenrollment with a reason code of "failure to pay fees". Individuals who are waived from paying enrollment fees are not disenrolled because of this exemption from enrollment fee payments. Disenrollment for failure to pay fees is either performed in DOES or through a batch 'disenrollment for failure to pay fees' system to system interaction.

Prior to processing a disenrollment with a reason of "non-payment of fees", the contractor must reconcile their fee payment system against the fee totals in DEERS. Once the contractor confirms that payment amounts match, the disenrollment may be entered in DOES or through the failure to pay fees interface.

When there is a disenrollment, the appropriate systems are notified, as necessary. The following table lists the functions and applications that allow each action:

| | DOES | BWE | FEE INTERFACE | PCM PANEL REASSIGNMENT | DEERS (UNSOLICITED) |
|---|---|---|---|---|---|
| Enrollment | X | X | | | |
| Enrollment Cancellation | X | X (if pending) | | | |
| Disenrollment | X | X | X (failure to pay fees only) | | X |
| Disenrollment Cancellation | X | | | | |
| PCM Change | X | X | | X | |
| PCM Cancellation | X | X (if pending) | | | |
| PCM Panel Reassignment | | | | X | |
| Modify Enrollment Begin Date | X | | | | X |
| Modify Prior Enrollment End Date | X | | | | X |

| | DOES | BWE | FEE INTERFACE | PCM PANEL REASSIGNMENT | DEERS (UNSOLICITED) |
|---|---|---|---|---|---|
| Modify Prior Enrollment End Reason | X | | | | X |
| Modify PCM Effective Date | X | | | | |
| Transfer | X | X | | | |
| Transfer Cancellation | X | X | | | X (if loss of eligibility before transfer) |
| Apply Enrollment Fee/ TRICARE Reserve Select (TRS) Premium | X | X (initial) | X | | |

### 1.2.7 Modification Of Enrollment

Whenever there is a modification to an enrollment, the appropriate systems are notified, as necessary.

#### 1.2.7.1 PCM Change And Cancellation

PCM reassignments occur when the enrollee changes regions or desires to change PCM's within the region or MTF. An enrollee changes PCMs by completing a PCM change request form and submitting the change request to the contractor, which makes the change via DOES. Only the current enrolling organization may change the PCM selection. A PCM change can be made only on the latest PCM segment. DEERS then terminates the previous PCM with an end date, which will be the day before the begin date for the new PCM. Upon change of PCM, DEERS will notify the enrollee of the new PCM information, as well as sending notifications to the appropriate MTFs and contractors.

DOES will allow PCM's with available capacities to be assigned as new PCM's. If a contractor is canceling a PCM assignment, DOES will permit reinstatement of a PCM whose capacity has been reached.

#### 1.2.7.2 PCM Panel Reassignment

PCM Panel Reassignment Application (PCMRA) allows the user to select all or part of a PCM's panel for reassignment to other PCMs. PCM reassignments are processed periodically by DEERS. DEERS will decrement and increment PCM capacities when processing panel reassignments, but will not prevent the reassignment if the selected gaining PCM does not have available capacity. As part of the moves, DEERS sends notifications to the appropriate systems. Note that PCM change letters may be suppressed during a panel reassignment, but the suppression must apply to the entire transaction.

##### 1.2.7.2.1 DC Care PCM Panel Reassignment

All PCM changes for DC PCMs must be performed by the MCSC. The MTF will set up the panel reassignments using PCMRA. The contractor shall complete the required moves using PCMRA within two business days of submission.

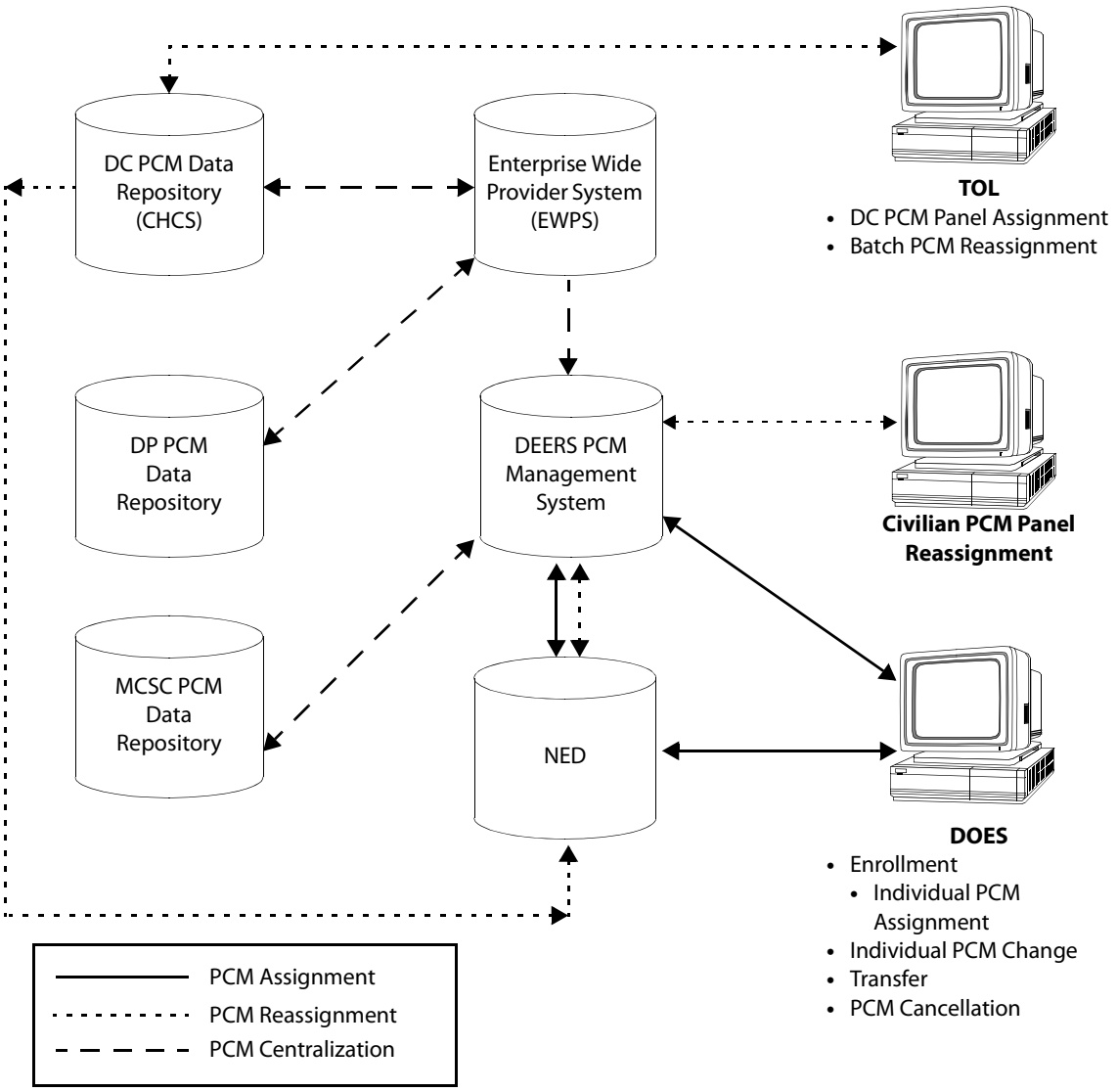
Panel changes that cross Composite Health Care System (CHCS) platforms must be coordinated not only with the contractor but with the designated TRICARE Management Activity (TMA) Representative and DEERS.

Emergency moves may be coordinated by the MTF with the MCSC by the best available means, including phone, fax, or secure e-mail.

#### 1.2.7.2.2 Civilian Panel Reassignment

DMDC provides a web application to allow contractors to perform mass reassignments of a civilian PCM's enrollees. There is an option to suppress the PCM change letters for civilian PCM panel reassignments.

