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TRICARE
MANAGEMENT ACTIVITY

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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 7950.1-M, reissued August 2002.

CHANGE TITLE: DEERS UPDATE (PHASE II)

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change consists of changes to update the TRICARE System Manual (TSM) to reflect current processes being followed by TRICARE contractors. Chapter 1, Section 1.1 modified to address contractor participation in system integration, implementation, and testing meetings. Chapter 3 updated program description and background information; referenced documents; concepts and definitions; the interface overview; DEERS functions specific to beneficiary web enrollment; policy consolidation; proration offices and catastrophic cap required by abbreviated policy periods; newborn placeholders; point of sale pharmacy inquiries; OHI business rules; and DMDC Support, Production, and Test Environment information.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Evie Lammler
Director, Program Requirements Division

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.1., paragraph 1.4. Added information specific to data correction activities.
2. Section 1.1., paragraph 2.0. Added information specific to System Integration, Implementation and Testing Meetings with contractor and Government representatives.

CHAPTER 3

3. Section 1.1., paragraph 2.1. Added language clarifying DEERS is the definitive data source for identification and verification of DoD affiliation.
4. Section 1.1., paragraph 2.2. Modified language to indicate DMDC and not the DEERS Rapids Program Office maintains contact with DEERS users through the JUSPAC, JUSMAC and JUSDAC.
5. Section 1.1., paragraph 2.3., page 7. Updated language to indicate the TRICARE Mail Order Pharmacy Program succeeded NMOP in the fall of 2003.
6. Section 1.1., paragraph 2.3., page 8. Updated language specific to DoD Smart Card technology.
7. Section 1.1., paragraph 2.3., page 9. Added language specific to the Personnel Identity Protection Program and implementation of the Final Policy Consolidation of enrollments for portability.
8. Section 1.2., paragraph 1.0. Added reference to DoDD 1000.25, "DoD Personnel Identity Protection (PIP) Program," dated July 19, 2004.
9. Section 1.2., paragraph 2.0. Added, "Beneficiary Web Enrollment (BWE) Enrollment Fee Gateway" specification to listing of Technical Specifications and removed reference to National Enrollment Database DOES Training document from listing.
10. Section 1.2., paragraph 3.0. Changed link to indicate a secure server must be utilized to access the DMDC web site.
11. Section 1.3., paragraph 2.1.1. Added language to clarify that an internal identifier is considered to be the "Patient ID" and/or "DEERS ID".

SUMMARY OF CHANGES (Continued)

CHAPTER 3 (Continued)

12. Section 1.3., paragraph 2.3.1. Added information indicating that DEERS does not track "fee exceptions" in the Enrollment fee accumulation and fee details.
13. Section 1.3., paragraph 3.2. Added information clarifying that distinct member category codes have been added to identify member status.
14. Section 1.3., paragraph 3.4. Added "Also known as the DoD EDI Person Identifier" to further clarify the patient identifier.
15. Section 1.3., paragraph, 6.1.2.6. Added clarifying language to identify USFHP use of Provider Type Option Codes and TRICARE Prime Coverage Plan Codes enrollments in accordance with information already provided in TSM, Chapter 3, Addendum C.
16. Section 1.3., paragraph 6.2. Corrected definition of GIQD from "Government Inquiry of DEERS" to "General Inquiry of DEERS."
17. Section 1.3., paragraph 7.6, Figure 3-1.3-2. Modified business events for OHI Inquiry, OHI Policy Add/Update and OHI Cancellation to indicate these events would also be applicable to Family enrollments.
18. Section 1.4., paragraph 2.1. Added "Department of Veterans Affairs" and "TRICARE Dual Eligible Fiscal Intermediary Contractor" to listing of communities DEERS interfaces with.
19. Section 1.4., paragraph 2.2. Added language clarifying the "Security Application" is specific to "Site Security" and added the listing of the SIT Verification to the Government Furnished Equipment applications list.
20. Section 1.4., paragraph 2.2.4. Added language to clarify the use of the OHI Maintenance Application and added the description of the SIT Verification Application.
21. Section 1.4., paragraph 2.2.6., Figure 3-1.4-1. Updated "Sending and Receiving Nodes" to include PDTS as appropriate. Also added Business Events for Point of Sale Inquiry; Point of Sale Response; Person Demographics Service Inquiry; Person Demographic Service Response and SIT Add/Update/Cancellation/Deactivation.

SUMMARY OF CHANGES (Continued)

CHAPTER 3 (Continued)

22. Section 1.4., paragraph 2.3. Removed reference to "Patient repository"; modified "OHI/SIT repository" to "OHI repository" and added "SIT database."
23. Section 1.4., paragraph 2.4. Corrected reference to "Privacy Act Information" from "Privacy level information".
24. Section 1.5., paragraph 1.1. Added language clarifying need for applications to allow operators to view and select correct individual when using partial match information.
25. Section 1.5., paragraph 1.2.1. Changed "enrollment fee history transaction" to identify the application used to view detailed information for a specified policy, "Fee/CCDD History application".
26. Section 1.5., paragraph 1.2.2. Added "Confirm Enrollment/PCM change (to support beneficiary web enrollment" to the listing of contractor performed enrollment functions through DOES.
27. Section 1.5., paragraph 1.2.3. Updated language specific to the Beneficiary Web Enrollment application, the enrollment events that may be accomplished through the application and the reference to the BWE Enrollment Fee Gateway Technical Specification. Also modified the requirement for contractor review of enrollments from four calendar days to six calendar days. Removed language specific to the provision of a daily report of web based pending enrollment by DEERS.
28. Section 1.5., paragraph 1.2.5. Added language clarifying that policies created by DEERS encompass all enrollments for a family and health care delivery plan. Also modified references from individual "plans" to "policies".
29. Section 1.5., paragraph 1.2.5.1.3. Updated language specific to the proration of enrollment fees required due to abbreviated policies.
30. Section 1.5., paragraph 1.2.5.1.4. Added clarifying language specific to the proration of the cat cap credit and removed transition language specific to the alignment of the enrollment year to the fiscal year.
31. Section 1.5., paragraph 1.2.5.2. Removed referenced to USFHP provider systems as the DEERS centralized PCM file contains MCSC civilian and Direct Care PCMs, not USFHP providers.

SUMMARY OF CHANGES (Continued)

CHAPTER 3 (Continued)

32. Section 1.5., paragraph 1.2.5.3. Added “and BWE”.
33. Section 1.5., paragraph 1.2.5.4. Added reference to BWE application to indicate PCM assignments can also be requested via that application.
34. Section 1.5., paragraph 1.2.5.5. Removed reference to PCM Batch Reassignment Access through TRICARE On Line.
35. Section 1.5., paragraph 1.2.7.3. Removed information specific to Direct Care PCM Panel Reassignment via the TRICARE On Line.
36. Section 1.5., paragraph 1.2.8.1. Added clarifying language that enrollment fee overpayments must be reported to DEERS and information specific to the posting of fee payments and adjustments through DOES or the Enrollment Fee Payment interface.
37. Section 1.5., paragraph 1.2.8.2. Removed language specific to split enrollments and enrollment fee payments since this information is obsolete due to the implementation of the Final Policy Consolidation of enrollments.
38. Section 1.5., paragraph 1.2.8.3. Added statement clarifying that DEERS will automatically apply any fees to beneficiary’s catastrophic cap when posted through DOES or Enrollment Fee Payment interface.
39. Section 1.5., paragraph 1.2.10. Removed reference to “Split Enrollment and Enrollment Fee Payments”.
40. Section 1.5., paragraph 1.2.11. Added information on “Beneficiary Web Enrollment Confirmation” actions by MCSCs or DPs.
41. Section 1.5., paragraph 1.4.1. Added language specific to “Notifications” received as a result of Beneficiary Web Enrollment actions.
42. Section 1.5., paragraph 1.4.3. Added information on the merging of OHI information by DEERS.
43. Section 1.5., paragraph 1.6. Modified reference to DEERS as a “centralized database” to a “centralized repository”.

SUMMARY OF CHANGES (Continued)

CHAPTER 3 (Continued)

44. Section 1.5., paragraph 1.6.1.1.3. Added reference to TSM, Chapter 3, Section 1.3, for more information on the identification of beneficiaries.
45. Section 1.5., paragraph 1.6.1.2.1. Added Note indicating newborn coverage information will only be reflected upon addition of the newborn to DEERS.
46. Section 1.5., paragraph 1.6.1.3., Figure 3-1.5-8 Added reference to the Technical Specification for information on Return Codes.
47. Section 1.5., paragraph 1.6.1.4.1.2. Changed language to clarify other “persons” not “beneficiaries” who are not on DEERS would not have a catastrophic cap record.
48. Section 1.5., paragraph 1.6.1.4.1.3. Added information to clarify the three years that may be used for CCDD Totals Inquiry is limited to the current year and two prior years.
49. Section 1.5., paragraph 1.6.1.5. Added language clarifying the use of a claim extension identifier for claims that do not span multiple Fiscal Years. And added information that indicates cost shares, copays or deductibles collected must be posted to CCDD even if limit has been met.
50. Section 1.5., paragraph 1.6.1.5.2.6. Updated information specific to the addition of newborn children to DEERS and the process used to identify multiple births.
51. Section 1.5., paragraph 1.6.2.3. Added “Under previous contracts,” and “Under current contracts,” to the second paragraph.
52. Section 1.5., paragraph 1.6.2.4. Removed statement indicating DEERS stores and archives CCDD data due to redundancy and added “...and fiscal year...” to the first paragraph.
53. Section 1.5., paragraph 1.6.3. Added new Section for Point of Sale Pharmacy Inquiries.

SUMMARY OF CHANGES (Continued)

CHAPTER 3 (Continued)

54. Section 1.5., paragraph 1.7. Added additional minimum information that must be provided in order to add OHI to a person record. Added clarification of timeframe for MCSC development requirements to 15 “business” days. Added information clarifying that DEERS is not the system of record for OHI information. Added information specific to the DEERS default to Comprehensive Medical Coverage for OHI unless indicated otherwise. Updated statement with regard to the retention of OHI policy data from three to five years.
55. Section 1.5., paragraph 1.7.1.1. Changed last sentence for clarification purposes.
56. Section 1.5., paragraph 1.7.1.2. Updated information specific to OHI Person Inquiries to include the OHI/SIT web application.
57. Section 1.5., paragraph 1.7.1.3. Modified information to indicate a specific time period must be indicated for an OHI information query to be performed.
58. Section 1.5., paragraph 1.7.1.4. Added statement clarifying the OHI/SIT web application will return OHI for a beneficiary, sponsor or family.
59. Section 1.5., paragraph 1.7.2. Updated OHI Policy Add section to reflect current processes being followed and fields used to add an OHI policy for a person.
60. Section 1.5., paragraph 1.7.3. Updated OHI Policy Update section to reflect current processes being followed.
61. Section 1.5., paragraph 1.7.4. Corrected typos.
62. Section 1.5., paragraph 1.8. Updated Standard Insurance Table section to reflect current processes being followed. Added Note indicating only requesting organization can cancel the request to add a carrier.
63. Section 1.5., paragraph 1.8.2. Added information clarifying the rejection of the addition of the Carrier to the SIT by the VPOC results in the cancellation of all policies associated with the Carrier.
64. Section 1.5., paragraph 1.8.3. Added information specific to the provision of SIT updates to subscribers.
65. Section 1.5., paragraph 1.8.4. Added language clarifying OHI policies associated with “unverified” (formerly referenced as “temporary”) carriers will be cancelled.

SUMMARY OF CHANGES (Continued)

CHAPTER 3 (Continued)

66. Section 1.5., paragraph 1.8.5. Added language clarifying that if a SIT add or update is rejected by the VPOC, DEERS will cancel any OHI policy associated with the rejected carrier.
67. Section 1.5., paragraph 1.8.6. Added language clarifying MHS organizations can request the VPOC to deactivate any carrier.
68. Section 1.5., paragraph 1.9. Updated information specific to data provided by DEERS to TDEFIC.
69. Section 1.6. Updated entire section to reflect current levels of support provided by DMDC.
70. Section 1.7., paragraph 1.2. Removed information specific to the recycling of the DEERS Production and Test environment.
71. Addendum D. Updated Business Rules to add information specific to the Disenrollment of beneficiaries from the TCDP or WMDP and Transitional Survivors of Active Duty Deceased Sponsors. Added Business Rule M (OHI Business Rules) and N (Patient ID).
72. Addendum F. Added new Addendum to provide “Newborn Placeholder Request Process for Retail Pharmacy and Pharmacy Data Transaction System” currently used today by Purchased Care contractors.

GENERAL ADP REQUIREMENTS

SECTION	SUBJECT
1.1	GENERAL ADP REQUIREMENTS
	1.0. General
	2.0. System Integration, Implementation, And Testing Meetings
	3.0. ADP Requirements
	4.0. Health Insurance Portability and Accountability Act (HIPAA)
	5.0. Physical Security Requirements
	6.0. Personnel Security ADP/IT Requirements
	7.0. Public Key Infrastructure (PKI)
	8.0. Telecommunications
ADDENDUM A	DoD 5200.2-R, JANUARY 1987 - AP6. APPENDIX 6
ADDENDUM B	FIPS PUB 140-2 - SECURITY REQUIREMENTS FOR CRYPTOGRAPHIC MODULES

GENERAL ADP REQUIREMENTS

1.0. GENERAL

1.1. The TRICARE Systems Manual (TSM) defines the contractor's responsibilities related to automated processing of health care information and transmission of relevant data between the contractor and TRICARE Management Activity (TMA). It covers three major categories of information flowing among the contractor and TMA/Defense Enrollment Eligibility Reporting System (DEERS): health care coverage information; provider information; and pricing information. For each of these categories it presents specifics of submission, record and data element specifications, editing requirements, and TMA reporting of detected errors to the contractor.

1.2. This chapter addresses major administrative, functional and technical requirements related to the flow of health care related Automated Data Processing (ADP) information between the contractor and TMA. TRICARE Encounter Data (TED) records as well as provider and pricing information shall be submitted to TMA in electronic media. This information is essential to both the accounting and statistical needs of TMA in management of the TRICARE program and in required reports to Department of Defense (DoD), Congress, other governmental entities, and to the public. Technical requirements for the transmission of data between the contractor and TMA are presented in this section. The requirements for submission of TED records and resubmission of records are outlined in Chapter 2, Section 1.1, the TMA requirements related to submission and updating of provider information are outlined in Chapter 2, Section 1.2 and the TMA requirements related to submission and updating of pricing information are outlined in Chapter 2, Section 1.3.

1.3. Management and quality controls specific to the accuracy and timeliness of transactions associated with ADP and financial functions are addressed in the TRICARE Operations Manual (TOM), Chapter 1, Section 4. In addition to those requirements, TMA also conducts reviews of ADP and financial functions for data integrity purposes and may identify issues specific to data quality (e.g., catastrophic cap coverage issues). Upon notification of data quality issues by TMA, contractors are required to participate in the development of a resolution to the issue(s) identified, as appropriate.

1.4. For the purposes of this contract, DoD/TMA data includes any information provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, capitation, fees, patient health information, protected as defined by DoD 6025.18-R, or any other information for which the source is the government. Any information received by a contractor or other functionary or system(s), whether government owned or contractor owned, in the course of performing government business is also DoD/TMA data. DoD/TMA data means any information, regardless of form or the media on which it may be recorded.

1.5. The ADP requirements shall incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated standards where required.

2.0. SYSTEM INTEGRATION, IMPLEMENTATION, AND TESTING MEETINGS

The TMA Purchased Care Systems Branch hosts regularly scheduled meetings, via teleconference, with contractor and government representatives. Government attendees may include, but are not limited to the Defense Manpower Data Center (DMDC), Tri-Service Information Management Program Office (TIMPO), and Defense Information System Agency (DISA). The purpose of these meetings is to:

- Review the status of system connectivity and communications
- Identify of new DEERS applications or modifications to existing applications, e.g., DEERS Online Enrollment System (DOES)
- Issue of software enhancements
- Implement of system changes required for the implementation of new Programs and/or benefits
- Review data correction issues and corrective actions to be taken (e.g., catastrophic cap effort--review, research and adjustments)
- Other activities as appropriate

TMA provides a standing agenda for the teleconference with the meeting announcement. Unique subjects for the meetings are identified as appropriate. Contractors are required to ensure representatives participating in the calls are subject matter experts for meeting agenda items and are able to provide the current status of activities for their organization. It is also the responsibility of the contractor to ensure testing activities are completed within the scheduled time frames and any problems experienced during testing are reported via "TestTrack Pro" for review and corrective action by TMA or their designee. Upon the provision of a corrective action strategy or implementation of a modification to a software application by TMA (to correct the problem reported by the contractor), the contractor is responsible for retesting the scenario to determine if the resolution is successful. Retesting shall be accomplished within the agreed upon timeframe. Contractors are required to update "TestTrack Pro" upon completion of retesting activities.

3.0. ADP REQUIREMENTS

It is the responsibility of the contractor to employ adequate hardware, software, personnel, procedures, controls, contingency plans, and documentation to satisfy TMA data processing and reporting requirements. Items requiring special attention are listed below.

3.1. Continuity of Operations Plan (COOP)

3.1.1. The contractor shall develop a single plan, deliverable to the TMA CO on an annual basis that ensures the continuous operation of their Information Technologies (IT) systems and data support of TRICARE. The plan shall provide information specific to all actions that will be taken by the prime and subcontractors in order to continue operations should an actual disaster be declared for their Region. The COOP shall ensure the availability

of the system and associated data in the event of hardware, software and/or communications failures. The COOP shall also include prime and subcontractor's plans for relocation/recovery of operations, timeline for recovery, and relocation site information in order to ensure compliance with the TOM, Chapter 1, Section 3 and TOM, Chapter 6, Section 1. Information specific to connection to the Business to Business (B2B) Gateway to and from the relocation/recovery site for operations shall also be included in the COOP. For relocation/recovery sites, contractors must ensure all security requirements are met and appropriate processes are followed for B2B Gateway connectivity. The contractor's COOP will enable compliance with all processing standards as defined in the TOM, Chapter 1, Section 3 and compliance with enrollment processing and PCM assignment requirements as defined in TOM, Chapter 6, Section 1.

3.2. Annual Disaster Recovery Tests

3.2.1. The prime contractor will coordinate annual disaster recovery testing of the COOP with its subcontractor. All aspects of the COOP are to be tested annually and coordinated with any contractors responsible for the transmission of TRICARE data. Each prime contractor must conduct its annual test once per year, coordinating with their subcontractor(s), ensuring major TRICARE functions are tested annually.

3.2.2. Annual disaster recovery tests will evaluate and validate the prime's COOP sufficiently ensures continuation of operations and the processing of TRICARE data in accordance with the TOM, Chapter 1, Section 3 and TOM, Chapter 6, Section 1. At a minimum, annual disaster recovery testing will include the processing of:

- A sufficient number of TRICARE Prime enrollments in the DEERS contractor test region to demonstrate the ability to comply with the TOM, Chapter 6, Section 1, paragraph 5.4., "The contractor shall electronically submit to DEERS updated records of enrollees and disenrollees using the government furnished system application, DOES."
- Preauthorizations/authorizations in sufficient numbers to demonstrate the ability to function from a recovery/alternate location. This number should be determined based on average daily processing volumes for preauthorizations/authorizations.
- Referrals in sufficient numbers to demonstrate the ability to function from a recovery/alternate location. This number should be determined based on average daily processing volumes for referrals.
- Claims in sufficient numbers to demonstrate the ability to function from a recovery/alternate location. This number may be determined based on average daily processing volumes for claims.
- Claims and catastrophic cap inquiries will be made against production DEERS and the Catastrophic Cap and Deductible Database (CCDD) from the recovery site and the ability to successfully submit claims inquiries and receive DEERS claim responses and catastrophic cap inquiries and responses. Contractors shall not perform catastrophic cap updates in the CCDD and DEERS production for test claims.

- To successfully demonstrate the ability to perform catastrophic cap updates and the creation of newborn placeholder records in DEERS, the contractor shall process a sufficient number of claims using the DEERS and CCDD test region.
- TED records will be created for test claims processed during the claims processing portion of the disaster recovery test. The contractor will demonstrate the ability to process provider, institutional and non-institutional claims. These test claims will be submitted to the TED benchmark area.

3.2.3. Contractors shall maintain static B2B Gateway connections or other government approved connections at relocation/recovery sites, that can be activated in the event a disaster is declared for their region.

3.2.4. In all cases, the results of the review and/or test results shall be reported to the TMA, Contract Management Division within 10 days of conclusion of the test. If the contractor determines that additional testing is required or corrective actions must be taken, the CO shall be provided this information with a report of the results of actions taken within 10 business days of completion.

3.3. DoD Information Assurance Certification And Accreditation Process (DIACAP) Requirements

Contractor Information Systems (IS)/networks involved in the operation of systems of records in support of the DoD Military Health System (MHS) requires obtaining, maintaining, and using sensitive and personal information strictly in accordance with controlling laws, regulations, and DoD policy.

3.3.1. The contractor's IS/networks involved in the operation of DoD systems of records shall be safeguarded through the use of a mixture of administrative, procedural, physical, communications, emanations, computer and personnel security measures that together achieve the same requisite level of security established for DoD IS/networks for the protection of information referred to as "Sensitive Information" (SI) and/or "Controlled Unclassified Information." The contractor shall provide a level of trust which encompasses trustworthiness of systems/networks, people and buildings that ensure the effective safeguarding of SI against unauthorized modifications, disclosure, destruction and denial of service.

3.3.2. Information System (IS)/Networks Certification and Accreditation (C&A)

3.3.2.1. The DIACAP dated July 6, 2006, was established for the authorization of the operation of DoD information systems consistent with the Federal Information Security Management Act (FISMA), Section 3541 of Title 44, United States Code, DoD Directive (DoDD) 8500.1, "Information Assurance (IA)," October 24, 2002, and DoDD 8100.1, "Global Information Grid (GIG) Overarching Policy," September 19, 2002. This process supersedes DoD Instruction (DoDI) 5200.40, "DoD Information Technology Security Certification and Accreditation Process (DITSCAP)," December 30, 1997 and DoD 8510.1-M, DoD Information Technology Security Certification and Accreditation Process (DITSCAP) Application Manual," July 2000.

3.3.2.2. The contractor's IS'/networks shall comply with the C&A process established under the DIACAP for safeguarding DoD SI accessed, maintained and used in the operation of systems of records under this contract. Although the DITSCAP has been superseded by the DIACAP, it should be noted there are no differences in the evaluation criteria. The difference between the processes is specific to reporting requirements by the Information Assurance evaluation team.

3.3.2.3. Accreditation is the formal approval by the government for the contractors' IS' to operate in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS' to operate within the given operational environment with stated interconnections; and with appropriate levels of information assurance security controls.

3.3.3. C&A Process

The C&A process ensures that the trust requirement is met for systems and networks. Certification is the determination of the appropriate level of protection required for IS'/networks. Certification also includes a comprehensive evaluation of the technical and nontechnical security features and countermeasures required for each system/network. Accreditation is the formal approval by the government to operate the contractor's IS'/networks in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS'/networks to operate within the given operational environment with stated interconnections; and with appropriate level of protection for the specified period. The C&A requirements apply to all DoD IS'/networks and contractor's IS'/networks that access, manage, store, or manipulate electronic DoD SI data.

3.4. The DIACAP is the standardized approach to the C&A process within DoD. Each IS'/network that undergoes DIACAP must have required security controls in place, must have documented the security components and operation of the IS'/network and must successfully complete testing of the required security controls. The contractor shall ensure DIACAP documentation is available for review and is accurate. The contractor shall also implement an information assurance vulnerability management program providing mitigation from known vulnerabilities. The contractor, as part of that program, shall provide a primary and secondary point of contact for the MHS Information Assurance Vulnerability Alert (IAVA) Monitor. The point of contact shall provide, upon receipt of a vulnerability message, an acknowledgment of receipt. The contractor shall mitigate the vulnerability, and upon mitigation, report compliance. Receipt and compliance messages to the government shall occur within the stipulated window, as stated in the vulnerability message, and be directed to the MHS IAVA Monitor. Mitigation compliance for IA vulnerabilities shall be assessed on an annual basis.

3.4.1. The contractor shall execute the DIACAP process by providing, for receipt by the CO within 60 days following contract award, the required documentation necessary to receive an Approval to Operate (ATO), and making their IS'/networks available for testing and initiate testing 120 days in advance of accessing DoD data or interconnecting with DoD IS'. The contractor shall ensure the proper contractor support staff is available to participate in all phases of the C&A process. They include, but are not limited to: (a) attending and supporting C&A meetings with the government; (b) supporting/conducting the vulnerability mitigation process; and (c) supporting the C&A Team during system security

testing. Contractors must confirm that their system baseline configuration remains static during the initial testing.

3.4.2. Confirmation of system baseline configuration shall be agreed upon during the definition of the C&A boundary and be signed by the government and the contractor and documented as part of the System Identification Profile (SIP) and artifacts.

3.4.3. During the actual baseline and mitigation assessment scans, the information system must remain frozen. The freeze is only in place during the actual testing periods. Changes between baseline testing and mitigation testing must be coordinated and approved by the MHS IA Program Office prior to implementation. Any reconfiguration or changes in the system during the C&A testing process may require a rebaselining of the system and documentation of system changes. This could result in a negative impact to the C&A timeline.

3.4.4. The contractor shall be required to mitigate the vulnerabilities identified for correction during the C&A process. The above requirements shall be met before interconnecting with any DoD IS/network or electronic access to DoD SI is authorized. The contractor shall comply with the MHS DIACAP Checklist. Reference material and DIACAP tools can be obtained at http://www.tricare.mil/tmis_new/ia.htm.

3.4.5. After contract award date, and an Approval to Operate (ATO) is granted to the contractor, reaccreditation is required every three years or when significant changes occur that impact the security posture of the contractors' information system. An annual review shall be conducted by the TMA Information Assurance Office that comprehensively evaluates existing contractor system security posture in accordance with FISMA.

3.5. Disposing of Electronic Media

Contractors shall follow the DoD standards, procedures and use approved products to dispose of unclassified hard drives and other electronic media, as appropriate, in accordance with DoD Memorandum, "Disposition of Unclassified Computer Hard Drives," June 4, 2001. DoD guidance on sanitization of other internal and external media components are found in DoDI 8500.2, "Information Assurance (IA) Implementation," February 6, 2003 (see PECS-1 in Enclosure 4, Attachment 5) and DoD 5220.22-M, "Industrial Security Program Operating Manual (NISPOM)," Chapter 8).

4.0. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The contractor shall be compliant with the HIPAA as implemented by the Department of Health and Human Services (DHHS) final rule on Health Insurance Reform: Security Standards (45 Code of Federal Regulations, Parts 160, 162, and 164), effective April 21, 2003. Although the compliance date established by the DHHS Final Rule is April 21, 2005, the contractor shall be in compliance with the requirements of the final rule at the start-work date of this contract.

5.0. PHYSICAL SECURITY REQUIREMENTS

The contractor shall employ physical security safeguards for IS/networks involved in the operation of its systems of records to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of DoD SI and to otherwise protect the confidentiality and ensure the authorized use of SI. In addition, the contractor shall support a Physical Security Assessment performed by the government of its internal information management infrastructure using the criteria from the Physical Security Assessment Matrix. The contractor shall correct any deficiencies identified by the government of its physical security posture. The Physical Security Audit Matrix can be accessed via the Policy and Guidance/ Security Matrices section at http://www.tricare.mil/tmis_new/ia.htm.

6.0. PERSONNEL SECURITY ADP/IT REQUIREMENTS

6.1. Policy References

Personnel to be assigned to an ADP/IT position must undergo a successful security screening before being provided access to DoD information technology (IT) resources. Prior to an employee being granted interim access to DoD SI, the organization must receive notification that the Office of Personnel Management (OPM) has scheduled the employee's investigation. The references and specific guidance below provided to TMA by the Under Secretary of Defense for Intelligence (USDI) and OPM safeguard against inappropriate use and disclosure.

- Privacy Act of 1974
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
- DoD 5200.2-R, "Personnel Security Program," (January 1987)"
- DoD 5220.22-M, "National Industrial Security Program Operating Manual" (NISPOM), January 1995 (Change 2, May 1, 2000)
- DoDI 8500.1, "Information Assurance (IA) (October 24, 2002)."

The requirement above must be met by contractors, subcontractors and others who have access to information systems containing information protected by the Privacy Act of 1974 and protected health information under HIPAA. Background checks are required for all ADP/IT personnel who receive, process, store, display, or transmit SI.

6.2. Formal Designations Required

All contractor personnel in positions requiring access to DoD IS/networks or Contractor Owned-Contractor Operated (COCO) IS/networks interconnected with DoD IS/networks must be designated as ADP/IT-I, ADP/IT-II, or ADP/IT-III. Only TRICARE contractors are permitted to submit ADP/IT background checks in accordance with this policy. Military Service and Military Treatment Facility (MTF) contractors are not to use this guidance.

6.3. Special Access Requirements

6.3.1. All contractor personnel accessing the DEERS database or the B2B Gateway must have an ADP/IT-II Trustworthiness Determination. Contractor personnel currently working in DEERS with an ADP/IT-III or an interim ADP/IT-III Trustworthiness Determination must upgrade to an ADP/IT-II or interim ADP/IT-II Trustworthiness Determination no later than October 1, 2004. DEERS access for contractor personnel with ADP/IT-III Trustworthiness Determinations will no longer be granted after October 1, 2004.

6.3.2. New employees hired by contractors are granted interim access for six months upon submission of the SF 85P and fingerprint cards to the OPM. Contractors must notify the TMA Privacy Office of the submission of SF 85Ps for new hires and the date submitted. In addition, Contractors are required to respond timely to the OPM for requests for additional information required for the processing of the SF 85P. Failure to respond timely to the OPM will result in the revocation of interim access by the TMA Privacy Office.

6.3.3. Contractors are required to ensure personnel viewing data obtained from DEERS or the B2B Gateway or viewing Privacy Act protected data follow contractor established procedures as required by the TOM, Chapter 1, Section 4, paragraph 3.0., to assure confidentiality of all beneficiary and provider information. The contractor is required to assure the rights of the individual are protected in accordance with the provisions of the Privacy Act, HIPAA, and HHS Privacy regulation and to prevent the unauthorized use of TMA files.

6.4. ADP/IT Category Guidance

In establishing the categories of positions, a combination of factors may affect the determination. Unique characteristics of the system or the safeguards protecting the system permit position category placement based on the agency's judgement. Guidance on ADP/IT categories is:

6.4.1. ADP/IT-I - Critical Sensitive Position. A position where the individual is responsible for the development and administration of MHS IS/network security programs and the direction and control of risk analysis and/or threat assessment. The required investigation is equivalent to a Single-Scope Background Investigation (SSBI). Responsibilities include:

- Significant involvement in life-critical or mission-critical systems.
- Responsibility for the preparation or approval of data for input into a system, which does not necessarily involve personal access to the system, but with relatively high risk for effecting severe damage to persons, properties or systems, or realizing significant personal gain.
- Relatively high risk assignments associated with or directly involving the accounting, disbursement, or authorization for disbursement from systems of (1) dollar amounts of \$10 million per year or greater; (2) lesser amounts if the activities of the individuals are not subject to technical review by higher authority in the ADP/IT-I category to insure the integrity of the system.

- Positions involving major responsibility for the direction, planning, design, testing, maintenance, operation, monitoring and or management of systems hardware and software.
- Other positions as designated by the DAA that involve a relatively high risk for causing severe damage to persons, property or systems, or potential for realizing a significant personal gain.

6.4.2. ADP/IT-II - Non-critical-Sensitive Position. A position where an individual is responsible for systems design, operation, testing, maintenance and/or monitoring that is carried out under technical review of higher authority in the ADP/IT-I category, includes but is not limited to: (1) access to and/or processing of proprietary data, information requiring protection under the Privacy Act of 1974, or Government-developed privileged information involving the award of contracts; (2) accounting, disbursement, or authorization for disbursement from systems of dollar amounts less than \$10 million per year.

6.4.2.1. Other positions are designated by the DAA that involve a degree of access to a system that creates a significant potential for damage or personal gain less than that in ADP/IT-I positions. The required investigation is equivalent to a National Agency Check with Law Enforcement and Credit (NACLCL).

6.4.2.2. ADP/ITs submitted as a NAC to DSS prior to 2000 were approved as ADP/IT-II/III. Effective 2000, OPM took over the investigation process for TMA. The submission requirements for ADP/IT levels were upgraded as follows: ADP/IT-III is a NAC; ADP/IT-II is a NACLCL and; an ADP/IT-I is a SSBI. Investigations submitted before 2000 for a NAC (ADP/IT-II/III) will need to submit a new SF85P User Form and fingerprint card for a NACLCL to be upgraded to an ADP/IT-II.

6.4.3. ADP/IT-III - Non-sensitive Position. All other positions involved in Federal computer activities. The required investigation is equivalent to a National Agency Check (NAC).

6.5. Additional ADP/IT Level Designation Guidance

All TMA contractors requiring ADP/IT-I Trustworthiness Determinations for their personnel are required to submit a written request for approval to the TMA Privacy Office prior to submitting applications to OPM. The justification will be submitted to the TMA Privacy Officer, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 20041, on the letterhead of the applicant's contracting company. The request letter must be signed by, at a minimum, the company security officer or other appropriate executive, include contact information for the security officer or other appropriate executive, and a thorough job description which justifies the need for the ADP/IT-I Trustworthiness Determination. Contractors shall not apply for an ADP/IT-I Trustworthiness Determination unless specifically authorized by the TMA Privacy Officer.

6.5.1. Required Forms

Each contractor shall be required to complete and submit the necessary standard forms, fingerprint forms, and other documentation as may be required by the OPM to open

and complete investigations. Additional information may be requested while the investigation is in progress. This information must be provided in the designated timeframe or the investigation may be closed. All contractor employees that are prior military should include Copy 4 of the DD214 (certificate of Release or Discharge from Active Duty) with their original submission. Forms and guidance can be found at <http://www.opm.gov/extra/investigate>.

NOTE: The appropriate billing code will be provided following contract award. Contractors should contact the TMA Privacy Office to obtain the PIPS Form 12 when applying for a Submitting Office Number (SON). The application and billing information must be requested from the TMA Privacy Office. Each contracting company or subcontracting company must contact the TMA Privacy Office individually for this information.

6.5.2. Interim Assignment: (U.S. Citizens Working In The U.S. Only)

6.5.2.1. Contractor personnel who are U.S. Citizens will receive an OPM Investigation Schedule Notice (ISN) from the TMA Privacy Office once the OPM has scheduled the investigation. TMA sends the ISN to the contracting security officer as validation for interim access. The contractor security officer may use receipt of the ISN as their authority to grant interim access to DoD IS/networks until a Trustworthiness Determination is made.

6.5.2.2. Contractor personnel undergoing the process to upgrade their current Trustworthiness Determination level (e.g., ADP/IT-III to ADP/IT-II) who maintain continuous employment with the contractor, or have had no lapse in employment with the contractor of greater than 24 months, shall continue to have the current access level during the upgrade process.

6.5.3. Temporary Assignments (U.S. Citizens Only)

Temporary employees include intermittent, volunteers, and seasonal workers. Efforts shall be taken to obtain an approved ADP/IT-II or ADP/IT-III Trustworthiness Determination for those positions requiring access to DoD SI. Interim access is allowed as outlined in paragraph 6.5.2.

6.5.4. Preferred/Partnership Providers At OCONUS MHS Facilities (U.S. Citizens Only)

To obtain an ADP Trustworthiness Determination for a preferred/partnership provider the Security Officer of the MTF will contact the TMA Privacy Officer for instructions and guidance on completing and submitting the SF85P User Form, fingerprint cards and system access. The TMA Privacy Officer will provide guidance on system access upon contact by the Security Officer of the MTF.

6.5.5. ADP/IT Level Trustworthiness Determination Upgrades

6.5.5.1. Contact the TMA Privacy Office if a higher ADP/IT level is required than what was submitted for an employee. In addition, the contractor's security officer must contact the OPM Federal Investigations Processing Center to determine the status of the investigation. OPM can upgrade the level of investigation only if the investigation has not been closed/

completed. If the NAC is pending, you may fax a request to upgrade the NAC to a NACLIC in writing to OPM, Attention: Corrections Technician. You must provide the name, SSN, and Case Number on your request (Case Number can be found on the ISN). If the SF85P User Form is missing information, the Correction Technician will call the requester for missing information. Addresses for each organization are shown below.