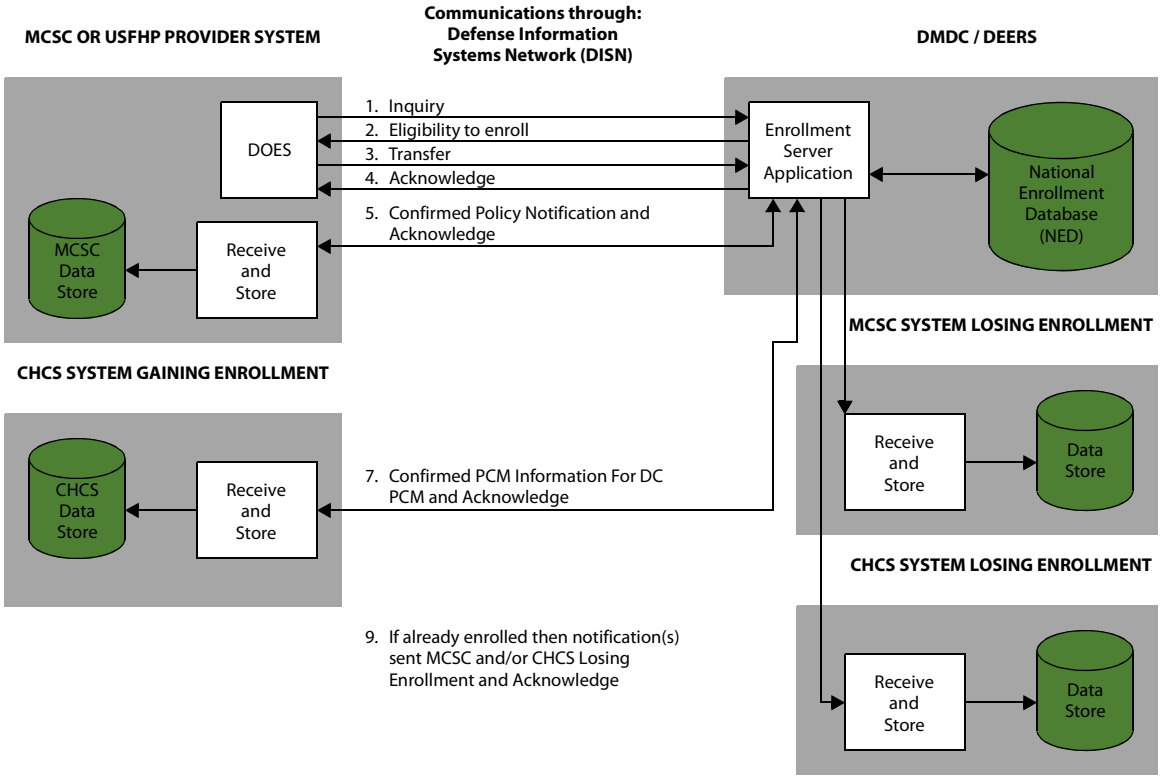
**FIGURE 3.1.4-6 PCM ASSIGNMENT PROCESS**



### 1.2.7.3 Transfer Of Enrollment And Transfer Cancellation

A transfer of enrollment moves the enrollment from one contract to another and thus moves the responsibility for the administration of the enrollment to the gaining contractor. DEERS supports transfers within plans (e.g., TRICARE Prime). A transfer may include a change to the Health Care Coverage (HCC) plan in some cases, such as TRICARE Prime for ADSMs to TPR for ADSMs. DEERS will enforce when such transfers are allowed.

**FIGURE 3.1.4-7 ENROLLMENT TRANSFER PROCESS**




If an enrollment transfer is performed in error, a transfer cancellation may be performed. This action results in reinstatement of the enrollment with the previous enrolling organization and the previous PCM.

### 1.2.7.4 Enrollment Period Change

This event is used to update an enrollee's begin or end date. Modifications can only be performed by the enrolling organization responsible for managing the enrollment. A contractor may change the enrollment end date only after performing a disenrollment. If the enrollment end date is the same as the loss of eligibility date, the user is not allowed to change the end date to a later date. DEERS changes the date range for the applicable PCM selection and policy to correspond with the new end dates if necessary.

If a person's eligibility in DEERS changes and affects an enrollment because the eligibility

period is either greater or less than originally stated, DEERS updates the enrollment period and pushes the PCM and policy changes to the appropriate systems managing the enrollment.

#### 1.2.7.5 Enrollment End Reason Change

Disenrollments can be done for various reasons and are mostly done by enrolling organizations. If a disenrollment is performed by an enrolling organization using an incorrect end reason code, the end reason code can be updated. Enrolling organizations enter an end date that precedes the date of loss of eligibility.

#### 1.2.7.6 Enrollment/Disenrollment Cancellation

**1.2.7.6.1** Enrollment cancellations can only be performed by the enrolling organization. An enrollment cancellation completely removes the enrollment from DEERS and it will not be shown on subsequent inquiries. Assuming that the beneficiary is still eligible, the prior enrollment and PCM will be reinstated if there was a contiguous change of plan (family to individual or Prime to TPR).

**1.2.7.6.2** Disenrollment cancellations can only be performed by the enrolling organization. A disenrollment cancellation removes the disenrollment event and reinstates the enrollment and PCM assignment as if the disenrollment never occurred.

### 1.2.8 Enrollment Fees And Enrollment Fee Waivers

DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment year in DOES.

DEERS provides a number of applications to support enrollment-fee-related transactions:

- Enrollment Fee Payment (Fee/CCDD Web Research application and Fee Interface)
- Update an enrollee's free-rider code (DOES)
- Terminate Policy For Failure To Pay Fees (DOES and Fee Interface)

DEERS will automatically set enrollment fee waivers for a policy based on the following events:

- Sponsor served in Bosnia
- One or more enrollees have Medicare Parts A and B
- The family has met their catastrophic cap
- Mid-month retiree enrollment

Fee waivers are stored at the family level. DEERS will provide the reason for fee waiver, whether it applies to one enrollee in the policy or more than one enrollee, and the begin and end dates, a status code, and status date associated to that waiver on the PNT. The status code indicates whether the waiver is active or inactive. Inactive waivers reflect waiver information that is no longer applicable because there has been a change to the fee waiver entitlement. Inactive waivers do not have an effect on the determination of fees due for the policy and are for audit purposes only. All waiver data is displayed in the Fee/CCDD Web Research application.

#### 1.2.8.1 Enrollment Fee Payment

Enrollment fees may be paid monthly, quarterly, or annually. The beneficiary specifies this payment option during enrollment and the contractor shall enter the fee information in the fee interface as part of the enrollment transaction. Contractors shall update DEERS with all subsequent enrollment fee payments and shall update a fee paid-through date for each. They shall transmit this information, including any credits to DEERS within one business day. With the exception of claims recoupments, all monetary receipts from beneficiaries must be treated as fee payments and reported to DEERS either as fee payments or credits, unless they are refunded to the beneficiary. There is no option to retain such records in the contractor's system. The contractor's system shall be able to process fee refunds as necessary.

DEERS will automatically apply any fee payments and adjustments posted through DOES or the Enrollment Fee Payment interface to the beneficiary's catastrophic cap. For individual policies, the beneficiary will be credited with the fee amount; for family policies, the fee will be posted under the sponsor's catastrophic cap. If the catastrophic cap is locked at the time the fee payment is sent, DEERS will reject the fee payment. The contractor shall resend the fee amount to DEERS daily until it is accepted. If the record remains locked longer than 48 hours, the contractor should contact the claims processor that placed the lock to determine the reason for the lock and when it will be released.

The enrollment fee payment interface perform edits against the submitted fee data. The contractor shall research and correct any data discrepancies identified by DEERS (both warnings and errors) within three business days.

DEERS records both the enrollment fee payment date and the enrollment fee paid-through date. The enrollment fee payment date reflects the date the fee was received by the contractor. The enrollment fee paid-through date reflects the last date for which coverage is paid. The purpose of tracking the paid-through date is to ensure portability. On an enrollment transfer, DEERS includes the fee information from the enrollee's policy on the notification to the new contractor.

DEERS does not prorate fees, determine the amount of the next enrollment fee payment, determine the date of the next enrollment fee payment, send enrollment fee payment due notifications, or identify which entity is responsible for enrollment fee payments. These actions are the responsibility of the enrolling organization. Additionally, the enrolling organization must be able to accommodate policies that are less than 12 months in length and prorate enrollment fees appropriately.

DEERS will automatically apply any fee payments posted through the Enrollment Fee Payment interface to the catastrophic cap.

#### 1.2.8.2 Fee Payments Interface

The contractor will send enrollment fee payment information to DEERS through a system-to-system interface. This interface includes new payments, payment adjustments, and updates to paid-through dates. Contractors must correct and resubmit enrollment fee payments rejected by DEERS or research, correct and resubmit fee payments for which DEERS has provided a warning within three business days of the error.

#### 1.2.8.3 TRICARE Reserve Select (TRS) Premium Payments

For the TRS Program, DEERS will accept premium payment paid through dates. Contractors are required to submit paid through dates to DEERS upon receipt of premium payments. Contractors will refund all overpayments of premiums to the TRS member. In the event the TRS member moves from one region to another region, billings for premiums shall be initiated on the first day of the next month with coverage effective the first day following the previous paid through date. In the event of a delinquent account, billing notification and delinquency actions may be required of the gaining contractor prior to the next billing cycle. Transfers shall not be initiated except upon notification by the TRS member of an address change to the contractor.

At a date to be determined later, contractors shall submit premium payment amounts received, including any overpayments, to DEERS. As with any other enrollment fee or premium payment, overpayments are considered part of the fee or premium amount that must be reported to DEERS.

**Note:** TRS premium payments are not applicable to the FY Catastrophic Cap.

#### 1.2.8.4 Enrollment Fee Waivers

DEERS will automatically maintain fee waiver entitlement data for families. Multiple fee waiver entitlements may exist at the same time (i.e., the family has a waiver for Medicare at the same time that they have met the catastrophic cap for part of a fiscal year). DEERS will supply all fee waiver entitlements, and the contractor is responsible for calculating fees due based on all waiver entitlement data.

When new enrollments are processed, certain fee waiver entitlements will be immediately available on the enrollment PNT. Under certain circumstances (i.e., mid-month enrollments), the enrollment data will be processed and a PNT is sent prior to the calculation of the fee waiver entitlements. In such cases, a subsequent PNT will be sent immediately after the fee waiver entitlement recalculation that will include the updated waiver data.

When primary data changes in DEERS that affect fee waivers, the corresponding entitlement periods will be recalculated. If a fee waiver entitlement affects the current or future fiscal years for an active policy, DEERS will send an unsolicited notification to the most recent contractor.

Additionally, if primary data in DEERS changes that makes an existing entitlement invalid (i.e., the family going back under the catastrophic cap), the existing entitlement will be marked inactive and an unsolicited PNT will be sent to the contractor if it affects an active policy's current or future fiscal years.

## 1.3 Address, Telephone Number, and E-Mail Address Updates

### 1.3.1 Addresses

DEERS receives address information from a number of source systems. Although most systems only update the residence address, DEERS actually maintains multiple addresses for each person. The contractor shall update the residential and mailing addresses through DOES or other

DEERS applications (e.g.,GIQD) whenever possible. These addresses shall not reflect unit, MTF, or MCSC addresses unless provided directly by the beneficiary. The mailing address captured on DEERS is primarily used to mail the enrollment card and other correspondence. The residential address is used to determine enrollment jurisdiction at the Zip Code level. DOES uses a commercial product to validate address information received online and from batch sources.

### 1.3.2 Telephone Numbers

DEERS has several types of telephone numbers for a person (e.g., home, work, and fax). Contractors shall make reasonable efforts to add or update telephone numbers.

### 1.3.3 E-mail Addresses

DEERS can store an e-mail address for each person. Contractors shall make reasonable efforts to add or update this e-mail address.

## 1.4 Notifications

Notifications are sent to contractor for various reasons and reflect the most current enrollment information for a beneficiary. The contractor must accept, apply, and store the data contained in the notification as sent from DEERS. Notifications may be sent due to new enrollments or updates to existing enrollments. If the contractor does not have the information contained in the notification, the contractor shall add it to their system. If the contractor already has enrollment information for the beneficiary, the contractor shall apply all information contained in the notification to their system. The contractor shall use the DEERS ID to match the notification to the correct beneficiary in their system. There are also circumstances where a contractor may receive a notification that does not appear to be updating the information that the contractor already has for the enrollee. Such notifications shall not be treated as errors by the contractor system and must be applied. The contractor is expected to acknowledge all notifications sent by DEERS. If DEERS does not receive an acknowledgement, the notification will continue to be sent until acknowledgement is received. The following information details examples of events that trigger DEERS to send notifications to a contractor.

### 1.4.1 Notifications Resulting From Enrollment Actions

DEERS sends notifications to the contractor detailing any enrollment update performed in the DOES or BWE application. This includes address updates made for enrollees. Additionally, DOES supports a feature for the contractor to request a notification to be sent without updating any address or enrollment information. The purpose of this request is to re-sync the contractor systems with the latest DEERS enrollment data.

Notifications sent as a result of enrollments, transfers, or PCM changes in BWE will indicate a pending status. The contractor shall apply all pending PNTs received, as well as reviewing and either confirming, rejecting or modifying the enrollment as needed. A second notification is sent when the action is confirmed in DOES. If the DOES operator modified the enrollment or PCM data, the second notification will contain the corrected data in a non-pending status.

During transfers in BWE, one non-pending disenrollment notification is sent to the losing contractor. There is no subsequent notification sent to the losing contractor when the enrollment

information is confirmed in DOES. If the transfer is cancelled before the gaining contractor approves it, the losing contractor will receive a cancellation of the disenrollment.

### 1.4.2 Unsolicited Notifications

Unsolicited notifications result from updates to a sponsor or family member's information made by an entity other than the enrolling contractor. Unsolicited notifications may result from various types of updates made in DEERS:

- Change to eligibility. As updates are made in DEERS that affect a beneficiary's entitlements to TRICARE benefits, DEERS modifies policy data based on those changes and sends notifications to the contractor and to CHCS, if appropriate. One example of this type of notification is notification of loss of eligibility.

- Extended Eligibility. For example, in the case of a 21-year old child that shows proof of being a full-time student, eligibility may be extended until the 23rd birthday.

- SSN, name, and date of birth changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or date of birth are communicated via unsolicited notification to the contractor.

- Address changes. The notification also includes information as to which type of entity made the update. Address changes performed by CHCS are also sent to the contractor.

- Data corrections made by the DMDC Support Office (DSO) or the DOES Help Desk. If a contractor requests the DSO to make a data correction for a current or future enrollment that the contractor cannot make themselves, notification detailing the update is sent to the contractor, and to CHCS, if appropriate.

- Automatic approvals of BWE actions. DEERS will send unsolicited notifications for all BWE actions approved without contractor action in DOES.

## 1.5 Patient ID Merge

Occasionally, incomplete or inaccurate person data is provided to DEERS and a single person may be temporarily assigned two patient IDs. When DEERS identifies this condition, DEERS makes this information available online for all contractors. The contractor is responsible for retrieving and applying this information on a weekly basis. The merge brings the data gathered under the two IDs under only one of the IDs and discards the other. Although DEERS retains both IDs for an indefinite period, from that point on only the one remaining ID shall be used by the contractor for that person and for subsequent interaction with DEERS and other MHS systems. If there are enrollments under both records being merged that overlap, the enrolling organizations are responsible for correcting the enrollments. The contractor shall also update the catastrophic cap that has been posted for these records if necessary. DEERS merges OHI by assigning the last updates of OHI active policies (not cancelled or systematically terminated) to the remaining Patient ID.