- TMA Privacy Office, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 22041
- OPM Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618
- OPM Corrections Department, Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618

6.5.5.2. If the investigation has been closed/completed, the original SF85P Agency User Form (coversheet) must be submitted for the higher ADP/IT level. The SF85P may be re-used within 120 days of the case closed date, with corrected ADP level code (ADP/IT-II=O8B). The letter "I" must be inserted in the Codes box located above C and D on the SF85P Agency User Form and no fingerprint card is needed. The contractor's Security Officer must update the SF85P Agency User Form, re-sign and re-date the form in Block P. The individual must line through any obsolete information, replacing it with corrected information and initial all changes made to the SF85P. The individual must re-sign and re-date the certification section of the form.

6.5.5.3. If it is beyond the 120 day period, the old SF85P may be used if all the information is updated and the certification part of the form is re-dated, and re-signed by the individual. A new SF85P Agency User Form (coversheet) showing the correct ADP/IT (O8B) level code is required at this time. Each correction/change made to the form must be initialed and dated by the individual. Fingerprint cards must be submitted if the case has been closed for more than 120 days.

6.6. Assignment Of Non-U.S. Citizens

6.6.1. Policy

Interim Access at CONUS locations for Non-U.S. Citizens is Not Authorized.

Non-U.S. citizen contractor employees are not being adjudicated for any Trustworthiness positions.

6.6.2. Grandfathering Of Non-U.S. Citizens

Earlier guidance authorized the grandfathering (continuation) of certain CONUS non-U.S. Citizens who previously were working on a TMA contract. Grandfathered contractor personnel are authorized to continue working under the existing contract until contract expiration date. This provision is not applicable to contractor employees who opt to transition employment from a contractor holding a legacy TRICARE contract to a contractor awarded a contract under the TRICARE Next Generation series of contracts.

6.6.3. End Date Of CONUS Non-U.S. Citizen Access

Access to DoD IS/networks or data will end on December 31, 2004 for all CONUS non-U.S. Citizen contractor personnel, or in accordance with the guidance provided in paragraph 6.6.2.

6.6.4. Non-U.S. Citizens/Foreign Nationals Working At OCONUS MHS Facilities

Non-U.S. Citizens/Foreign Nationals employed by DoD organizations overseas, whose duties do not require access to classified information, shall be the subject of record checks that include host-government law enforcement and security agency checks at the city, state (province), and national level, whenever permissible by the laws of the host government, initiated by the appropriate Military Department investigative organization prior to employment.

6.7. Transfers Between Contractor Organizations

6.7.1. When contractor employees transfer employment from one government contractor to another, while their investigation for ADP/IT Trustworthiness Determination is in process, the investigation being conducted for the previous employer may be applied to the new employing contractor. The new contracting company will send an Excel spreadsheet to the TMA Privacy Office to provide notification of the addition of the new employee from a previous TRICARE contractor. The spreadsheet must contain the following:

- Name
- Social Security Number
- Name of the former employing contractor
- ADP/IT level applied for
- Effective date of the transfer/employment

6.7.2. TMA will verify the status of the Trustworthiness Determination/scheduled investigation for the employee(s) being transferred. If the investigation has not been completed, the TMA Privacy Office will notify OPM to transfer the investigation from the old SON (submitting office number) to the new SON. If the investigation has been completed, OPM cannot affect the transfer. If the Trustworthiness Determination has been approved, TMA will verify the approval of the Trustworthiness Determination and send a copy to the new employing contractor's office.

6.8. New Contractor Personnel With Recent Secret Clearance

New contractor personnel who have had an active secret clearance within the last two years do not need to submit a SF85P User Form. The contracting company will need to send a copy of the Letter of Consent (LOC) to the TMA Privacy Office for verification.

6.9. Notification Of Submittal And Termination

Contracting companies must notify the TMA Privacy Office when the Security Officer has submitted the SF85P User Form to OPM for new employees. Upon termination of

a contractor employee from the TRICARE Contract, contracting companies must notify the TMA Privacy Office and OPM of the action, including the termination date.

6.10. Exception Or Extensions

Exceptions to or extensions beyond any end date or other requirement will be granted (if approved) only by the Director, TRICARE or the Deputy Director, TRICARE. Any exception or extension, if provided, will be in response to a written request, and based upon appropriate health program interests.

7.0. PUBLIC KEY INFRASTRUCTURE (PKI)

7.1. The DoD has initiated a Public Key Infrastructure policy to enhance the identification and authentication of users and systems within DoD. The PKI program is in its initial stage and is evolving. The following paragraphs provide current DoD PKI requirements. Additional guidance as it applies to this contract will be provided as the policy and implementation guidance is finalized within DoD.

7.2. The contractor is required to obtain PKI certificates for individuals who will be directly accessing any DoD applications which reside either on a DoD Local Area Network or a DoD private (restricted access, e.g., username/password) Web server including, but not limited to, the following:

- The Defense Online Enrollment System (DOES) [DEERS client/server application]
- The General Inquiry of DEERS (GIQD) application [DEERS Web application]
- The TRICARE Duplicate Claims System (DCS) [TMA Web application]
- The Enterprise Wide Referral and Authorization System (EWRAS) [Web application]
- Civilian PCM Panel Reassignment [DEERS Client/Server application]
- Catastrophic Cap and Deductible/Fee Research [DEERS Web application]
- PCM Research [DEERS Web application]
- DEERS Security Web Application [Web application]
- OHI/SIT [DEERS Web application]
- Direct Care PCM Panel Reassignment [Web application]
- Purchased Care [Web application]

7.3. Contractor personnel who access these systems from a .mil domain will be eligible to receive their certificates from the government. PKI certificates for contractor personnel that access the above listed systems from non-.mil domains may be purchased through DoD approved External Certification Authorities (ECAs).

7.4. Additionally the contractor is required to obtain DoD acceptable PKI server certificates for identity and authentication of the servers involved in the following system-to-

system or host-to-host interfaces. These interfaces include, but are not limited to, the following:

- Contractor systems for claims eligibility inquiries and responses and DEERS
- Contractor systems and the TED Processing Center

8.0. TELECOMMUNICATIONS

8.1. MHS Demilitarized Zone (DMZ) Managed Partner Care B2B Gateway

8.1.1. All contractor systems that will communicate with DoD systems will interconnect through the established MHS B2B gateway. For all Web applications, contractors will connect to a DISA-established Web DMZ.

8.1.2. In accordance with contract requirements, MCS contractors will connect to the B2B gateway via a contractor procured Internet Service Provider (ISP) connection. Contractors will assume all responsibilities for establishing and maintaining their connectivity to the B2B Gateway. This will include acquiring and maintaining the circuit to the B2B Gateway and acquiring a Virtual Private Network (VPN) device compatible with the MHS VPN device.

8.1.3. It is anticipated that modifications will also allow provisioning of dedicated point-to-point commercial circuits to the B2B gateway. The DISA B2B Gateway is a redundant service that is provisioned at two locations. If contractors require high availability, they may acquire redundant circuits to both locations.

8.1.4. Contractors will comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies.

8.2. Contractor Provided IT Infrastructure

8.2.1. Platforms shall support HTTP, HTTPS, Web derived Java Applets, client/server, FTP, secure FTP, and all software that the contractor proposes to use to interconnect with DoD facilities.

NOTE: The DoD is phasing out the use of FTP. Upon notification from the government, the contractor shall cease using FTP and begin utilizing the FTP alternative stipulated by the government.

8.2.2. Contractors shall configure their networks to support access to government systems (e.g., configure ports and protocols for access).

8.2.3. Contractors shall provide full time connections to a TIER 1 or TIER 2 ISP. Dial-up ISP connections are not acceptable.

8.3. DISA Form 41 Submission

All contractors that use the DoD gateways to access government systems must submit a DISA Form 41 or equivalent in accordance with CO guidance. In addition, Form 41s

are required for each system administrator responsible for each host-to-host interface. Contractors shall complete and submit to TMA one Form 41 for their organization, attached to which shall be a listing of those individuals for whom background checks have been completed or for whom requests/applications for background checks have been completed, submitted to the OPM, and acknowledgements have been received from OPM that the applications are complete and are pending action by OPM. The request must clearly delineate the ports and protocols used for each IP address. The contractor shall complete the form and submit it to the government for final processing.

8.4. MHS Systems Telecommunications

8.4.1. The primary communication links shall be via Secure Internet Protocol (IPSEC) virtual private network (VPN) tunnels between the contractor's primary site and the MHS B2B Gateway.

8.4.2. The contractor shall place the VPN appliance device outside the contractor's firewalls and shall allow full management access to this device (e.g., in router access control lists) to allow Central VPN Management services provided by the DISA or other source of service as designated by the MHS to remotely manage, configure, and support this VPN device as part of the MHS VPN domain.

8.4.3. For backup purposes, an auxiliary VPN device for contractor locations shall also be procured and configured for operation to minimize any downtime associated with problems of the primary VPN.

8.4.4. The MHS VPN management authority (e.g., DISA) will remotely configure the VPN once installed by the contractor.

8.4.5. Maintenance and repair of contractor procured VPN equipment shall be the responsibility of the contractor. Troubleshooting of VPN equipment shall be the responsibility of the government.

8.5. Contractors Located On MTFs

8.5.1. If the contractor plans to locate personnel on a military facility, the contractor must coordinate with the Base/Post/Camp communications office and the MTF.

8.5.2. Contractors located on military facilities who require direct access to government systems shall coordinate/obtain these connections with the local MTF and Base/Post/Camp communication personnel. These connections will be furnished by the government.

8.5.3. Contractors located on military facilities that require direct connections to their networks shall either:

- Coordinate their network connections to the respective military infrastructure and through the MHS B2B Gateway.
- If the contractor requires a direct connection back to the contractor's network, they shall provide an isolated IT infrastructure, coordinate with the Base/Post/Camp communications personnel and the MTF in order to get approval

for a contractor procured circuit to be installed and to ensure the contractor is within compliance with the respective organizational security policies, guidance and protocols. Note: In some cases, the contractor may not be allowed to establish these connections due to local administrative/security requirements.

8.5.4. The contractor shall be responsible for all security certification documentation as required to support DoD Information Assurance requirements for network interconnections. Further, the contractor shall provide, on request, detailed network configuration diagrams to support DIACAP accreditation requirements. The contractor shall comply with DIACAP accreditation requirements. All network traffic shall be via TCP/IP using ports and protocols in accordance with current Service security policy. All traffic that traverses MHS, DMDC, and/or military Service Base/Post/Camp security infrastructure is subject to monitoring by security staff using Intrusion Detection Systems.

8.6. DEERS

8.6.1. Primary Site

8.6.1.1. The DEERS primary site is located in Auburn Hills, Michigan and the backup site is located in Seaside, California.

8.6.1.2. The contractor shall communicate with DEERS through the MHS B2B Gateway.

8.6.2. PCs/Hardware

The contractor is responsible for all systems and operating system software needed internally to support the DOES.

8.7. TMA/TED

8.7.1. Primary Site

The TED primary site is currently located in Denver, Colorado, and operated by the Defense Enterprise Computing Center (DECC), Denver Detachment for the DISA. Note: The location of the primary site may be changed. The contractor shall be advised should this occur.

8.7.2. General

The common means of administrative communication between Government representatives and the contractor is via telephone and e-mail. An alternate method may be approved by TMA, as validated and authorized by TMA. Each contractor on the telecommunication network is responsible for furnishing to TMA at the start-up planning meeting (and update when a change occurs), the name, address, and telephone number of the person who will serve as the technical point of contact. Contractors shall also furnish a separate computer center (Help Desk) number to TMA which the TMA computer operator can use for resolution of problems related to data transmissions.

8.7.3. TED-Specific Data Communications Technical Requirements

8.7.3.1. Systems Interface Requirements

The contractor shall communicate with the government’s Data Center through the MHS B2B Gateway.

8.7.3.2. Communication Protocol Requirements

8.7.3.2.1. File transfer software shall be used to support communications with the TED Data Processing Center. CONNECT:Direct is the current communications software standard for TED transmissions. The contractor is expected to upgrade/comply with any changes to this software. The contractor shall provide this product and a platform capable of supporting this product with the TCP/IP option included. Details on this product can be obtained from:

Sterling Commerce
 4600 Lakehurst Court
 P.O. Box 8000
 Dublin, OH 43016-2000 USA
<http://www.sterlingcommerce.com/solutions/products/ebi/connect/direct.html>
 Phone: 614-793-7000 / Fax: 614-793-4040

8.7.3.2.2. For Ports and Protocol support, TCP/IP communications software incorporating the TN3270 emulation shall be provided by the contractor.

8.7.3.2.3. Transmission size is limited to any combination of 250,000 records at one time.

8.7.3.2.4. “As Required” Transfers

Ad hoc movement of data files shall be coordinated through and executed by the network administrator or designated representative at the source file site. Generally speaking, the requestor needs only to provide the point of contact at the remote site, and the source file name. Destination file names shall be obtained from the network administrator at the site receiving the data. Compliance with naming conventions used for recurring automated transfers is not required. Other site specific requirements, such as security constraints and pool names are generally known to the network administrators.

8.7.3.2.5. File Naming Convention

8.7.3.2.5.1. All files received by and sent from the TMA data processing site shall comply with the following standard when using CONNECT:Direct:

POSITION(S)	CONTENT
1 - 2	‘TD’
3 - 8	YYMMDD Date of transmission
9 - 10	Contractor number
11 - 12	Sequence number of the file sent on a particular day. Ranges from 01 to 99. Reset with the first file transmission the next day.

8.7.3.2.5.2. All files sent from the TMA data processing site shall be named after coordination with receiving entities in order to accommodate specific communication requirements for the receivers.

8.7.3.2.5.3. Timing

Telecommunication transfers during normal business hours may be adversely affected by normal processing. Therefore, every attempt shall be made to maximize utilization of telecommunications lines by deferring transfers to night-time operation. Ideally, a single file will be transmitted at night. However, there are no restrictions on the number of files that may be transmitted. Under most circumstances, the source file site shall initiate automated processes to cause transmission to occur. With considerations for timing and frequency, activation of transfers for each application shall be addressed on a case by case basis.

8.7.3.2.5.4. Alternate Transmission

Should the contractor not be able to transmit their files through the normal operating means, the contractor should notify TMA (EL/DS Operations) that they will be sending their files by tape via overnight delivery.

8.8. TMA/MHS Referral And Authorization System

8.8.1. Primary Site

The MHS Referral and Authorization System primary site is to be determined.

8.8.2. PCs/Hardware

The contractor is responsible for all systems and operating system software needed internally to support the MHS Referral and Authorization System.

8.9. TMA/TRICARE DCS

8.9.1. Primary Site

The TRICARE DCS primary site is located in Aurora, Colorado.

8.9.2. Contractor Connection With TMA For The DCS

The DCS is planned to operate as a web application. The contractor is responsible for providing internal connectivity to the public Internet. The contractor is responsible for all systems and operating system software needed internally to support the DCS. (See the TOM, Chapters 9 and 10 for DCS Specifications.)

DEERS

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1.5	DEERS FUNCTIONS FIGURE 3-1.5-1 DEERS Enrollment And Claims Interaction FIGURE 3-1.5-2 Enrollment Process FIGURE 3-1.5-3 PCM Assignment Process FIGURE 3-1.5-4 Enrollment Transfer Process FIGURE 3-1.5-5 Batch Fee Payment Process FIGURE 3-1.5-6 Claims Inquiry To DEERS FIGURE 3-1.5-7 Inquiry Person Type Code FIGURE 3-1.5-8 Health Care Coverage Inquiry For Claims: Responses And Actions FIGURE 3-1.5-9 CCDD Totals Inquiry FIGURE 3-1.5-10 Coverage Inquiry And CCDD Update Process

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ADDENDUM E	DEERS TYPE 3 RESPONSE RECORD DATA ELEMENT DEFINITION FIGURE 3-E-1 Region 11 - Transition To West Region FIGURE 3-E-2 Regions 2 And 5 - Transition To North Region FIGURE 3-E-3 Regions 9, 10, And 12 - Transition To West Region FIGURE 3-E-4 Regions 3 And 4 - Transition To South Region FIGURE 3-E-5 Region 1 - Transition To North Region FIGURE 3-E-6 Central Region - Transition To West Region FIGURE 3-E-7 Region 6 - Transition To South Region FIGURE 3-E-8 Designated Provider - Implementation 02/01/2004 FIGURE 3-E-9 Designated Provider - Implementation 03/01/2004 FIGURE 3-E-10 Designated Provider - Implementation 04/01/2004 FIGURE 3-E-11 Designated Provider - Implementation 05/01/2004 FIGURE 3-E-12 Designated Provider - Implementation 06/01/2004

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ADDENDUM F	NEWBORN PLACEHOLDER REQUEST PROCESS FOR TRICARE RETAIL PHARMACY (TRRX) AND PHARMACY DATA TRANSACTION SYSTEM (PDTS)
	1.0. Background
	2.0. General Overview
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	FIGURE 3-F-1 Sample Newborn Placeholder Request Form

SCOPE

FOREWORD

All Defense Enrollment Eligibility Reporting System (DEERS) data provided by the Defense Manpower Data Center (DMDC) to the TRICARE Management Activity (TMA) for the use of determining medical eligibility, enrollment and medical claims payment are subject to the Privacy Act of 1974, as amended.

Release is made to you in accordance with the provisions of the Act allowing for intra-Department release when an appropriate "need to know" exists. As such, the authorized organizations are responsible for using the protected Privacy Act data in accordance with the applicable provisions of the Act.

This Includes:

Only personnel (military, civilian, contractor) with a need to know in the official performance of their duties may be given access, and

The data may only used for the specific purposes agreed to by DMDC, and TMA.

The organization to which these data are provided must insure that sufficient physical and procedural safeguards are in place to satisfy the requirements of the Act.

These data should be returned to DMDC or destroyed when the approved use has been accomplished and no copies should be retained.

Any additional intended uses must first be submitted through TMA to DMDC for approval and are prohibited unless and until favorably coordinated with DMDC.

In addition, DMDC only provides the DEERS data for the specific purposes defined:

- Enrollment data is for the authorized enrollment of beneficiaries into valid health care plans as defined under the provisions of this Request For Proposal (RFP).
- Eligibility data is for reporting the eligibility of a beneficiary on DEERS as of the time of the eligibility inquiry.
- Claims data is for the processing and resolution of claims submitted for reimbursement of medical care received.

1.0. PURPOSE

The purpose of this chapter is to outline the systems and technical procedures to be followed in carrying out the data interchange between the Defense Enrollment Eligibility Reporting System (DEERS) and contractor systems for TRICARE benefit eligibility, enrollment, other health insurance (OHI), and catastrophic caps and deductibles with DEERS.

This document provides specifications for the Managed Care Support Contractors' (MCSCs) and the Uniformed Services Family Health Plan (USFHP) providers interface with DEERS. Additionally, the DEERS Business Rules document is a companion document to this chapter.

This document details the following:

- Terminology used within DEERS (see Chapter 3, Addendums A and B)
- Methodology for identifying individuals within DEERS
- Functional events from the MCSCs and the USFHP providers that trigger a request to inquire and/or update data within DEERS
- "Rules of the road" for accessing and updating data within DEERS

2.0. SYSTEM OVERVIEW

2.1. Program Description

DEERS serves as a centralized Department of Defense (DoD) data repository of personnel and medical data and is the definitive data source of identify and the verification of affiliation with the DoD. The DEERS database contains detailed personnel eligibility information for benefits and entitlements distribution to Uniformed Services¹ members; United States (U.S.) sponsored foreign military members; DoD and Uniformed Services civilians; other personnel as directed by the DoD; and their eligible family members. DEERS supports essential day-to-day operations in a broad range of functional areas, including personnel, medical, and finance.

DEERS is updated by batch transactions from the Uniformed Services' automated personnel, finance, medical, and mobilization management systems, the Department of Veterans Affairs (VA), and the Centers for Medicare and Medicaid Services (CMS). DEERS is also accessed and updated by online DEERS client applications, such as the Real-Time Automated Personnel Identification System (RAPIDS), and interfacing client systems of the Military Health System (MHS), such as the Composite Health Care System (CHCS). DEERS helps detect and prevent fraud and abuse in DoD benefits and entitlements distribution.

DEERS provides and receives updates to enrollment and eligibility verification data from existing DEERS' applications and interfacing information systems, as well as from other

¹ The seven Uniformed Services are: U.S. Army, U.S. Navy, U.S. Marine Corps, U.S. Air Force, U.S. Coast Guard, their National Guard and Reserve components, U.S. Public Health Service (USPHS), and the National Oceanic and Atmospheric Administration (NOAA) Commissioned Corps.

DoD, Uniformed Services, and non-DoD information systems, in accordance with DoD Directive (DoDD) 8000.1, "Defense Information Management (IM) Program," dated 27 October 1992, Reference (1). It provides statistical and demographic data to support DoD and Uniformed Services peacetime and wartime missions. DEERS maintains casualty identification data on members of the Uniformed Services, and other personnel as designated by DoD, to support casualty identification and verification of entitlement eligibility for surviving family members.

DEERS maintains information that helps make administration of the MHS more effective and efficient, along with other benefit and entitlement systems which derive basic eligibility information from DEERS. DEERS also provides and maintains medical and personnel readiness information on Uniformed Services members and other personnel as designated by the DoD. It maintains data on Uniformed Services members and retired sponsors to facilitate eligibility verification for Government educational programs, for example, the Montgomery GI Bill (MGIB). DEERS helps make Uniformed Services members, other personnel as designated by the DoD, and their family members more aware of their benefits and entitlements, which are verified through DEERS. It improves the timeliness of providing DoD benefits and entitlements to Uniformed Services members, other personnel as designated by the DoD, and their family members.

DEERS serves as DoD's centralized personnel locator service, in accordance with Section 113 of 10 United States Code (USC)² by maintaining current addresses for members of the Armed Forces, and providing those addresses upon request to the Federal Parent Locator Service of the Department of Health and Human Services' Office of Child Support Enforcement. It maintains the right index fingerprint³ of all eligible individuals in a pay or annuity status, including active duty and Reserve military personnel, retired sponsors, survivors receiving annuity payments derived from the service of a deceased person, and civilian employees with identification cards issued through RAPIDS. The Undersecretary of Defense (USD) (Comptroller) uses these fingerprints to improve service member identification and verification techniques.

2.2. DEERS Users

DEERS supports multiple functional communities, as well as multiple user levels within those communities. DEERS users include Federal (DoD and non-DoD) Government agencies and organizations, state government agencies, and Government support contractors who access DEERS data through DEERS' client applications or the user's interfacing client system.

DEERS data users include:

- Benefits and entitlements providers for eligibility verification in conjunction with claims processing and providing or denying services
- The Designated Providers (DPs)

² Section 113 of Title 10, United States Code, "Enforcement of Child Support Obligations of Members of the Armed Forces," Reference (4).

³ The right index fingerprint will be kept for use by the USD (Comptroller), as authorized by USD (P&R) memorandum, "Fingerprint Capture Policy," dated 15 July 1997, Reference (5).

- Uniformed Services personnel activities, recruit reception centers, and academies that add or update individual beneficiary DEERS data and issue the Uniformed Services identification (ID) cards
- Health care managers, health benefits advisors (HBAs), and specialists in DoD medical and dental communities
- DMDC Support Office (DSO) staff who perform beneficiary and user support operations
- DoD and Uniformed Services executive community, which uses DEERS statistics and demographic data for a number of functions
- Military Health system (MHS) Data Repository (MDR)

The Office of the Undersecretary of Defense (OUSD) for Personnel and Readiness (P&R) and the DMDC maintain contact with DEERS users through the Joint Uniformed Services Personnel Advisory Committee (JUSPAC), the Joint Uniformed Services Medical Advisory Committee (JUSMAC), and the Joint Uniformed Services Dental Advisory Committee (JUSDAC). These committees are composed of functional members from the personnel, medical, and dental communities within the active duty, National Guard, and Reserve components. Members of the personnel, medical, and dental communities who function at the level of the Office of the Secretary of Defense (OSD) support these committees.

2.3. History

The DoD provides certain benefits and entitlements, such as medical and dental care, commissary, exchange, and morale, welfare, and recreation (MWR) privileges, to its Uniformed Services members, retired sponsors, certain civilian employees, and family members. DEERS was initiated to improve the control and management of how these benefits and entitlements are distributed.

Originally, DoD medical care was provided only by military hospitals and dental clinics. Medical care provided by civilian sources was first authorized for eligible family members of active duty Uniformed Services members (including National Guard and Reserve component members on active duty in excess of 30 days) on December 7, 1957. During January 1967, civilian medical care was extended to retired service members, and their eligible family members, as well as to widows and widowers of deceased service members. In 1981, civilian medical care was extended to family members of North Atlantic Treaty Organization (NATO)-sponsored foreign military members serving in the U.S. The program providing medical care by civilian sources was called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) until 1996, when it was renamed DoD Managed Care Program, TRICARE. TRICARE is currently governed by 32 Code of Federal Regulations (CFR) Part 199, Reference (7).

Based on several General Accounting Office (GAO) investigative audits of accountability deficiencies in the CHAMPUS program, the GAO published "Potential for Improvements in the Civilian Health and Medical Program of the Uniformed Services (Summary Report)," dated 19 July 1971, Reference (9). This report identified the use of the Uniformed Services ID cards issued to Uniformed Services members, retired sponsors, DoD and Uniformed Services civilians, State Department employees, NATO-sponsored foreign

military members, and their eligible family members, as insufficient tools to manage military medical care and contain the growth of CHAMPUS costs. The report provided recommendations for improving military medical care and CHAMPUS program management.

In response to the GAO report, the OASD for Health and Environment (H&E) created the Health Personnel All-Volunteer Task Force to study the report's conclusions and recommendations, and to offer corrective solutions to Congress. Between 1971 and 1975, studies conducted by the Health Personnel All-Volunteer Health Task Force; the Center for Advanced Studies; the GAO; and the Assistant for Audit Operations, OASD (H&E) (Comptroller), indicated that fraudulent use of military health care services cost the DoD approximately \$60 million annually. This \$60 million included approximately \$20 million in unauthorized direct care services provided at military treatment facilities (MTFs), and approximately \$40 million in unauthorized CHAMPUS claims payments.

Based on the findings in these reports, the House Appropriations Committee Report for Fiscal Year (FY) 1975 (No. 93-1255), Reference (9), directed the DoD to: (1) initiate a program to improve the control and distribution of available military health care services; (2) project and allocate costs for health care programs; and (3) minimize fraudulent use of military health care benefits and entitlements by unauthorized persons.

After two years of study, the OASD (H&E) Health Studies Task Force published The Health Beneficiary Enrollment Eligibility System for the Department of Defense working paper in February 1977, Reference (10). This paper concluded that the best method to deter fraudulent use of medical services was to institute eligibility verification. This verification required that an automated, centralized system be established to contain the names of all eligible beneficiaries and match or link those beneficiaries to specific sponsors.

The working paper acknowledged that the DoD and the seven Uniformed Services already had a basic eligibility verification vehicle in place, namely the Application for the Uniformed Services Identification and Privilege Card (Department of Defense [DD] Form 1172)⁴. This form was completed by the sponsor and used by the Uniformed Services to authorize issuance of the DoD Uniformed Services Identification and Privilege Card (DD Form 1173) to family members. The DD Form 1173 authorized the family member's access not only to medical care, but also to DoD commissary, exchange, and MWR benefits or entitlements. The DD Form 1172 could serve as the enrollment form for the centralized beneficiary system, and the DD Form 1173 could serve as the membership card certifying eligibility for benefits or entitlements. Since DoD and Uniformed Services procedures were already in place to issue both DD Form 1172 and DD Form 1173, using these forms would not require additional training for the Uniformed Services personnel completing or processing the forms.

The next steps were to identify the functional and technical requirements for an automated centralized beneficiary system that would support the beneficiary enrollment and eligibility verification concept, and to build a demonstration model. The Enrollment Demonstration System was completed in 1978. Based on the Enrollment Demonstration

⁴ The DD Form 1172 was redesigned in 1981 and renamed the "Uniformed Services Identification Card and DEERS Enrollment."

System's successful operation, both the House and Senate Appropriations Committee Reports of December 1979 (for FY 1980) recommended funding for DoD enrollment and eligibility verification project. Following congressional approval of the funding, the OASD (HA) and the OASD for Manpower, Installations, and Logistics (MI&L) established the DEERS Project.

In early 1980, the DEERS Project evolved into the DEERS Program. On October 14, 1981, the Deputy Secretary of Defense (DepSecDef) published DoDD 1341.1, "Defense Enrollment Eligibility Reporting System (DEERS)," Reference (11), that officially established the DEERS Program; the DEERS PM position; the DEERS Program Office (DPO); and assigned overall policy and procedural responsibilities for the DEERS Program jointly to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) and the Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics (ASD (MRA&L)).

On March 2, 1982 the Deputy Secretary of Defense (DepSecDef) published DoD Instruction (DoDI) 1341.2, "Defense Enrollment Eligibility Reporting System Procedures," Reference (12), which: (1) further delineated the specific responsibilities of the DPO PM; and (2) created the DEERS Steering Group, DEERS Steering Group Secretariat, DEERS Work Groups and Work Group Committees, and the Configuration Control Board.

In 1982, the DoD expanded the DEERS Program to include verification of beneficiary eligibility for non-medical benefits and entitlements to commissary, exchange, and MWR. This expansion was based on the need to control fraud, waste, and abuse in the management of DoD non-medical benefits and entitlements that were previously mandated by Congress in Title 10 USC, Chapter 54. Since DD Form 1172 and the ID card were already in use to validate these benefits and entitlements, as well as to verify eligibility for medical entitlements, it made sense to include verification for all benefits and entitlements in DEERS.

In 1985, the OASD (HA) established the Reportable Disease Database (RDDDB) to collect information on reportable infectious diseases. This DEERS client application collects information on Human Immunodeficiency Virus (HIV) infection test results from all service military members and from certain DoD and Uniformed Services civilian employees. The RDDDB can collect information on other diseases, such as hepatitis. The negative or positive results of these HIV tests are reported to the DEERS Division for test registration into DEERS. The data in the RDDDB is extremely sensitive and can only be accessed online by designated persons in the Offices of the Surgeons General of the Uniformed Services. The DEERS database reports a Yes flag for the HIV test, which indicates only that a test was taken, and the date the test went on file. Personnel community users are restricted to viewing only *Yes* or *No* flags and test registration dates for this medical data.

In 1986, the DEERS mission was expanded by Congress⁵ to include enrolling non-active duty National Guard and Reserve members and their eligible family members. This enrollment supported the DoD mission to project future military medical costs in the event of the activation and/or mobilization of these National Guard and Reserve members; and to estimate future Military Treatment Facility (MTF), CHAMPUS, and space available (contract) dental care costs for their family members. Additionally, this enrollment supported eligibility

⁵ National Defense Appropriations Bill for Fiscal Year 1986.

verification for commissary, exchange, and MWR benefits or entitlements which Title 10 USC, Chapter 54 authorized for this population.

Also in 1986, for FY 1987⁶, Congress modified Title 10 USC, Chapter 55 to direct the DoD to develop and implement a dental insurance plan for CHAMPUS-eligible family members of active duty and National Guard and Reserve sponsors who were on active duty orders for at least 24 months. The DEERS mission was again expanded to support eligibility verification for this program, which was titled the Uniformed Services Active Duty Dependent Dental Plan (DDP), and subsequently renamed the TRICARE Active Duty Family Member Dental Plan (TFMDDP) program.

Between 1986 and 1990, DEERS expanded further when several client applications (interfacing client systems) were developed to support the medical community. These client applications were and are still used to add and update tumor data, and to add the storage location of the duplicate dental pan-oral radiograph (Panograph) used for casualty identification. Personnel community users are restricted to viewing the date of the most recently received Panograph. The client applications and interfacing client systems allowed the medical community user to view beneficiary eligibility data in read-only mode, and to update beneficiary residential addresses and telephone numbers.

Because certain DoD military installations were to be closed, the National Defense Authorization Act (NDAA) for FY 1993 required the DoD to include a mail order and retail pharmacy program in all managed care programs initiated, awarded, or renewed after January 1993. This program is referred to as the Base Realignment and Closure (BRAC) Pharmacy program. The BRAC Pharmacy program applies to DoD beneficiaries, including Medicare-eligibles, residing in the vicinity of a BRAC-closed installation. The BRAC Pharmacy contractor uses a proprietary application to view the BRAC enrollment data. Mail-order pharmacy benefits are currently administered through the National Mail Order Pharmacy (NMOP). The TRICARE Mail Order Pharmacy Program (TMOP) succeeded NMOP in the fall 2003.

In July 1997, the DEERS mission was once again expanded to store the right index fingerprint⁷ of all eligible individuals in a pay or annuity status, including active duty and Reserve military personnel; retired sponsors; survivors receiving annuity payments derived from the service of a deceased person; and entitled civilian employees to be used by the USD (Comptroller). This improved service member identification and verification techniques. In October 1997, DEERS was tasked to serve as the Department's centralized personnel locator service in accordance with Section 113 of 10 USC⁸ by maintaining current addresses for members of the Armed Forces, and providing addresses upon request to the Federal Parent Locator Service of the Department of Health and Human Services' Office of Child Support Enforcement. The TRICARE Selected Reserve Dental Program (TSRDP) was also implemented in 1997. In 1998, the TRICARE Retiree Dental Program (TRDP) was

⁶ National Defense Appropriations Bill for Fiscal Year 1987.

⁷ The right index fingerprint will be kept for use by the USD (Comptroller), as authorized by the USD (P&R) memorandum, "Fingerprint Capture Policy," dated 15 July 1997, Reference (f).

⁸ Section 113 of Title 10, United States Code, "Enforcement of Child Support Obligations of Members of the Armed Forces," Reference (e).

implemented. The DEERS mission expanded to support eligibility determination for both dental programs.

Earlier attempts at a partial DEERS redesign included an application merge effort to consolidate online applications accessing the Eligibility Database, and an Enrollment Sponsor Redesign, initiated to modularize and incorporate tables in the existing Enrollment Database's software. In 1994, DEERS was designated as an OUSD (P&R) migration system. To ensure DEERS' orderly evolution to an open systems environment and conformance with DoD standards, the Enrollment Eligibility Reconciliation (E2R) project was begun in January 1995. This project was initiated to reengineer the DEERS data model. The new data model would implement new business rules using rules-based tables to derive Uniformed Services benefits/entitlements, and capitalize upon many advances in hardware, software, and system design techniques. This new data model would improve data quality and overcome DEERS' limitations of inflexibility, high maintenance and modification costs, and inefficiency. Analyzing benefit categories and the rules of eligibility applied to them clearly indicated that the benefits/entitlements rules could be defined to support automated determination of the benefits/entitlements eligibility set.

Because RAPIDS is the primary means for updating eligible family member information in the DEERS Eligibility Database, it was chosen as the first client application to be reengineered for compatibility with the DEERS environment. Together, DEERS and RAPIDS reengineering efforts were known as the DEERS Redesign Project.

From 1998 through 1999 DEERS continued to coordinate the TMA directed requirements for the expanded Eligibility, Enrollment, OHI, and Claims Coverage included in the DEERS/Medical Interface Operational Description of November 5, 1999. In addition, during this period the TMA along with DEERS investigated how to make the TRICARE health plans portable across the individually managed geographic regions and contracts. The direction, from the Joint Chiefs of Staff, to make the program plans portable for the benefit of the enrolled beneficiary population, and the standing Congressional mandate to develop a central enrolled database for the TRICARE programs, led to the development of the National Enrollment Database (NED).

DEERS phased in elements of the NED with the implementation of the Defense Online Eligibility and Enrollment System (DOES) in support of the Federal Employee Health Benefit Plan (FEHBP) enrollment in 2000. The DOES is the standard enrollment application developed by DEERS to verify eligibility and perform enrollment related functions into any DEERS maintained Health Care Delivery Program (HCDP). DOES became the eligibility and enrollment application for the TRICARE Senior Supplement Demonstration (TSSD) project.

During the period of 1999 DEERS\RAPIDS was assigned a role in the development of the DoD Smart Card using Integrated Circuit Chips (ICCs) and Public Key Infrastructure (PKI) certification and intelligent data chip on the card. This project evolved into the DoD Common Access Card (CAC) for DoD affiliated sponsors. The DMDC formed the Access and Authentication Technology Division (AATD) from DEERS to focus on the DoD CAC project, which was implemented worldwide in the fall of 2001.

In the spring of 2005, AATD was renamed Card Technology and Identity Solutions (CTIS). Also, based on the NDAA FY 2000, Public Law 106-65, sec. 711, Chapter 55 of title 10,

USC 1076a., 32 CFR 199.13 the TRICARE Active Duty Family Member Dental Plan (TFMDP) and the Guard/Reserve Dental Program were consolidated into one inclusive dental insurance program with expanded coverage for the Guard/Reserve sponsors and their family members. The consolidated program, the TRICARE Dental Program (TDP), became the first implementation of the expanded business process using DOES as the eligibility and enrollment application, automated notifications back to the enrolling entity, and claims coverage inquiries for the processing of TDP dental claims. The TDP became the first medical program to operate all business processes in the NED.