## 1.6 Enrollment Cards And Letter Production

The contractor is responsible for processing all mail returned for bad addresses and shall research the address, correct it on DEERS, and re-mail the correspondence to the beneficiary.

**1.6.1** DEERS is responsible for producing the TRICARE universal beneficiary card for both Continental United States (CONUS) and Outside the Continental United States (OCONUS). The cards are produced for beneficiaries enrolled in all TRICARE Prime programs or TRICARE Reserve Select. Enrollment cards are not produced for enrollments to USFHPs.

New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new region, unless the enrollment operator specifies in DOES not to send an enrollment card. A contractor may request a replacement enrollment card for an enrollee at any time. DEERS sends enrollment card request information in a notification to the contractor indicating the last date an enrollment card was generated for the enrollee.

**1.6.2** In addition to the enrollment card, DEERS sends a letter to the beneficiary indicating their PCM selection, if applicable. This letter is sent even if no card is generated. PCM change letters may be suppressed through both DOES and PCM Panel Reassignment (PCMRS).

DEERS also sends a letter to a beneficiary upon disenrollment. If the disenrollment is due to loss of eligibility for all MHS medical benefits, DEERS will send a Certificate of Creditable Coverage (CoCC) instead of the disenrollment letter. DEERS will send appropriate letters when the loss of eligibility is due to death of the beneficiary. The contractor shall not send additional letters that duplicate those already provided by DEERS.

## 1.7 Claims, Catastrophic Cap, And Deductible Data

DEERS is the system of record for eligibility and enrollment information. As such, in the process of claims adjudication, the contractor shall query DEERS to determine eligibility and/or enrollment status for a given period of time. The contractor shall use DEERS as the database of record for:

- Person Identification
- Eligibility
- Enrollment and PCM information
- Enrollment and FY to date totals for CC&D amounts
- Other Government Programs (OGP)

The contractor shall not override this data with information from other sources.

Although DEERS is not the database of record for address, it is a centralized repository that is reliant on numerous organizations to verify, update and add to at every opportunity. The address data received as part of the claims inquiry shall be used as part of the claims adjudication process. If the contractor has evidence of additional or more current address information they shall process claims using the additional or more current information and update DEERS within two business days.

Although DEERS is not the database of record for OHI, it is a centralized repository of OHI

information that is reliant on the MHS organizations to verify, update and add to at every opportunity. The OHI data received as part of the claims inquiry shall be used as part of the claims adjudication process. If the contractor has evidence of additional or more current OHI information they shall process claims using the additional or more current information. After the claims adjudication process is complete, the contractor shall send the updated or additional OHI information to DEERS within two business days.

DEERS stores enrollment and FY CC&D data in a central repository. DEERS stores the current and the four prior enrollment and FY CC&D totals. The purpose of the DEERS CCDD repository is to maintain and provide accurate CC&D amounts, making them universally accessible to DoD claims processors.

### 1.7.1 Data Events: Inquiries And Responses

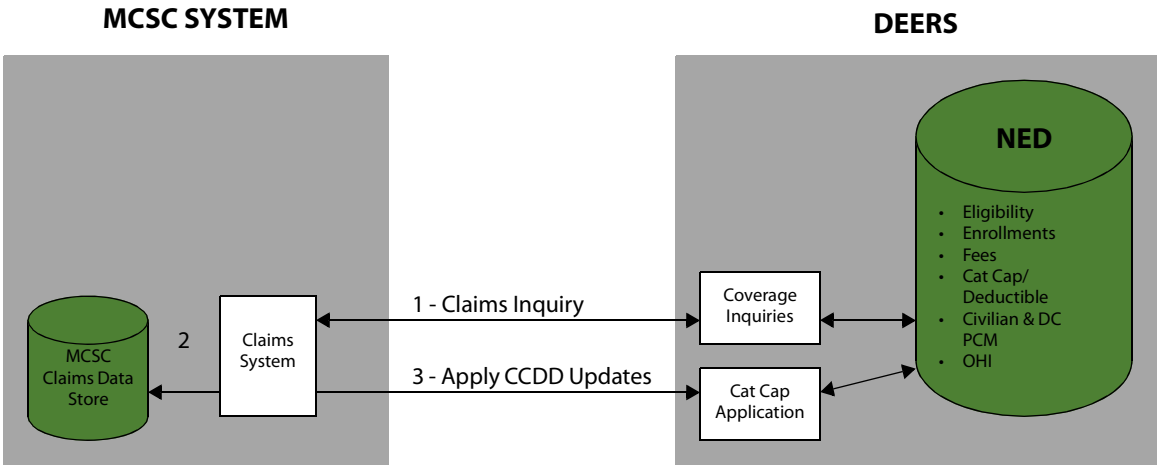
This section identifies the main events, including the inquiries and responses between the contractors and DEERS, associated with CCDD transactions. The main events to support processing this information include:

- HCC Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

#### 1.7.1.1 HCC Inquiry For Claims

The contractor shall install a prepayment eligibility verification system into its TRICARE operation that results in a query against DEERS for TRICARE claims and adjustments. The interface should be conducted early in the claims processing cycle to assure extensive development/claims review is not done on claims for ineligible beneficiaries. The DEERS HCC Inquiry for Claims supports business events associated with HCC and CCDD data for processing medical claims. This inquiry may also be used for general customer service requests or for referrals and authorizations.

**FIGURE 3.1.4-8 CLAIMS INQUIRY TO DEERS**



The contractor must use the eligibility, enrollment, OGPs (e.g., Medicare), and the PCM information returned on the DEERS response to process the claim. The contractor must use CCDD information either from this DEERS response or from a totals inquiry completed immediately prior to adjudication. The contractor may use address and OHI information from any source but must update DEERS with any differing information within two business days if the information is more current.

There are multiple options for inquiring about coverage information while including CCDD information. These different inquiry options allow the inquirer to receive coverage information and CCDD totals with or without locking the CCDD information for the family. A coverage inquiry and lock of the CCDD accumulations is necessary prior to updating this data on DEERS.

For audit and performance review purposes, the contractor is required to retain a copy of every transaction and response sent and received for claims adjudication procedures. This information is to be retained for the period required by the TRICARE Policy Manual (TPM) or TRICARE Operations Manual (TOM).

Unless authorized by the contracting officer, the contractor may not bypass the query/ response process. If either DEERS or the contractor is down for 24 hours or any other extended period of time the contractor shall work directly with DEERS and TMA to develop a mutually agreeable method and schedule for processing the backlog or implementing their disaster recovery processes.

#### 1.7.1.1.1 Exceptions To The DEERS Eligibility Query Process

Claims processing adjudication requires a query to DEERS except in cases where a claim contains only services that will be totally denied and no monies are to be applied to the CCDD. No query is needed for:

- Another claim or adjustment for the same beneficiary that is being processed at the same time.
- Negative Adjustments
- Total Cancellations

#### 1.7.1.1.2 Information Required For A HCC Inquiry For Claims

The information needed to perform this type of coverage inquiry includes:

- Person identification information, including person or family transaction type
- Begin and end dates for the inquiry period

#### 1.7.1.1.3 Person Identification

A beneficiary's information is accessed with the coverage inquiry using the identification information from the claim. DEERS performs the identification of the individual and returns the system identifiers (DEERS ID and Patient ID). The DEERS IDs shall be used for subsequent communications on this claim.

### 1.7.1.1.4 Inquiry Options: Person Or Family

The inquirer must specify if the coverage inquiry is for a person or the entire family. The person inquiry option should be used when specific person identification is known. If person information is incomplete, the family inquiry mode can be used. In family inquiries, the Inquiry Person Type Code is required to indicate if the SSN, Foreign ID, or Temporary ID is for the sponsor or family member. In such inquiries, DEERS returns both sponsor and family member information. If there is more than one person or family match, DEERS will return a partial match response. The contractor shall select the correct person and resend the coverage inquiry.

**FIGURE 3.1.4-9 INQUIRY PERSON TYPE CODE**

| PERSONS TO RETURN | WHAT INFORMATION IS AVAILABLE FROM THE CLAIM | VALUES TO SET | USAGE |
|---|---|---|---|
| RETURN ONLY A SINGLE SPONSOR/FAMILY MEMBER (PNF_TXN_TYP_CD = P) | SPONSOR INFORMATION IS PROVIDED (INQ_PN_TYPE_CD=S) | INQUIRY SPONSOR INFO SECTION:<br>SPN_INQ_PN_ID<br>SPN_INQ_PN_ID_TYP_CD<br>SPN_PN_LST_NM<br>SPN_PN _1ST_NM<br>SPN_PN-BRTH_DT<br><br>INQUIRY PERSON INFO SECTION:<br>INQ-PN_ID<br>INQ-PN_ID_TYP_CD<br>and/or<br>PN-LST-NM<br>PN-1ST_NM<br>PN_BRTH_DT | <br>R<br>R<br>O<br>O<br>O<br><br><br>S<br>S<br><br>NA<br>S<br>S |
| RETURN ONLY A SINGLE PERSON SINGLE SPONSOR/ FAMILY MEMBER (PNF_TXN_TYP_CD=P) | NO SPONSOR INFORMATION IS PROVIDED** (INQ_PN_TYP_CD=P) | INQUIRY SPONSOR INFO SECTION:<br><br>INQUIRY PERSON INFO SECTION:<br>INQ_PN_ID<br>INQ_PN_ID_TYP_CD<br>PN_LST_NM<br>PN_1ST_NM<br>PN_BRTH_DT | NA<br><br><br>R<br>R<br>O<br>O<br>O |
| RETURN THE WHOLE FAMILY (PNF_TXN_TYP_CD=F) | SPONSOR INFORMATION PROVIDED (INQ_PN_TYP_CD=S) | INQUIRY SPONSOR INFO SECTION:<br>SPN_INQ_PN_ID<br>SPN_NQ_PN_ID_TYP_CD<br>SPN_PN_LST_NM<br>SPN_PN_1ST_NM<br>SPN_PN_BRTH_DT<br><br>INQUIRY PERSON INFO SECTION: | <br>R<br>R<br>O<br>O<br>O<br><br>NA |

**LEGEND: R - Required; O - Optional; S - Situational**

**Note:** * The Inquiry Person information section on a family member inquiry must either have the INQ_PN_ID and INQ_PN_TYP_CD OR if none is available then at least a PN_1ST_NM and PN_BRTH_DT.

**The period of time required for this type of inquiry to DEERS is significantly longer than for a family member based inquiry using a sponsor and should be used only infrequently when NO sponsor PN_ID information is provided on the claim.

The HICN (H) is only valid in the Person Inquiry section, not in the sponsor section and only on PERSON pulls (leave sponsor section blank).

#### 1.7.1.1.5 Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may either be a single day or can span multiple days. Historical dates are valid, as long as the requested dates are within five years. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period. For claims, the contractor shall use the dates of service on the claim.

#### 1.7.1.1.6 Lock indicator

The contractor chooses whether to lock Catastrophic Cap Deductible (CCD) totals. If the contractor intends to update the CCD amounts, the contractor must lock the totals.

### 1.7.1.2 Information Returned In The HCC Inquiry For Claims

The DEERS ID is returned in response to a coverage inquiry. The contractor shall store the DEERS ID for use in subsequent CCD update transactions for this claim. In addition, the Patient ID is returned in the coverage response. The contractor shall store the Patient ID. The contractor must put the Patient ID and DEERS ID on the TRICARE Encounter Data (TED) record.

When implementing applications that use system to system interfaces that return partial matches (such as claims), those applications must allow the operator to view and select the correct individual, as described above. The partial match response is designed to provide unique identifiers (Patient ID or DEERS ID) that can ensure that subsequent processing will uniquely identify the correct individual or beneficiary.

#### 1.7.1.2.1 Data Returned In A Coverage Inquiry That Repeats For Every Coverage Plan

In response to a HCC Inquiry for Claims, DEERS returns the specified coverage information in effect for the inquiry period. The following list shows the information DEERS returns for each coverage plan in effect during the inquiry period:

- Coverage plan information (assigned or enrolled)
- Coverage plan begin and end dates within the inquiry period
- Sponsor branch of service and family member category and relationship to the sponsor during coverage period

**Note:** Newborn coverage information will only be reflected after the newborn is added to DEERS. See TOM, Chapter 3.

#### 1.7.1.2.2 Data Returned In A Coverage Inquiry Independently From The Coverage Plan Information

The DEERS coverage response will always return:

- Sponsor Personnel Information: All current personnel segments will be returned, including dual eligible segments. The contractor shall not use this information for

claims processing. This information is intended to be used for the TED only.

- Person information including the mailing address.

- The residential zip code will be returned for jurisdiction purposes.

- CCDD totals: Both family and individual CCDD accumulations are provided in the coverage response.

- Lock Indicator: The status of the lock on CCDD totals is returned on the coverage response.

The DEERS coverage response may include the following information. If nothing is returned, this means that DEERS does not have this information for the requested inquiry dates.

- Primary care manager information: PCM information is returned for some enrolled coverage plans. No PCM information is present for the DoD assigned coverage plans and some enrolled coverage plans. PCM information provided includes DMIS, the PCM Network Provider Type Code, and individual PCM information if available in DEERS.

- OHI: Limited OHI information is returned.

- OGPs: Complete OGP information is provided in the response.

#### 1.7.1.2.3 HCC Copayment Factor For Coverage Inquiries

The HCC Copayment Factor Code for a beneficiary is determined by DEERS and is returned on a claims inquiry, but may be influenced by treatment information from a claim. The contractor shall use this factor code to determine the actual copayment for the claim.

The different factors are determined by legislation, which considers factors such as pay grade and personnel category, such as retired sponsor or active duty. Although the rates are based on the population to which they pertain, such as retired sponsor, these rates also apply to a sponsor's family members. Examples of copayment factors are:

- Pay Grade Corporal/Sergeant or Petty Officer Third Class and below rate
- Pay Grade Sergeant/Staff Sergeant or Petty Officer Second Class and above rate
- Retiree and Surviving family members of deceased active duty sponsors rate
- Foreign Military rate

The contractor's system should be flexible enough to permit additional rate codes to be added, as required by the DoD.

#### 1.7.1.2.4 Special Entitlements

Congressional legislation may affect deductibles and rates. The Special Entitlement Code and dates if applicable provide information to support this legislation. Effective dates will also be included in the response from DEERS. Note that a person may have multiple special

entitlements.

Examples are:

- Special entitlement for participation in Operation Joint Endeavor. This code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the special entitlement section of the data returned.

- Special entitlement for participation in Operation Noble Eagle. This code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the special entitlement section of the data returned. In addition, non-participating physicians will be paid up to 115% of the CHAMPUS Maximum Allowable Charge (CMAC) or billed charges whichever is less.

#### 1.7.1.3 Multiple Responses To A Single HCC Inquiry for Claims

DEERS may need to send multiple responses to a single HCC Inquiry for Claims if a person has multiple DEERS IDs within the inquiry period. It is necessary for DEERS to capture family member entitlements and benefit coverage corresponding to each instance of the person's DEERS ID. For example, in a joint service marriage, a child may be covered by the mother from January through May (DEERS ID #1) and covered by the father from June through December (DEERS ID #2). These responses are returned in a single transaction. (Note: multiple responses are returned only when an individual inquiry is submitted.) Family inquiries will not produce multiple responses. Upon receiving a multiple response, the contractor shall select the correct beneficiary and resubmit a properly configured claims inquiry.