On July 16, 2001 the NED was successfully implemented to TRICARE medical-facilities worldwide using a central eligibility and enrollment application platform (DOES), a central enrollment database of record NED and the portability of health care coverage and fees across the geographically managed health care contracts. At the same time DEERS became the issuing source for the TRICARE universal beneficiary health care enrollment card. This card is issued to each TRICARE-enrolled beneficiary upon initial enrollment, transfer across contracts, change of enrollment program, and may be reissued when the card is lost or damaged. This is the first time the enrollment card is issued centrally with a standard format in support of the health care portability initiatives.

On July 19, 2004, the Deputy Secretary of Defense signed DoDD 1000.25, the Personnel Identity Protection (PIP) Program, which directs the Department to use emerging technologies to support the protection of individual identity and safeguard DoD physical assets and logical systems. In conjunction with this directive, DEERS is identified as the official identification system for the DoD. The Identity Authentication Office was established to focus on identity services to support physical and logical access needs across the DoD.

On September 24, 2005, the final step to ensuring enrollment portability was achieved with the Final Policy Consolidation. DMDC converted all enrollment policies to DoD level policies rather than contractor-based policies.

While legislative updates and Congressional mandates often expand current programs and business processes, DEERS keeps focused on providing responsive service to the DoD beneficiary population.

3.0. DOCUMENT OVERVIEW

This document is divided into the following sections:

- Chapter 3, Section 1.1 describes the scope of this document.
- Chapter 3, Section 1.2 lists the documents that are referenced within this document.
- Chapter 3, Section 1.3 presents the basic terms and concepts necessary to understand DEERS and its interfaces.
- Chapter 3, Section 1.4 presents an overview of the interface design.
- Chapter 3, Section 1.5 details the functions supported by the DEERS interface.
- Chapter 3, Section 1.6 describes DEERS Technical Support Operations (Help Desk Support).

- Chapter 3, Section 1.7 details the Test and production Environments.

REFERENCED DOCUMENTS

1.0. DOCUMENTS REFERENCED BY NUMBERS

- Department of Defense Directive (DoDD) 8000.1, "Defense Information Management Program," dated 27 October 1992.
- Section 113 of Title 10, United States Code (USC), "Enforcement of Child Support Obligations of Members of the Armed Forces".
- Undersecretary of Defense for Personnel and Reserve Affairs Memorandum, "Fingerprint Capture Policy," dated 15 July 1997.
- 32 Code of Federal Regulations (CFR), Part 199.
- General Accounting Office (GAO) Summary Report, "Potential for Improvements in the Civilian Health and Medical Program of the Uniformed Services," dated 19 July 1971.
- House Appropriations Committee Report for Fiscal Year (FY) 1975 (No. 93-1255).
- Office of the Assistant Secretary of Defense for Health and Environment Health Studies Task Force Working Paper, "The Health Beneficiary Enrollment Eligibility System for the Department of Defense," dated February 1977.
- DoDD 1341.1, "Defense Enrollment Eligibility Reporting System (DEERS)," dated 29 May 1999.
- Department of Defense Instruction (DoDI) 1341.2, "Defense Enrollment Eligibility Reporting System Procedures," dated 19 March 1999.
- DEERS Business Rules
- DoDD 1000.25, "DoD Personnel Identity Protection (PIP) Program," dated 19 July 2004.

2.0. OTHER RELATED DOCUMENTS

- National Enrollment Database (NED) (DEERS Online Enrollment System (DOES)) Training document
- DEERS Medical Data Dictionary
- DEERS Technical Specifications
 - Gold File
 - Policy Notification
 - Claims
 - Catastrophic Cap and Deductible Database (CCDD)
 - Batch Enrollment Fee/Failure to Pay
 - Civilian PCM Load

- Health Insurance Carrier (HIC)/Other Health Insurance (OHI)
- Patient ID Change Notification
- Beneficiary Web Enrollment (BWE) Enrollment Fee Gateway
- Privacy Act of 1974
- Defense Logistics Agency Regulation 5400.21
- DoD Standard 5200.28-STD
- DoDI 1000.13, "Identification Cards (ID) for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals," dated 1 December 1997.
- DEERS/Military Health System (MHS) System/Subsystem Requirements Specification, dated September 1998
- ANSI ASC X12 Standards, Version 4 Release 1, December 1997
- Database Roles
- DEERS Business Rules
- Defense Manpower Data Center (DMDC) DEERS/MHS TRICARE Next Generation (T-NEX) Contractor Testing, Benchmark, and Production Problem Reporting

3.0. WEB SITE RESOURCES FOR DOCUMENTS

DMDC home page: <https://www.dmdc.osd.mil/deers>

4.0. ACRONYMS AND ABBREVIATIONS

See Chapter 3, Addendums A and B for listings of acronyms and abbreviations.

DEERS CONCEPTS AND DEFINITIONS

1.0. INTRODUCTION

Defense Enrollment Eligibility Reporting System (DEERS) is designed around the concept of a person. DEERS is a person repository that contains all Department of Defense (DoD) beneficiaries plus the capability to store information for people who are not eligible for DoD benefits. Within DEERS, interfaces with external systems are based on commercial standards where it supports the business requirements or standardized DEERS defined messages where needed.

2.0. TYPES OF DATA DEERS USES AND STORES

Three basic types of information: Person and Personnel, Beneficiary, Medical and Benefit, can be stored and provided to the Military Health System (MHS) through a central repository. Each is detailed below.

2.1. Person And Personnel Information

This is basic characteristic data about individuals, including both affiliations to DoD organizations or organizations designated by DoD, and affiliations within family units. Although historical data is available for longitudinal studies and demographic trend analysis, only current data is required for day-to-day clinical operations.

2.1.1. Person Data

- Primary (internal) identification - A mutually agreed-upon internal identifier [Patient Identifier (Patient ID) {Electronic Data Interchange Person Number - EDIPN}, DEERS Identifier (DEERS ID)] shared between the repository and external interfacing systems
- Secondary (external) identification - Name, Social Security Number (SSN), and Date of Birth (DOB)
- General characteristics - Sex, blood type, etc.
- Person-based programs - Organ donor
- Family association - Self, child, etc.
- Contact information - Address, telephone number

2.1.2. Personnel Data

- Personnel category - Active Duty (AD), reserve, retired, etc.
- Service or organization - Army, Navy, DoD civilians, etc.

- Position - Rank
- Personnel readiness programs - Reportable Disease Database (RDDDB) or DNA

2.2. Beneficiary Information

This information combines the underlying rules-based system that captures DoD Instruction (DoDI) 1000.13, "Identification (ID) Cards for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals" and other applicable regulations and procedures with enrollment information, as maintained by the MHS community. This data is provided for past, current, and future periods from the inquiry date, and consists of specific Health Care Delivery Program (HCDP) information.

Examples of this information are:

- DoD HCDPs: DoD HCDPs are defined by DEERS as the methods of providing basic health benefits. Examples of these include TRICARE Prime, Uniform Services Family Health Plan (USFHP), Federal Employees Health Benefits Program (FEHBP) Demonstration Project, and Continued Health Care Benefit Program (CHCBP).
- Other Government Programs (OGPs): OGP are defined by DEERS as programs or plans provided and supported by a U.S. Government agency other than the DoD. The two current types of programs stored in DEERS are Medicare and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Other Health Insurance (OHI) (Commercial): OHI information is stored in DEERS to support third party collections.

2.3. Medical Benefit Information

2.3.1. General Policy

Examples of medical benefit information that DEERS tracks on a policy level include:

- Deductible accumulation
- Catastrophic cap accumulation
- Enrollment fee accumulation and fee details (including fee exceptions)

2.3.2. Person Related

Examples of medical benefit information that DEERS tracks on a person level include:

- OHI
- Enrollment fee waiver information

3.0. SPECIFIC DEERS ROLES

3.1. Person Role

An individual exists within DEERS first and foremost as a person who may have multiple roles, including but not limited to: a sponsor, a family member, a beneficiary, and a patient. This implies the existence of certain attributes tied to a person that do not normally change as his or her role within the system changes. For example, a person has a name, DOB, weight, height, hair color, eye color, and possibly an SSN. Both sponsor and family member are possible but not mutually exclusive roles of a person in the DEERS database. The family member role is supported by person association and condition data that cross-references the family member's sponsor. This expanded person role exists solely within DEERS.

3.2. Sponsor And Family Member Roles

A sponsor is any person who, as a direct affiliate or member of an organization within the DoD, is entitled to benefits from the DoD and who, through that affiliation or membership, entitles his or her family members to benefits. Members of non-DoD organizations whose employees are authorized DoD benefits are also sponsors, and often accord eligibility to their family members.

As of October 1, 2003, a former spouse will also be considered a sponsor and will no longer be identified by their previous relationship to a Uniformed Services service member. A former spouse will be identified by their individual SSN and not the SSN of the military service member. DMDC will provide contractors with a crosswalk file for former spouses previously identified by the military service member's SSN.

TRICARE entitlement for an unremarried former spouse is ended with the existence of an employer sponsored health plan. Contractors can identify an unremarried former spouse on the DEERS claims response from a discreet member category code that indicates the type of DoD Beneficiary. (See the DEERS Data Dictionary for Member Category Codes.) There is a unique member category code for each category of unremarried former spouse. If a DEERS claims response shows a person to be an unremarried former spouse (via the member category code) and the claim shows the possible existence of an employer sponsored health plan, the contractor shall proceed in accordance with the TRICARE Policy Manual (TPM).

Abused dependents, like unremarried former spouses, are now part of the DoD Beneficiary Population on DEERS, and have a distinct member category code indicating their status. The presence of OHI does not remove an abused dependent's entitlement to TRICARE.

DoDI 1000.13 defines which relationships to sponsors make individual family members eligible for benefits. Some restrictions that influence the definition of a child family member include age, degree of support by the sponsor, physical disability, and educational status.

3.3. Beneficiary Role - Multiple Entitlements/Dual Eligibility

DEERS considers both sponsors and family members as beneficiaries (i.e., recipients of DoD benefits). The role of beneficiary is, however, ambiguous because a person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor or by being a sponsor in one family while being a member of another. An example is a person that is a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as **multiple entitlements**. DEERS supports multiple entitlements by not only storing persons but any combination of their current and past associations.

Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. Becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

In some cases, the roles leading to multiple entitlements may change back and forth. For example, a child of married reservists who move in and out of AD assignments may have transitory periods of entitlement to medical benefits under each sponsor. Each sponsor in this family has the potential to provide medical benefits for the family member (child) for various periods of time. Therefore, this multiple-entitled child may need to be changed back and forth between the two sponsor spouses as the situation changes. The concept of **dual eligibility** occurs when multiple entitlements are concurrent. This situation can occur when a sponsor is both a retired sponsor and a civil servant on overseas assignment. The beneficiary would have a coverage plan as the retired sponsor and another coverage plan as the civil servant. Hence, dual eligibility results when a person is associated with more than one DoD affiliation.

All instances of family membership and/or sponsorship are stored under unique identifiers. These identifiers are associated to a family as the DEERS Family Identifier (Family ID-nine digit DEERS-assigned number) and each member of the family, including the sponsor, is further delineated by the DEERS Beneficiary Identifier (Beneficiary ID-two digit DEERS-assigned number within each DEERS Family ID). All systems storing benefits or enrollment information about a beneficiary must do so by DEERS Family ID and DEERS Beneficiary ID (in combination known as the DEERS ID for a beneficiary). All information about TRICARE enrollments and policies to and from NED in DEERS and the regional contractors must be done using this Identifier. Updates of all other secondary attributes including SSN, Name, or DOB are exchanged using this DEERS ID as primary means of identification.

3.4. Patient Role

The patient role results from an association between a person and a DoD Health Care delivery provider. It is important to note that a person is not required to be currently eligible for DoD benefits to be considered a patient. For example, the patient may have been a beneficiary in the past but is no longer eligible for DoD benefits. In certain cases, an individual who is not an authorized DoD beneficiary may be treated in an emergency situation at a DoD Military Treatment Facility (MTF), and is therefore a patient. Persons on the Person Data Repository (PDR) of DEERS and on clinical systems within the DoD are identified in the patient role by the Patient ID, also known as the EDIPN Identifier. All

clinical and reporting data must be exchanged using this identifier. TRICARE contractors must store this identifier associated with each enrollee on their database.

3.5. Beneficiary Roles Within HCDPs

3.5.1. Subscriber Role

A subscriber is an individual who is the primary holder of a DoD policy (i.e., the primary holder of a DoD entitlement) for health care benefits based on his or her affiliation with the DoD. The subscriber is the sponsor.

3.5.2. Insured Role

An insured is an individual who is covered by a Uniformed Services health benefits program (i.e., an HCDP) for medical coverage. The individual is entitled to these programs based upon his or her association to a subscriber. A person may be both a subscriber and an insured. For example, under TRICARE Prime Individual Coverage for Retired Sponsors and Family Members, the sponsor is both the subscriber and an insured. However, other sponsors may be a subscriber and not be an insured. For example, a sponsor on AD may be the subscriber for his or her family members that are insured under TRICARE Prime Family Coverage for Active Duty Family Members (ADFMs).

3.6. Sponsor, Subscriber, Beneficiary, And Insured Roles

As stated above, a sponsor is first and foremost, a person within DEERS. As a sponsor, the person may also be the subscriber who holds the DoD “policy” for health care benefits. As a beneficiary, the person may also be an insured who is covered by a DoD “policy” for health care benefits.

3.7. Family Member, Beneficiary, And Insured Roles

As stated previously, a family member is first and foremost, a person within DEERS. As a sponsor, the person may also be the subscriber who holds the DoD policy for health care benefits. Another person, through associations and relationships, may be a family member to the sponsor, which implies a role as a beneficiary. As a beneficiary, the person may also be an insured who is covered by a DoD policy for health care benefits.

4.0. TERMINOLOGY USED IN DEERS

The DoD, MHS and DEERS are migrating to a design based on commercial practices and standards. DMDC is modeling the solution for DEERS on commercial health insurance concepts and terminology.

4.1. Plan Sponsor

The plan sponsor is the organization or entity responsible for funding the coverage contained within the insurance plan. Within MHS, the DoD is the plan sponsor.

4.2. Insurer

The insurer is the insurance company. For DEERS, the DoD is the insurer (i.e., self-insured).

4.3. Insurance Program

The insurance program is the collection of insurance plans, offered by the plan sponsor, that make up the benefit structure for the beneficiary population.

4.4. Insurance Plans

The insurance plans are the individual benefit packages offering coverage for the beneficiary. For the DoD, this includes a medical benefit plan, a dental benefit plan, and a life insurance plan. For DEERS, the insurance plans are referred to as HCDPs.

4.5. Insurance Plan Options

Insurance plan options represent the different types of coverage available within each insurance plan. For DEERS, insurance plan options are called HCDP Coverage Plans. Some examples of coverage plans include TRICARE Prime Individual Coverage for AD Sponsors and TRICARE Prime Family Coverage for Retired Sponsors and Family Members.

4.6. Insurance Policy

An insurance policy is the unique insurance plan option selected by the beneficiary for each available insurance plan.

4.7. Subscriber

A subscriber is the individual who is the primary holder of an insurance policy. For DEERS, the subscriber is the sponsor.

4.8. Insured

The insured is the individual person covered under the insurance policy. For DEERS, the insured is the beneficiary.

5.0. TRICARE POPULATIONS

The TRICARE programs serve a wide range of beneficiaries holding various statuses throughout their lifetime. The following information details the populations covered by the TRICARE benefit. The definition of the populations may be modified as legislation or TMA requires. These populations include:

- Active Duty Service Members (ADSMs) and ADFMs
- Transitional Assistance Management Program (TAMP) Sponsors and Family Members

- Transitional Survivors of AD Deceased Sponsors - Family members of an ADSM who died within the past three years while on AD. This also includes the family members of a Guard/Reserve sponsor who died within the past three years while on AD for more than 30 days. If the family members are enrolled in TRICARE Prime when the sponsor dies, DEERS automatically disenrolls them from the ADFM plan and enrolls them for three years in the Transitional Survivor plan.
- Survivors of AD Deceased Sponsors - Family members of an ADSM who died over three years ago while on AD. This also includes the family members of a Guard/Reserve sponsor who died over three years ago while on AD for more than 30 days.
- Retired Sponsors and Family Members - Retirees eligible for retirement pay and their family members as well as Medal of Honor recipients.
- Transitional Survivors of Guard/Reserve Deceased Sponsors - Family members of a Guard/Reserve sponsor who died within the past three years, while on AD for less than 30 days. These beneficiaries have no prior eligibility for TRICARE Prime, so DEERS does not automatically enroll them.
- Survivors of Guard/Reserve Deceased Sponsors - Family members of a Guard/Reserve sponsor who died in service over three years ago, while on AD for less than 30 days.

6.0. TYPES OF HCDP PLANS

Delivery programs are methods of providing basic health benefits. Coverage under these programs may be either individual or family, depending on the number of beneficiaries enrolled and beneficiaries' affiliation to the sponsor, as well as the program definition.

There are two types of plans within DEERS: assigned and enrolled. Assigned plans represent the base entitlement of a beneficiary (e.g., TRICARE Standard). Assigned plans are based on a sponsor's affiliation to a DoD organization (e.g., Army AD); therefore, when a sponsor's DoD affiliation changes (e.g., Army AD to Army Reserves), a new assigned plan is created. Enrolled plans represent another level of benefit into which the beneficiary has elected enrollment (e.g., TRICARE Prime).

The Uniformed Services Health Benefit Program consists of various health care coverage plans.

6.1. Uniformed Services Health Benefit Program

The following sections detail the various types of health care plans currently available within the DoD. The Managed Care Support Contractor (MCSC)/USFHP provider is required to implement a system that allows changes to health care plans and HCDP plan coverage codes as legislation and regulation require. Refer to Chapter 3, Addendum C, HCDP Plan Coverage Details, for specific information related to each plan.

6.1.1. DEERS Assigned Plans

These plans are the defaults assigned by DEERS for beneficiaries based on their eligibility status. Assigned plans do not require enrollment actions.

6.1.1.1. Health Care Plan: AD - Direct Care (DC)

The AD - DC HCDP is the basic coverage assigned by DEERS for eligible beneficiaries, specifically AD sponsors.

6.1.1.2. Health Care Plan: TRICARE Standard

The TRICARE Standard HCDP is the basic coverage assigned by DEERS for eligible beneficiaries and results when a beneficiary under the age of 65, or 65 and over but not Medicare eligible, is entitled to both DC and Civilian Health Care (CHC).

6.1.1.3. Health Care Plan: TRICARE Extra

TRICARE Extra allows a beneficiary eligible for TRICARE Standard to seek care from a TRICARE network provider, thus obtaining a discount on services and a reduced cost share. Since TRICARE Extra acts like TRICARE Standard for DEERS purposes, DEERS does not track this option.

6.1.1.4. Health Care Plan: DC

This plan allows beneficiaries who are not entitled to civilian health care to obtain care in MTFs. Examples of the eligible population include dependent parents and parents-in-law, or beneficiaries age 65 and over eligible for the Medicare benefit that do not have both Medicare Parts A and B.

6.1.1.5. Health Care Plan: TRICARE For Life (TFL)

Beneficiaries age 65 and over with Medicare Parts A and B are eligible for the TFL benefit. The National Defense Authorization Act for Fiscal Year (FY) 2001 (NDAA FY 2001) required this delivery program, which became effective October 1, 2001.

6.1.1.6. Health Care Plans for DoD Affiliates

DoD affiliates are a conglomerate category of individuals entitled to DC or CHC at different levels than the groups defined in other HCDPs. The currently defined compositions of the DC categories are:

6.1.1.6.1. Health Care Plan: DC Continental United States (CONUS) For DoD Affiliates

This health care plan is available for the following population(s):

- North Atlantic Treaty Organization (NATO) Sponsored, Partnership for Peace, and NATO Non-Sponsored Foreign Military and their Family Members
- Non-NATO Sponsored Foreign Military and their Family Members

6.1.1.6.2. Health Care Plan: DC Outside The Continental United States (OCONUS) For DoD Affiliates

This health care plan is available for the following population(s):

- NATO and Non-NATO Foreign Military and their Family Members
- Civilian Personnel of DoD and other government agencies and their accompanying family members
- Civilian contractors under contract to the DoD or the Uniformed Services
- Uniformed and non-uniformed full-time personnel of the Red Cross and their family members
- Area executives, center directors and assistant directors of the USO and their family members
- United Seaman's Service (USS) personnel and their accompanying family members
- Military Sealift Command (MSC) Civil Service personnel

6.1.1.6.3. Health Care Plan: TRICARE Standard CONUS For DoD Affiliates

This health care plan is available for the following population(s):

- Family Members of Sponsored and Non-sponsored NATO Foreign Military

6.1.2. Enrolled Plans

6.1.2.1. Health Care Plan: AD - TRICARE Prime

ADSMs eligible for DC benefits are eligible to enroll into TRICARE Prime, which is similar to commercial Health Maintenance Organization (HMO) coverage. Beneficiaries must enroll through an authorized enrolling organization. Beneficiaries then select or are assigned a Primary Care Manager (PCM) in a MTF.

6.1.2.2. Health Care Plan: TRICARE Prime Remote Active Duty Service Member (TPRADSM)

The NDAA FY 1998 requires medical care coverage for AD members of the armed forces assigned to remote locations. This coverage is provided through the TRICARE Prime Remote (TPR) Program.

Eligibility for this health care coverage requires that the ADSM's permanent duty location and residence be more than 50 miles from a MTF or designated clinic or in a Lead Agent authorized zip code. The contractor may be notified by the Lead Agent to treat a zip code as remote prior to it appearing on the DEERS file as an authorized remote zip code. When the contractor enrolls a person in DOES, DOES will edit the zip code for TPR approval. The contractor can override the edit and proceed to enroll the person in TPR if the zip code is one that the Lead Agent has authorized. DOES uses the service member's residential and daily work location zip codes to determine if the member is eligible for remote coverage. Refer to Chapter 3, Addendum D, Medical Business Rules, for system edits based on these zip codes. Under this program, the ADSM may enroll and select a civilian or USFHP PCM. Since in some locations PCMs are not available, AD personnel may be enrolled in TPR without a PCM assignment.

TRICARE utilization review and utilization management requirements are not applied to this program; and designated Service Points of Contact (SPOCs) may authorize care not normally covered under the TRICARE Prime Uniform Benefit Program. When there is a change to the service member's residential or work zip code and either or both no longer fall outside of the 50 mile range from an MTF or designated clinic, DOES prompts the enrollment clerk to disenroll the member from TPR coverage.

6.1.2.3. Health Care Plan: TRICARE Prime

Beneficiaries who are eligible for TRICARE Standard may elect to enroll into TRICARE Prime, which is similar to commercial HMO coverage. Beneficiaries must enroll through an authorized enrolling organization. Beneficiaries then select or are assigned a PCM, and under some coverage plans may pay an annual fee for coverage.

6.1.2.4. Health Care Plan: TRICARE Prime Remote Active Duty Family Member (TPRADFM)

Under the provision of the NDAA FY 2001, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) has extended the remote medical coverage provisions of the NDAA FY 1998 to family members of the ADSMs assigned to remote regions. The current effective date for this plan is September 1, 2002. DOES enforces plan effective dates.

Eligibility for this health care coverage requires that the ADSM's permanent duty location and residence be more than 50 miles from an MTF or designated clinic, as determined by residential and daily work location zip codes; and that the family member has the same residential zip code as the sponsor Lead Agents also may authorize zip codes for TPR. If these zip codes no longer meet these requirements, DOES prompts the user to disenroll the appropriate family member(s). Refer to Chapter 3, Addendum D, Medical Business Rules. Under this program the family members may enroll and select a civilian

PCM. Since in some locations PCMs are not available, ADFMs may be enrolled in TPR without a PCM assignment.

There is a Point of Service (POS) option under this program. TRICARE utilization review and utilization management requirements do apply to this program.

6.1.2.5. Health Care Plan: TRICARE Plus

The TRICARE Plus program is a DC-based program that became effective October 1, 2001. Enrolled beneficiaries must be eligible for DC, and may or may not have an entitlement to CHC. There are two types of TRICARE Plus coverage to differentiate between those beneficiaries with a CHC entitlement and those without. Coverage is at the individual level. There are no family policies. A family may have more than one individual policy, with each family member holding an individual policy.

6.1.2.6. Health Care Plan: USFHP

The USFHP is a TRICARE program for major medical health care, preventive care, and medically necessary care including prescription drug coverage. The USFHP is currently composed of civilian health care facilities contracted by the DoD to provide health care through the USFHP. USFHP enrollees are enrolled into the TRICARE Prime coverage plans with a USFHP PCM Network Provider Type Option Code of 'U'. The USFHP also covers beneficiaries age 65 and over that are Medicare-eligible, as well as dependent parent and parent-in-laws that have been grandfathered into the program. The beneficiaries are enrolled in separate USFHP plans for persons only having a DC entitlement. (See Chapter 3, Addendum C for HCDP and PCM Network Provider Type Codes.)

6.1.2.7. Health Care Plan: TRICARE Senior Prime (TSP)

This coverage plan is referenced for historical purposes only.

Beneficiaries who were eligible for DC as well as Medicare may have chosen to enroll into the TSP coverage plan demonstration. Enrollees in this program selected a PCM in a participating MTF and were enrolled for the longevity of the program, which ended on December 31, 2001. Enrollment fees did not apply to this program. TSP did not offer a family coverage option, but allowed more than one individual plan for a family.

6.1.2.8. Health Care Plan: FEHBP Demonstration Project

The NDAA FY 1999 directed the DoD and the Office of Personnel Management (OPM) to develop a demonstration project to allow Medicare eligible military retirees age 65 and over, their family members, certain unremarried former spouses of military members or former members, and family members of deceased military members or former members to enroll into an FEHBP coverage plan for their health care.

The FEHBP demonstration project lasts three years at ten demonstration sites. Health care coverage began January 1, 2000 and ends December 31, 2002. Enrollment is managed through the FEHBP Demonstration Project Information Processing Center. The eligibility criteria and program requirements are beyond the scope of this document.

MCSCs do not perform enrollments for FEHBP.

6.1.2.9. Health Care Plan: CHCBP

The CHCBP is optional coverage to which beneficiaries may subscribe for a specified period (not to exceed 36 months) after the sponsor's entitlement to DoD benefits ends. Enrollment into the CHCBP program is performed by the CHCBP enrollment contractor. Details of this program are beyond the scope of this document (see the TPM, Chapter 10, Section 4.1).

6.1.2.10. Health Care Plan: TRICARE Reserve Select (TRS) Program

The TRS program is optional coverage to which Reserve Component members may subscribe when they commit to continued service in the Selected Reserve after release from AD to which the member was called or ordered for a period of more than 30 days on or after September 11, 2001, under one of the activation authorities in Section 101(a)(13)(B) of Title 10, U.S. Code and have served continuous for 90 days or more pursuant to such call or order to AD unless such continuous service on AD is less than 90 days solely due to an injury, illness or disease incurred or aggravated while deployed. Beneficiaries enrolled in the TRS program are not entitled to care at the MTF and must pay a premium for coverage.

6.2. Special Health Care Programs

DEERS supports any special health care program mandated by the DoD. These special health care programs are programs into which a beneficiary can enroll or register, regardless of other assigned or enrolled health care coverage plans to which they are entitled.

The Program for Persons with Disabilities (PPPWD) has been expanded to include an extended home health care benefit. The name of the TRICARE PFPWD has been changed to TRICARE Extended Care Health Option (ECHO). ECHO beneficiaries must be ADFMs, have a qualifying condition, and be registered to receive ECHO benefits on DEERS. MCSCs and USFHP providers are required to review appropriate documentation, including registration documents, and ascertain that individuals are ECHO eligible. Once a determination that an individual is ECHO eligible, MCSCs and USFHP providers must register the individual on DEERS. Registration will be performed through a Government Furnished Equipment (GFE) application and will include entering at least the following information, 1) ECHO, as a Special Health Care Coverage Plan Code, and 2) Registration Start Date. (**NOTE:** If the Begin Date is not entered, DOES will enter a default date using the 20th of the month rule.) ECHO-related codes needed for claims processing purposes shall be returned as a Special Health Care Program within the Health Care Coverage Claims Response. Contractors may also utilize the web-based General Inquiry of DEERS (GIQD) application to obtain ECHO coverage information. See the TPM and TRICARE Operations Manual (TOM) for details regarding this program.

7.0. IDENTIFICATION SCHEMA FOR ELECTRONIC DATA INTERCHANGE (EDI)

7.1. Primary And Secondary Identifiers

Identification of persons in the DEERS database is established via primary identifiers and secondary identifiers. A primary identifier must be unambiguous, so that information systems and software can process it without the need for intervention by users or artificial intelligence technology. Secondary identifiers can be ambiguous and must be processed by users who match these secondary identifiers to persons in the DEERS database. Because secondary identifiers are ambiguous, system users generally use more than one secondary identifier to minimize mistakes in the identification process. More information on primary and secondary identifiers is explained in the next section of this document.

7.2. Person Identification

Sources external to DEERS identify persons initially in the DEERS database using only secondary identifiers. DEERS is the definitive system for person identification. The secondary identifiers are:

- Sponsor's SSN
- First three characters of the last name
- DOB

If only the SSN is provided, duplicate records are often resolved manually and thus system-to-system identification cannot be done. The last name and DOB are used to resolve duplications when two or more individuals have the same SSN, and to correct inaccurate identification of persons caused by using only the SSN. Usually, a person may be positively identified by an end user by matching an SSN along with the first three characters of the last name and the DOB. Data for both sponsors and individual family members may be accessed in this manner.

Since DEERS does not contain every family member's SSN, the user may access these individuals by using the sponsor's secondary identification information. This returns a list of each family member associated with the sponsor.

7.3. Beneficiary Identification

Beneficiaries in the DEERS database are positively identified using a system-generated DEERS ID. DEERS IDs are internal to DEERS and its interface systems, and therefore are not entered by users. As previously stated, each DEERS ID is a primary identifier, and formed by a combination of the following:

- Family ID, a DEERS-assigned nine-digit number unique to each family, plus a
- Beneficiary ID, a DEERS-assigned two-digit number unique to each individual in a family

Although a person may have more than one DEERS ID, stemming from multiple entitlements (defined previously), DEERS IDs positively identify each beneficiary. DEERS

IDs, therefore, serve as primary identifiers and are used by information systems when passing data about individual beneficiaries and families.

A person may have multiple DEERS IDs over time and some of these instances are described as follows:

- A person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor. For example, a person may be a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as multiple entitlements.
- Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. In this case, the person would have a DEERS ID as a family member and as a sponsor. However, becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

7.4. Secondary Identification

In order to obtain a DEERS ID for a beneficiary, a system interfacing with DEERS must provide secondary identification information in one of several forms. This ensures the correct beneficiary is found, received, and stored with a DEERS ID. In the table below, the "Inquiry Information" column describes required information entering DEERS, and the "Response" column describes information returned by DEERS.

FIGURE 3-1.3-1 SECONDARY IDENTIFICATION

INQUIRY INFORMATION	RESPONSE
Family Member's Person Identifier and Person Identifier Type Code (S=SSN, D=DEERS assigned Temporary ID, F=DEERS assigned Foreign ID), Inquiry Person Type Code (sponsor or family member), Last Name and DOB (optional).	Family member option may return more than one DEERS ID if this beneficiary is in more than one family. User must then select correct beneficiary.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional), and family option.	Returns entire family of beneficiaries (one DEERS Family ID). User must select beneficiary from family.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional). AND Family Member's Person Identifier and Person Identifier Type Code (S=SSN, D=DEERS assigned Temporary ID, F=DEERS assigned foreign ID).	Returns one beneficiary.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional). AND Family Member's First Name and DOB.	Usually returns only one beneficiary except in some rare cases of same named twins.

7.5. Patient Identification

Patients have a primary identifier called the Patient ID, which is a DEERS-assigned ten-digit number. This is used similarly to the DEERS ID, although the primary purpose is to reliably access patient and person level information. DEERS generates a Patient ID to link all

MHS systems. The MCSC system must accommodate both the DEERS Patient ID and the HIPAA Patient ID.

7.6. Person Identification For Business Events

The following table identifies the options and type of data necessary to perform a DEERS/Medical business event for system-to-system interactions.

Legend (an “X” in a column indicates that the information may be used):

- Secondary identification: refer to the secondary identification section above.
- Individual/Family: indicates if the business event can be done for an individual, a family, or both.
- Refer to the specific business events throughout the Interface Operational Description (IOD) and the DEERS Business Rules for additional information.

FIGURE 3-1.3-2 PERSON IDENTIFICATION FOR BUSINESS EVENTS

PERSON IDENTIFICATION FOR BUSINESS EVENTS				
SECONDARY IDENTIFICATION	DEERS ID	PATIENT ID	INDIVIDUAL/FAMILY	BUSINESS EVENT
	X	X	I	Policy Notification
	X (Subscriber only)		I, F Depending on policy type	Enrollment Fee Payment
	X (Subscriber only)		I, F Depending on policy type	Disenrollment for failure to pay fees
X			I, F Depending on policy type	Enrollment Fee Payment Transaction History Request
X			I, F	Health Care Coverage Inquiry for Claims
	X		I	Catastrophic Cap & Deductible Updates
X			I, F	Catastrophic Cap & Deductible Transaction History Request
	X		I, F	Catastrophic Cap & Deductible Totals Inquiry
		X	I	OHI Notification
		X	I, F	OHI Inquiry
		X	I, F	OHI Policy Add/Update
		X	I, F	OHI Cancellation

7.7. HCDP Enrollment Management Contractor Identification

HCDP Enrollment Management Contractors are entities that are authorized to enroll MHS-eligible sponsors and family members into DoD coverage plans and are responsible for maintaining an individual’s HCDP policy. The organizations include MCSCs and USFHP providers and are referred to as enrolling organizations. DEERS tracks the enrolling

organization that is responsible for an individual's policy. A person only has one enrollment management contractor that is responsible for managing their coverage at any given point in time. DEERS creates a system identifier for each enrolling organization, and distributes the identifier to each system. Each MCSC and USFHP provider system has a system identifier for each contract, not region. This system identifier is used to identify the MCSC or USFHP provider system in system-to-system interactions with DEERS.

7.8. PCM Enrolling Division Identification

The PCM Enrolling Division is the organization that is primarily responsible for delivering the beneficiary's health care. This represents a grouping of providers in the Civilian, DC, resource sharing, and USFHP networks. Examples include MTFs, satellite clinics of MTFs, and possibly clinics within the MTF. DEERS maintains a table of organizations into which eligible subscribers and family members are enrolled. These organizations are identified by Defense Medical Information System (DMIS) IDs, which are associated to the regions in which they are located.

The MCSC shall implement each monthly DMIS table on the first day of the month following the download. Downloads are available on the DMIS web site.

7.9. PCM Identification

DEERS uses the MCSC PCM ID as an interim solution until a National Provider Identifier (NPI) becomes available. At that time, DEERS will utilize the NPI. MCSCs must not re-use PCM IDs. The MCSC is responsible for providing a crosswalk for converting PCM assignments from the MCSC provider ID to the national provider ID. The PCM ID cannot exceed 32 bytes.

7.10. Policy Identification

The MCSC must be able to match a policy using this information. DEERS uses the following combination to uniquely identify a policy:

- DEERS Family ID
- HCDP Type
- HCDP Plan Coverage Code
- DEERS Policy Begin Date

A sponsor can be a subscriber to multiple policies.

INTERFACE OVERVIEW

1.0. OPERATIONAL POLICIES AND CONSTRAINTS

Defense Enrollment Eligibility Reporting System (DEERS) and its interfacing systems operate under the following policies and constraints:

- Standard Provider, Payer, and Patient Identifiers (IDs) will be used, as legislated under Health Insurance Portability and Accountability Act (HIPAA) when these ID's are mandated for implementation.

2.0. SYSTEM DESCRIPTION

2.1. Interface

DEERS supports various interfaces to systems within the Military Health System (MHS) and outside the MHS including Centers for Medicare and Medicaid Services (CMS) and the state Medicaid agencies.