Contractors shall deny a claim (either totally or partially) if the services were received partially or entirely outside any period of eligibility.

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's date of birth. If the date of birth is within 365 days of the date of the query (i.e., a newborn less than I year old), the contractor shall release the claim for normal processing.

CHAMPVA claims shall be forwarded to Health Administration Center, CHAMPVA Program, PO Box 65024, Denver CO 80206-5024.

A list of key DSO personnel and the Joint Uniformed Services Personnel Advisory Committee (JUSPAC) and the Joint Uniformed Services Medical Advisory Committee (JUSMAC) Members is provided at the TMA web site at http://www.tricare.osd.mil. These individuals are designated by the TMA to assist DoD beneficiaries on issues regarding claims payments. In extreme cases the DSO may direct the claims processor to override the DEERS information; however, in most cases the DSO is able to correct the database to allow the claim to be reprocessed appropriately. The procedure the contractor shall use to request data corrections is in Section 1.5.

Any overrides issued by the DSO will be in writing detailing the information needed to process the claim. Overrides cannot be processed verbally, and overrides are not allowed in cases

where correction of the data is the appropriate action. Only in cases of aged data that can not be corrected will DSO authorize an override. The contractor will provide designated Point Of Contact (POC) for the DSO personnel and the JUSPAC/JUSMAC members identified on the TMA web site.

#### 1.7.1.4 CCDD Totals Inquiry

The CCDD Totals Inquiry is used to obtain CCDD balances for the year(s) that correspond to the requested inquiry period. The contractor must inquire and lock CCDD totals before updating DEERS CCDD amounts.

**Note:** A catastrophic cap record is not required for persons who are authorized benefits but are not on DEERS or eligible for medical benefits, such as prisoners or government employees. The purpose of the catastrophic cap is to benefit those beneficiaries who are eligible for MHS benefits. Those persons that are authorized benefits who would not under any other circumstances be eligible, are not subject to catastrophic cap requirements.

##### 1.7.1.4.1 Information Required To Inquire For Totals

The following information details the data required to inquire for CCDD totals.

###### 1.7.1.4.1.1 Person Information

The contractor must use the DEERS ID for the beneficiary whose claim is being processed for this inquiry. The DEERS ID is returned by DEERS on the policy notification or coverage response. Even though only one person's DEERS ID is used, both individual and family totals will be returned in the response.

###### 1.7.1.4.1.2 CCDD Totals Inquiry Period

The inquiry period used for the CCDD Totals Inquiry may be a single date or a date range, not more than five years in the past (current FY and four prior FYs). Future dates are not valid.

###### 1.7.1.4.1.3 Lock Indicator

If the contractor intends to update the CCDD amounts, the contractor must lock the CCDD totals.

##### 1.7.1.4.2 Response To CCDD Totals Inquiry

The following information details the information returned from a CCDD totals and inquiry.

###### 1.7.1.4.2.1 CCDD Totals

DEERS sends a response showing year-to-date CCDD totals for each FY, based on the inquiry dates requested. Dates must be within the current FY or four prior FYs. Both individual and family totals are displayed. If there are no CCDD totals accumulated for any FY in the inquiry period requested, DEERS will show a zero value for that fiscal year.

If the inquiry period spans multiple FYs, the CCDD totals would repeat multiple times. For example, if the inquiry dates are September 1, 2007 through October 25, 2007, there would be two sets of CCDD totals, one for FY 2007 and one for FY 2008.

#### 1.7.1.4.2.2 Lock Information

- If a contractor inquires for CCDD totals and does not request a lock on the totals, DEERS returns any totals accumulated for the inquiry period and any lock information if the totals were already locked.

- If a contractor inquires for totals with a request to lock and the totals were not already locked, DEERS would return the accumulated totals and the lock information, including the locking organization, the lock date, and the lock time.

- If an contractor inquires and requests a lock for a beneficiary whose totals are already locked, only the locking organization, the lock date, and the lock time will be returned. No totals will be returned in this situation.

### 1.7.1.5 Updating CCDD Amounts

The CCDD total can be updated online for the current and four prior FYs. This update transaction requires the DEERS ID, which may be obtained from a coverage or CCDD totals inquiry. Only the same organization that placed the lock may update the locked record and remove the lock. DEERS validates that the updating organization is the same as the organization that placed the lock. If there is a discrepancy, DEERS does not allow the update and sends a response that the update was not successful. If there are more claims outstanding for the same family, the contractor may choose not to remove the lock. In this case, the record would remain locked until the 48-hour time period expires, or the lock is removed, whichever comes first.

Each transaction should only include updates for one claim. CCDD amounts for multiple claims should be sent in separate transactions. In the split claim situation, multiple transactions must be sent for the same claim. For example, if a claim spans FYs and is split, updates for FY 2000 and FY 2001 must be sent in two transactions using the claim extension identifier to distinguish the two updates from one another. If a claim does not span multiple fiscal or enrollment years, the claim extension identifier should be set to '000'. Split claims will use a unique claim extension identifier for each FY in which the claim occurs.

If cost-shares, copays or deductibles are collected, these amounts must be posted to CCDD, even if the catastrophic cap has been met. If cost-shares, copays or deductibles were reduced or waived based on the CCDD totals returned, those amounts shall also be posted to DEERS even if the catastrophic cap has been met. If the catastrophic cap is exceeded, the contractor shall refund the overage to the beneficiary.

Do not send CCDD updates for programs for which they do not apply (e.g., Extended Care Health Option (ECHO)). See the TPM.

#### 1.7.1.5.1 Information Required To Update CCDD Amounts

The contractor must provide the following information to update the CCDD amounts:

- DEERS ID: This identifies the beneficiary for whom the update is applied.
- Catastrophic cap, deductible, and/or point of service dollar amount. The contractor sends DEERS the CCDD amount for the beneficiary. DEERS knows to which family the beneficiary belongs and rolls up the totals for the correct family using the DEERS ID.
- Identifier for the claim, enrollment fee, or adjustment.

**Note:** If there is a discrepancy between the identifier used for locking and the identifier used for updating, DEERS does not allow the update.

- Claim extension identifier. When a claim spans FYs, the claim extension is used to identify a split claim. These claims should have the same claim identifier with a different claim extension identifier. Splitting the claim is the responsibility of the claims processor, who splits the claim, adds the claim extension, and sends this information to DEERS.
- Lock information (remove or do not remove lock).
- Dates provided for the catastrophic cap and/or deductible update. The dates shall include the date(s) of service for the claim (both begin and end date). These dates are necessary for accumulating the CCDD totals for the correct time period and HCDP.

#### 1.7.1.5.2 Types Of CCDD Updates

DEERS supports CCDD update functionality including adding, adjusting, and canceling amounts. Adds, adjustments, and cancellations may be made for the current and previous four FYs.

##### 1.7.1.5.2.1 Adds

The contractor utilizes the CCDD update to add new CCDD amounts to the DEERS CCDD repository.

##### 1.7.1.5.2.2 Adjustments

The contractor utilizes the CCDD update to adjust posted CCDD amounts. The same claim identifier as the original claim must be provided for the adjustment. The appropriate negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, a contractor must provide the same information for updating a claim as outlined in the previous section. For example, a contractor updates a claim with a $50 catastrophic cap amount, then two weeks later discovers that the claim was incorrectly adjudicated and the catastrophic cap amount should have been $35. The contractor would then update the beneficiary's catastrophic cap for the

same claim number with an amount of -$15. The DEERS catastrophic cap balance would then show $35 for that claim. To cancel a catastrophic cap amount, adjust the claims to zero out the previous amount applied for that claim.