Major communities that DEERS interfaces with include:

- Composite Health Care System (CHCS)
- Department of Defense (DoD) service personnel systems
- MHS clinical systems
- MHS Data Repository (MDR)
- Managed Care Support Contractors (MCSCs)/claims processors
- Uniformed Services Family Health Plan (USFHP) Providers
- Health benefits advisors and other users throughout the Continental United States (CONUS) and Outside Continental United States (OCONUS) via the General Inquiry of DEERS (GIQD) application
- Pharmacy Data Transaction System (PDTS)
- Continued Health Care Benefit Program (CHCBP) administrator
- TRICARE Dental contractors
- Department of Veterans Affairs (DVA)
- TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)
- Other organizations as identified

2.2. DEERS Operational Environment and Characteristics

The DEERS system environment consists of a Relational Database Management System (RDBMS), rules-based applications processing DoD entitlements and eligibility, a Transmission Control Protocol/Internet Protocol (TCP/IP) sockets listener, application servers that enforce business rules, and web servers.

DEERS provides client/server applications, web applications, and system to system interfaces.

The government provides the MCSCs/USFHP providers with several Government Furnished Equipment (GFE) applications including:

- DEERS Online Enrollment System (DOES)
- Civilian Primary Care Manager (PCM) Maintenance
- Direct Care (DC) PCM Panel Reassignment
- Application Download
- PCM Research
- GIQD
- Catastrophic Cap and Deductible Database (CCDD) Research (MCSC only) and Enrollment Fee Payment Transaction Research
- Other Health Insurance (OHI) Maintenance Application
- Site Security Application
- Standard Insurance Table (SIT) Verification

DOES is a required GFE web-based application that supports enrollment and research functions.

The Civilian PCM Maintenance application is a required GFE web application used to perform Civilian PCM Panel Reassignments.

PCM Research application is an optional application that allows MCSCs to view PCMs and their usage.

2.2.1. Client Server Requirements

DOES is a required GFE client server application that supports enrollment and research functions.

The Civilian PCM Maintenance application is a required GFE client server application used to perform Civilian PCM Panel Reassignments. This is a companion application to DOES. If authorized for both applications, the user can access either application once they have successfully completed the common login.

The following is the “minimal” hardware and software requirements for all workstations running the DOES and Civilian PCM Maintenance applications. It is based on the same standard for running Microsoft Windows 2000. Like Microsoft Windows 2000, it is strongly suggested that workstations running the DOES and Civilian PCM Maintenance application exceed the minimal requirements for optimal performance.

2.2.1.1. Hardware Platform

At a minimum, the hardware platform will consist of a 1 Gigahertz (GHz) or faster Pentium compatible CPU with a minimum of 256 MB RAM and a minimum display resolution of 800 x 600. These minimum requirements are solely for the purpose of running the DOES and Civilian PCM Maintenance applications in a Microsoft Windows 2000 environment. It is strongly suggested that workstations running applications in addition to these exceed these minimal requirements for optimal performance.

2.2.2. Operating System

Microsoft Windows 2000. MCSCs shall plan for operating systems upgrades consistent with ongoing Microsoft releases. System upgrades shall be coordinated with Defense Manpower Data Center (DMDC) through the TRICARE Management Activity (TMA).

2.2.3. Disk Space

Microsoft Windows 2000 recommends a minimum hard drive of 2 Gigabytes.

2.2.4. Web Requirements

PCM Research application is an optional application that allows MCSC to view PCMS and their usage.

GIQD is a web-based GFE application used for research purposes that displays demographics, coverage and PCM assignment information. GIQD is available to the MCSC upon request through the Contracting Officer (CO).

The CCDD Research and Enrollment Fee Payment Transaction Research Application is a web-based GFE application that supports research on the history of CCDD and enrollment fee payment transactions posted to DEERS and stored on-line (total of three years).

NOTE: DOES will show all fee payments for an existing policy, as well as for policies that have ended within the last 12 months.

The OHI Maintenance Application is a web-based GFE application that is used by MCSCs, USFHP Providers, PDTS, and CHCS. It allows add, update, and cancellation of OHI policies as well as SIT carrier adds, updates, cancellations, and deactivations. This application is available to the MCSC, USFHP providers, and PDTS upon request through the CO.

The SIT Verification Application is a web-based GFE application that is used exclusively by TMA Uniform Business Office (UBO), the Verification Point of Contact (VPOC). The application queues all SIT transactions for review and verification by the VPOC.

GIQD and the CCDD Research Application require the MCSC/USFHP to use Netscape 4.0 or higher, or Internet Explorer 5.0 or higher browser using HTTPS.

The Security application is a web-based application. This required GFE application is used by the MCSC/USFHP provider to establish users and grant access to applications and other privileges. The MCSC/USFHP provider is responsible for designating one site security manager and one backup to manage all users and their access to DEERS applications. The MCSC/USFHP provider is required to remove access to all DEERS systems immediately upon departure of an employee from performing the function.

2.2.5. System Maintenance/Downtime

DMDC has routinely scheduled times for system maintenance and will schedule additional downtimes as required. The routinely scheduled downtimes are:

- Weekly - 2100 Eastern Saturday to 0600 Eastern Sunday
- Daily (if needed) - 2355 Eastern to 0100 Eastern

When DMDC identifies a telecommunications, hardware, or software problem outside a scheduled maintenance window that results in downtime for two contiguous or intermittent hours in the contractor interface, DMDC must notify the TMA DEERS Liaison Officer of the problem and approximately when it is expected to be corrected. The TMA DEERS Liaison Officer will then contact the TMA Contracting Officer's Representative (CORs)/Administrative Contracting Officer's Representative (ACORs). The TMA CORs/ACORs will notify all TMA contractors reliant upon DEERS of the situation and provide guidance as appropriate.

When the contractor experiences downtime for two hours contiguously or intermittently in the DEERS interface, and has not been contacted by the COR/ACOR, the contractor must thoroughly research the problem from their end to determine that they are not the source of the problem. If the contractor identifies the source of the problem on their end and the contractor anticipates it will take more than two or more hours to resolve, the contractor must inform the COR/ACOR. If the problem was expected to be resolved in less than two hours but is still unresolved after two hours, the contractor must contact the COR/ACOR.

If the contractor determines that telecommunications, hardware or software is operating normally at their end, then they shall contact the help desk at DMDC directly to notify DMDC of the problems being experienced. DMDC will validate whether a known problem exists and the approximate time required for resolution. If the problem identified by DMDC is expected to require more than two hours to resolve, the MCSC must notify the COR/ACOR immediately.

If DMDC is unaware of a problem at the time of contact by the contractor, they will initiate the appropriate action required to identify and resolve the problem and notify

the contractor of the amount of time required to resolve the problem once the source is determined. If DMDC determines the problem will require more than two hours to resolve, DMDC will contact the TMA DEERS Liaison Officer.

In a single day, any downtime, either intermittently or contiguously for greater than two hours must be reported to TMA, whether the source of the problem is the contractor, DMDC or unidentified.

2.2.6. System To System Interactions

FIGURE 3-1.4-1 SYSTEM TO SYSTEM INTERACTION

REFERENCE CHAPTER 3, SECTION 1.5 PARAGRAPH	BUSINESS EVENT	SENDING NODE	RECEIVING NODE	FORMAT	FREQUENCY
1.2.5.2.	PCM Interface Sending node organizations send addition and modification records.	MCSC USFHP provider	DEERS	XML	Event Driven
1.2.8.2.	Batch Fee Payment/Failure To Pay Fees	MCSC USFHP provider	DEERS	Batch: Fixed Length DEERS Defined	Nightly
1.4.	Notification of Policy Information This message sends a new image of demographic, address, policy, PCM, fee, and other pass through information.	DEERS	MCSC USFHP provider	Variable Length DEERS Defined	Event Driven
1.4.3.	Notification of Patient ID Change (This is a publish and subscribe model.)	DEERS	MCSC USFHP provider CHCS	XML	Weekly
1.6.1.1.	Health Care Coverage Inquiry	MCSC Claims Processor PDS	DEERS	Fixed Length DEERS Defined	Event Driven
1.6.1.2.	Health Care Coverage Response	DEERS	MCSC Claims Processor PDS	Variable Length DEERS Defined	Event Driven
1.6.1.3.	Partial Match Response to a Health Care Coverage Inquiry	DEERS	MCSC Claims Processor PDS	Variable Length DEERS Defined	Event Driven
1.6.1.4.1.	CCDD Totals Inquiry	MCSC Claims Processor PDS	DEERS	Fixed Length DEERS Defined	Event Driven
1.6.1.4.1.5.	CCDD Totals Response	DEERS	MCSC Claims Processor PDS	Variable Length DEERS Defined	Event Driven

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CHAPTER 3, SECTION 1.4

INTERFACE OVERVIEW

FIGURE 3-1.4-1 SYSTEM TO SYSTEM INTERACTION (CONTINUED)

REFERENCE CHAPTER 3, SECTION 1.5 PARAGRAPH	BUSINESS EVENT	SENDING NODE	RECEIVING NODE	FORMAT	FREQUENCY
1.6.1.5.	CCDD Update	MCSC Claims Processor TRRx and USFHP	DEERS	Fixed Length DEERS Defined	Event Driven
1.6.3.1.	Point of Sale (POS) Inquiry	PDTS	DEERS	XML	Event Driven
1.6.3.2.	Point of Sale (POS) Response	PDTS	TRRx	XML	Event Driven
1.6.3.4.	Person Demographics Service (PDS) Inquiry	PDTS	DEERS	XML	Event Driven
1.6.3.5.	PDS Response	DEERS	PDTS	XML	Event Driven
1.7.1.	OHI Policy Inquiry	MCSC Claims Processor TRRx CHCS	DEERS	XML	Event Driven
1.7.1.4.	OHI Policy Inquiry Response	DEERS	MCSC Claims Processor TRRx CHCS	XML	Event Driven
1.7.2., 1.7.3., 1.7.4.	OHI Policy Add/Update/ Cancellation	MCSC TRRx CHCS	DEERS	XML	Event Driven
1.8.2., 1.8.3., 1.8.4.	SIT Add/Update/Cancellation/ Deactivation	MCSC Claims Processor TRRx CHCS	DEERS	XML	Event Driven
1.8.2., 1.8.3., 1.8.4.	SIT Add/Update/Cancellation/ Deactivation	DEERS	MCSC Claims Processor TRRx CHCS	XML	Event Driven
1.8.5.	Publish and Subscribe for the SIT Table Change Any change to the SIT Table (e.g., adds, deactivation, temp to perm on a carrier ID, or updates) requires all holders of the SIT to download the SIT.	MCSC Claims Processor TRRx CHCS	DEERS	XML	Check Nightly
1.9.	File of CMS Information	DEERS	TDEFIC	FTP Fixed Length DEERS Defined	Monthly

2.3. DEERS Major System Components

Major components of DEERS include:

- Person repository
- National Enrollment Database (NED)
- Centralized CCDD repository
- PCM repository
- OHI repository
- SIT database

2.4. External Systems

All system to system interfaces to DEERS must use TCP/IP, FTP, HTTP, or HTTPS as specified by DEERS

- DEERS utilizes standard message protocols where appropriate
- DEERS defines the content and format of messages between DEERS and the MCSC
- DEERS and MCSC's and USFHP providers must utilize encryption for all messages that contain Privacy Act information
- DEERS specifies the method of encryption and authentication for all external interfaces (see Chapter 1, Section 1.1, paragraph 8.4., DEERS and MHS Telecommunications)
- All notifications are sent as full database images; they are not transaction-based. The MCSC must accept and apply the full image sent by DEERS. The MCSC or USFHP provider should add the information, if not present in their system. The MCSC or USFHP provider should update their system, if the information is present, by replacing their information with what is newly received from DEERS. Notifications are only intended to synchronize the most current information between DEERS and the MCSC. They do not synchronize history.
- DMDC centrally enforces all business rules for enrollment and enrollment-related events
- DEERS is the database of record for all eligibility and enrollment information

2.4.1. Data Sequencing

Since DEERS is tasked with resolving data conflicts from external systems using rules-based applications, the MCSC shall ensure proper data sequencing of transactions sent to DEERS. This aids in maintaining data validity and integrity.

DEERS FUNCTIONS

1.0. As the centralized data repository of Department of Defense (DoD) personnel and medical data and the National Enrollment Database (NED) for the portability of the MHS worldwide TRICARE program, the 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, assign a Primary Care Manager (PCM), transfer enrollments, perform a claims inquiry, and the associated updates of address information, Catastrophic Cap and Deductible Database (CCDD) information, Other Health Insurance (OHI) and the Standard Insurance Table (SIT). The expected data stores for the Managed Care Support Contractor (MCSC) are illustrated in Figure 3-1.5-1. Deviation from the intended concept of operations between the MCSC and DEERS shown in the figure below is at the contractors technical and financial risk.

1.1. Partial Match

DEERS provides two views of benefits and entitlements information: Eligibility for Enrollment and Coverage. [NOTE: The Eligibility for Enrollment view is provided through the DEERS Online Enrollment System (DOES) application only.] Both views of eligibility may result in a partial match situation due to person ambiguity. Person ambiguity can occur when two or more persons have the same Social Security Number (SSN) within DEERS. As mentioned previously with multiple entitlements, a person's role within DEERS may change over time, meaning he or she may be both a family member and a sponsor. Therefore, DEERS uses the Person Type Code (sponsor or family member) to identify the role the person is representing in the family. If the request uses the SSN of the sponsor, DEERS conducts the search where the SSN is used for a person representing a sponsor. If DEERS determines that the SSN is associated with multiple sponsors, DEERS provides a partial match response.

Likewise, if the request uses the SSN of a family member, DEERS conducts the search where the SSN is used for a person representing a family member. If DEERS determines that the SSN is associated with multiple family members, DEERS provides a partial match response.

If there is ambiguity, then a partial match response is returned. There will be a separate listing for each person or family matching the requested SSN. The listing includes the sponsor and family member identification information needed to determine the correct beneficiary or family including the DEERS Identifier (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. A partial match response may be returned for any inquiry that does not use a DEERS ID or Patient ID.

After this selection, the requesting organization would use the additional information returned (e.g., Date of Birth (DOB), Name) “to resend the inquiry.”

When implementing applications that use system to system interfaces that return partial matches (such as claims), those applications need to allow for their operator to be able to view and select the correct individual, as described above. The partial match response is designed to provide unique identifiers (Patient ID [Electronic Data Interchange Person Number - EDIPN] or DEERS ID) that can ensure that subsequent processing will uniquely identify the correct individual or beneficiary.

1.2. Health Care Delivery Program (HCDP) 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 insures that the individual is still eligible to use the benefits and that the MCSC or the Designated Provider (DP) has the most current information.

A beneficiary who is considered eligible for DoD benefits, according to 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

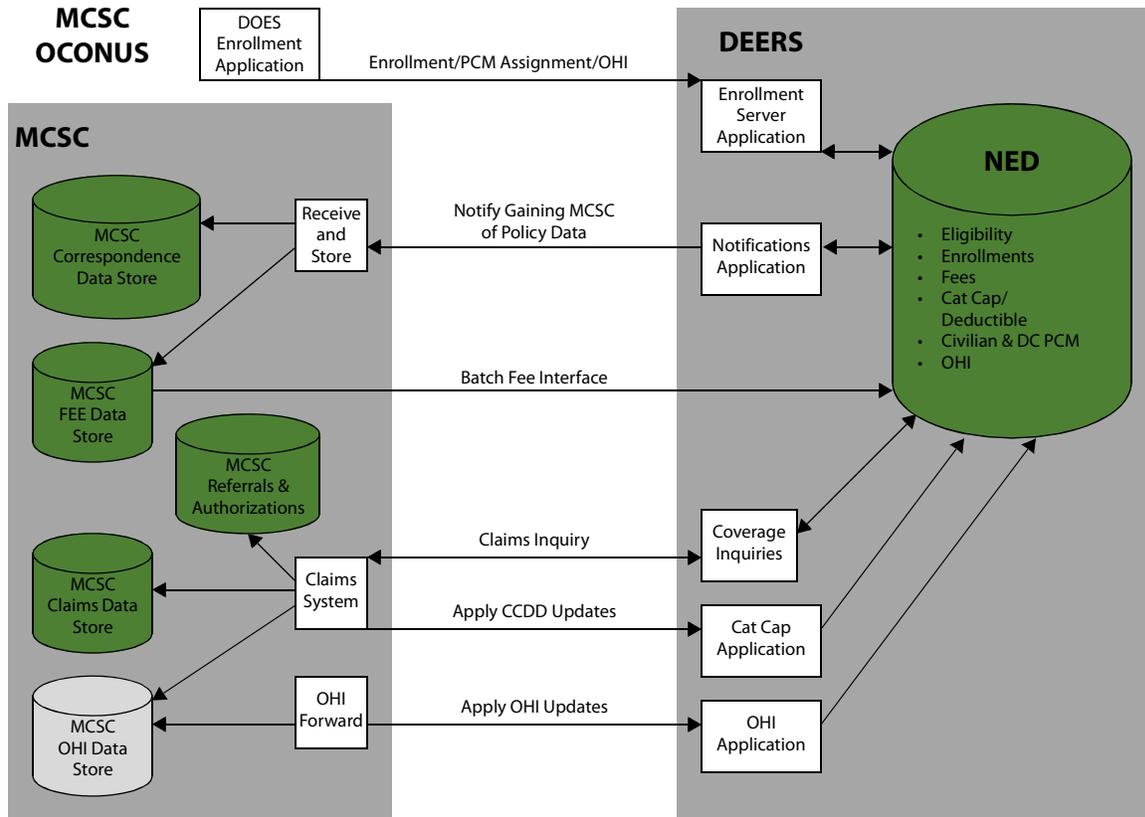
Enrollment related business events include:

- 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 HCDP coverage plans or for adding family members to an existing family enrollment. 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:
 - Specify enrollment fee information
 - 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 PCM selection
 - Transfer enrollment (enrollment portability) or cancel a transfer
 - Change enrollment begin date
 - Cancel enrollment/disenrollment
- Individual fee waiver information is used to indicate that an enrollee is exempt from paying enrollment fees.
- Enrollment fee payments and enrollment fee exceptions are used to indicate payment of, or exception from payment of, enrollment fees. The Fee/CCDD History 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).
- Modifications to a previous enrollment (updates) are used to change some information in the previous enrollment plan. Modifications of the previous enrollment include the following functions:
 - Change enrollment end date
 - Change enrollment end reason
- Request an enrollment card replacement
- Add OHI information for an enrollee
- Request a replacement letter for PCM change or disenrollment

The following figure shows the data and process flow required by the Government. Deviations from this diagram are at the contractor's technical and financial risk.

FIGURE 3-1.5-1 DEERS ENROLLMENT AND CLAIMS INTERACTION



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 and research. DOES interacts with both the main DEERS database as well as 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. MCSCs and Uniformed Services Family Health Plan (USFHP) providers 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
- Enrollment Fee Waiver Update for an Individual
- Beneficiary Update
- OHI Add
- Confirm Enrollment/PCM change (to support beneficiary web enrollment)

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

The NED (DOES) Training document may be referenced for examples of screens for DOES (Chapter 3, Section 1.2).

1.2.3. Beneficiary Self-Service

The Government will provide a web application for the beneficiary to perform enrollment-related activities. This application Beneficiary Web Enrollment (BWE) will serve all TRICARE eligible beneficiaries and will support most enrollment programs. BWE will interface with the MCSC/DP systems for the purposes of accommodating on-line payment of enrollment fees. See the BWE Enrollment Fee Gateway Technical Specification for more detail.

The web application will include all of the data elements contained on the Office of Management and Budget (OMB) approved universal enrollment/PCM change form. DEERS will pre-populate data elements where possible. The beneficiary can perform the following enrollment events:

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

The web application will contain checks for beneficiary eligibility and hard edits requiring the beneficiary to fulfill established DEERS business rules and enrollment criteria. Upon completion of the web application, the beneficiary is informed that the enrollment actions will be reviewed by the appropriate MCSC for accuracy and compliance with established Regional requirements, and that they will receive further notice from the MCSC as to any need for additional information. DEERS will send the MCSC or USFHP provider a Policy Notification, informing the MCSC or USFHP provider that a pending enrollment exists for the beneficiary. Using DOES, the MCSC or USFHP provider shall review and acknowledge all pending enrollment-related activities (including, but not limited to, enrollments, PCM changes, and transfers of enrollment). All reviews and acknowledgements shall be accomplished within six calendar days of receipt of the information. DEERS will perform a daily process to finalize pending enrollment actions after six calendar days of no

action by the MCSC/DP. DEERS will send a policy notification indicating that the MCSC/DP has approved the enrollment action in DOES. Additionally, within six calendar days of the submission, the MCSC or USFHP Provider shall contact the beneficiary to resolve discrepancies in the web-submitted application (if necessary). If the application is not accepted, the MCSC or USFHP provider shall send the beneficiary an explanatory letter within five calendar days. The MCSC or USFHP provider shall also cancel the enrollment using DOES. The MCSCs and USFHP providers shall consider beneficiary provided data on the enrollment web application as having the same validity as beneficiary provided data on paper enrollment forms. DEERS will not provide support or interfaces to MCSC web applications that perform any enrollment-related functions.

The following descriptions provide an overview of each enrollment-related business event.

1.2.4. Eligibility For Enrollment

The DoD provides assigned HCDPs 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 General 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. Refer to Chapter 3, Addendum C, HCDP Plan Coverage Details, for additional information on the coverage plans a beneficiary is eligible for based on the DEERS assigned coverage.

When a sponsor and family member are first added into DEERS, DEERS determines basic eligibility for health care benefits based on DoDI 1000.13 and establishes an assigned HCDP coverage plan together with coverage dates.

For example, when an Active Duty (AD) sponsor and family members are added to DEERS:

- A sponsor is assigned a Direct Care (DC) plan for AD Sponsors in which he or she is the subscriber and the insured with DC entitlement only. 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 (ADFM) assigned plan. The sponsor is not insured under this coverage plan.
- Eligible family members are assigned a TRICARE Standard plan for ADFMs as insured with both DC and civilian health care 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. Enrollments cannot span multiple assigned plans.

Enrollments are at the individual or family level, depending on the number of family members wishing to enroll. DEERS allows one family member to enroll in a family plan, but does not allow more than one family member to enroll in an individual plan when a family plan is available. DEERS creates a policy that encompasses all enrollments for a family and a HCDP. DEERS automatically switches enrollment policies from individual to family upon the enrollment of a second family member; however, DEERS does not make automatic adjustments from family to individual policies upon the disenrollment of all but one family member. It is the MCSC's or USFHP provider's responsibility to make such changes via DOES. Some HCDP's, such as TRICARE Plus, only offer enrollment on an individual basis, and there is no family option. For these plans, DEERS does not limit the number of individual policies that a family may have.

The MCSC or USFHP provider is required to enter the following information into DOES in order to complete an enrollment:

- Coverage plan
- Enrollment begin date (if different than DOES default)
- 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

Restrictions on use and limits on how far an enrollment can be backdated are addressed in the Chapter 3, Addendum D, Medical Business Rules and the TRICARE Policy Manual (TPM).

Enrollment anniversary dates for all enrollees are being transitioned to a fiscal year (FY) basis, i.e., October 1 through September 30. To accomplish this, on new enrollments or when a policy is up for renewal, the MCSC shall only establish the policy and prorate the enrollment fees as described below. At the end of that fiscal year, the MCSC shall renew the policy for the next fiscal year with an anniversary date of October. Through this transition, the enrollment year will become aligned with the fiscal year for all enrollments.

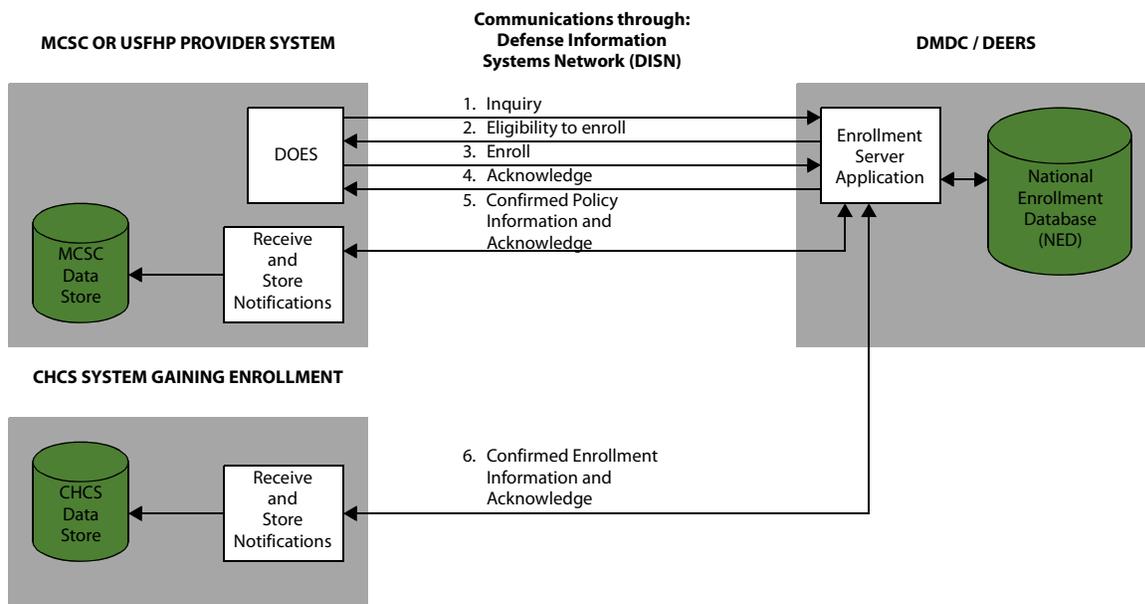
For enrollees that pay fees on an annual basis, the MCSC shall collect the entire prorated fee covering the period through September 30 of the current fiscal year. For enrollees that pay fees on a quarterly basis, the MCSC shall collect a prorated fee covering the period until the next fiscal year quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30 of the current fiscal year. For enrollees that pay fees on a monthly basis (by Electronic Funds Transfer (EFT) or monthly allotments), MCSCs 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 during the transition from enrollment year to fiscal year, the first three-month payment crosses into the next fiscal year, the MCSC 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 fiscal year and the remaining one or two months of fees to the beginning of the new enrollment beginning on October 1 of the next fiscal year. When a three month fee is paid and monthly allotments or EFTs are indicated and there are less than 90 days but more than 45 days remaining on the policy ending September 30, DEERS will create the new policy (beginning October 1) and apply the one or two remaining fee payments from the previous policy.

For example, if a beneficiary's enrollment anniversary date is August 1 and they wish to pay by monthly allotment or EFT, the MCSC should collect a full three months of enrollment fees and send that amount to DEERS. DEERS will apply two months of the fee to the enrollment covering the period August 1 through September 30 and the remaining one-month's fees to the new (fiscal year aligned) policy beginning October 1. The monthly allotments or EFT payments should start by November 1 (first day of the fourth month following the previous enrollment anniversary date of August 1). See paragraph 1.2.8.1. MCSCs shall be responsible for accommodating enrollment periods that are not aligned with the fiscal year for transitioned and transferred policies as well as for new enrollment policies that begin on some date other than October 1.

The following figure illustrates the process of system interactions for enrollments and enrollment updates:

FIGURE 3-1.5-2 ENROLLMENT PROCESS



1.2.5.1. Enrollment Fees

1.2.5.1.1. Enrollment Year To Fiscal Year Alignment

By statute, enrollees are entitled to both an enrollment year and a fiscal year 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 being transitioned to a fiscal year basis, i.e., October 1 through September 30. To accomplish this, for new enrollments or policies that are up for renewal (that have not already been aligned to the fiscal year), enrollment policy anniversary and end dates must be adjusted and the associated enrollment fees and catastrophic cap amounts prorated. Upon transition from an outgoing MCSC to an incoming MCSC region, DEERS will provide the incoming MCSC with a "Gold File" that contains enrollment information for enrollees being transitioned to the incoming MCSC.

1.2.5.1.2. Enrollment Policy Anniversary, End, And Paid Through Dates

For certain enrollments in the "Gold File," DEERS will have set the enrollment policy end dates to be September 30. For others, the enrollment policy end date will be as they were established by the outgoing MCSC or DP. The determining variable, as to whether an end date is set by DEERS to be September 30 or not, is who has responsibility for a particular re-enrollment during the fiscal year in which the transition is occurring, i.e., the current fiscal year. If a re-enrollment is performed by an outgoing MCSC or DP (prior to the start of health care delivery of the incoming MCSC or DP) during the fiscal year in which the transition occurs, DEERS will set the policy end date of that re-enrollment on the "Gold File" to be September 30 or less depending on eligibility. For example, if an enrollment policy begins in March 2004 (FY 2004) and the contract transition is April 2004 (FY 2004), the FY 2004 re-enrollment was performed by the outgoing MCSC or DP; therefore, DEERS will set the policy end date to September 30 **on the Gold File**. If a re-enrollment is due to be performed by the incoming MCSC or DP effective on or after the start of health care delivery, DEERS will not alter the enrollment policy end date. The incoming MCSC or DP, at the time of the re-enrollment, will set the enrollment end date to be September 30. For example, if an enrollment policy begins in June 2003 (FY 2003) and the contractor transition is April 2004 (FY 2004), the FY 2004 re-enrollment will be performed by the incoming MCSC or DP; therefore DEERS will not alter the enrollment policy end date.

The incoming MCSC or DP will receive from the outgoing MCSC or DP at transition, the MCSC's or DP's fee information which will show the "paid through" dates. The incoming MCSC or DP shall submit the fee amount and "paid through" dates to DEERS for the policies on the Gold File **and for any new enrollments** using DOES or the Batch Fee Interface.

For enrollments performed during the current fiscal year by the outgoing MCSC or DP that are effective prior to the start of health care delivery of the incoming MCSC or DP, and where DEERS has set the enrollment policy end date to be September 30 **on the Gold File**, the enrollment "paid through" date may be before or after September 30 depending on whether the enrollee paid enrollment fees on an annual or quarterly basis.

If the enrollee paid the outgoing MCSC or DP on a quarterly basis, the quarterly payment dates may not fall precisely on a fiscal year quarter (October 1, January 1, April 1, or July 1). For an enrollment where the "paid through" date does not fall precisely on a fiscal year quarter, the MCSC or DP shall collect a prorated fee covering the one or two month period until the next fiscal year quarter and collect quarterly fees thereafter through September 30.

If, for example, the outgoing MCSC or DP performed a re-enrollment effective November 1 and the enrollee is paying on a quarterly basis (and the incoming MCSC or DP start of health care delivery is April 1), the outgoing MCSC or DP fee information will show a "paid through" date of April 30. In this case, the enrollee paid the outgoing MCSC or DP two quarterly payments, November 1 - January 31 and February 1 - April 30. The incoming MCSC or DP shall collect two months of enrollment fees covering May 1 through June 30 (the end of the current fiscal quarter) and resume collecting a full quarterly fee covering the period July 1 through September 30. NOTE: The "Gold File" enrollment policy end date for this example re-enrollment will already have been set by DEERS to be September 30 since the re-enrollment was performed by the outgoing MCSC or DP in the current fiscal year but prior to the start of health care delivery of the incoming MCSC or DP (April 1).

For enrollments performed by the outgoing MCSC or DP in the current fiscal year but prior to the start of health care delivery of the incoming MCSC or DP, DEERS will have set the enrollment policy end date on the "Gold File" to be September 30. For enrollees that paid fees on an annual basis, the outgoing MCSC or DP fee information will show the "paid through" date to be what the outgoing MCSC or DP had established. In this case, when the incoming MCSC or DP re-enrolls such individuals on October 1 (beginning of the next fiscal year), they shall collect a prorated fee for the period beginning on the first of the month following the "paid through" date as shown in the outgoing MCSC or DP fee information. For example, if the outgoing MCSC or DP re-enrolled an individual effective November 1 and the enrollee paid the annual fee at the time of re-enrollment, then that enrollee is paid through October 31 of the following year. The "Gold File" that the incoming MCSC or DP contractor receives will show the enrollment end date to be September 30 but the "paid through" date will be October 31. When the time comes to re-enroll this individual (within 45 days prior to September 30), the incoming MCSC or DP will re-enroll this individual effective October 1 but collect an 11 month prorated enrollment fee beginning with and covering the period from November 1 through the following September 30. This is because the enrollee had already paid through October 31.

1.2.5.1.3. Prorated Enrollment Fees

For new enrollments DEERS will establish abbreviated (less than 12 months) policies ending September 30 and the MCSC/DP 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). At the end of the abbreviated enrollment (end of the current fiscal year), the MCSC or DP shall renew the policy for the next fiscal year with an anniversary date of October 1 **and resume collecting the full enrollment fees.**

For enrollees that pay fees on an annual basis, the MCSC or DP shall collect the entire prorated fee covering the period from the enrollment begin date through September 30 of the current fiscal year. For enrollees that pay fees on a quarterly basis, the MCSC or DP shall collect a prorated fee covering the period from the new or re-enrollment effective date through the end of the current fiscal year quarter (e.g., September 30, December 31, March 31, June 30) and collect quarterly fees thereafter through September 30 of the current fiscal year.

For enrollees that pay fees on a monthly basis (by EFT or by monthly allotments), the MCSC or DP 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 begin date. If during the transition from enrollment year to fiscal year, the first three month payment crosses into the next fiscal year, the MCSC or DP 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 current fiscal year and the remaining one or two months of fees to the next fiscal year.

For example, if a beneficiary's enrollment policy anniversary date is August 1 and they request to pay by monthly allotment or EFT, the MCSC or DP shall collect a full three months of enrollment fees and report that amount to DEERS. DEERS will apply two months of the fee to the enrollment period, August 1 through September 30, and the remaining one-month's fees to the new (fiscal year aligned) policy beginning October 1. In this example, the MCSC or DP shall send a "paid through" date of October 31. The monthly allotments or EFT payments should start by November 1 (first day of the fourth month following the previous enrollment anniversary date of August 1). MCSCs or DPs shall be responsible for accommodating enrollment periods that are not aligned with the fiscal year for transitioned and transferred policies, as well as, for new enrollment policies that begin on some date other than October 1. **If fees are collected and these are more than 90 days remaining on the policy ending September 30, DEERS will store the fee amounts and apply any dollars to the next policy when DEERS creates.**

1.2.5.1.4. Prorated Catastrophic Cap Amounts

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

Catastrophic cap credits are always applied to the fiscal year in which the abbreviated enrollment occurs. The concept being that the Government is applying, through a credit, an amount that will permit an enrollee to meet the catastrophic cap amount during the initial abbreviated enrollment year. Only policies where fees are required will receive a one-time enrollment year catastrophic cap credit when out-of-pocket expenses cannot be applied during a full 12 months to the fiscal year catastrophic cap limit, to achieve the

enrollment year catastrophic cap amount, i.e., those enrollments without an effective date of October 1.

Catastrophic cap credit amounts will be reported by DEERS to the DEERS CCDD. Catastrophic cap credits will always be applied toward the catastrophic cap of an individual enrollee and subsequently appear in the family total for that individual. For individual policies, the individual totals will be the same as the family totals for that individual. For family policies, the catastrophic cap credit will be applied to the sponsor's individual catastrophic cap total and will subsequently appear in the sponsor's family total. Catastrophic cap credits shall be applied only once per family regardless of whether the family consists of just the sponsor or the family consists of the sponsor and other family members, or the family is split across multiple contracts.

If DEERS has applied a credit for an enrollment policy that is later cancelled or terminated within the first fiscal year, DEERS will remove the credit by applying a negative adjustment, with the exception of cases where the cancellation or termination was due to loss of eligibility. In such cases, if the catastrophic cap limit had not been reached by the application of the credit, and the enrollment policy was cancelled or terminated, no further action is required by the contractor. If the catastrophic cap limit had been reached due to the application of a claim or fee payment, the Purchased Care Contractor shall reprocess any claims or fee payments from the date and time the catastrophic cap was met in accordance with catastrophic cap application requirements.

When a TRICARE Standard beneficiary (non-AD and non-ADFM) enrolls in Prime, the catastrophic cap credit will be added to any fiscal year catastrophic cap amounts already paid during the current fiscal year. Application of the credit could cause the family total to come close to or actually meeting the catastrophic cap limit. Should this happen, the MCSC shall determine the amount of the enrollment fees owed, if any, and collect accordingly. Of course, once an individual or family catastrophic cap limit has been met, no further covered out-of-pocket expenses shall be incurred by the individual or family. Expenses for non-covered services as well as Point of Service (POS) deductibles and cost-shares will continue to be paid by the individual or family even though the catastrophic cap limits have been reached.

1.2.5.1.5. Alignment of the enrollment year to the fiscal year must also be performed for enrollees of the USFHP. The process, as described for the MCSCs above, is the same for USFHP enrollments. See Chapter 3, Addendum E for charts detailing the enrollment year to fiscal year alignment of enrollment dates, prorated enrollment fees, and prorated catastrophic cap amounts for managed care support contractors and the USFHP.