#### 1.7.1.5.2.3 The 48-Hour Rule

If a contractor places a lock on a record and fails to update that record within the specified 48-hour time period, the contractor will be unable to update CCDD amounts, because the lock will have expired. To remove a lock, a contractor shall perform a CCDD update specifying to remove the lock. In this case, the contractor would send no catastrophic cap or deductible amounts, only an indication of the removal of the lock.

#### 1.7.1.5.2.4 Add Newborn

CCDD amounts for a newborn are posted to DEERS by using the CCDD update transaction and setting the Newborn Addition Indicator Code to 'Y'. The 'Y' code indicates that a newborn placeholder is to be added. If DEERS returns an error code on a newborn add indicating that the person is already on the database, the contractor shall query to determine if this is actually the same person. If so, then the contractor shall use the returned information to apply the CCDD to the existing record. Contractors shall not create duplicate newborn placeholders within the same family; special care should be taken when the newborn may have multiple sponsors. (E.g, the child of two active duty sponsors should be tracked only under one of the two sponsors if at all possible.)

The CCDD update transaction shall include both the newborn information and the CCDD amounts. After the newborn has been added to DEERS, the CCDD update will be posted to the database (provided that the family record is not locked). In the event that the CCDD update was unable to be posted, it is the contractor's responsibility to query DEERS to verify that the newborn has been created. The contractor is then to resend the CCDD update transaction, setting the Newborn Addition Indicator Code to 'N'.

Adding the newborn in DEERS via CCDD updates will not generate eligibility for the newborn, but the newborn will show in GIQD and in claims responses. Once the sponsor "adds" the newborn in DEERS through the Real-Time Automated Personnel Identification System (RAPIDS), the newborn will be eligible like any other beneficiary.

### 1.7.2 CCDD Transaction History Request

CCDD transaction history information is useful for customer service requests, for auditing purposes, or for researching any problems associated with CCDD updates in relation to a particular claim. DEERS maintains a record of each update transaction applied toward CCDD information. This detailed transaction information is available through the CCDD web application.

## 1.8 SIT Program

The SIT program supports the MHS billing and collection process. The SIT is validated by the TMA Uniform Business Office (UBO) through the DoD Verification Point of Contact (VPOC). The VPOC is ultimately responsible for maintaining the SIT in DEERS, which is the system of record for SIT information. The SIT provides uniform billing information for reimbursement of medical care costs covered through commercial policies held by the DoD beneficiary population. MHS

personnel use the SIT to obtain other payer information in a standardized format.

The Health Insurance Carrier (HIC) Identifier (ID) is the unique identifier for a carrier. Once a standard national health plan identifier is adopted by the Secretary, Health and Human Services (HHS), DEERS and MHS trading partners will migrate to that identifier.

All systems identified as trading partners will request an initial full SIT subscription from DEERS. See the Technical Specification, "Health Insurance Carrier/Other Health Insurance" for subscription procedures. In addition, holders of the SIT shall subscribe to DEERS at least daily in order to receive subsequent updates of the SIT.

Field users perform five actions with the SIT:

- Inquiry actions can be performed on the OHI/SIT web application or through the local SIT file.
- An add action to report a new SIT entry for validation by the DoD VPOC.
- An update action to report an updated SIT entry for validation by the DoD VPOC.
- The cancellation of a carrier add sent to the SIT for verification by the DoD VPOC.

**Note:** Only the organization requesting a carrier to be added can cancel the request.

- A request to deactivate a verified HIC previously sent to the SIT for verification by the DoD VPOC.

### 1.8.1 SIT Inquiry

Local holders of the SIT cannot perform system-to-system inquiries against the central SIT maintained on DEERS.

### 1.8.2 SIT Add

When MHS personnel add a complete OHI record to a person or patient, they will need the HIC ID from the SIT. The HIC ID represents the identifier assigned to insurance carriers in the SIT provided by DEERS. The HIC ID Status Code identifies the ID as standard or temporary. See the "Technical Specifications for the HIC SIT and the OHI" for detailed information about the data elements required for the SIT add process.

When a HIC is not on the SIT, the user may send a request to add it to the SIT on DEERS. DEERS responds with a HIC ID, a HIC Status Code with the designation of "temporary," and a HIC Verification Status Code of "unverified". Unverified carriers are made available to all local holders of the SIT through the daily subscription process to prevent duplicate requests requiring VPOC validation. OHI may be assigned to unverified carriers. When the DoD VPOC validates the SIT, the HIC Verification Status Code will be changed from "unverified" to "verified."

### 1.8.3 SIT Update

For updates to an existing SIT record, the existing HIC ID must be sent with the update. These updates are sent to all subscribers though the daily subscription process. Rejection of SIT updates by the DoD VPOC is reported to all local holders of the SIT. DEERS does not allow an update to a HIC when the HIC has a Verification Status Code of "unverified."

### 1.8.4 SIT Add Cancellation

The MHS personnel may need to cancel a previously submitted "add" to the SIT. A cancel can only be done by the system that submitted the "add" and only if the "add" has not yet been verified by the DoD VPOC. DEERS cancels any OHI policy on the DEERS database associated with the cancelled "unverified" HIC. After the "add" request is cancelled, DEERS will provide the cancellations to all local holders of the SIT through the daily subscription process.

### 1.8.5 Validation Of HIC Information

Validation of a SIT update includes verifying the name, mailing address, and telephone number information for the HIC. In addition, the DoD VPOC assigns the HIC Status Code of "Standard" to validated HICs. If the DoD VPOC determines that the requested update is not correct, the DoD VPOC assigns a HIC Status Code of "rejected". Rejected updates are returned to all local holders of the SIT.

If a SIT "add" or "update" request is rejected by the DoD VPOC, DEERS cancels any OHI policy on the DEERS database associated with the rejected HIC. All SIT additions and updates that are validated by the DoD VPOC are made available to all systems identified to DEERS as authorized holders of a local copy of the SIT.

### 1.8.6 Deactivation of a HIC

MHS organizations can request the DoD VPOC to deactivate any HIC on the SIT. DEERS does not allow a deactivation of a HIC with a HIC Status Code of "temporary" and/or a HIC Verification Status Code of "unverified", until validated by the DoD VPOC. DEERS deactivates any OHI policy on the DEERS database associated with the deactivated HIC. DEERS reports the deactivation of the HIC to all local holders of the SIT.

## 1.9 OHI

OHI identifies non-DoD health insurance held by a beneficiary. The requirements for OHI are validated by the TMA Uniform Business Office (UBO). OHI information includes:

- OHI policy and carrier
- Policyholder
- Type of coverage provided by the additional insurance policy
- Employer information offering coverage, if applicable
- Effective period of the policy

OHI transactions allow adding, updating, canceling, or viewing all OHI policy information. OHI policy updates can accompany enrollments or be performed alone. OHI information can be

added to DEERS or updated on DEERS through multiple mechanisms. At the time of enrollment the contractor will determine the existence of OHI. The contractor can add or update minimal OHI data through the DOES application used by the contractor to enter enrollments into DEERS. In addition, DEERS will accept OHI updates from a claims processor through a system to system interface. Other MHS systems can add or update the OHI through the OHI/SIT Web application provided by DEERS. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information.

The minimum information necessary to add OHI to a person record is:

- Policy Identifier (policy number)
- OHI Effective Date
- HIPAA Insurance Type Code
- HIPAA Person Association Code
- Claim Filing Code
- OHI Coverage Type Code
- OHI Coverage Payer Type Code
- OHI Coverage Effective Date
- OHI Policy Coverage Precedence Code
- HIC Name or HIC ID
- Health Insurance Coverage Type Code
- Health Insurance Payer Type Code

**Note:** There are additional data elements necessary if the policy being added is a Group Employee policy.

If only the minimum required data is entered by the contractor, the contractor is required to fully develop the remaining OHI data necessary to complete the OHI record within 15 business days. Detailed requirements for the exchange of OHI information are contained in the "Technical Specifications for the Health Insurance Carriers Standard Insurance Table (SIT) and the Other Health Insurance (OHI) Carriers." HIC information is validated against the SIT which maintains the valid insurance carrier information on DEERS.

DEERS requires the contractor to perform an OHI Inquiry before attempting to add or update an OHI policy. The MHS organizations are reliant on the individual beneficiary to provide accurate OHI information and DEERS is reliant on the MHS organizations for the accurate assignment of policy information to the individual record. DEERS is not the system of record for OHI information. Performing an OHI Inquiry on a person before adding or attempting to update an OHI policy helps ensure that the proper policy is updated based on the most current information or the person.

Examples of OHI coverages are:

- Comprehensive Medical coverage (Plans with multiple coverage types)
- Medical coverage
- Inpatient coverage
- Outpatient coverage
- Pharmacy coverage
- Dental coverage
- Long-term care coverage

- Mental health coverage
- Vision coverage
- Partial hospitalization coverage
- Skilled nursing care coverage

The default coverage will be Comprehensive Medical Coverage unless another of the above coverages is selected. The indication of Comprehensive Medical Coverage presumes medical coverage, inpatient coverage, outpatient coverage, and pharmacy coverage. The MCSC must develop the OHI within 15 days but is not responsible for development of pharmacy. The pharmacy contractor is expected to develop pharmacy OHI.

In addition, each OHI policy carries a code indicating whether the policy is active, inactive, or deactivated. The deactivation of an OHI policy only occurs when the DoD VPOC at TMA deactivates the HIC on the SIT. DEERS retains OHI policy data for five years after an OHI policy expires or is deactivated or terminated.

### 1.9.1 OHI Policy Inquiry

#### 1.9.1.1 Person Identification For OHI Policy Inquiry

OHI information is requested using the Patient ID, which is person-level identification. Person identification is used for the sponsor or family member. If the Patient ID is unknown, a coverage inquiry to DEERS can be performed to obtain it.

#### 1.9.1.2 OHI Person Inquiry

The OHI data is by person. A system-to-system OHI inquiry is only for individual person requests. The OHI/SIT web application allows a family OHI inquiry. DEERS allows multiple OHI policies for each person. DEERS does not support an inquiry that shows all insured persons in a particular policy.

#### 1.9.1.3 OHI Information

In addition, queries may be filtered by the HIC ID or the HIC Name, the OHI Policy ID or the OHI Coverage Type Code.

The HIC ID represents the identifier assigned to insurance carriers in the SIT provided by the DoD VPOC to DEERS. A requester can seek information on a specific coverage for a beneficiary by using the OHI Coverage Type Code in the OHI inquiry sent to DEERS, or for a specific insurance carrier by using the HIC Name. If a requestor is unsure about a specific OHI Policy, a time period should be specified for the inquiry to return the OHI Policy information in effect.

#### 1.9.1.4 Information Returned In The OHI Inquiry Response

The DEERS response returns all OHI policies in effect during the specified time period for the beneficiary. OHI policies that are inactive or deactivated are returned if the OHI policies were in effect for any portion of the OHI inquiry period. If a specific coverage type is selected in the inquiry, only policies having that coverage type are included in the DEERS response.

The OHI/SIT web application will return OHI for a requested beneficiary or a sponsor and family. OHI is displayed one person at a time. If DEERS cannot find OHI information, DEERS does not return any OHI policies for the requested OHI inquiry period. When the Patient ID is included in the OHI inquiry, the Patient ID is returned in the response.

### 1.9.2 OHI Policy Add

DEERS allows the MHS and contractor systems to add an OHI policy for a person when information is presented to them. An OHI Inquiry should be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Inquiry, the OHI data can be added as necessary. OHI data can be added during an enrollment via the DOES application. OHI can be updated any time after enrollment through the web application provided by DEERS, or through the system to system interface. The presence of an OHI Policy discovered during routine claims processing shall be entered on DEERS within two business days. Within 15 business days, the contractor shall provide all OHI data not initially entered.

The fields required to add an OHI policy for a person are:

- Patient ID
- HIC ID
- OHI Policy ID
- OHI Effective Calendar Date
- HIPAA Insurance Type Code
- HIPAA Person Association Code
- OHI Claims Filing Code
- OHI Policy Coverage Effective Date
- OHI Policy Coverage Precedence Code
- HIC Coverage Type Code
- HIC Coverage Payer Type Code
- OHI Coverage Type Code
- OHI Carrier Coverage Payer Type Code

When the MHS organization enters the HIC ID DEERS will check it against the SIT for validation of the HIC information. If the HIC ID is not on the SIT, the MHS organization may add a new HIC and Coverage. If the insurance carrier is not known, the MHS organization shall use the carrier "Placeholder HIC ID", which is the placeholder entry on the SIT. The HIC "Placeholder HIC ID" has an assigned HIC ID of "UNKVA0001" with a coverage type of "XM". For "Placeholder HIC ID" OHI policies, the default coverage indicator is "comprehensive medical"; however, any coverage indicator can be assigned to it. The single placeholder OHI policy can be used to indicate that an OHI policy exists for a beneficiary. The enrolling entity or updating system is responsible for obtaining the complete OHI information and updating the placeholder OHI policy in DEERS within 15 business days.

Pharmacy placeholder policies will be developed by the pharmacy contractor, regardless of which organization created the placeholder. All other placeholder policies will be developed by the contractor, regardless of which organization created the placeholder. MHS organizations will not normally enter placeholder policies but would develop them if they created them.

A person can have multiple types of OHI coverage for one policy. For example, to add an

OHI policy that covers medical and vision, two OHI coverage types, one for medical coverage and one for vision coverage, would be sent to DEERS.

A person can have multiple OHI policies. Multiple OHI policies may have the same or different HICs, and/or the same or different OHI policy effective periods.

The HIC ID, OHI Policy ID, and OHI Effective Date cannot be updated once an OHI policy has been added to DEERS. These attributes, along with the person identification, uniquely associate an OHI Policy to a person. All messages sent to DEERS are acknowledged as either accepted or rejected.

### 1.9.3 OHI Policy Update

DEERS allows the MHS systems to update existing OHI policy and coverage information for a person when policy change information is presented. Policy and coverage updates include modifications to existing policy and coverage information. Updates can also be used to terminate an existing policy or coverage, that is when the policy or coverage no longer applies to the person. An OHI Inquiry must be done prior to updating an OHI policy. Following the OHI Inquiry, the OHI data can be updated as necessary.

If OHI is identified during routine claims processing or other contract activities, the contractor shall send the OHI information to DEERS within two business days.

### 1.9.4 OHI Policy Cancellation

Cancellation of an OHI policy is used to remove a policy that was erroneously associated to a person. The OHI Policy Cancellation is not used to terminate an existing policy (see OHI Policy Update above). An OHI policy cancellation completely removes the policy. DEERS verifies that the cancellation is performed by the entity that added or last updated the OHI policy.

**Note:** Terminations do not remove the policy from a person's record.

When canceling an OHI policy, an OHI Policy Inquiry must be done to verify the information necessary to perform a cancellation. Canceling an OHI policy requires the following data elements:

- Patient ID
- HIC ID
- OHI Policy ID
- OHI Effective Calendar Date
- OHI Expiration Calendar Date
- OHI End Reason Code

## 1.10 Medicare Data

DEERS performs a match with the Centers for Medicare and Medicaid Services (CMS) to obtain Medicare data and incorporates the Medicare data into the DEERS database as OGPs entitlement information. This information includes Medicare Parts A, B, C, and D eligibility along with the effective dates. The match includes all potential Medicare-eligible beneficiaries.

DEERS sends Medicare Parts A and B information to the TDEFIC. The TDEFIC sends the information to the CMS Fiscal Intermediaries for identification of Medicare eligibles during claims adjudication.

- END -