1.2.5.2. PCM Assignment Within The DOES Application

DEERS has a centralized PCM file containing all MCSCs' civilian network PCMs and PCMs for the DC systems. Additions and modifications of PCMs are performed in the MCSC provider system. The MCSCs shall provide daily additions and modifications on their provider files for retrieval by DEERS. If an MCSC wishes to deactivate or delete a PCM, they may 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. MCSCs cannot reuse

PCM IDs that are deactivated or deleted PCMs from their provider system. DEERS will not allow subsequent assignments to a deactivated PCM. The DOES application accesses the central PCM file to perform provider assignments.

1.2.5.3. DC PCM Assignment

The MCSC shall perform DC PCM assignment at the time of enrollment in the DOES application. The MCSC 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 Active Duty Service Members (ADSMs), if the enrollment form has a UIC specified and the MTF has established a default provider for the UIC, the MCSC should use the default. If the enrollment form contains a specialty or gender preference, the MCSC 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 MOU or other government direction, the MCSC 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 Identifier (DMIS ID). The MCSC 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 MCSC shall assign the beneficiary to the civilian network.

1.2.5.4. Civilian PCM Assignment (MCSC And DP)

The MCSC shall perform Civilian PCM assignment at the time of enrollment in the DOES application. The MCSC shall use the PCM preference indicated on the enrollment form. If the enrollment form contains a specialty or gender preference, the MCSC shall use the preference filters available in DOES to select a PCM. DOES and BWE have incorporated logic to search for providers using at least one of the following combinations and returns all PCM records matching the criteria:

- PCM ID, PCM Name (no wildcards)
- PCM Group Name (no wildcards)
- PCM Zip Code (entire zip code or the first three digits only)
- PCM City, PCM State
- PCM Specialty, PCM Zip Code (entire zip code or the first three digits only)
- PCM Specialty, PCM City, PCM State
- PCM Gender, PCM Zip Code (entire zip code or the first three digits only)
- PCM Gender, PCM City, PCM State
- DMIS ID (for DC PCMs)

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.

NOTE: DEERS will not send disenrollment letters to beneficiaries when the loss of eligibility is due to death.

1.2.6.1. Disenrollment - Loss Of Eligibility

A loss of eligibility includes both a loss or change in eligibility for: 1) DoD health care benefits according to the current DoDI 1000.13; or 2) an individual health coverage plan. The end of eligibility is sent to the MCSC or the DP at the time of enrollment. Under these circumstances, DEERS terminates any current enrollment or cancels an enrollment effective at a future date. DEERS sends an unsolicited disenrollment notification when loss of eligibility occurs, if eligibility ends on a date earlier than expected.

Because DEERS reapplies its rules-based logic each time benefits determination data about a sponsor or family member changes, certain events may trigger disenrollment.

For example, when the sponsor's eligibility terminates, such as upon separation from service at an earlier date than expected, this terminates the assigned coverage for the entire family. The termination of assigned coverage affects the insureds' enrollment information; therefore DEERS terminates their current enrollments and/or cancels future enrollments into an HCDP. Unsolicited disenrollment transactions are sent to the necessary systems notifying them of the termination of coverage benefits.

Since enrollments extend through the end of eligibility, DEERS does not send notifications for projected loss of eligibility communicated at the time of disenrollment. The end of eligibility is communicated to the MCSC or the DP at the time of enrollment. The MCSC/DP systems must accommodate future end dates for policies and PCMs.

In cases where eligibility changes based on a change to the sponsor's affiliation with a DoD organization, DEERS will terminate any enrollment associated to the previous eligibility segment, but will not automatically enroll beneficiaries for the new eligibility segment. The most common example of this is when a service member retires. The loss of eligibility for TRICARE for ADSMs will terminate the individual's enrollment in that program.

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 if the enrollee is a non-fee payer.

1.2.6.3. Disenrollment - Voluntary

An insured 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 coverage plan for the insured and reverts to the DEERS-

assigned coverage, starting on the day after the termination of the previous 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 subscriber 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 MCSC or USFHP provider must reconcile their fee payment system against the fee totals in DEERS. Once the MCSC confirms that payment amounts match, the disenrollment may be entered in DOES or through failure to pay fees batch interface.

When there is a disenrollment, the appropriate systems are notified, as necessary.

1.2.7. Modification Of Enrollment

There are several reasons to modify an enrollment:

- Change or cancel a PCM selection
- Transfer enrollment (enrollment portability) or cancel a transfer
- Change enrollment begin or end date
- Change enrollment end reason
- Cancel enrollment/disenrollment

When 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 MCSC, which makes the change via DOES. Only the current enrolling organization may change the PCM selection. A PCM change can occur at any time during an active or future enrollment; however, the effective date for the new PCM must fall within the defined business rules (see Chapter 3, Addendum D). DEERS 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.

A PCM cancellation may be performed for the enrollment's most current PCM assignment and can only be performed in the DOES application. Cancellation of a PCM change can only be performed by the enrolling organization responsible for managing the enrollment, and must be performed within the time period specified in the business rules

(see Chapter 3, Addendum D). When canceling a PCM, the enrolling organization may reinstate the previous PCM, or choose to select a new PCM to replace the one being cancelled. There can be no date gaps between PCM selections for plans that require a PCM. DOES will decrement and increment PCM capacities as PCM actions are performed.

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

1.2.7.2. Civilian PCM Panel Reassignment

DMDC provides a Civilian PCM Panel Reassignment application to allow MCSCs and USFHP providers to perform mass reassignments of a PCM's enrollees. Within a MCSC or a USFHP provider, a MCSC or USFHP provider may move a Civilian PCM's entire panel to a new Civilian PCM.

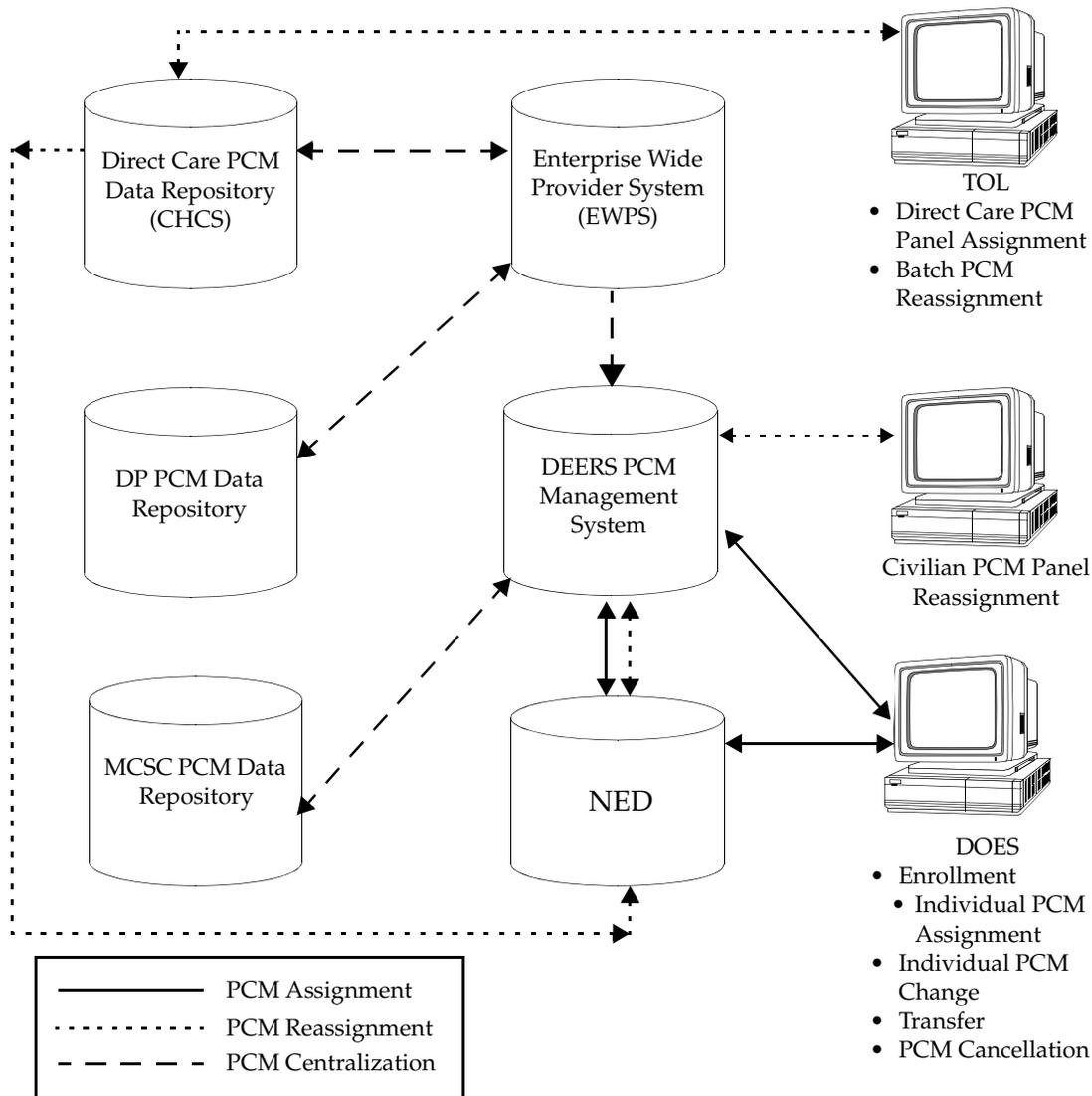
The reassignments selected by the MCSC are processed periodically by DEERS. As the PCM reassignments are processed, DEERS sends notifications to the appropriate systems. DEERS will decrement and increment PCM capacities as necessary, but will not prevent the reassignment if the selected PCM does not have available capacity. For DC PCM panel reassignments, please refer to paragraph 1.2.5.3. and the TRICARE Operations Manual (TOM), Chapter 6, Section 1, paragraph 3.1.

1.2.7.3. DC PCM Panel Reassignment

MTFs have the responsibility for reassigning all enrollees assigned Resource Sharing PCMs under the current managed care support contracts to other MTF PCMs or "Pseudo" PCMs using Composite Health Care System (CHCS). These reassignments must be completed not later than 14 days prior to the start of health care delivery. If instructed by the MTF Commander, the incoming contractor will be required to reassign such enrollees to new DC PCMs using DOES/DEERS. The MTF's instructions to accomplish this task will be in writing and will include sufficient information to reasonably identify the beneficiary, as well as the PCM currently assigned and the PCM to be assigned. These DC PCM reassignments should not cross DMISs, CHCS platforms, or regions. They should be initiated by the MTF within 15 days of the start of health care delivery and will be completed by the contractor within 30 days of receipt.

Batch changes for DC PCMs may be performed in several ways. Changes between PCMs in DMIS IDs within a single CHCS platform must be coordinated between the MTF and the MCSC. The MCSC shall enter the PCM change criteria in a government-provided web application. Batch changes of DMIS IDs where the PCM assignment does not change must be coordinated with the MTF, MCSC and DEERS. DEERS will effect the change in DMIS ID. If the PCM assignment must be changed in addition to the DMIS ID, the MCSC must enter each PCM change transaction into the DOES application. Changes in DMIS IDs across CHCS platforms also must be performed individually by the MCSC in DOES. In all cases, upon acceptance of the PCM change, DEERS will send a Policy Notification to the MCSC and a PCM Change Letter to the beneficiary.

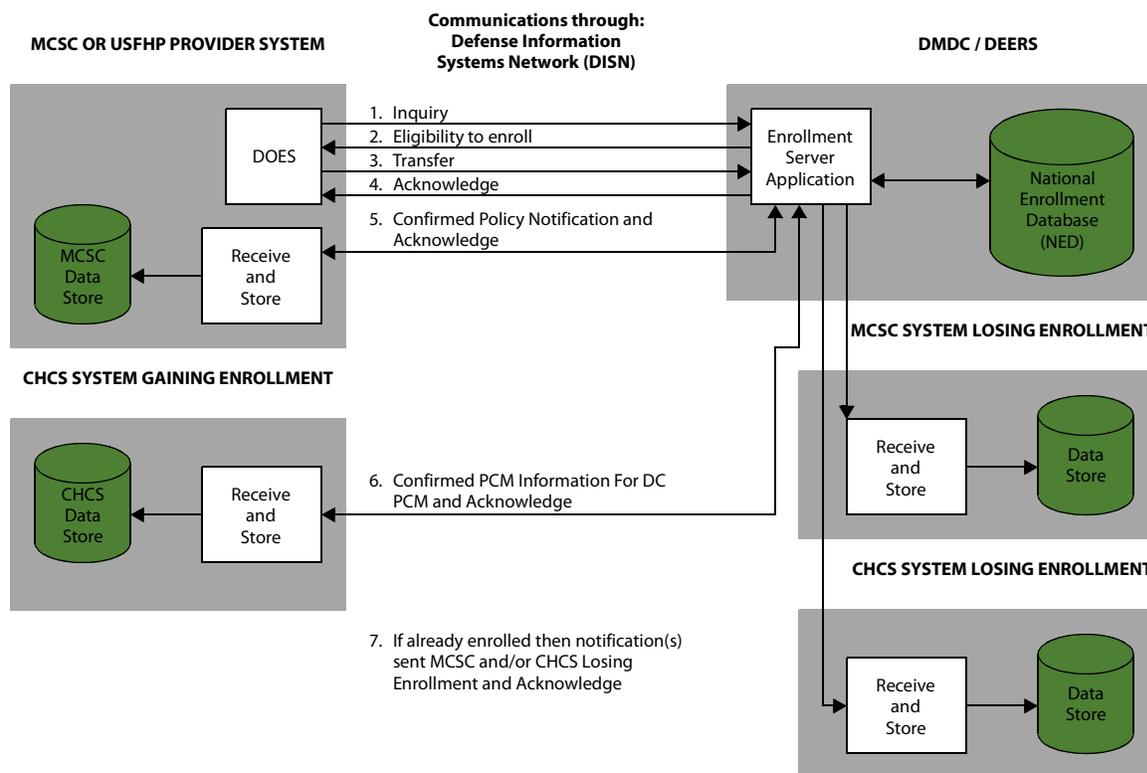
FIGURE 3-1.5-3 PCM ASSIGNMENT PROCESS



1.2.7.4. 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 among coverage plans (e.g., medical, dental) within a health care plan (e.g., TRICARE Prime). Portability does not exist between some health care plans (e.g., TRICARE Prime and TRICARE Plus). If a beneficiary is enrolled in TRICARE Prime and wishes to enroll into TRICARE Plus or vice versa, upon moving to a new enrolling organization's region, a transfer of enrollment is not applicable. A disenrollment from TRICARE Prime with the previous contractor and a new enrollment into TRICARE Plus must be established with the new contractor. See Chapter 3, Addendum D, Medical Business Rules, for limitations regarding transfer and transfer cancellation transactions.

FIGURE 3-1.5-4 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.

1.2.7.5. Enrollment Period Change

This event is used to update an enrollee's begin or end date. These modifications can only be performed by the enrolling organization responsible for managing the enrollment, and must be performed within the timeframes established in the business rules (see Chapter 3, Addendum D). DEERS changes the date range for a PCM selection based on the enrollment period changes. 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 greater date. If the enrollment has been terminated due to a voluntary disenrollment or failure to pay fees, the user may change the disenrollment end date in accordance with the business rules in Chapter 3, Addendum D. A change to an end date may only occur after a disenrollment. DEERS modifies the enrollee's policy based on the new date(s) 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. See the Unsolicited Notifications section for more information.

1.2.7.6. 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. However, enrolling organizations may not change an end reason indicating loss of eligibility without changing the end date.

1.2.7.7. Enrollment/Disenrollment Cancellation

Enrollment and disenrollment cancellations can only be performed by the entity managing the affected enrollment. An enrollment cancellation completely removes the enrollment from DEERS, and it will not be shown on subsequent inquiries. A disenrollment cancellation is used to reinstate the prior enrollment. Both events must be done within the time period prescribed in the business rules (see Chapter 3, Addendum D).

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/fiscal year in DOES.

DEERS supports several enrollment-fee-related transactions:

- Enrollment Fee Payment (DOES and Batch Fee Interface)
- Update Individual Enrollment Fee Waiver Information (DOES)
- Terminate Policy For Failure To Pay Fees (DOES and Batch Fee Interface)

For Enrollment Fee Payment Research, DEERS provides a web-based application.

1.2.8.1. Enrollment Fee Payment

Enrollment fees may be paid periodically (e.g., monthly, quarterly, or annually). The beneficiary specifies this payment option during enrollment and the MCSC or DP may enter the fee information in DOES or the batch fee interface as part of the enrollment transaction. To send DEERS fee information separate from the enrollment, MCSC's and Designated Providers Integrator (DPI) should use the batch enrollment fee payment process. If this information is entered into DOES, DEERS includes it on the notification to the MCSC or DP. MCSCs and DPs also update DEERS with subsequent enrollment fee payments for a policy when the quarterly or monthly option is selected, or to update a fee paid-through date or fee payment exception reason. The MCSC and DPI shall send all fee payment updates, including any overpayments, to DEERS within one business day. 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. The subscriber's DEERS ID, policy, and enrollment fee payment information are required when performing this transaction. DEERS keeps track of the accumulated enrollment fee payment information by policy for the enrollment/fiscal year.

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 MCSC/DP shall resend the fee amount to DEERS at a later time when the lock is removed from the catastrophic cap.

Both DOES and the enrollment fee payment interface perform edits against the submitted fee data. The MCSC/DP shall research and correct any data discrepancies identified by DEERS (both warnings and errors) within the designated business days. The MCSC/DP shall reconcile and correct the fee payments for all such policies prior to the next reporting month.

For monthly EFT or monthly allotments, MCSCs and DPs must collect and post a quarterly amount at the time of enrollment with monthly EFT or allotments beginning on the first day of the fourth month following the enrollment anniversary date (beginning of the next quarter) (see the TOM, Chapter 6, Section 1, paragraph 8.1., "Monthly Payment Fee Option"). Regardless of the date the MCSC or DP receives the monthly EFT or allotment, the contractor must post the payment through to the end of the next applicable payment period by entering the applicable enrollment fee "paid through" date.

DEERS records both the enrollment fee payment date and the enrollment fee paid-through date. The enrollment fee paid-through date reflects the time period for which coverage is paid. The date represents neither when the enrollment fee payment information was received nor when it was sent to DEERS. The purpose of tracking the period an enrollment fee covers is to ensure portability. On an enrollment transfer, DEERS includes the fee information from the enrollee's policy on the notification to the new MCSC or DP.

NOTE: Enrolling organizations may indicate a "paid through" date that crosses the fiscal year when collecting the initial three month enrollment fee when establishing monthly allotments or EFTs, if there are less than three months remaining in the policy.

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, identify what entity is responsible for enrollment fee payments, or automatically apply enrollment fee payments to catastrophic cap accumulations. 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.

Under certain circumstances, enrollment fees may not be required because the catastrophic cap amount has been met or an enrollment fee payment is waived for an individual. If the catastrophic cap amount has been met for the family, no further enrollment fee payment should be collected for the remainder of that enrollment period. This non-payment fee information should be sent to DEERS by the enrolling organization indicating the catastrophic cap was met for this period. In the same way, an enrollment fee payment may be less than the amount expected for the coverage plan because there is an individual in the policy who is exempt from paying fees due to a waiver or the fee payment would exceed the catastrophic cap limit. The reason for a partial or non-payment of enrollment fee

information would be sent to DEERS using the HCDP Enrollment Fee Payment Exception Reason Code. It is necessary for DEERS to have this information for portability.

See Chapter 3, Addendum C, HCDP Plan Coverage Details and TOM, Chapter 6, Section 1, for application of enrollment fees.

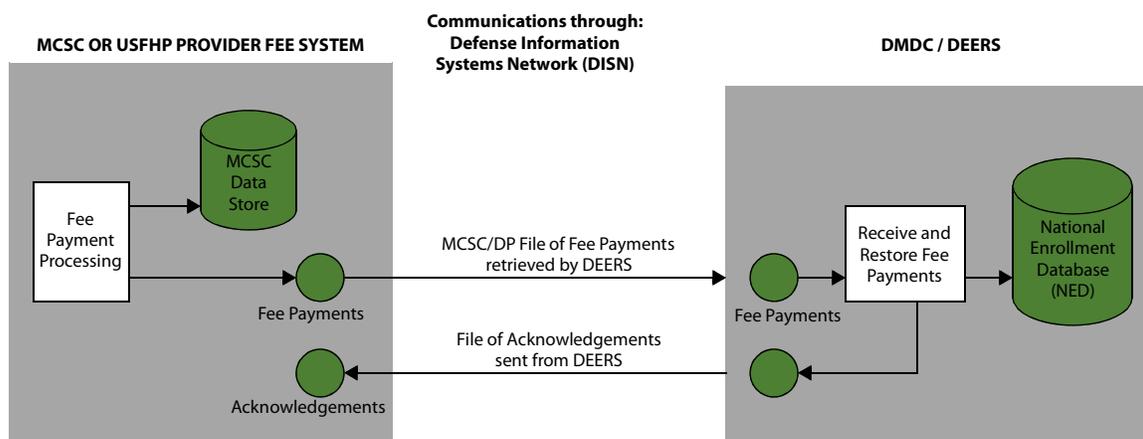
1.2.8.2. Batch Fee Payments

In addition to sending enrollment fee payment information to DEERS through DOES, the MCSC may also send the information to DEERS in batch format. The batch fee payment updates include new payments, payment adjustments, and updates to enrollment fee payment exception reason codes, or paid-through dates. MCSCs and DPIs must correct and resubmit enrollment fee payments rejected by DEERS or research, correct and resubmit fee payments for which DEERS has provided a warning.

DEERS will automatically apply any fee payments posted through DOES or the Enrollment Fee Payment interface to the beneficiary's catastrophic cap.

The following figure illustrates the process for sending batch fee payment updates to DEERS:

FIGURE 3-1.5-5 BATCH FEE PAYMENT PROCESS



1.2.8.3. Premium Payments

Upon implementation of the TRICARE Reserve Select (TRS) Program, DEERS will accept premium payment paid through dates. MCSCs are required to submit paid through dates to DEERS upon receipt of premium payments. MCSCs 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, MCSCs 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 Fiscal Year Catastrophic Cap.

1.2.9. Enrollment Attribute Updates

The DOES application supports the entry of additional enrollment-related information to support MCSC and DP processing that is external to DEERS. The following sections describe the data that may be entered or updated in DOES. Upon update of this information, DEERS sends a notification to the MCSC or DP reflecting the update.

1.2.9.1. Enrollment Fee Waiver Update For An Individual

Under certain circumstances (e.g., beneficiaries under age 65 with Medicare Parts A and B), enrollment fees may be fully or partially waived. Fee waivers should not be confused with non-payment of enrollment fees due to meeting catastrophic cap amounts. Enrollment fee waivers are associated at the individual beneficiary level and should be sent to DEERS by the MCSC or DP. For example, if three family members are waived from paying enrollment fees, an enrollment fee waiver must be applied to each person individually. The waiver information is a reason that indicates that there is a waiver during an enrollment period. There are no dates associated with the enrollment fee waiver and waiver information can be updated at any time during the enrollment period. The fee payment waiver status for an individual is used to distinguish between enrollment fees that were waived versus ones that were not paid. If a family is disenrolled due to failure to pay enrollment fees, and there is an individual family member with an enrollment fee waiver, that individual cannot be disenrolled, because he or she is exempt from paying fees. The MCSC or DP is responsible for setting and removing enrollment fee waivers as appropriate as well as setting fee payment exception reason codes based on the existence of fee waivers.

1.2.9.2. Work Zip Code

A work zip code is supported for TRICARE Prime Remote (TPR) plan determinations. TPR plan determinations are based on the sponsor's daily work location and residential zip codes as well as the family member's residential zip code. Refer to Chapter 3, Addendum D, DEERS Business Rules, for more information.

1.2.10. Re-Enrollment

Many types of coverage plans require annual re-enrollment. The enrollment year will be aligned to the fiscal year for enrollment fee payments and CCDD accumulations. This applies to all new enrollments as well as renewals for transitioned or transferred policies. Annual re-enrollment, where required by plan, is handled simultaneously by the MCSC or DP and DEERS. DEERS will create a new enrollment year for the policies requiring re-enrollment on the 16th of the month prior to the month the policy expires. For example, if a policy ends on September 30th, the re-enrollment will occur on August 16th. If the enrolled beneficiaries lose eligibility prior to the end of the next enrollment year, DEERS adjusts the

policy to the latest end of eligibility date for the family and notifies the MCSC or DP of the new policy end date. See “Enrollment” (paragraph 1.2.5.) for more details on the migration of enrollment year to fiscal year basis.

1.2.11. Beneficiary Web Enrollment Confirmation

Most actions performed in BWE require confirmation by the MCSC/DP in DOES. These transactions are identified by the ‘pending’ status on the Policy Notification Transaction (PNT) resulting from the BWE transaction. As part of the confirmation process, the MCSC/DP may modify the effective date and/or PCM assignment information. The confirmation (and modification, if applicable) will result in a subsequent PNT to update the MCSC/DPI system with the confirmed enrollment action. See paragraph 1.4. for more information about Notifications.

1.3. Address And Telephone Number Updates

DEERS receives address information from a number of source systems. 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 in cases where a beneficiary has separate mailing and residential addresses. Jurisdiction is performed at the zip code level. A beneficiary update is used to update addresses. Beneficiaries may provide up to two addresses (residential and mailing) which are entered into DEERS using DOES. The TRICARE enrollment form contains a mailing address and a residential address. Addresses are updated through the DOES application. DOES uses a commercial product to validate address information online.

DEERS has several types of telephone numbers for a person (e.g., home, work, and fax). These telephone numbers can be added and updated as necessary by the MHS and MCSC/DP. Phone numbers are updated through the DOES application.

DEERS also stores a home e-mail address for a person. This e-mail address can be added and updated as necessary by the MHS and MCSC or DP. The home e-mail address is updated through the DOES application.

1.4. Notifications

Notifications are sent to MCSCs and DPI for various reasons, and reflect the most current policy information for a beneficiary. The MCSC or DPI must accept, apply, and store the data contained in the notification as sent from DEERS. Notifications may be sent resulting from new enrollments or updates to existing enrollments. If the MCSC or DP does not have the information contained in the notification, the MCSC or DPI shall add it to their system. If the MCSC or DP already has enrollment information for the beneficiary, the MCSC or DP shall apply all information contained in the notification to their system. The MCSC or DP shall use the DEERS ID to match the notification to the correct beneficiary in their system. There are also circumstances where a MCSC or DP may receive a notification that does not appear to be updating the information that the MCSC or DP already has for the enrollee. Such notifications shall not be treated as errors by the MCSC or DP system and must be applied. The MCSC or DP 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 MCSC or DPI.

1.4.1. Notifications Resulting From Enrollment Actions

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

Notifications sent as a result of enrollments, transfers, or PCM changes in BWE will indicate a pending status. This notification should trigger the MCSC to confirm the enrollment. 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.

1.4.2. Unsolicited Notifications

These types of notifications are unsolicited to the MCSC or DP and result from updates to a sponsor or family member's information made by an entity other than the enrolling MCSC or DP. Unsolicited notifications may result from various types of updates made in DEERS, to include ECHO Registration and the TRS program:

- 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 MCSC or DP 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 is extended until the 23rd birthday.
- SSN, name, and DOB changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or DOB are communicated via unsolicited notification to the MCSC or DP.
- 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 MCSC or DP.
- Data corrections made by DMDC Support Office (DSO) or the DOES Help Desk. If a MCSC or DP requests the DSO to make a data correction for a current or future enrollment that the MCSC or DP cannot make themselves, notification detailing the update is sent to the MCSC or DP, and to CHCS, if appropriate.

1.4.3. 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 MCSCs and DPs. The MCSC 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 MCSC or DP 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. DEERS merges OHI by assigning the last updates of OHI active policies (not cancelled or systematically terminated) to the remaining Patient ID.

1.5. Enrollment Cards And Letter Production

DEERS is responsible for producing the TRICARE universal beneficiary card for both CONUS and OCONUS. The cards are produced for beneficiaries enrolled in TRICARE Prime, TRICARE Remote, and TRS coverage plans. Enrollment cards are not produced for enrollments with DPs.

New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new MCSC, unless the enrollment operator specifies in DOES not to send an enrollment card. Cards are also automatically generated upon a PCM change to a new TRICARE region that has different information-line phone numbers than the previous region or upon a change of a coverage plan that changes the type of card.

A MCSC may request a replacement enrollment card for an enrollee at any time. DEERS sends enrollment card request information in a notification to the MCSC indicating the last date an enrollment card was generated for the enrollee.

Along with the enrollment card, DEERS sends a letter to the beneficiary indicating their PCM selection as entered in DOES for TRICARE Prime and TRICARE Remote enrollment.

The MCSC may initiate a PCM change that does not require a new enrollment card. In these cases, DEERS sends a PCM change letter to the beneficiary. In the event PCM change letters or enrollment cards are returned to the MCSC due to a bad address, the MCSC researches the address, corrects it on DEERS, and re-mails the correspondence to the beneficiary.

1.6. 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 MCSC shall query DEERS to determine eligibility and/or enrollment status for a given period of time. The MCSC shall use DEERS as the database of record for:

- Person Identification

- Eligibility
- Enrollment and PCM information
- Enrollment/fiscal year to date totals for CCDD amounts
- Other Government Program (OGP)

Upon receipt of this data from DEERS, the MCSC shall not override this data with information from other sources.

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. An MHS organization can verify, update or add OHI during eligibility and enrollment claims inquiries, or direct OHI related events identified in the OHI section of this document. The OHI data received as part of the claims inquiry shall be used as part of the claims adjudication process. If the MCSC 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 MCSC shall send the updated or additional OHI information to DEERS using the system to system process or other mechanisms identified in the OHI section of this document.

DEERS stores enrollment/fiscal year CCDD data in a central repository. DEERS stores the current and the two prior enrollment/fiscal year CCDD totals. The purpose of the DEERS CCDD repository is to maintain and provide accurate CCDD amounts, making them universally accessible to DoD claims-processors.

1.6.1. Data Events: Inquiries And Responses

This section identifies the main events, including the inquiries and responses between the MCSCs and DEERS, associated with CCDD transactions.

The main events to support processing this information include:

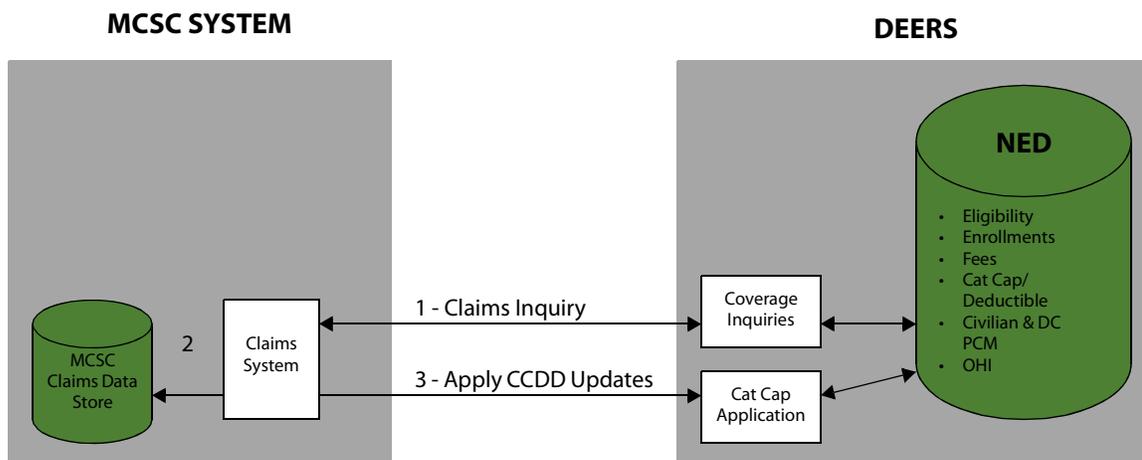
- Health Care Coverage Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

1.6.1.1. Health Care Coverage 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 Health Care Coverage Inquiry for Claims supports business events associated with health care coverage and CCDD data for processing medical claims. This inquiry may also be used for general customer service requests or for referrals and authorizations.

FIGURE 3-1.5-6 CLAIMS INQUIRY TO DEERS



The MCSC must use the eligibility, enrollment, OHI, OGP (e.g., Medicare), PCM, and CCDD information returned on the DEERS response to process the claim.

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 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 same period as required by the TPM or TOM.

Unless notified by the contracting officer, the contractor may not bypass the query/response process for the prior day's claims if either DEERS or the contractor is down for 24 hours or any other extended period of time. Instead, when this situation occurs, the contractor shall work directly with DEERS to develop a mutually agreeable schedule for processing the backlog. The contractor shall develop a method for ensuring the query/response process continues, even if an extended period of downtime occurs. This alternative method can be either a batch backup to the on-line system, weekend processing, off-hours processing, or any other method proposed by the contractor and accepted by DEERS and TMA.

1.6.1.1.1. 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 deductible.

There are three exceptions to the requirement for sending a query for TRICARE adjustments. No query is needed for:

- Another claim or adjustment for the same beneficiary that is being processed at the same time. (A contractor may query for a claim or money adjustment using a “claim status query” for one of several claims.)
- Negative Adjustments
- Total Cancellations

1.6.1.1.2. Information Required For A Health Care Coverage 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

1.6.1.1.3. 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. See Chapter 3, Section 1.3, paragraph 3.3. and 3.4. for more information on the identification of beneficiaries.

1.6.1.1.4. 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, the correct person must be selected, then the coverage inquiry re-sent.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1.5

DEERS FUNCTIONS

FIGURE 3-1.5-7 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)	<u>INQUIRY SPONSOR INFO SECTION:</u> SPN_INQ_PN_ID SPN_INQ_PN_ID_TYP_CD SPN_PN_LST_NM SPN_PN_1ST_NM SPN_PN_BRTH_DT <u>INQUIRY PERSON INFO SECTION*:</u> INQ-PN_ID INQ-PN_ID_TYP_CD and/or PN-LST-NM PN-1ST_NM PN_BRTH_DT	R R O O O S S NA S 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)	<u>INQUIRY SPONSOR INFO SECTION:</u> <u>INQUIRY PERSON INFO SECTION:</u> INQ_PN_ID INQ_PN_ID_TYP_CD PN_LST_NM PN_1ST_NM PN_BRTH_DT	NA R R O O O
RETURN THE WHOLE FAMILY (PNF_TXN_TYP_CD = F)	SPONSOR INFORMATION PROVIDED (INQ_PN_TYP_CD = S)	<u>INQUIRY SPONSOR INFO SECTION:</u> SPN_INQ_PN_ID SPN_NQ_PN_ID_TYP_CD SPN_PN_LST_NM SPN_PN_1ST_NM SPN_PN_BRTH_DT <u>INQUIRY PERSON INFO SECTION:</u>	R R O O O 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).

1.6.1.1.5. 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 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.

1.6.1.2. Information Returned In The Health Care Coverage Inquiry For Claims

The DEERS ID is returned in response to a coverage inquiry. The MCSC should store the DEERS ID for use in subsequent update transactions for this claim. The DEERS ID ensures correct person identification and provides uniform beneficiary identification across the MHS. In addition, the Patient ID is returned in the coverage response. The MCSC is required to store the Patient ID. The Patient ID provides uniform person identification and patient identification across the MHS. The MCSC must put the Patient ID and DEERS ID on the TRICARE Encounter Data (TED) record.

1.6.1.2.1. Data Returned In A Coverage Inquiry That Repeats For Every Coverage Plan

In response to a Health Care Coverage 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 for 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 when the newborn is added to DEERS. See paragraph 1.6.1.5.2.6.

1.6.1.2.2. Data Returned In A Coverage Inquiry Independently From The Coverage Plan Information

The DEERS coverage response could include PCM, OHI and OGP information, and CCDD totals and lock information, independently from the health care coverage information. If no PCM, OHI, and OGP information is returned, this means that DEERS does not have this information in effect for the requested inquiry dates.

- **Sponsor Personnel Information:** All current personnel segments will be returned, including dual eligible segments. The MCSC shall not use this information for claims processing. This information is intended to be used for the TED only.
- **PCM 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. OGPs include CHAMPVA and Medicare.
- **CCDD totals:** Both family and individual CCDD accumulations are provided in the coverage response.

1.6.1.2.3. Health Care Coverage Copayment Factor For Coverage Inquiries

The copayment for an insured is determined using information provided by DEERS and may also include treatment information from a claim. The different factors are determined by legislation, which considers factors such as pay grade and personnel category, such as retired sponsor or AD.

The Health Care Coverage Copayment Factor Code is determined by DEERS and is returned on a claims inquiry. The MCSC shall use this factor code to determine the actual copayment for the claim.

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 activity duty sponsors rate
- Foreign Military rate

NOTE: More rate codes can be added, as required by the DoD.

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.

1.6.1.2.4. Special Entitlements

Congressional legislation may effect deductibles and rates. The Special Entitlement Code, and dates if applicable, provide information to support this legislation. 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 CMAC or billing charges whichever is less.

Effective dates will also be included in the response from DEERS. A person may have multiple special entitlements. Refer to TOM and TPM.

1.6.1.3. Multiple Responses To A Single Health Care Coverage Inquiry for Claims

DEERS may need to send multiple responses to a single Health Care Coverage Inquiry for Claims, and these responses are returned in a single transaction. This situation could occur 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).

FIGURE 3-1.5-8 HEALTH CARE COVERAGE INQUIRY FOR CLAIMS: RESPONSES AND ACTIONS

CONDITION	RESPONSE	MCSC ACTION
Based on INQUIRY PERSON TYPE CODE of 'S' (individual family member inquiry with Sponsor and family member information provided)		
1. Multiple sponsors matched	Partial match transfer with multiple families TXN_TYP_CD = 'F' Return Status 0 and Return Code 00000 in header section	Select correct sponsor, re-query DEERS using the selected sponsor's SPN_PN_ID and SPN_PN_ID_TYP_CD, SPN_PN_LST_NM and SPN_PN_BRTH_DT and at least the PN_ID, PN_ID_TYP_CD of the family member selected.
2. Sponsor found, family member not found	Partial match transfer with one family TXN_TYP_CD = 'F' Return Status 0 and Return code 00000 in header section	Select correct family member, re-query DEERS using both the returned sponsor's and family members PN_ID and PN_ID_TYP_CD.
3. Sponsor found, multiple family members matched	Partial match transfer with one family TXN_TYP_CD = 'F' Return Status 0 and Return Code 00000 in header section	Select correct family member, re-query DEERS using the originally sent sponsor data but now add PN_ID and PN_ID_TYP_CD returned to the new inquiry
4. Sponsor found, family member found	Health care coverage transfer TXN_TYP_CD = 'P' Return Status 0 and Return Code 00000 in header section	Adjudicate claim based on response.
Based on INQUIRY PERSON TYPE CODE of 'P' (person inquiry with no sponsor information available)		
1. Person found in multiple families during inquiry period	Partial match transfer with multiple families	Select correct sponsor, re-query DEERS using both the returned sponsor's and family members PN_ID and PN_ID_TYP_CD.
2. Person found in single family during inquiry period	Health care coverage response	Adjudicate claim based on response.
Based on TRANSACTION TYPE CODE of 'W', 'E', or 'S' (errors or warnings encountered)		
1. Person not found	Application Warning or Error Transfer TXN_TYP_CD = 'W' Return Status 4 and Return Code 00001 in header section	Deny claim and direct beneficiary to a military ID card facility to have information updated in DEERS.
2. Application Error or warning other than Person not found	Application Warning or Error Transfer TXN_TYP-CD = 'W' Return Status 4 and Return Code 00002 through 99999 in header section	For action, see Return Code section 10.0 of the Technical Specification.

FIGURE 3-1.5-8 HEALTH CARE COVERAGE INQUIRY FOR CLAIMS: RESPONSES AND ACTIONS

CONDITION	RESPONSE	MCSC ACTION
3. Inquiry Transfer handling Error	Application Warning or Error Transfer TXN_TYP_CD = 'E' Return Status 1 and Return Code 00001 through 99999 in header section	For action, see Return Code section 10.0 of the Technical Specification.
4. System Error	Application Warning or Error Transfer TXN_TYP_CD = 'S' Return Status 1, 2, 3, 5, 6, 7, 8, 9 and Return Code 00001 through 99999 in header section	For action, see Return Code section 10.0 of the Technical Specification.

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's DOB. If the DOB is within 365 days of the date of the query (i.e., a newborn less than 1 year old), the contractor shall release the claim for normal processing.

If the DOB is over 365 days from the date of query, the contractor shall check the duty station or residence of the sponsor. If the sponsor resides overseas and/or an APO/FPO address is indicated for the sponsor, the claim shall be released for normal processing.

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

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 Joint Uniformed Services Medical Advisory Committee (JUSMAC) members is provided at the TMA web site at <http://www.tricare.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 Chapter 3, Section 1.6.

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 Points of Contact (POC) for the DSO personnel and the JUSPAC/JUSMAC members identified on the TMA web site.

1.6.1.4. CCDD Totals Inquiry

The CCDD Totals Inquiry is used to obtain CCDD balances for the fiscal year(s) that correspond to the requested inquiry period. The MCSC must inquire and lock CCDD totals before updating DEERS CCDD amounts with enrollment fee payment information.

1.6.1.4.1. Information Required To Inquire For Totals

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

1.6.1.4.1.1. Person Information

The MCSC must have the DEERS ID, returned by DEERS on the policy notification or coverage response, for this inquiry. Either the sponsor's or family member's DEERS ID is used for the totals inquiry. Even though only one person's DEERS ID is used, both individual and family totals will be returned in the response.

1.6.1.4.1.2. Other Persons Not On DEERS

A catastrophic cap record is not required for persons who are not on DEERS, for example, prisoners and MTF employees. The purpose of the catastrophic cap is to benefit those beneficiaries who are eligible for MHS benefits through their registration on DEERS, therefore, those persons that are authorized benefits, who would not under any other circumstances be eligible, are not subject to catastrophic cap requirements.

1.6.1.4.1.3. 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 three years (current year and two prior years) in the past. Future dates are not valid.

1.6.1.4.1.4. Lock Indicator

The MCSC chooses whether to lock CCDD totals. However, if the MCSC intends to update the CCDD amounts, the MCSC must lock the CCDD totals. See locking description in the Health Care Coverage Inquiry section. At TMA discretion, certain non-MCSC organizations are waived from locking prior to updating CCDD (for example: Pharmacy Data Transaction System (PDS)).

1.6.1.4.1.5. Response To CCDD Totals Inquiry

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

1.6.1.4.1.6. CCDD Totals

DEERS sends a response showing year-to-date CCDD totals for each FY, based on the inquiry dates requested, not greater than three years in the past. Both individual and family totals are displayed, showing CCDD balances separately. If there are no CCDD totals accumulated for any FY in the inquiry period requested, DEERS will show a zero value for that FY.

If the inquiry period spans fiscal or enrollment years, the CCDD totals would repeat multiple times. For example, if the inquiry dates are September 1, 2003 through

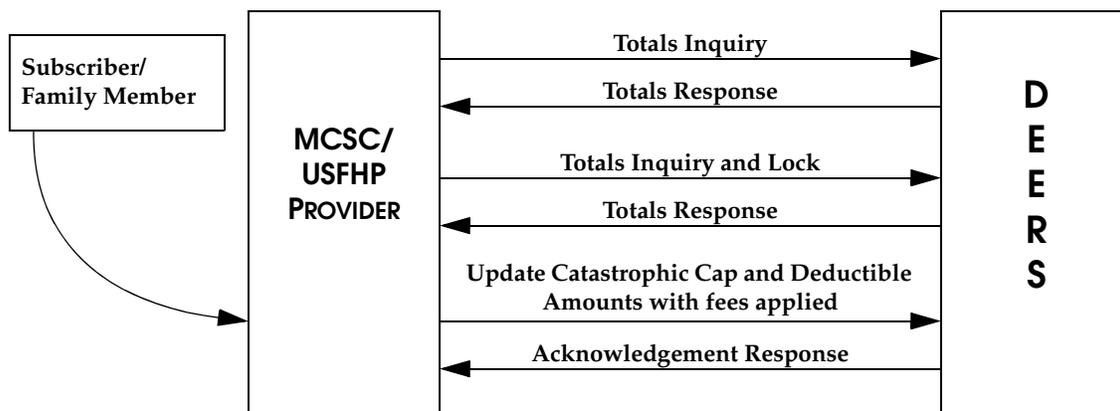
October 25, 2003, there would be two sets of fiscal year totals, one for FY 2003 and one for FY 2004.

1.6.1.4.1.7. Lock Information

If an MCSC or DP inquires for CCDD totals and does not place a lock on the totals, DEERS returns any totals accumulated for the inquiry period and lock information if the totals were presently locked. If an MCSC inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that MCSC's lock information, including their lock organization, lock date, and lock time. If an MCSC inquires and locks CCDD totals for a beneficiary whose totals are already locked, only the lock organization, lock date, and lock time will be returned. No totals will be returned in this situation.

The following diagram depicts a CCDD Totals Inquiry.

FIGURE 3-1.5-9 CCDD TOTALS INQUIRY



1.6.1.5. Updating CCDD Amounts

The FY CCDD total can be updated online for the current and two prior fiscal years. This update transaction requires the DEERS ID, which may be obtained from a coverage or CCDD totals inquiry. Claim extension identifier note: If claim does not span multiple fiscal years, the claim extension identifier should be set to '000'. A split claim will set the claim extension identifier to '001' for the first FY the claim occurs in and increment the claim extension identifier for each additional FY the claim occurs. 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 MCSC 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.

CCDD amounts can be updated online for the current year and two prior fiscal years. 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 fiscal years and is split, updates for FY 2000 and FY 2001 must be sent in two transactions using the claim extension identifier (explained below) to distinguish the two updates from one another.

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

If cost-shares, copays, or deductibles have been collected, these amounts must be posted to the CCDD, even if the limit has been met.

1.6.1.5.1. Information Required To Update CCDD Amounts

The MCSC 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 (POS) dollar amount

The MCSC 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 fiscal years, 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 may include the date(s) of service for the claim (both begin and end date) or the fiscal year, as appropriate. These dates are necessary for accumulating the CCDD totals for the correct time period and HCDP.

- For fiscal year updates, the MCSC must send DEERS the fiscal year for which the CCDD applies.
- For updates associated with a claim, the period of service for the claim should be sent to DEERS, so that the information can be referenced with CCDD details.

1.6.1.5.2. Types Of CCDD Updates

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

1.6.1.5.2.1. Adds

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

1.6.1.5.2.2. Adjustments

The MCSC utilizes the CCDD update to adjust posted CCDD amounts. The same claim identifier as the original claim must be provided for the adjustment. A negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, an MCSC must provide the same information for updating a claim as outlined in the previous section. For example, an MCSC 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 MCSC 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.

1.6.1.5.2.3. Canceling A Catastrophic Cap Or Deductible Amount

The MCSC utilizes this update transaction to cancel (zero out a posted amount) a previously submitted catastrophic cap or deductible amount.

Claim cancellations are handled similarly to adjustments. For example, an MCSC updates a claim with a \$120 deductible amount, then one week later discovers that this was incorrect, and there should not have been any adjudicated deductible amount. The MCSC would then update the insured's deductible with an amount of -\$120. This would zero out the previous amount applied for that claim.

1.6.1.5.2.4. The 48-Hour Rule

DEERS enforces a 48-hour lockout rule. If an MCSC places a lock on a record and fails to update that record within the specified 48-hour time period, the MCSC will be unable to update CCDD amounts, because the lock will have expired.

1.6.1.5.2.5. Removing A Lock

If an MCSC places a lock, then realizes the lock is unnecessary, the preferred way to remove that lock is to perform a CCDD update specifying to remove the lock. In this case, the MCSC would send no catastrophic cap or deductible amounts, only an indication of the removal of the lock.

1.6.1.5.2.6. 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 is to be added. If DEERS returns an error code on a newborn and that person is already on the database, then the contractor should query to determine if this is the same person. If so, then use the return information to apply the CCDD. The field for "Person First Name" should be populated with 'NEWBORN' or 'developed first name'. If the record is required for a multiple birth, the MCSC should submit a request for the addition of an additional placeholder record to DSO via the DSO Web Request (DWR) web-based application (an on-line system), and submit an actual name for the additional record(s). MCSCs should request the first name of the initial placeholder record to be changed from 'NEWBORN' to the developed name for multiple births upon completion of development activities. DMDC's expected turnaround for the processing of requests for additional placeholder records is six work days. If the MCSC has not received the placeholder record, they may contact DSO to follow-up on their request. When sponsors register their newborn children in Real-Time Automated Personnel Identification System (RAPIDS), the Verifying Official will change the placeholder field for "Person First Name" to the actual name of the newborn child. All catastrophic cap records for the placeholder record will be merged under the verifying record as appropriate.

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'.

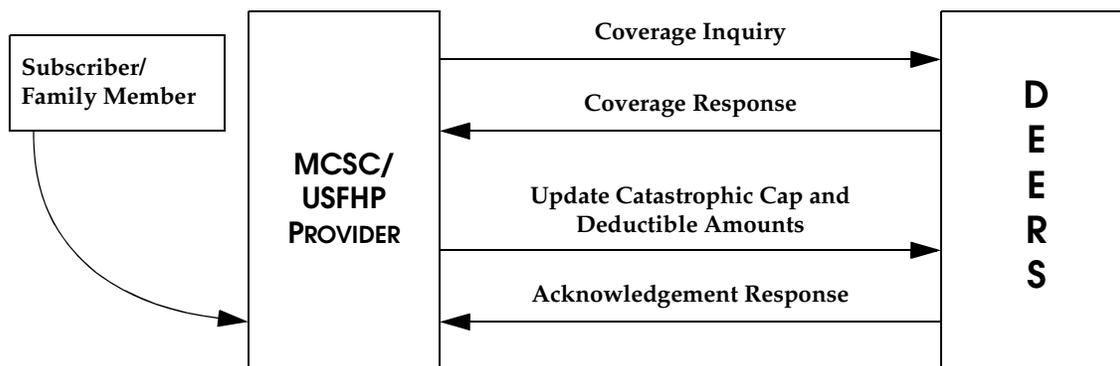
Adding the newborn in DEERS via CCDD updates will not generate eligibility for the newborn, but the newborn will show in GIQD and in claims responses. Once the sponsor "adds" the newborn in DEERS through RAPIDS, the newborn will be eligible like any other beneficiary.

NOTE: When the addition of a newborn placeholder is requested by the pharmacy contractor, see Chapter 3, Addendum F for procedures.

1.6.1.6. Response To Updating CCDD Amounts

DEERS sends an acknowledgement message after a successful CCDD update. The following figure details the flow of a CCDD Amounts Update.

FIGURE 3-1.5-10 COVERAGE INQUIRY AND CCDD UPDATE PROCESS



1.6.2. 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 transaction history request. The following transaction history request types are available via the Catastrophic Cap and Fee Research Web application:

- Service Period Dates
- Claim ID

1.6.2.1. Information Required To Request A CCDD Transaction History

The required information for a transaction history request includes:

- Subscriber Person ID and ID Type Code
- Fiscal year

1.6.2.1.1. Inquiry Period

The inquiry period may be either a fiscal year or three fiscal years (current plus past two). Historical dates are valid, as long as the requested dates are within three years.

1.6.2.1.2. Detail Identifier

The inquirer may filter for CCDD transaction history information for a specific update using the detail identifier. The detail identifier corresponds to the claim number, enrollment fee identifier, or adjustment identifier used for posting the CCDD amounts.

1.6.2.2. Information Returned In Response To A CCDD Transaction History Request

DEERS returns each individual CCDD detail that was applied during the inquiry period for each member of the family inquired upon. Amounts returned in the response may include both positive and negative amounts.

For example, if the inquiry period were FY 2001, all CCDD amounts that were applied to the FY 2001 are returned in the transaction history response regardless of the date in which the update was actually sent to DEERS. DEERS does not use the transaction date to determine what detail to return in the response. DEERS uses the period to which the update actually applies.

1.6.2.3. CCDD Data Transfer

TRICARE Standard CCDD data has been maintained in the Central Deductible and Catastrophic Cap File (CDCF) since FY 1995 for claims with a date of service on or after October 1, 1994. This data will be transferred to the new regional contractor during transition. It is the responsibility of the new Regional contractor to ensure DEERS reflects the correct TRICARE Prime Point of Service (POS) deductible total for all FYs stored on DEERS. This data will be migrated from the CDCF to the DEERS CCDD repository via initial load.

Under previous contracts, TRICARE Prime Point of Service (POS) deductible data has been maintained separately by MCSC's. Under current contracts, TRICARE Prime Point of Service (POS) deductible data will be stored by DEERS for enrollees under the new regional contracts.

1.6.2.4. CCDD Data Storage

DEERS stores CCDD data both by beneficiary and fiscal year. For TRICARE Standard and Extra, DEERS tabulates and stores CCDD balances by fiscal year, which is October 1 through September 30. DEERS treats Standard and Extra as one type of catastrophic cap.

For TRICARE Prime Point of Service (POS), DEERS tabulates and stores the deductible balance by fiscal year.

DEERS stores and archives CCDD data. The most recent three years of CCDD data is maintained online after contract transition.

1.6.3. Point of Sale (POS) for Pharmacy Inquiries

DEERS has implemented a dedicated eligibility interface for the TRICARE pharmacies called the Point of Sale (POS). This interface provides current eligibility only, and is implemented to ensure sub second response times required by the retail pharmacies, where beneficiaries are waiting for a response at the counter. The Point of Sale (POS) interface is used for all TRICARE Retail Pharmacy (TRRx) and TRICARE Mail Order Pharmacy (TMOP) transactions that are not date of service based paper claims. For date of service based claims, the claims interface must be used.

1.6.3.1. Point of Sale (POS) Inquiry

The Point of Sale (POS) is an XML-based web application that accepts secondary identification based on sponsor or primary identification based on the Patient ID. The pharmacy should base inquiries primarily on the sponsor's family member attributes. For example, sponsor SSN, family member DOB from the ID card. The Patient ID can be used in situations where secondary identification cannot yield a single beneficiary (i.e., twins with the same name).

1.6.3.2. Point of Sale (POS) Response

The Point of Sale (POS) response returns the Patient ID (which is needed for drug utilization review) as well as an eligibility indicator, Plan, CCDD contributions, OHI indicators, and Medicare indicators. This data is necessary to both grant eligibility and determine correct copayment or cost share amounts to be collected in real time at the pharmacy.

1.6.3.3. Person Demographics Service (PDS) for Pharmacy Inquiries

The PDS is an XML-based batch interface used to query additional data attributes required for TRICARE Encounter Data submissions that are included in the Point of Sale (POS) response. The PDS batch interface is used to request demographics for the previous days eligibility inquiries that resulted in eligible responses. The PDS response only returns data current at the time of the PDS batch inquiry. When TED records reject because of demographics, the pharmacy should utilize the claims interface to correct the data based on the date of service.

1.6.3.4. PDS Inquiry

The PDS is an XML-based web application that accepts multiple Patient IDs. Batch submission should be limited to sizes of 10,000 records to minimize potential processing problems that can occur on large files.

1.6.3.5. PDS Response

The PDS response returns data elements required for TED processing. When no person is found, the submitted Patient ID is returned. When the person is found, but not eligible, only person attributes are returned. When a person currently eligible for pharmacy benefits is returned, Plan, PCM (when available), Medicare and sponsor personnel data is also returned.

1.7. 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 MCSC will determine the existence of OHI. The MCSC can add or update minimal OHI data through the DOES application used by the MCSC to enter enrollments into DEERS. Other MHS systems can add or update the OHI through the OHI/SIT web application provided by DEERS. In addition, DEERS will accept OHI updates from a claims processor through a system to system interface. 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. Please see the “Technical Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI)” for more detailed information.

These fields are the minimum-required data entered at the time of enrollment or during any beneficiary contact when the beneficiary indicates he or she has OHI. If only the minimum required data is entered by the MCSC, the MCSC is required to fully develop for the remaining OHI data necessary to complete the OHI record within 15 business days. Detailed requirements for the exchange of OHI information is contained in the “Technical Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI).” HIC information is validated against the SIT which maintains the valid insurance carrier information on DEERS.

DEERS requires the MCSC 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 for the person.

Examples of OHI coverages are:

- Comprehensive Medical coverage (plans with multiple coverage types)
- Medical coverage
- Dental coverage
- Inpatient coverage
- Outpatient coverage
- Long-term care coverage
- Pharmacy 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. 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 Verification Point of Contact (VPOC) at TMA deactivates the HIC on the SIT. Refer to the SIT section for more information. DEERS retains OHI policy data for five years after an OHI policy expires or is deactivated or terminated.

1.7.1. OHI Policy Inquiry

1.7.1.1. 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.

1.7.1.2. 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.

1.7.1.3. OHI Information

There are multiple ways the requester can specify the OHI information for the inquiry. The requester must specify a time period (begin and end date) or through combinations of the time period, the HIC ID or the HIC Name, the OHI Policy ID and 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.

1.7.1.4. 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 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.

1.7.2. OHI Policy Add

DEERS allows the MHS and MCSC systems to add an OHI policy for a person when documented information is presented to the MHS clinical personnel or to the MCSC. 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 MCSC shall provide all OHI data not initially entered.

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

- Patient ID
- HIC Name or 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 Name, DEERS will check it against the SIT for validation of the HIC information. If the HIC Name is not on the SIT, the MHS organization may add a new HIC and Coverage. If the insurance carrier is not known, enter the carrier "Placeholder HIC ID", which is the placeholder entry on the SIT. The single placeholder entry on the SIT can be used to indicate that an OHI policy exists for a beneficiary. Additional fields required to complete the OHI record are at Addendum D, Table X. This HIC of "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 enrolling entity or updating system is responsible for obtaining the complete OHI information and updating the placeholder OHI policy in DEERS within 15 work days.

Then the OHI can be added to the person as an indication that OHI exists. More information on the SIT is contained in paragraph 1.8.

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. For example, two OHI policies would be sent to DEERS, one OHI Policy ID covers medical and a second OHI Policy ID, with a different HIC and the same dates, covers dental.

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.

1.7.3. 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. OHI data can be updated during an enrollment via the DOES application.

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

1.7.4. OHI Policy Cancellation

NOTE: 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

1.8. SIT

The SIT program supports the MHS billing and collection process. The requirements for the SIT are validated by the TMA UBO through the DoD VPOC. DEERS is the system of record for SIT information, but not OHI information. The VPOC at TMA maintains the SIT in DEERS. The MHS personnel use the SIT to obtain other payer information in a standardized format. The SIT provides uniform billing information for reimbursement of medical care costs covered through commercial policies held by the DoD beneficiary population.

The HIC ID is the key used for associating a person's OHI policy with a commercial insurance company on the SIT. The HIC ID consists of the first three characters of the insurance company name, the two-letter standard state or country abbreviation, and a four-character identifier assigned by the DMDC. Once a standard national health plan identifier is adopted by the Secretary, Health and Human Services (HHS), DEERS and 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 Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI)" for subscription procedures. The holders of the SIT shall subscribe to DEERS daily in order to receive subsequent updates of the SIT. These updates may result from a user request or may be additions or updates made directly by the DoD VPOC.

Field users perform five actions with the SIT:

- Inquiry actions can be performed on the OHI/SIT web application or through their 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 be added can cancel the request.

- The deactivation of a verified HIC sent to the SIT for verification by the DoD VPOC.

1.8.1. SIT Inquiry

Local holders of the SIT cannot perform inquiries against the central SIT maintained on DEERS. All actions against the SIT on DEERS will be defined in paragraphs 1.8.2. through 1.8.6.

1.8.2. SIT Add

When the MHS personnel add a complete OHI record to a person or patient, they will need the HIC ID that matches an entry in 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 Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (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. If the DoD VPOC rejects the request to add the HIC, all OHI Policies associated with the HIC are automatically cancelled. 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. When the DoD VPOC validates the SIT, the HIC Verification Status Code will be changed from "unverified" to "verified." DEERS will make updates available with the appropriate HIC information to all local holders of the SIT through the daily subscription process.

1.8.3. SIT Update

For updates to an existing SIT record, the existing HIC ID is sent with the update. These updates are sent to all subscribers through the daily subscription process. Without the HIC ID, DEERS is not able to report a validation or a rejection of the SIT update. Returning all the insurer information in the update assists in the rapid validation of the SIT by the DoD VPOC. 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

DEERS, provides the TMA UBO an application that allows the DoD VPOC to validate SIT.

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. Medicare Data

DEERS performs a match with Centers for Medicare and Medicaid Services (CMS) to obtain Medicare data and incorporates the Medicare data into the DEERS database as OTHER GOVERNMENT PROGRAMS (OGP) entitlement information. This information includes both Medicare A and Medicare B eligibility along with the effective dates. The match includes beneficiaries who are either over or under 65 on the DEERS.

DEERS sends the Medicare information to the TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC). The TDEFIC sends the information to the CMS Fiscal Intermediaries for identification of Medicare eligibles during claims adjudication.

DEERS sends the TDEFIC three types of files based on the population of beneficiaries being sent:

- A monthly file of beneficiaries who will turn 65 years old within the next 60 to 90 days and beneficiaries over age 65 that did not have Medicare on DEERS within the preceding month.
- A quarterly file of all beneficiaries under age 65 that CMS identified as having Medicare.
- Every six months, DEERS sends the TDEFIC a file of all beneficiaries over age 65 with Medicare reported on DEERS.

1.10. Resource Utilization

1.10.1. Performance Characteristics

DEERS response times provided in this section are based on internal system response time. Internal system response time is defined as the interval of time from the receipt of the last bit of the incoming transaction to DEERS' communications system until the first bit of the response leaves DEERS' communications system. Communications time is not included in these estimates.

DEERS average response times for online data updates (data push) from socket to socket connections is seven seconds, and for online data queries (data pull) from socket to socket is five to eight seconds.

Average online response time in the current version of DOES is four to six seconds.

Batch transaction response time varies with the batch volume and overall concurrent batches processed.

X12 or HL7 transactions are beyond the scope of these estimates, but are expected to run slower than the batch response times due to the overhead of the translation.

DEFENSE MANPOWER DATA CENTER (DMDC) SUPPORT

1.0. DEFENSE MANPOWER DATA CENTER (DMDC) SUPPORT

DMDC Support Services are provided by the Defense Enrollment Eligibility Reporting System (DEERS) Support Center and the DMDC Support Office (DSO). The DEERS Support Center provides 24 hour a day, seven days a week global support for DEERS/Military Health System (MHS) system problems that may arise. The DSO researches and resolves personnel or person discrepancies and corrects enrollment records. Information on contacting, as well as reporting issues to the DEERS Support Center can be found in the T-NEX Problem Resolution Guide.

2.0. DMDC SUPPORT OFFICE (DSO)

2.1. Contractor Obligations

Contractors must fulfill the following obligations before contacting the DSO for problem resolution:

- Only two individuals (one primary, one backup) per contractor in each region may contact the DSO. It is the responsibility of the contractor to designate these individuals, inform their organization that all issues must be routed through either of these two people, ensure these two individuals are properly trained and technically competent, and ensure compliance with this requirement.
- Contractors will forward the names, Social Security Numbers (SSNs), telephone numbers, and e-mail addresses of their region's designated primary and backup Points of Contact (POC) via password protected or encrypted e-mail to the DSO POC at dso.tma@osd.pentagon.mil and the TRICARE Management Activity (TMA) Program Manager. A contact number should be included in the e-mail for any follow-up that may be required. Each name listed should indicate whether the individual is the primary or back-up POC. For those contractors with more than one region, a single e-mail identifying the POC by region is sufficient.
- Contractors will forward updates to the DSO via password protected or encrypted e-mail when a primary or backup POC replacement occurs. The e-mail will provide the replacement's notification information as identified above as well as identifying who is being replaced.
- Individuals who contact the DSO who are not on the approved list, but should be, will be requested to have their manager/supervisor submit e-mail containing updated POC information to the Help Desk. The Help Desk will not modify the Approved List without supporting e-mail from the contractors.

- Individuals who contact the DSO who are not on the approved list and who are not replacing a current primary or backup POC will be asked to coordinate their issues with their designated POC.
- Contractors must make reasonable efforts to internally resolve any issue prior to use of the DMDC support services. For example, the contractor must verify connectivity on its own network.
- The contractor will provide an adequate amount of information to the DMDC so that a problem can be replicated before the commencement of DMDC's support.
- Issues submitted with inadequate information will be returned to the contractor.
- All TRICARE Correction Requests shall be checked for accuracy by the designated POCs prior to submission to DSO.
- All updates to DEERS Online Enrollment System (DOES) must be tested by the Managed Care Support Contractor (MCSC)/Uniformed Services Family Health Plan (USFHP) provider and, if operable, installed and used. DEERS will only support the current and prior release of the DOES application.

NOTE: DMDC is not responsible for any problem caused by the following:

- Incorporation of attachment of a feature, program, or device to DOES, or any part thereof
- Any nonconformance caused by accident, transportation, neglect, misuse, alteration, modification, or enhancement of DOES
- The failure to provide a suitable installation environment
- Use of DOES for other than the specific purpose for which DOES is designed
- Use of DOES on any systems other than the specified supported hardware platform and/or operating system
- Use of defective media or defective duplication of DOES
- Failure to incorporate any previously released update
- Communications Issues
- Firewalls external to DMDC
- Software distribution & installation of software used by the MCSC/USFHP contractor

3.0. REPORTING ISSUES TO DSO

3.1. The DSO is responsible for researching and resolving personnel or person discrepancies and correcting enrollment records. The contractor is responsible for establishing designated POC with the DSO, and the DSO will only accept issues submitted by these POCs. The contractor must have a quality control process in place. The POCs are responsible for reviewing all DSO requests for accuracy and necessity prior to submission in order to ensure that requests include sufficient information to clearly identify the problem. Any request that is not clear or complete will be returned to the contractor with a "Note to

Contractor" identifying information or clarification needed and a request to resubmit the request with the information required.

3.2. Reporting Discrepancies And Corrections To Health Care Delivery Program (HCDP) Enrollments

Problems or requests that are related to personnel or person discrepancies should be reported directly to DSO via DSO Web Request (DWR) application (formerly referred to as the DMDC Medical Interface (DMI), a web-based on-line system. Any issue that affects the beneficiary's immediate medical care should be indicated as "1-urgent". Any issue that impacts their enrollment or disenrollment should be indicated "2-high priority". All other issues should be indicated "3-routine". The DSO will provide assistance for resolution of issues in the areas outlined below.

- Beneficiary doesn't show as eligible, contractor has documents that indicate eligibility
- Duplicate person (individual listed as both spouse and child or a duplicate of the same person)
- Erroneous person data (such as incorrect Date of Birth (DOB))

Required Enrollment corrections that cannot be performed in DOES include changes to an enrollment or Primary Care Manager (PCM) that is not the most current enrollment or PCM segment, and cannot be made current through a cancellation of a later segment via DOES. These types of requests should follow the TRICARE Correction Request procedures outlined below:

- Contractors must make reasonable efforts to internally resolve any issue prior to use of the DSO support services. The contractors should perform all actions to the extent possible in DOES before submitting the request to DSO for assistance. The DWR form will require an explanation of why the corrective action could not be performed in some cases.
- Requests submitted through DWR with inadequate information will be returned to the contractor for additional information.
- All requests must be submitted in accordance with the guidelines provided in the User's Guide. The request must be submitted using the DWR located at: <https://www.dmdc.osd.mil/tma>.
- All correction requests must include the POCs name and telephone number. The DSO analyst may contact the POC via telephone, if there is a question regarding the request.
- The status of the request may be viewed by the contractor at any time. Completion of the request can be verified by accessing the request through the Main Menu and selecting View Request Status.
- All requests will be handled on a priority basis, but the volume of requests directly impact the response time. Note: Only those issues that affect the beneficiary's immediate care should be marked as urgent - Category 1.

TEST ENVIRONMENT

1.0. One region is available for both contractor testing and training. Typically, as fixes are applied and tested, the modified software will be installed in the contractor region for testing. Defense Manpower Data Center (DMDC) will coordinate with TRICARE Management Activity (TMA) and the contractors when the test region will be upgraded with software for the next major release (as opposed to continuing software modifications for the current release) and available for contractor testing. DMDC will coordinate changes with contractors to the baseline set of Social Security Numbers (SSNs).

1.1. Releases

New releases of the Defense Enrollment Eligibility Reporting System (DEERS) Online Enrollment System (DOES) software will be posted to the DMDC web site for download. Notification of new releases of DOES and back-end software to support DOES and other interfaces with the Managed Care Support Contractors (MCSCs) or Uniformed Services Family Health Plan (USFHP) providers will be sent to contractors in advance via e-mail. The contractor will upgrade/comply with any changes to the DOES software.

Changes to the following are excluded: DataBase, Core Changes, Real-Time Automated Personnel Identification System (RAPIDS), Automated Central Tumor Registry (ACTUR), Montgomery GI Bill (MGIB), or other non-MCSC/USFHP provider related projects.

Emergency fixes are evaluated and, depending on the scope and severity may be released by DEERS to Production prior to the contractor test region. Notification of such an emergency release will be sent via e-mail.

1.2. Maintenance Window

The weekly maintenance window occurs on Saturday at 9:00 p.m. to Sunday at 6:00 a.m. EST/EDT. The DEERS contractor testing environment is available to contractors for testing and training Monday through Friday 8:00 a.m. to 9:30 p.m and Saturday from 8:00 a.m. to 9:00 p.m. EST/EDT.

BUSINESS RULES

BUSINESS RULES LEGEND	
SHEET	BUSINESS EVENT
A	Eligibility for Enrollment Inquiry
B	Enrollment Into Health Benefit Program
B (cont.)	Enrollment Into Health Benefit Program (CHCBP)
B (cont.)	Enrollment Into Health Benefit Program (TRSP)
B (cont.)	Enrollment Into Health Benefit Program (WMTC)
C	Disenrollment
D	Modification of Enrollment (PCM Change)/PCM Panel Reassignment
E	Modification of Enrollment (PCM Cancellation and Transfer Cancellation)
F	Modification of Enrollment (Transfer)
G	Modification of Enrollment (Enrollment Period Change)
H	Modification of Enrollment (Enrollment End Reason Code Change)
I	Modification of Enrollment (Enrollment/Disenrollment Cancellation)
J	Online Enrollment Fee Payment
K	Enrollment Fee Waiver Information Update for an Individual
L	Beneficiary Update
M	Other Health Insurance (OHI)
N	Patient ID Change

Within each sheet (DOES business events):

-  Indicates fields that the user will NOT enter in DOES.
- * Data Type: O=Optional; R=Required; S=Situational; B=Subscriber; I=Insured; UP=USFHP Provider; CV=Civilian; DP=Designated Provider; RS=Resources Sharing
 - ** Enforced By: M=MCSC/USFHP Provider; D=DEERS

Note: If an MCSC/USFHP provider has the need to modify an enrollment outside of the allowable modification period (as stated in the business rules for each event), the MCSC/USFHP Provider must contact the DEERS Support Office (DSO) to make the change.

Each worksheet represents a DEERS Medical business event. The business rules begin with a listing of general rules that apply to all programs and plans. Following the generalized rules, the programs or coverage plans for which the business event applies are listed. Each data attribute included in the business event is then listed by program or coverage plan with the specific rules including data usage, system edits, entity responsible for enforcing the business rule, and error message returned if the business rule is not met (if applicable).

DMDC reserves the right to modify these business rules at any time based on new requirements or further developments of existing requirements.

BUSINESS RULES: A. ELIGIBILITY FOR ENROLLMENT INQUIRY

EVENT AND DATA FLOW	DATA TYPE*	BUSINESS RULES	ENFORCED BY**
		This inquiry is used for eligibility for enrollment only.	
		Eligibility inquiries are made for a family.	
		Eligibility for Enrollment inquiries will show the current health care program information for the inquiry date.	
		If an enrollment exists in the last 12 months, enrollment information will be returned in the Eligibility for Enrollment Inquiry response.	
		PCM information (if applicable) will only be displayed for the past 12 months.	
		If the beneficiary is eligible to enroll in other coverage plans for the HCDP requested, DEERS will return all appropriate coverage plans and dates of eligibility.	
		Parent and Parent-in-Laws are no longer eligible to enroll in TRICARE. However, if they are already enrolled, their enrollments can be modified but the PCM selection MUST remain within the USFHP provider network.	
		Foreign military are not eligible to enroll in any TRICARE program.	

BUSINESS RULES: A. ELIGIBILITY FOR ENROLLMENT INQUIRY

EVENT AND DATA FLOW	DATA TYPE*	BUSINESS RULES BY COVERAGE PLAN	ENFORCED BY**
1. Person/Family Transaction Type Code	R	Family	D
2. Inquiry Person Type Code	R	Identifies whose ID is being submitted, sponsor or family member. DOES defaults to sponsor; if ID is not found as sponsor, DEERS will look for the ID as a family member.	D
3. Inquiry Person Identifier	R		D
4. Inquiry Person Identifier Type Code	R	Acceptable values are SSN, TIN, and FIN. DOES defaults to SSN, but user may change.	D
5. HCDP Type Code	R	Specifies if the inquiry is for Medical or Dental programs. DOES defaults to the HCDP Type Code for which the user has enrollment permissions.	D
6. HCDP Code	R	Specifies the health care delivery program (e.g., Prime, CHCBP) for which eligibility is being requested. DOES defaults to all HCDP Codes for which the user has enrollment permissions.	M, D
7. HCDP Eligibility Inquiry Point-in-Time Calendar Date	R	DOES defaults to the system date and will display eligibility from the past 60 to 90 days in the future.	D

BUSINESS RULES: B. ENROLLMENT INTO HEALTH BENEFIT PROGRAM

GENERAL BUSINESS RULES	ENFORCED BY**
Length of enrollment is indefinite or less based on eligibility.	D
A person cannot be enrolled in multiple coverage plans during the same time period.	D
Until policies are consolidated across contracts, a family cannot have multiple coverage policies of the same plan type with the same contractor during the same time period.	D
Once policies are consolidated across contracts, a family cannot have multiple coverage policies of the same plan type during the same time period.	D
Enrollment fee payments may be waived. DEERS will allow this information to be communicated through the HCDP Individual Enrollment Fee Waiver Reason Code.	M
MCSC/USFHP providers should use the Enrollment Fee Payment Exception Reason Code to indicate the reason an enrollment fee payment is less than expected.	M
A beneficiary can only enroll in a plan for which he/she is eligible, based upon the DEERS response to an Eligibility for Enrollment Inquiry. DEERS will validate that the enrollee lives within the enrolling organization's jurisdiction. If the enrollee's zip code is outside jurisdiction (as determined on the Service Area File), DOES will provide a warning message but will allow the enrollment.	M, D
DEERS will validate that the PCM Region Code falls within the enrolling organization's Contract ID.	M, D
The policy enrollment period begin date is set based on the first person enrolled in the coverage plan and is equal to that person's enrollment begin date.	D
If an enrollment into a plan that require fees must be effective other than on the first of the month, DOES will only enroll the beneficiary through the end of that month. The MCSC/USFHP provider should waive fees for this period and set a fee exception reason. It is also the MCSC/USFHP provider's responsibility to re-enroll the beneficiary effective the first of the following month in order to provide continuous enrollment and to set the anniversary date.	D
Enrollment fees and OHI may be added to DEERS at the time of enrollment. Refer to the Online Enrollment Fee Payment and OHI Add business rules for more details.	M, D
Parent and parent-in-laws are no longer eligible to enroll. However, if they are already enrolled, their enrollments can be modified, but the PCM selection MUST remain within the USFHP network.	D
Foreign military are not eligible to enroll in any TRICARE program.	D
DEERS will disenroll beneficiaries from the TCDP or WMDP if the beneficiary disenrolls from TRICARE Prime or TRICARE Prime Remote for any reason.	D

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CHAPTER 3, ADDENDUM D

BUSINESS RULES

BUSINESS RULES: B. ENROLLMENT INTO HEALTH BENEFIT PROGRAM (CONTINUED)

ENROLLMENT IS REQUIRED FOR THESE PLANS	PLAN AND DATA TYPE										ENFORCED BY**					
	TRICARE PRIME PLANS					TRICARE USFHP PLANS						TRICARE PLUS PLANS	TRICARE ECHO PROGRAM			
11. EVENT AND DATA FLOW EMC Enrollment Work Mailing Address US Postal Region Zip Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	A. Required for TRICARE Remote only; if zip is invalid for enrollment (jurisdiction or program), DOCS will provide a warning. B. If the sponsor's residential zip code is the identical address as the residential address zip code if there is no residential address on DEERS, but user may change it. B. If the sponsor and family member's residential zip codes are not equal, DOCS will prompt the user to disenroll the family member.
12. Sponsor BMC Enrollment Residence Mailing Address US Postal Region Zip Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	A. Required for TRICARE Remote only; if zip is invalid for enrollment (jurisdiction or program), DOCS will provide a warning. B. If the sponsor's residential zip code is the identical address as the residential address on DEERS, but user may change it. B. If the sponsor and family member's residential zip codes are not equal, DOCS will prompt the user to disenroll the family member.
13. HCDFP Enrollment Card Request Status Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Indicates whether or not an ID card should be generated. Default is to generate card upon enrollment.
14. HCDFP Enrollment Card Request Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Enrollment card issued only when Enrollment Card is Requested.
15. PCM Region Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	The PCM Region Code must fall under the Contract ID submitting the enrollment. If there is only one, DOCS will default.
16. PCM Network Provider Type Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Value must be appropriate for the coverage plan. DOCS will default, but the user may change if there is more than one option.
17. PCM Mailing Division DMS Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	A. For DC, UP and RS network enrollments, the user will select the DMS ID/DMS Name in DOCS; DOCS will only display DMS that fall within the PCM Region Code. B. For CV network enrollments, DOCS will default based on the PCM Region Code and search criteria.
18. PCM Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria
19. PCM Identifier Type Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria
20. PCM License Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria; only applicable to DC/RS PCMs
21. PCM Name	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria
22. PCM Group Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria; only applicable to DC/RS PCMs
23. PCM Group Name	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria
24. PCM Place of Care Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria; only applicable to DC/RS PCMs
25. PCM Place of Care Name	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria; only applicable to DC/RS PCMs
26. PCM Telephone Number Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	PCM search criteria
27. Mailing Address City Name	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Civilian PCM search criteria

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CHAPTER 3, ADDENDUM D

BUSINESS RULES

BUSINESS RULES: B. ENROLLMENT INTO HEALTH BENEFIT PROGRAM (CONTINUED)

ENROLLMENT IS REQUIRED FOR THESE PLANS.	PLAN AND DATA TYPE										ENFORCED BY**			
	TRICARE PRIME PLANS		TRICARE USFHP PLANS				TRICARE PLUS PLANS					TRICARE ECHO PROGRAM		
28. EVENT AND DATA FLOW	PC/M Mailing Address	S	S	S	S	S	S	S	S	S	S	S	PC/M search criteria	M, D
29. US Postal Region State Code	US Postal Region State Code	S	S	S	S	S	S	S	S	S	S	S	Civilian PC/M search criteria	M, D
30. US Postal Region ZIP Code	US Postal Region ZIP Code	S	S	S	S	S	S	S	S	S	S	S	Civilian PC/M search criteria	M, D
31. PC/M Mailing Address Country Code	PC/M Mailing Address Country Code	S	S	S	S	S	S	S	S	S	S	S	PC/M search criteria	M, D
32. PC/M Specialty Code	PC/M Specialty Code	S	S	S	S	S	S	S	S	S	S	S	PC/M search criteria	M, D
33. PC/M Sex Code	PC/M Sex Code	S	S	S	S	S	S	S	S	S	S	S	PC/M search criteria	M, D
34. PC/M Location Begin Calendar Date	PC/M Location Begin Calendar Date	S	S	S	S	S	S	S	S	S	S	S	Upon PC/M selection, DOES will validate that this date is on or prior to the BMC Enrollment Begin Calendar Date. If not, DOES will display an error and the user must select another PC/M.	M, D
35. PC/M Location End Calendar Date	PC/M Location End Calendar Date	S	S	S	S	S	S	S	S	S	S	S	Upon PC/M selection, DOES will validate that this date is on or prior to the BMC Enrollment Begin Calendar Date. If not, DOES will display an error and the user must select another PC/M.	M, D
36. PC/M Default Assignment LUC	PC/M Default Assignment LUC	S	S	S	S	S	S	S	S	S	S	S	Default criteria for DC PC/Ms only. If the beneficiary does not indicate any PC/M preference, DOES will default a DC PC/M based on the sponsor's LUC.	D
37. PC/M Assigned Employee Quantity	PC/M Assigned Employee Quantity	R	R	R	R	R	R	R	R	R	R	R	DOES will ensure that the selected PC/M has available capacity.	D

BUSINESS RULES: B. (CONT.) ENROLLMENT INTO HEALTH BENEFIT PROGRAM (CHCBP)

GENERAL BUSINESS RULES		ENFORCED BY**
Foreign military are not eligible to enroll in any TRICARE program.		D
Person must not be enrolled in any other managed care programs established or operated under the auspices of the DoD.		D
Enrollment in the CHCBP program cannot extend beyond 36 months except in the case of an unremarried former spouse.		M

BUSINESS RULES: B. (CONT.) ENROLLMENT INTO HEALTH BENEFIT PROGRAM (CHCBP)

<i>Enrollment required for these plans:</i>		ENFORCED BY**
PLAN AND DATA TYPE*		
EVENT AND DATA FLOW	CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) PLANS	BUSINESS RULES BY COVERAGE PLAN
	(a) CHCBP - Individual Coverage	(b) CHCBP - Family Coverage
37. HCDF Plan Coverage Code	R	R
38. BMC Enrollment Begin Calendar Date	R	R
39. BMC Enrollment End Calendar Date	R	R

Valid with DEERS "eligible for" coverage.
 DEERS sets this field to the beginning of eligibility for CHCBP coverage.
 A. Cannot exceed end of eligibility. DEERS defaults to a 36 month enrollment period.
 B. Must be greater than or equal to enrollment begin date. Enrollment period may not be greater than 36 months except for URBS.
 DEERS enforces that enrollment periods do not overlap.

BUSINESS RULES: B. (CONT.) ENROLLMENT INTO HEALTH BENEFIT PROGRAM (TRSP)

GENERAL BUSINESS RULES		ENFORCED BY**
DEERS will validate that the TRS member lives within the enrolling organization's jurisdiction. If the TRS member's zip code is outside jurisdiction (as determined on the Service Area File), DOES will provide a warning and will not allow the enrollment, unless the zip code is not on the SAF. DOES will determine the region in which each family member resides and enroll them to the appropriate contractor. If a family member does not have a zip code on the SAF, DOES will assign the contractor code of the TRS member.		M, D
The policy enrollment period begin date is set based on TRS member's enrollment begin date. There will be one policy for a family regardless of the contractor(s) they are enrolled to. (The contractor code on the policy will be set to 00.)		D

BUSINESS RULES: B. (CONT.) ENROLLMENT INTO HEALTH BENEFIT PROGRAM (TRSP)

<i>Enrollment is required for these plans:</i>		ENFORCED BY**
PLAN AND DATA TYPE*		
EVENT AND DATA FLOW	TRICARE RESERVE SELECT (TRS) PROGRAMS	BUSINESS RULES BY COVERAGE PLAN
	(a) TRS - Member-Only Coverage (Contingency Ops)	(b) TRS - Member & Family Coverage (Contingency Ops)
40. DEERS ID (Insured)	R	R
41. HCDF Enrollment Update Code	R	R
42. HCDF Type Code	R	R
43. HCDF Plan Coverage Code	R	R
44. BMC Enrollment Begin Calendar Date	R	R
45. BMC Enrollment End Calendar Date	R	R
46. HCDF Individual Enrollment Fee Waiver Reason Code	N/A	N/A
47. BMC HCDF Enrollment Application Received Calendar Date	O	O
48. BMC HCDF Enrollment Application Received Calendar Date	O	O
49. BMC Enrollment Residence Mailing Address US Postal Region Zip Code	R	R
50. BMC Enrollment Work Mailing Address US Postal Region Zip Code	N/A	N/A
51. Sponsor BMC Enrollment Residence Mailing Address US Postal Region zip Code	N/A	N/A
52. HCDF Enrollment Card Request Status Code	R	R
53. HCDF Enrollment Card Request Calendar Date	S	S

Information only provided for clarity of data may be entered under each plan.
 Handled by DEERS.
 M = Family Care handled by DEERS.
 Validated with DEERS "eligible for" coverage.
 A. Must be within eligibility start date and end of eligibility. DEERS may change.
 B. Must be within eligibility end date and end of eligibility.
 A. DEERS sets this field to the end of eligibility for the enrolled coverage plan.
 B. DEERS enforces that enrollment periods do not overlap.
 Required to perform jurisdiction. DEERS will validate that the member lives within the enrolling organization's jurisdiction. If the member's zip code is outside jurisdiction (as determined on the Service Area File), DOES will provide a warning and will not allow the enrollment, unless the zip code is not on the SAF. DOES will determine the region in which each family member resides and enroll them to the appropriate contractor. If a family member does not have a zip code on the SAF, DOES will assign the contractor code of the member.
 Indicates whether or not an enrollment card should be generated. Default is to generate card upon enrollment.
 Current date changed only when enrollment card is requested.

BUSINESS RULES: B. (CONT.) ENROLLMENT INTO HEALTH BENEFIT PROGRAM (WMTC)

GENERAL BUSINESS RULES

		ENFORCED BY**
A person cannot be enrolled in multiple special program coverage plans during the same time period.		D
Allowable periods of enrollments are 289 days prior and 90 days in the future.		D
Do not allow enrollment if a lock out has been flagged for that program.		D
The earliest Enrollments begin date is 2005-12-01.		D
The end date of WMDP/TCDP enrollments should not be greater than the program end date of 2008-09-30.		D
To be eligible to participate in TCDP beneficiaries must :		
a) Residing in CO, MN, MO, and KS;		M
b) Be enrolled in TRICARE Prime or TRICARE Prime Remote;		M, D
c) Be aged 18-64; and		M, D
d) Not be entitled to Medicare.		M, D
e) ECHO and Special Plans enrollees will not be eligible to participate in the TCDP.		M, D
To be eligible to participate in WMDP beneficiaries must :		
a) Be enrolled in TRICARE Prime or TRICARE Prime Remote;		M, D
b) Be aged 18-64; and		M, D
c) Not be entitled to Medicare A.		M, D
d) ECHO and Special Plans enrollees will not be eligible to participate in the WMDP.		M, D
e) Not an ADSM (Sponsor)		M, D
f) Residing in IL, IN, OH, and MI.		M
A beneficiary can only enroll in a plan for which he/she is eligible, based upon the DEERS response to an Eligibility for Enrollment Inquiry.		M, D
The policy enrollment period begin date is set based on sponsor's enrollment begin date. There will be one policy for a Family regardless of the contractor(s) they are enrolled to. (The contractor code on the policy will be set to 00.)		D
DEERS will disenroll beneficiaries from the TCDP or WMDP if the beneficiary disenrolls from Prime for any reason.		D
Notifications will be generated when the enrollments for a beneficiary changes.		D
No PCM assignments for WMTC enrollments.		D

BUSINESS RULES: B. (CONT.) ENROLLMENT INTO HEALTH BENEFIT PROGRAM (WMTC)

EVENT AND DATA FLOW	PLAN AND DATA TYPE		ENFORCED BY**
	(a) TRICARE TCDP	(b) TRICARE WMDP	
56. DEERS ID (Insured)	R, I	R, I	D
57. HCDP Enrollment Update Code	R	R	D
58. HCDP Type Code	R	R	D
59. HCDP Plan Coverage Code	R	R	D
60. BMC Enrollment Begin Calendar Date	R	R	M, D
61. BMC Enrollment End Calendar Date	R	R	M, D
62. HCDP Individual Enrollment Fee Waiver Reason Code	N/A	N/A	D
63. BMC HCDP Enrollment Application Received Calendar Date	O	O	M
64. BMC HCDP Enrollment Application Received Calendar Date	O	O	M
65. BMC Enrollment Residence Mailing Address US Postal Region Zip Code	R	R	M, D
66. BMC Enrollment Work Mailing Address US Postal Region Zip Code	N/A	N/A	M, D
67. Sponsor BMC Enrollment Residence Mailing Address US Postal Region Zip Code	N/A	N/A	M, D
68. HCDP Enrollment Card Request Status Code	R	R	M, D
69. HCDP Enrollment Card Request Calendar Date	S	S	D

Enrollment is required for these plans.

PLAN AND DATA TYPE

TRICARE RESERVE SELECT (TRS) PROGRAMS

BUSINESS RULES BY COVERAGE PLAN

Information only provided for clarity of data may be entered under each plan.

Handled by DEERS.

Handled by DEERS.

Special Programs handled by DEERS: HCDF_CD=003

Validated with DEERS' eligible for coverage: TCDP_HCDP_PLAN_CVG_CD=400, WMDP_HCDP_PLAN_CVG_CD=404.

A. Must be within eligibility period (may vary by program).

B. Must be within eligibility period (may vary by program).

A. DEERS sets this field to the end of eligibility for the enrolled coverage plan.

B. DEERS enforces that enrollment periods do not overlap.

Required to perform jurisdiction; DEERS will validate that the enrollee lives within the enrolling organization's jurisdiction. If the subscriber's zip code is outside jurisdiction (as determined on the Service Area File), DEERS will provide a warning and will not allow the enrollment, unless the zip code is not on the SAFE.

Indicates whether or not an enrollment card should be generated. Default is to generate card upon enrollment.

Current date; changed only when Enrollment Card is Requested.

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BUSINESS RULES: C. DISENROLLMENT

EVENT AND DATA FLOW	DATA TYPE*	GENERAL BUSINESS RULES	ENFORCED BY*
Disenrollment		DOES will display all active enrollments in the family for the user to select appropriate beneficiaries to disenroll.	D
		DEERS will set the PCM Selection End Calendar Date based on the EMC Enrollment End Calendar Date.	D
		DEERS will set the PCM Selection End Reason Code based on the EMC Enrollment End Reason Code	D
		DEERS will revert coverage to the DEERS assigned health coverage plan starting the day following the disenrollment if the beneficiary is still eligible for coverage.	D
		Disenrollments can only be performed on the latest active enrollment.	D
		A disenrollment is done for an individual.	D
		If an AD sponsor loses eligibility, DEERS will disenroll all family members.	D
		DEERS will send disenrollment notifications to all enrollment management and PCM enrolling divisions systems as necessary. For TRS, the notifications will only go to the contractor to whom the member is enrolled.	D
		If an AD sponsor dies, DEERS will automatically disenroll all family members from the AD plan and enroll them in a Transitional Survivor plan for three years (or less depending on eligibility) following the date of death. If the family member was enrolled in TPR with no PCM, DEERS will not re-enroll into the Transitional Survivor plan, it is the MIDST's responsibility to do so.	M, D
		If a retired sponsor dies, family members will not be disenrolled from their coverage plan.	D
		When enrollees with a USFHP PCM lose eligibility for TRICARE Prime due to reaching age 65, DEERS will automatically disenroll them from Prime and enroll them in the appropriate TRICARE USFHP coverage plan.	D
		Parent and parent-in-laws are no longer eligible to enroll.	D
		If a parent or parent-in-law disenrolls from the program, he or she will NOT be eligible to re-enroll at any time.	D

BUSINESS RULES: C. DISENROLLMENT

EVENT AND DATA FLOW	DATA TYPE*	BUSINESS RULES BY PROGRAM	ENFORCED BY*
Disenrollment Unsolicited Notification from DEERS		Unsolicited notification sent by DEERS.	
Disenrollment performed for all health care plans in these groups:		Refer to Policy Notification.	
TRICARE Prime (including Remote) and TRICARE Plus	a	Refer to Policy Notification.	
TRICARE USFHP DC	b	Refer to Policy Notification.	
TRICARE ECHO Program	c	Refer to Policy Notification.	
CHCBP	d	No notification will be sent from DEERS because there is no EDI solution for management of these plans.	
TRS	e	Refer to Policy Notification.	
WMTC	f	Refer to Policy Notification.	
(a) TRICARE TCDP (b) TRICARE WMDP		Disenrollment sent to DEERS by MCSC/USFHP via DOES.	M
Disenrollment - Voluntary/Involuntary		If a beneficiary is waived from paying enrollment fees, the individual will not be disenrolled for non-payment of fees.	D
		If a beneficiary moves to another region, but does not wish to transfer enrollment, the MCSC/USFHP provider in the new region will be permitted to disenroll the beneficiary.	M, D

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CHAPTER 3, ADDENDUM D

BUSINESS RULES

BUSINESS RULES: C. DISENROLLMENT

EVENT AND DATA FLOW	DATA TYPE*						ENFORCED BY**
	TRICARE PRIME (INCLUDING REMOTE) AND TRICARE PLUS	TRICARE USFHP DC	TRICARE ECHO PROGRAM	CHCBP	TRS	WMTC (A) TRICARE TCDP (B) TRICARE WMDP	
1. DEERS ID (Insured)	R	R	R	R	R	R	D
2. HCDP Enrollment Update Code	R	R	R	R	R	R	D
3. HCDP Type Code	R	R	R	R	R	R	D
4. HCDP Plan Coverage Code	R	R	R	R	R	R	D
5. EMC Enrollment Begin Calendar Date	R	R	R	R	R	R	D
6. EMC Enrollment End Calendar Date	R	R	R	R	R	R	D
7. EMC Enrollment End Reason Code	R	R	R	R	R	R	M, D
8. EMC Lockout Period Code	R	R	R	R	R	R	M

BUSINESS RULES BY PROGRAM

Handled by DOES.

Handled by DOES.

M=Health Care; handled by DOES.

Applicable for latest unexpired enrollment only.

S=Special Programs; handled by DOES.

Latest unexpired enrollment begin date.

Must not be more than 289 days in the past (for CHCBP, cannot be before program begin date) or 30 days in the future.

Must be appropriate for coverage plan (i.e., "Failure to Pay Fees" reason code can only be used for coverage plans to which enrollment fees apply). DEERS will not allow a disenrollment for "Failure to Pay Fees", if the enrollment plan fees are current for the policy.

WMTC Enrollment End Reason = "S" if termination was due to termination of TRICARE Prime/TRICARE Prime Remote Enrollment

For TRS, the default is to set the lockout indicator.

For WMTC, the default is to set the lockout indicator.

For TCDP, will not default is to set the lockout indicator.

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CHAPTER 3, ADDENDUM D
BUSINESS RULES

BUSINESS RULES: D. MODIFICATION OF ENROLLMENT (PCM CHANGE)/PCM PANEL REASSIGNMENT

GENERAL BUSINESS RULES	ENFORCED BY**
Only the current system managing the enrollment can update PCM information.	D
Parents and parents-in-law are no longer eligible to enroll. However, if they are already enrolled, their enrollments can be modified but the PCM selection MUST remain within the USFHP network.	D

BUSINESS RULES: D. MODIFICATION ENROLLMENT (PCM CHANGE)/PCM PANEL REASSIGNMENT

EVENT AND DATA FLOW	PLAN AND DATA TYPE*										ENFORCED BY**										
	TRICARE PRIME PLANS					TRICARE USFHP PLANS						TRICARE PLUS PLANS									
1. DEERS ID (Issued)	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
2. HCDP Type Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
3. HCDP Plan Coverage Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
4. BMC Enrollment Begin Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
5. PCM Selection Update Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
6. PCM Region Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
7. PCM Network Provider Type Code	None	R	R	R	R	None	R	R	R	R	None	R	R	R	R	None	R	R	R	R	M, D
8. PCM Enrolling Division DMIS Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
9. PCM Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
10. PCM Identifier Type Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
11. PCM License Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
12. PCM Name	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
13. PCM Group Identifier	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M, D
14. PCM Group Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M, D
15. PCM Place of Care Identifier	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M, D
16. PCM Place of Care Name	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M, D
17. PCM Telephone Number Code	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M

BUSINESS RULES: E. MODIFICATION OF ENROLLMENT (PCM CANCELLATION AND TRANSFER CANCELLATION)

GENERAL BUSINESS RULES	ENFORCED BY**
DOES will display all enrollments for the family when a cancellation event falls within the prescribed business rules below. The user must select the appropriate enrollee(s).	D
The user may reinstate the previous PCM or replace the current PCM with a new one. (See PCM Change business rules for the latter option.) If there is only one PCM for the enrollment, thus no PCM to reinstate, a PCM cancellation will not be allowed, the user must cancel the enrollment.	D
The instance of the PCM selection being cancelled will be removed and will not be displayed by DEERS in subsequent transactions.	D
DEERS will send policy change notifications to all systems participating in the management of the enrollment. For TRS, the notifications will only go to the contractor to whom the TRS member is enrolled.	D
Only the current MCSC/USFHP provider managing the enrollment can update PCM information; only the MCSC/USFHP provider that performed the transfer may cancel it. For TRS, the contractor to whom the TRS member is enrolled must perform the transfer cancellation. The PCM or transfer effective date cannot be more than 60 days in the past.	D

BUSINESS RULES: E. MODIFICATION OF ENROLLMENT (PCM CANCELLATION AND TRANSFER CANCELLATION)

EVENT AND DATA FLOW	PLAN AND DATA TYPE												ENFORCED BY**			
	TRICARE PRIME PLANS				TRICARE USFHP PLANS				TRICARE PLUS PLANS - PCM CANCELLATION ONLY					TRS - CANCEL XFER ONLY		
1. DEERS (P/Insured)	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
2. FICDP Type Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
3. FICDP Plan Coverage Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
4. BMC Enrollment Begin Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
5. PCM Selection Update Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	D
6. PCM Region Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
7. PCM Handling Division	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
8. PCM Network/Provider Type Code	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	M, D
9. PCM Identifier	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D
10. PCM Identifier Type Code	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	M, D

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BUSINESS RULES

BUSINESS RULES: E. MODIFICATION OF ENROLLMENT (PCM CANCELLATION AND TRANSFER CANCELLATION) (CONTINUED)

PLAN AND DATA TYPE*	TRICARE PLUS PLANS - PCM CANCELLATION ONLY		TRICARE USFHP PLANS		TRICARE PRIME PLANS		ENFORCED BY**
	TRICARE PLUS PLANS - PCM CANCELLATION ONLY	TRICARE USFHP PLANS	TRICARE PRIME PLANS	TRICARE USFHP PLANS	TRICARE PRIME PLANS		
TRICARE Plus Coverage for Survivors of Guard/Reserve Deceased Sponsors	(an) TRS - Member and Family	N/A	N/A	N/A	N/A	N/A	M, D
	(am) TRS - Member-Only	N/A	N/A	N/A	N/A	N/A	M, D
TRICARE Plus Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors	(al) TRICARE Plus Coverage for Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
	(ak) TRICARE Plus with CHC Coverage for Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Plus Coverage for Retired Sponsors, Family Members and Medal of Honor	(aj) TRICARE Plus Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
	(ah) TRICARE Plus with CHC Coverage for Retired Sponsors, Family Members and Medal of Honor	R	S	R	R	R	M, D
TRICARE Plus Coverage for Survivors of AD Deceased Sponsors	(ag) TRICARE Plus Coverage for Retired Sponsors, Family Members and Medal of Honor	R	S	R	R	R	M, D
	(af) TRICARE Plus Coverage for Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Plus Coverage for Transitional Survivors of AD Deceased Sponsors	(ae) TRICARE Plus with CHC Coverage for Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
	(ad) TRICARE Plus Coverage for Transitional Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Plus Coverage for ADFMs	(ac) TRICARE Plus with CHC Coverage for Transitional Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
	(aa) TRICARE Plus with CHC Coverage for ADFMs	R	S	R	R	R	M, D
TRICARE USFHP DC Family Coverage for Survivors of Guard/Reserve Deceased Sponsors	(z) TRICARE USFHP DC Family Coverage for Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
	(y) TRICARE USFHP DC Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
TRICARE USFHP DC Family Coverage for Retired Sponsors and Family Members	(x) TRICARE USFHP DC Family Coverage for Retired Sponsors and Family Members	R	S	R	R	R	M, D
	(w) TRICARE USFHP DC Individual Coverage for Retired Sponsors and Family Members	R	S	R	R	R	M, D
TRICARE USFHP DC Family Coverage for Survivors of AD Sponsors	(v) TRICARE USFHP DC Family Coverage for Survivors of AD Sponsors	R	S	R	R	R	M, D
	(u) TRICARE USFHP DC Individual Coverage for Survivors of AD Sponsors	R	S	R	R	R	M, D
TRICARE USFHP DC Coverage for Transitional Survivors of AD Sponsors	(t) TRICARE USFHP DC Coverage for Transitional Survivors of AD Sponsors	R	S	R	R	R	M, D
	(s) TRICARE USFHP DC Coverage for ADFMs	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for Survivors of Guard/Reserve Deceased Sponsors	(r) Prime Family Coverage for Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
	(q) Prime Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors	(p) Prime Family Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
	(o) Prime Individual Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members	(n) TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members	R	S	R	R	R	M, D
	(m) TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for Retired Sponsors and Family Members	(l) TRICARE Prime Family Coverage for Retired Sponsors and Family Members	R	S	R	R	R	M, D
	(k) TRICARE Prime Individual Coverage for Retired Sponsors and Family Members	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for Survivors of AD Deceased Sponsors	(j) TRICARE Prime Family Coverage for Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
	(i) TRICARE Prime Individual Coverage for Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for Transitional Survivors of AD Deceased Sponsors	(h) TRICARE Prime Family Coverage for Transitional Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
	(g) TRICARE Prime Individual Coverage for Transitional Survivors of AD Deceased Sponsors	R	S	R	R	R	M, D
TRICARE Prime Family Coverage for ADFMs	(f) TRICARE Prime Family Coverage for ADFMs	R	S	R	R	R	M, D
	(e) TRICARE Prime Individual Coverage for ADFMs	R	S	R	R	R	M, D
TRICARE Prime Individual Coverage for AD Sponsors	(d) TRICARE Prime Individual Coverage for AD Sponsors	R	S	R	R	R	M, D
	(c) TRICARE Remote Family Coverage for ADFMs	R	S	R	R	R	M, D
TRICARE Remote Individual Coverage for ADFMs	(b) TRICARE Remote Individual Coverage for ADFMs	R	S	R	R	R	M, D
	(a) TRICARE Remote for ADMSs	R	S	R	R	R	M, D

BUSINESS RULES BY COVERAGE PLAN

A. PCM being cancelled.
 B. There cannot be any date gaps for PCM; certain PCM is required for an enrollment with more than 289 days in the past.
 C. Must not be more than 289 days in the past.
 D. If there is only one PCM for this enrollment, new PCM selection information must be included with the enrollment.
 E. If the user chooses, DDOS will restate the previous PCM selection.
 F. Invalid Entry.

PCM/transfer cancellation
 PCM/transfer cancellations
 must be processed within
 90 days of the date stated herein.

EVENT AND DATA FLOW
 T1. PCM Name
 T2. PCM Group Name
 T3. PCM Selection Begin
 Calendar Date

BUSINESS RULES: F. MODIFICATION OF ENROLLMENT (TRANSFER)

GENERAL BUSINESS RULES	ENFORCED BY**
DOES will list all family members enrolled in different MCSC/USFHP provider contracts for the user to select.	D
A transfer of enrollment is done for each family member being transferred.	M
When an enrollee relocates to another contractor's region, the transfer is done by the gaining contractor. For TRS, a transfer is based on the enrollee moving to a new region; the transfer must be done by the contractor to whom the member is enrolled.	M, D
DEERS will validate that the enrollee lives within the enrolling organization's jurisdiction. If the enrollee's zip code is outside jurisdiction (as determined on the Service Area File), DOES will provide a warning message but will allow the transfer. For TRS, DEERS will validate that the TRS member lives within the enrolling organization's jurisdiction. If the TRS member's zip code is outside jurisdiction (as determined on the Service Area File), DOES will provide a warning and will not allow the enrollment, unless the zip code is not on the SAF. DOES will determine the region in which each family member resides and enroll them to the appropriate contractor. If a family member does not have a zip code on the SAF, DOES will assign the contractor code of the TRS member.	M, D
If there are current and future enrollments for the person being transferred, the future segment must first be cancelled by the MCSC/USFHP provider managing that future enrollment.	D
DEERS will set the EMC Enrollment End Calendar Date and the PCM Selection End Calendar Date for the losing organization, and the EMC Enrollment Begin Calendar Date and PCM Selection Begin Calendar Date for the gaining organization based on the transfer effective date.	D
DEERS will check that enrollment fees for the previous policy, if applicable, have been paid to date. If fees are not current, DOES will provide the user with a warning, but will allow the transfer.	D
Enrollment fees and OHI may be added to DEERS at the time of transfer. Refer to the Online Enrollment Fee Payment and OHI Add business rules for more details.	M, D
DEERS will send policy change notifications to all systems participating in the management of the enrollment. For TRS, the notifications will only go to the contractor to whom the TRS member is enrolled.	D
Parents and parents-in-law are no longer eligible to enroll. However, if they are already enrolled, their enrollments can be modified but the PCM selection MUST remain within the USFHP network.	D

BUSINESS RULES: F. MODIFICATION OF ENROLLMENT (TRANSFER)

ENROLLMENT TRANSFER	PLAN AND DATA TYPE	ENFORCED BY**		
Transfer of Enrollment allowed for these plans:	TRICARE PRIME PLANS	(a) TRICARE Remote for AD SMs (b) TRICARE Remote Individual Coverage for ADFMs (c) TRICARE Remote Family Coverage for ADFMs (d) TRICARE Prime Individual Coverage for AD Sponsors (e) TRICARE Prime Individual Coverage for ADFMs (f) TRICARE Prime Family Coverage for ADFMs (g) TRICARE Prime Individual Coverage for Transitional Survivors of AD Deceased Sponsors (h) TRICARE Prime Family Coverage for Transitional Survivors of AD Deceased Sponsors (i) TRICARE Prime Individual Coverage for Survivors of AD Deceased Sponsors (j) TRICARE Prime Family Coverage for Survivors of AD Deceased Sponsors (k) TRICARE Prime Individual Coverage for Retired Sponsors and Family Members (l) TRICARE Prime Family Coverage for Retired Sponsors and Family Members (m) TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members (n) TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members (o) Prime Individual Coverage for Transitional Survivors Guard/Reserve Deceased Sponsors (p) Prime Family Coverage for Transitional Survivors Guard/Reserve Deceased Sponsors (q) Prime Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors (r) Prime Family Coverage for Survivors of Guard/Reserve Deceased Sponsors (s) TRICARE USFHP DC Coverage for ADFMs (t) TRICARE USFHP DC Coverage for Transitional Survivors of AD Sponsors (u) TRICARE USFHP DC Individual Coverage for Survivors of AD Sponsors (v) TRICARE USFHP DC Family Coverage for Survivors of AD Sponsors (w) TRS - Member-Only Coverage (Contingency Ops) (x) TRS - Member and Family Coverage (Contingency Ops)		
	TRICARE USFHP PLAN			
	TRS			
	EVENT AND DATA FLOW		D	
	1. DEERS ID (Issued)		R	
	2. HCDFP Type Code		R	
	3. PCM Selection Update Code		R	
	4. HCDFP Plan Coverage Code		R	
	BUSINESS RULES BY COVERAGE PLAN		D	
	Handled by DOES:		D	
	M+Health Care, handled by DOES:		D	
	This is an update to an existing EKDFP because the person is still covered within the same coverage plan; handled by DOES:		D	
	Latest current or future coverage plan:		D	

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BUSINESS RULES

BUSINESS RULES: F: MODIFICATION OF ENROLLMENT (TRANSFER) (CONTINUED)

ENROLLMENT TRANSFER	PLAN AND DATA TYPE		TRICARE PRIME PLANS		TRICARE USFHP PLANS		TRS		ENFORCED BY**
	Transfer of Enrollment allowed for these plans:								
5. EVENT AND DATA FLOW									
5. EMC Enrollment Begin Calendar Date	R	R	R	R	R	R	R	R	M, D
6. EMC Enrollment End Calendar Date	R	R	R	R	R	R	R	R	D
7. HCDF Individual Enrollment Fee Waiver Reason Code	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	D
8. EMC HCDF Enrollment Application Received Calendar Date	O	O	O	O	O	O	O	O	M
9. HCDF Enrollment Application Received Calendar Date	O	O	O	O	O	O	O	O	M
10. EMC Enrollment Residence Mailing Address US Postal Region/Zip Code	R	R	R	R	R	R	R	R	M, D
11. EMC Enrollment Work Mailing Address US Postal Region/Zip Code	R	R	R	R	R	R	R	R	D
12. Sponsor EMC Enrollment Residence Mailing Address US Postal Region/Zip Code	R	R	R	R	R	R	R	R	M, D
13. HCDF Enrollment Card Request Status Code	R	R	R	R	R	R	R	R	M, D
14. HCDF Enrollment Card Request Calendar Date	S	S	S	S	S	S	S	S	M, D
15. PCM Region Code	R	R	R	R	R	R	R	R	D
16. PCM Network Provider Type Code	None CV UP	None CV UP	None CV UP	None CV UP	None CV UP	None CV UP	None CV UP	None CV UP	M, D
17. PCM Enrolling Division DMSIS Identifier	R	R	R	R	R	R	R	R	M, D
18. PCM Identifier	R	R	R	R	R	R	R	R	M, D
19. PCM Identifier Type Code	R	R	R	R	R	R	R	R	M, D
20. PCM License Identifier	R	R	R	R	R	R	R	R	M
21. PCM Name	O	O	O	O	O	O	O	O	M, D
22. PCM Group Identifier	R	R	R	R	R	R	R	R	M, D
23. PCM Place of Care Identifier	O	O	O	O	O	O	O	O	M, D
24. PCM Place of Care Name	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M, D
25. PCM Telephone Number Code	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M
26. PCM Mailing Address City Name	O	O	O	O	O	O	O	O	M, D
27. PCM Mailing Address US Postal Region State Code	S	S	S	S	S	S	S	S	M, D
28. PCM Mailing Address US Postal Region Zip Code	S	S	S	S	S	S	S	S	M, D
29. PCM Mailing Address Country Code	O	O	O	O	O	O	O	O	M, D
30. PCM Specialty Code	S	S	S	S	S	S	S	S	M, D
31. PCM Sex Code	S	S	S	S	S	S	S	S	M, D
32. PCM Location Begin Calendar Date	S	S	S	S	S	S	S	S	M, D
33. PCM Location End Calendar Date	S	S	S	S	S	S	S	S	M, D

BUSINESS RULES BY COVERAGE PLAN
 A. If the sponsor's enrollment transfer is effective, the user must select the correct plan in the past or 289 days in the future, within the eligibility and at least 30 days before the start of the new plan's enrollment. B. DEERS will terminate the enrollment with the previous MGS/USFHP provider one day prior to this date. C. DEERS will set the PCM Selection Begin Calendar Date equal to this date. D. DEERS enforces that enrollment periods do not overlap. E. If an individual is waived from enrollment fee payments, the reason for the waiver should be sent to DEERS, applicable to coverage plans.

A. Required to perform jurisdiction; if zip is invalid for enrollment (jurisdiction or program), DEERS will provide a warning and allow the user to select a valid residential address zip code for mailing address zip code if there is no residential address on file. B. For TRS upon an address change, if the member's zip code is updated to a new region, DEERS will update the contractor code associated to the enrollment. C. Required for TRICARE Remote only; if zip is invalid for enrollment (jurisdiction or program), DEERS will provide a warning and allow the enrollment (DEERS), but user may change it. D. If the sponsor and family member's residential zip codes are not equal, DEERS will prompt the user to disenroll the family member.

A. Required for TRS and TRS only; if zip is invalid for enrollment (jurisdiction or program), DEERS will provide a warning and allow the enrollment. B. If the sponsor's residential zip code is modified to be different than the family members' that are enrolled in TPR ADPM in another contract, DEERS will automatically disenroll the family members and send appropriate notifications. C. Indicates whether or not an ID card should be generated. Default is to generate card upon transfer. D. Default to current date; change only when Enrollment Card is requested. E. The PCM Region Code must fall under their contract ID managing the enrollment transfer. If there is only one DOBS will default.

A. Value must be appropriate for the coverage plan. DEERS will default, but the user may change if there is more than one option. B. For DC, UP and RS network enrollments, the user will select the DMSIS ID/DMSIS Name in DEERS. DEERS will only display DMSIS that fall within the PCM Region Code. C. For CV network enrollments, DEERS will default based on the PCM Region Code and coverage plan. D. PCM search criteria.

A. Civilian PCM search criteria. B. Civilian PCM search criteria. C. Civilian PCM search criteria. D. Civilian PCM search criteria. E. Civilian PCM search criteria. F. Civilian PCM search criteria. G. Civilian PCM search criteria. H. Civilian PCM search criteria. I. Civilian PCM search criteria. J. Civilian PCM search criteria. K. Civilian PCM search criteria. L. Civilian PCM search criteria. M. Civilian PCM search criteria. N. Civilian PCM search criteria. O. Civilian PCM search criteria. P. Civilian PCM search criteria. Q. Civilian PCM search criteria. R. Civilian PCM search criteria. S. Civilian PCM search criteria. T. Civilian PCM search criteria. U. Civilian PCM search criteria. V. Civilian PCM search criteria. W. Civilian PCM search criteria. X. Civilian PCM search criteria. Y. Civilian PCM search criteria. Z. Civilian PCM search criteria.

A. This date must be on or after the EMC Enrollment Begin Calendar Date. If this date is before the EMC Enrollment End Calendar Date, DEERS will provide a warning, but will not prevent PCM assignment. B. DEERS will only validate this upon PCM selection. NOT when changes are made to the PCM begin or end date.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 3, ADDENDUM D

BUSINESS RULES

BUSINESS RULES: G. CHANGE ENROLLMENT PERIOD

EVENT AND DATA FLOW	DATA TYPE*	GENERAL BUSINESS RULES	ENFORCED BY**
		DOES will display all family members that may have the enrollment period changed based on the business rules below.	D
		An enrollment cannot extend past eligibility.	D
		DEERS will send enrollment change notifications to all systems participating in the management of the enrollment. For TRS, the notifications will only go to the contractor to whom the TRS member is enrolled.	D
		DEERS will ensure enrollment periods do not overlap.	D
		DEERS will only allow modification of a begin date to the latest current or future enrollment if it began within the past 60 days. DEERS will allow modification to the last terminated enrollment's end date if the current end date is within the past 60 days and there is no later enrollment.	D
		Only the entity that managed the enrollment may change the enrollment end date and the change must be made within 60 days of the disenrollment date. The end date can be changed to an earlier date that does not fall into an earlier PCM segment with a different DMIS ID than the last PCM*** and is not more than 60 days in the past of the current date. The end date may be changed to a later date within eligibility that does not overlap a later enrollment and is not more than 90 days in the future of the current date. For TRS, the contractor to whom the TRS member is enrolled must make these changes.	D
		If there has been a change of coverage plan within the HCDP (e.g., change from Prime to Plus) and the begin date of the later enrollment is modified, the end date of the previous enrollment will be modified accordingly to provide continuous enrollment.	D
		Only the entity that created the enrollment may change the enrollment begin date. The begin date can be changed to an earlier date that does not overlap another enrollment and is not more than 60 days from the current date. The begin date can be changed to a later date that is not more than 90 days in the future of the current begin date and does not fall into a later PCM segment with a different DMIS ID than the first PCM***.	D
		DOES will update the policy enrollment period for a family based on the new enrollment dates. DOES will honor differences in an individual's enrollment begin date. Family members may have different enrollment end dates based on length of eligibility.	D

*** Restriction based on the type of updates Legacy DEERS can accept. May be re-evaluated when Legacy DEERS is no longer used for claims inquiries.

BUSINESS RULES: G. CHANGE ENROLLMENT PERIOD

Enrollment Period Change for an Individual <i>Change of enrollment period allowed for all health care plans in these health care delivery programs:</i>	DATA TYPE*				ENFORCED BY**
	TRICARE PRIME (INCLUDING REMOTE)	TRICARE USFHP DC	TRICARE PLUS	TRS	
EVENT AND DATA FLOW	R	R	R	R	M, D
1. DEERS ID (Insured)					M, D
2. HCDP Enrollment Update Code	Update				M, D
3. HCDP Type Code	R	R	R	R	M, D
4. HCDP Plan Coverage Code	R	R	R	R	M, D
5. EMC Enrollment Begin Calendar Date	R	R	R	R	M, D
6. EMC Enrollment End Calendar Date	R	R	R	R	M, D

BUSINESS RULES BY COVERAGE PLAN

Handled by DOES.

Handled by DOES.

ME-Health Care; handled by DOES.

The latest current or future coverage plan for begin date modifications; the latest coverage plan (must be terminated) for end date modifications.

A. The EMC Enrollment Begin Calendar Date can be changed only if it is currently not more than 289 days in the past or 90 days in the future.

B. The new EMC Enrollment Begin Calendar Date must be within eligibility and must be within 289 days prior to or 90 days in the future of the current EMC Enrollment Begin Calendar Date. The new begin date may not be changed if there is a later PCM with a different DMIS ID than the first***.

A. If the new EMC Policy Enrollment Period Begin Calendar Date precedes the original EMC Enrollment Begin Calendar Date, the EMC Policy Enrollment Period Begin Calendar Date will be modified to this date.

B. The EMC Policy Enrollment Period End Calendar Date will also be modified accordingly to a 12-month (or less depending on eligibility) period, if applicable.

C. DOES will set the initial PCM Selection Begin Calendar Date equal to this date.

A. For enrollments terminated by an enrolling organization, this date must not be more than 289 days in the past. The new EMC Enrollment End Calendar Date must not be more than 60 days in the past, or more than 30 days in the future of the current EMC Enrollment End Calendar Date and cannot exceed eligibility.

B. For enrollments terminated by DEERS, this date may only be changed to a later date if the enrollee's eligibility has been extended.

C. The end date can be changed to an earlier date that does not fall into an earlier PCM segment with a different DMIS ID than the last PCM*** and is not more than 289 days in the past of the current date. The end date may be changed to a later date within eligibility that does not overlap a later enrollment and is not more than 90 days in the future of the current date.

A. DOES will set the last PCM Selection End Calendar Date equal to this date.

B. If this is the last active enrollment in the policy, the EMC Policy Enrollment Period End Calendar Date will reflect this date.

*** Restriction based on the type of updates Legacy DEERS can accept. May be re-evaluated when Legacy DEERS is no longer used for claims inquiries.

BUSINESS RULES: H. CHANGE ENROLLMENT END REASON CODE

EVENT AND DATA FLOW	DATA TYPE*	GENERAL BUSINESS RULES	ENFORCED BY**
		DOES will display all family members that may have their enrollment end reason code changed based on the business rules below.	D
		The system identifier must be the system who managed the enrollment. For TRS, this will be the contractor to whom the TRS member is enrolled.	D
		The Enrollment End Reason Code may only be changed within the 60 days following the disenrollment date and only if it is the latest enrollment.	D
		Enrollment End Reason Codes set by DEERS cannot be changed.	D

BUSINESS RULES: H. CHANGE ENROLLMENT END REASON CODE

Enrollment End Reason Code Change <i>Change of enrollment end reason allowed for plans in these health care delivery programs:</i>	DATA TYPE*					BUSINESS RULES BY COVERAGE PLAN	ENFORCED BY**
	TRICARE PRIME	TRICARE USFHP DC	TRICARE PLUS	TRS	WMTC (A) TRICARE TCDP (B) TRICARE WMDP		
1. DEERS ID (Insured)	R	R	R	R	R	Handled by DOES.	D
2. HCDP Enrollment Update Code	R	R	R	R	R	Handled by DOES.	D
3. HCDP Type Code	R	R	R	R	R	M=Health Care; handled by DOES. S=Special Program; handled by DOES.	D
4. HCDP Plan Coverage Code	R	R	R	R	R	The latest coverage plan.	D
5. EMC Enrollment Begin Calendar Date	R	R	R	R	R	Enrollment period being changed.	M, D
6. EMC Enrollment End Calendar Date	R	R	R	R	R	Enrollment period being changed. May not be more than 289 days in the past.	M, D
7. EMC Enrollment End Reason Code	R	R	R	R	R	Must be appropriate for coverage plan (i.e., "Failure to Pay Fees" reason code can only be used for coverage plans to which enrollment fees apply). DEERS will not allow a disenrollment for "Failure to Pay Fees", if the enrollment plan fees are current for the policy. WMTC Enrollment End Reason = "S" if termination was due to termination of TRICARE Prime/TPR Enrollment.	M, D
8. EMC Lockout Period Code	R	R	R	R	R		D

BUSINESS RULES: I. ENROLLMENT/DISENROLLMENT CANCELLATION

EVENT AND DATA FLOW	DATA TYPE*	GENERAL BUSINESS RULES	ENFORCED By**
		DOES will display all family members who may have an enrollment/ disenrollment cancelled based on the business rules below.	D
		The instance of the enrollment or disenrollment (including PCM information) will be removed and will not be displayed by DEERS in subsequent transactions.	D
		Any fee payment adjustments should be made prior to cancelling the last enrollment in a policy. Once all enrollments have been cancelled, fee information will be inaccessible.	D
		For disenrollment cancellations, DEERS will reinstate the enrollment, including fee information, as it existed prior to the disenrollment.	D
		DEERS will adjust policy dates for the family as necessary.	D
		DEERS will send policy change notifications to all systems participating in the management of the enrollment. For TRS, the notifications will only go to the contractor to whom the TRS member is enrolled.	D
		For enrollment and disenrollment cancellations, the system identifier must be the current MCSC/DP managing this enrollment. If there has been a transfer of enrollment, the gaining contractor may only cancel the transfer, not the enrollment. For TRS, this must be the contractor to whom the TRS member is enrolled.	D
		When an enrollment is cancelled, DOES will reinstate the previous enrollment if it ended due to a change in coverage plans within the same HCDP (e.g., changed enrollment from Prime to Plus).	D
		An enrollment cannot be cancelled if there is more than one PCM segment with a different DMIS ID than the first PCM segment***.	D
		If the TRICARE Prime or TPR plan is reinstated (cancel disenrollment), the corresponding WMTC enrollment will be reinstated. If the TRICARE Prime or TRICARE Prime enrollment is cancelled or disenrolled, the corresponding WMTC plan will be cancelled or disenrolled. If the WMTC enrollment is cancelled or disenrolled, this will not affect the existing TRICARE Prime or TPR plan.	

*** Restriction based on the type of updates Legacy DEERS can accept. May be re-evaluated when Legacy DEERS is no longer used for claims inquiries.

BUSINESS RULES: I. ENROLLMENT/DISENROLLMENT CANCELLATION

Event/Disenrollment Cancellation	DATA TYPE*						ENFORCED BY**
	TRICARE PRIME (INCLUDING REMOTE) AND TRICARE PLUS	TRICARE USFHP DC	TRICARE ECHO PROGRAM	CHCBP	TRS	WMTC (A) TRICARE TCDP (B) TRICARE WMDP	
EVENT AND DATA FLOW							
1. DEERS ID (Insured)	R	R	R	R	R	R	D
2. HCDP Enrollment Update Code			Cancel				D
3. HCDP Type Code	R	R	R	R	R	R	D
4. HCDP Plan Coverage Code	R	R	R	R	R	R	D
5. EMC Enrollment Begin Calendar Date	R	R	R	R	R	R	M, D
6. EMC Enrollment End Calendar Date	R	R	R	R	R	R	M, D
						R	M, D
							M, D
7. EMC Enrollment End Reason Code	R	R	R	R	R	R	M, D
8. EMC Lockout Period Code	R	R	N/A	N/A	R	R	M, D
						R	M, D

BUSINESS RULES BY COVERAGE PLAN

Handled by DOES.

This is the cancellation of a current or future HCDP; handled by DOES.

M=Health Care; handled by DOES.

Current or future coverage plan for Enrollment Cancellation (if there is a future coverage plan, this plan must be cancelled before the current plan may be cancelled); previous coverage plan for Disenrollment Cancellation.

A. The begin date of the enrollment/disenrollment selected for cancellation.

B. For an enrollment cancellation, this date must be no longer than 289 days in the past or 90 days in the future.

A. The end date of the enrollment/disenrollment selected for cancellation.

B. For a disenrollment cancellation, this date must be no longer than 289 days in the past or 30 days in the future.

If the TCDP enrollment is terminated with a "S" and the Prime/Remote enrollment is not terminated or has a termination date later than the TCDP enrollment then DOES will allow cancel disenrollment and reinstates the enrollment with:

1. For a future WMTC End Date: The End Date set to eligibility end date (if Prime/Remote enrollment is not terminated) and end reason set to "Q".
2. For a past WMTC End Date: End Date set to the Prime/Remote enrollment end date (disenrollment date) and end reason set to "S" (Past).

Invalid Entry".

WMDP: When a disenrollment is cancelled the lock out indicator is set to blank (lock out removed).

BUSINESS RULES: J. ONLINE ENROLLMENT FEE PAYMENT

GENERAL BUSINESS RULES	ENFORCED BY*
This transaction is used for making enrollment fee payments and adjustments, and for disenrollment requests for failure to pay fees.	M, D
DEERS will accumulate individual enrollment fee payments for each policy enrollment period at the policy level.	D
Partial or non-payment of enrollment fees will be accepted by DEERS and should be communicated through the HCDP Enrollment Fee Payment Exception Reason Code.	M
Fee payments may be made for the last two policies that are previous, current or future.	M, D
The system identifier is obtained by DEERS from the message header and is used to track the enrollment fee payment notification.	D
DEERS only accepts fee payments (or adjustments) and disenrollment requests for policies that require fees.	D
DEERS will not allow a disenrollment for "Failure to Pay Fees" if enrollment fees are current for the policy or if the person is waived from paying fees.	D
It is yet to be determined which edits will result in a warning vs. a rejection of the fee update. MCSCs/USFHP providers must correct and resubmit to DEERS any fee transaction that has resulted in a warning or rejection.	M, D
For TRS, DEERS will collect a paid through date (at a date to be determined later, DEERS shall report all premium payment amounts, including overpayments, received by the contractors)	M, D

BUSINESS RULES: J. ONLINE ENROLLMENT FEE PAYMENT

EVENT AND DATA FLOW	PLAN AND DATA TYPE										ENFORCED BY**		
	TRICARE PRIME PLANS					TRICARE USFHP DIRECT CARE PLANS						TRS	
1. DEERS ID Submitter Identification	R	R	R	R	R	R	R	R	R	R	R	R	M, D
2. HCDP Plan Coverage Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
3. HCDP Policy Enrollment Period Begin Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	M, D
4. HCDP Enrollment Fee Payment Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	D
5. HCDP Enrollment Fee Payment Paid Through Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	M
6. HCDP Enrollment Fee Payment Plan Type Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
7. HCDP Enrollment Fee Payment Type Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
8. HCDP Enrollment Year Fee Payment Amount	R	R	R	R	R	R	R	R	R	R	R	R	M, D
9. HCDP Enrollment Fee Payment Exception Reason Code	S	S	S	S	S	S	S	S	S	S	S	S	M
10. HCDP Enrollment Fee Payment Action Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
11. HCDP Fee Payment Type Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
12. Account Type Code	S	S	S	S	S	S	S	S	S	S	S	S	M, D
13. Account Person First Name	S	S	S	S	S	S	S	S	S	S	S	S	M, D
14. Account Person Middle Name	S	S	S	S	S	S	S	S	S	S	S	S	M, D
15. Account Person Last Name	S	S	S	S	S	S	S	S	S	S	S	S	M, D

BUSINESS RULES BY COVERAGE PLAN

1. Must identify a sponsor on DEERS.	M, D
2. Must identify a previous, current or future policy.	M, D
3. The begin date of the policy to which the fee or adjustment apply, must identify a policy on DEERS.	M, D
4. HCDP Enrollment Fee Payment Type Code is "Request for EFT/Alloiment" and there are less than 3 months in the Policy Enrollment Period, DEERS will create the new Policy Enrollment Period and apply the fee coverage.	D
5. This date must be within the policy enrollment period of the policy identified in #2 unless the HCDP Enrollment Fee Payment Plan Type Code is "Request to begin EFT/alloiment" and there are less than 90 days in the policy enrollment period (in this case DEERS will apply the coverage to the next period) or if the Fee Action Code is "E". For TRS, the only edit is that this date is within the policy.	M
6. Cannot be "monthly" if this is the initial fee payment or if there is not a previous HCDP Enrollment Fee Payment Plan Type Code of "request to begin EFT/alloiment".	M, D
7. Cannot be "EFT" or "Alloiment" unless there is a previous quarterly payment with HCDP Enrollment Fee Payment Plan Type Code of "request to begin EFT/alloiment".	M, D
8. This should be a dollar amount (with decimal and dollar sign). Can be negative if the amount posted results in the cumulative fee payment being above or below the expected limit and there are no exceptions reason. DEERS issues a warning/ error.	M, D
9. Required if partial payment or non-payment of fees. This field must be reset each time a fee payment is made if it is still applicable.	M
10. Available for HCDP Enrollment Fee Payment Type Code is "EFT".	M, D
11. Available for HCDP Enrollment Fee Payment Type Code is "EFT".	M, D
12. Available for HCDP Enrollment Fee Payment Type Code is "EFT".	M, D
13. Available for HCDP Enrollment Fee Payment Type Code is "EFT".	M, D

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BUSINESS RULES

BUSINESS RULES: J. ONLINE ENROLLMENT FEE PAYMENT (CONTINUED)

EVENT AND DATA FLOW	ONLINE ENROLLMENT FEE PAYMENT <i>Enrollment fees required for these plans:</i>		PLAN AND DATA TYPE		ENFORCED BY**
	TRICARE PRIME PLANS	TRICARE USFHP DIRECT CARE PLANS	TRICARE USFHP DIRECT	TRS	
16. Financial Institution Name	Y	Y	Y	Y	MD
17. Financial Institution Line Number Identifier	Y	Y	Y	Y	MD
18. Financial Institution Mailing Address Line 1 Text	Y	Y	Y	Y	MD
19. Financial Institution Mailing Address Line 2 Text	Y	Y	Y	Y	MD
20. Financial Institution Mailing Address City Name	Y	Y	Y	Y	MD
21. Financial Institution Mailing Address Postal Region State Code	Y	Y	Y	Y	MD
22. Financial Institution Mailing Address US Postal Region Zip Code	Y	Y	Y	Y	MD
23. Financial Institution Mailing Address US Postal Region Zip Extension Code	Y	Y	Y	Y	MD
24. Financial Institution Mailing Address Country Code	Y	Y	Y	Y	MD
25. Financial Institution Telephone Number	Y	Y	Y	Y	MD
26. Bank Routing Transit Number Identifier	Y	Y	Y	Y	MD
27. Bank Account Number Identifier	Y	Y	Y	Y	MD
BUSINESS RULES BY COVERAGE PLAN					
	N/A	N/A	N/A	N/A	MD
(n) TRS - Member and Family Coverage (Contingency Ops)	N/A	N/A	N/A	N/A	MD
(m) TRS - Member-Only Coverage (Contingency Ops)	N/A	N/A	N/A	N/A	MD
(i) TRICARE USFHP DC Family Coverage for Survivors of Guard/Reserve Deceased Sponsors	Y	Y	Y	Y	MD
(j) TRICARE USFHP DC Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors	Y	Y	Y	Y	MD
(k) TRICARE USFHP DC Family Coverage for Retired Sponsors and Family Members	Y	Y	Y	Y	MD
(l) TRICARE USFHP DC Individual Coverage for Retired Sponsors and Family Members	Y	Y	Y	Y	MD
(h) TRICARE USFHP DC Family Coverage for Survivors of AD Sponsors	Y	Y	Y	Y	MD
(g) TRICARE USFHP DC Individual Coverage for Survivors of AD Sponsors	Y	Y	Y	Y	MD
(f) Prime Family Coverage for Survivors of Guard/Reserve Deceased Sponsors	Y	Y	Y	Y	MD
(e) Prime Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors	Y	Y	Y	Y	MD
(d) TRICARE Prime Family Coverage for Retired Sponsors and Family Members	Y	Y	Y	Y	MD
(c) TRICARE Prime Individual Coverage for Retired Sponsors and Family Members	Y	Y	Y	Y	MD
(b) TRICARE Prime Family Coverage for Survivors of AD Deceased Sponsors	Y	Y	Y	Y	MD
(a) TRICARE Prime Individual Coverage for Survivors of AD Deceased Sponsors	Y	Y	Y	Y	MD

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BUSINESS RULES

BUSINESS RULES: K. ENROLLMENT FEE WAIVER UPDATE FOR AN INDIVIDUAL

GENERAL BUSINESS RULES	ENFORCED BY**
There are no dates associated with the waiver; it can be set or removed as necessary and no history is kept on the setting of this field.	D

BUSINESS RULES: K. ENROLLMENT FEE WAIVER UPDATE FOR AN INDIVIDUAL

EVENT AND DATA FLOW	PLAN AND DATA TYPE*												ENFORCED BY**
	TRICARE PRIME PLANS						TRICARE USRHP DIRECT CARE PLANS						
1. DEERSID (Insured)	R	R	R	R	R	R	R	R	R	R	R	R	M, D
2. HCDFP Enrollment Update Code	R	R	R	R	R	R	R	R	R	R	R	R	D
3. HCDFP Type Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
4. HCDFP Plan Coverage Code	R	R	R	R	R	R	R	R	R	R	R	R	M, D
5. EMC Enrollment Begin Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	M, D
6. EMC Enrollment End Calendar Date	R	R	R	R	R	R	R	R	R	R	R	R	M, D
7. HCDFP Individual Enrollment Fee Waiver Reason Code	R	R	R	R	R	R	R	R	R	R	R	R	M

BUSINESS RULES BY COVERAGE PLAN
 The beneficiary who is exempt from paying enrollment fees, handled by DOIES.
 Handled by DOIES.
 M=Health Care handled by DOIES.
 The latest current or future coverage plan.
 A. The enrollment period for which the enrollment fee waiver is effective.
 B. Enrollment must exist in DEERS.
 C. Enrollment period for which the enrollment fee waiver is effective.
 D. The enrollment list in DEERS.
 E. The reason for which a beneficiary is waived from paying enrollment fees should be sent to DEERS.

BUSINESS RULES: L. BENEFICIARY UPDATE

EVENT AND DATA FLOW	DATA TYPE*	BUSINESS RULES	ENFORCED By**
		When an enrollee's address is updated in DOES, a policy notification will be sent to the MCSC managing the enrollment, and a PIT will be sent to the appropriate CHCS host site (if any).	D
		The Mailing Address Maintenance Source Code will indicate whether the address was last updated by an MCSC, a USFHP provider, CHCS, or a military personnel update.	D
		For OCONUS addresses, zip codes should be entered on Address Line 2 in DOES.	M
Person Information			
1. DEERS ID	R	Handled by DOES.	D
2. E-mail Address Update Code	S	Handled by DOES.	D
3. E-mail Address Use Priority Code	S	Residence e-mail address.	D
4. E-mail Address Text	O		M
5. Mailing Address Update Code	R	Required if address is being updated.	D
6. Mailing Address Type Code	S	A. Must be included if updating the address information; indicates if mailing or residential address is being updated. B. Address is a complete unit. All required elements must be included for a successful update. C. If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update.	M, D
7. Mailing Address Effective Calendar Date	S	A. Must be included if updating the address information. B. Address is a complete unit. All required elements must be included for a successful update. C. If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update.	M, D
8. Mailing Address Quality Code	R	This field will be populated by DEERS after Code-1 is run and returned on the policy notification.	D
9. Mailing Address Maintenance Source Code	R	Indicates the source of a mailing address update. If update is made in DOES by an MCSC/USFHP provider, the value should be "MCSC". If update is made in DOES by the Dental Contractor, the value should be "Dental". This will trigger a policy notification and if necessary, a PIT notification.	D
10. Mailing Address Line 1 Text	S	A. Must be included if updating the address information. B. Address is a complete unit. All required elements must be included for a successful update. C. If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update.	M, D
11. Mailing Address Line 2 Text	O	A. Depends on length of address. B. Address is a complete unit. All required elements must be included for a successful update. C. If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update.	M, D
12. Mailing Address City Name	R	Address is a complete unit. All required elements must be included for a successful update.	M, D
13. Mailing Address US Postal Region State Code	S	A. Required if address is in the U.S. and Puerto Rico. B. Address is a complete unit. All required elements must be included for a successful update. C. If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update.	M, D
14. Mailing Address US Postal Region Zip Code	S	A. Required if address is in the U.S. and Puerto Rico. B. Address is a complete unit. All required elements must be included for a successful update. C. If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update.	M, D
15. Mailing Address US Postal Region Zip Extension Code	O	Recommended if known and address is in the U.S. and Puerto Rico.	M
16. Mailing Address Country Code	S	If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update. Address is a complete unit. All required elements must be included for a successful update.	D
17. Telephone Number Update Code	S	If current address calendar date in DEERS is greater than date submitted, DEERS will not apply an address update. Handled by DOES.	D
18. Home Telephone Number Code	S	At least one telephone number must be populated if the Telephone Number Update Code indicates an update.	M, D
19. Work Telephone Number Code	S	At least one telephone number must be populated if the Telephone Number Update Code indicates an update.	M, D
20. Fax Telephone Number Code	S	At least one telephone number must be populated if the Telephone Number Update Code indicates an update.	M, D

BUSINESS RULES: M. OTHER HEALTH INSURANCE (OHI)

1.	DEERS will serve as a central repository of OHI data which will be used by the DC system and purchased care contractors as another source of OHI data.
2.	While there will not be an initial load of purchased care data to the DEERS OHI data repository, MCSCs shall begin querying and updating the DEERS OHI/SIT data repository at the time pre-enrollment activity begins (approximately 40 days prior to the start of Health Care Delivery). Pharmacy contractors shall begin querying and updating the DEERS OHI / SIT data repository at the start of health care delivery or upon direction from the Contracting Officer. USFHP contractors shall begin querying and updating the DEERS OHI/SIT data repository upon direction from the Contracting Officer.
3.	Since purchased care contractors will be entering OHI data on the DEERS OHI data repository prior to the initial CHCS OHI conversions, DMDC shall reject CHCS OHI records that match exactly with previously entered purchased care records when performing the initial CHCS conversions on the presumption that the purchased care data is more current. A CHCS OHI record will be rejected if it matches exactly with the following data elements: Patient ID; OHI Policy ID; OHI Effective Calendar Date; OHI Policy Coverage Type Code; OHI Carrier Coverage Payer Type Code; OHI Coverage Claim Filing Code; OHI Policy Coverage Precedence Indicator; OHI Policy Coverage Effective Calendar Date.
4.	DEERS is not the OHI database of record for claims processing purposes. Purchased care contractors will process claims based on the OHI information contained in their own systems and received on claims.
5.	Evidence of the existence of OHI on the DEERS OHI data repository is sufficient to deny claims. If the claim indicates no OHI coverage but DEERS or a contractor's file indicates otherwise, a statement by the beneficiary or sponsor furnishing the termination date of the OHI is necessary to inactivate the positive OHI record on DEERS. Prior to processing a claim, where DEERS or the contractor's file indicates OHI coverage for the beneficiary, the contractor must have evidence that the claim was adjudicated by the OHI carrier first (See TRICARE Reimbursement Manual (TRM), Chapter 4 for Double Coverage Requirements). Acceptable evidence of other carrier adjudication includes the presence of an allowed or paid amount on the claim or an attached Explanation of Benefits (EOB). This applies to all contracts with claims processing requirements including the TDEFIC.
6.	DEERS will maintain both complete and placeholder OHI records.
7.	When a purchased care contractor receives information that medical OHI may exist via claims, customer service contacts, correspondence, etc., the contractor shall initiate development for the potential OHI.
8.	MCSCs and/or the DP's shall be responsible for developing for medical OHI. OHI associated with TDEFIC beneficiaries shall be developed by the TDEFIC contractor. TRRx shall be responsible for developing for pharmacy OHI. When an MCSC identifies potential pharmacy coverage, the MCSC shall refer such cases to TRRx for development. When TRRx identifies potential medical coverage, TRRx shall refer such cases to the appropriate MCSC for development. TRRx shall develop for pharmacy coverage when comprehensive medical coverage (XM) has been entered on DEERS. USFHP enrolled beneficiaries are locked out of pharmacy services within the MHS.
9.	If development questionnaire (or other vehicle) indicates that a beneficiary has medical and pharmacy OHI coverage, the MCSC or DP shall enter "MD" and "RX" on DEERS. If questionnaire indicates medical coverage and states that there is no pharmacy coverage, the MCSC or DP shall enter "MD" only. If questionnaire indicates medical coverage but does not provide positive evidence that pharmacy coverage exists, the MCSC or DP shall enter "XM" on DEERS. Only when the MCSC or DP has positive evidence that pharmacy coverage exists will they enter an "RX" on DEERS. Only when the TRRx contractor has positive evidence that medical coverage exists will they enter an "MD" on DEERS.
10.	When the TRRx contractor develops for pharmacy OHI where an "XM" exists on DEERS and they determine that there is no pharmacy coverage, the TRRx contractor shall terminate the "XM" and add the "MD".
11.	If there is no "XM" or "MD" and the TRRx contractor receives a paper claim, develops for OHI and determines that there is no pharmacy coverage and no medical coverage, the TRRx contractor shall enter nothing on DEERS.
12.	If on development the TRRx contractor determines that there is no pharmacy coverage but suspects that there may be medical coverage, the TRRx contractor shall not enter anything on DEERS but rather will forward the information to the appropriate MCSC for development of medical OHI.
13.	If on development the TRRx contractor finds pharmacy coverage, they will enter an "RX" in DEERS and forward the information to the appropriate MCSC for development of potential medical coverage. If on development the TRRx contractor finds pharmacy only coverage and no indication of medical coverage, no information will be forwarded to the MCSC.
14.	Purchased care contractors are required to update DEERS within two business days of receiving sufficient data to enter the minimum information necessary to add an OHI record. If only the minimum data is entered, purchased care contractors are required to develop for the remaining OHI data necessary to complete the OHI record within 15 business days of receiving evidence of potential OHI.
15.	Purchased care contractors shall enter temporary OHI placeholder records only when there is evidence that an OHI carrier has adjudicated a claim by the presence of an allowed amount or paid amount and there is insufficient data to enter the minimum information necessary to add an OHI record.

BUSINESS RULES: M. OTHER HEALTH INSURANCE (OHI) (CONTINUED)

- 16. If a purchased care contractor does not have a record in their OHI system and DEERS shows a valid OHI for a particular date of service, the purchased care contractor will not create a placeholder record.
- 17. If DEERS has a termination date that is prior to the DOS, then the purchased care contractor shall enter a placeholder record if there is evidence that an OHI carrier has adjudicated a claim by the presence of an allowed amount or paid amount and there is insufficient data to enter the minimum information necessary to add an OHI record.
- 18. If DEERS has an indefinite termination date, then the purchased care contractor shall not enter a placeholder record.
- 19. Once a placeholder record is entered and full OHI information is obtained later, the placeholder record shall be cancelled and the full complete record entered.
- 20. OHI Placeholder Records shall utilize the following default values for required data elements:

DATA ELEMENT	DEFAULT VALUES	NOTES
Patient Identifier (10 characters)	Provided By DEERS	Can't Update
HIC Identifier (9 characters)	HIC ID For The Applicable Carrier Or The SIT Default OF UNKVA0001	OHI Key to SIT
OHI Action Code	A = ADD	Transfer Only
OHI Policy Identifier (20 characters)	99999999999999999999	20 9's. Can't Update
OHI HIPAA Insurance Type Code (2 characters)	CI	
OHI Effective Calendar Date (8 characters)	20040401 (YYYYMMDD)	Can't Update
OHI End Reason Code (1 character)		Conditional. Required if termination date is provided.
OHI Policyholder HIPAA Person Association Code (2 characters)	21 = unknown	
OHI Coverage Claim Filing Code (2 characters)	09 = Self-pay	
START OF COVERAGE		
OHI Coverage Type Code (2 characters)	XM = Comprehensive Medical	
OHI Carrier Coverage Payer Type Code (1 character)	B = Both	Transfer Only
OHI Coverage Action Code	A = ADD	
HIC Coverage Type Code (2 characters)	XM = Comprehensive Medical	Will self populate from HIC record
HIC Coverage Payer Type Code (1 character)	B = Both	Will self populate from HIC record.
OHI Policy Coverage Effective Date (8 characters)	20040401 (YYYYMMDD)	Can't Update
OHI Policy Coverage Precedence Code (1 character)	N = Non-ranked	

- 21. A statement by the beneficiary or sponsor, that OHI coverage no longer exists is required to inactivate (terminate) a positive OHI record on DEERS. (TRICARE Reimbursement Manual (TRM), Chapter 4, Section 2, paragraph II.B.1.)
- 22. DEERS is the system of record for MHS Eligibility; if the claims query returns OGP and an eligible HCDDP code, the beneficiary is eligible. If the claims query returns OGP and an ineligible HCDDP code, the beneficiary is ineligible. Claims should be processed based on the response received from DEERS.
- 23. OHI case data shared among organizations shall be in an Excel spreadsheet format (sample provided) and common password protected. Passwords will be in an agreed upon format [lyymm + word] and change on the first of every month. The following statement shall appear on the spreadsheet: "For Official Use Only. The data contained is for official use only." Any printouts of the Excel spreadsheet shall contain the statement, "For Official Use Only. The data contained is for official use only."
- 24. See Sample Excel spreadsheet format.

BUSINESS RULES: N. PATIENT ID CHANGE

EVENT AND DATA FLOW	DATA TYPE*	BUSINESS RULES	ENFORCED By**
Inquiry Information			
1. Total Records Changed Request Indicator Code	R	Required for an inquiry to retrieve all Patient Identification Change records.	M
2. Last Records Changed Request Calendar Date	S	Required for an inquiry to retrieve all changes as of a specific date, such as all Patient ID changes that have occurred since the last inquiry was performed.	M
Inquiry Response Information			
3. DoD Electronic Data Interchange Person Identifier	R	These three elements will be repeated for each Patient ID Change listed in the response file. This is the individual's old identifier.	
4. DoD Electronic Data Interchange Cross-Reference Person Identifier	R	This is the new identifier for this individual.	
5. DoD Electronic Data Interchange Person Identifier Change Effective Calendar Date	R	This is the date that the new identifier became effective.	

NEWBORN PLACEHOLDER REQUEST PROCESS FOR TRICARE RETAIL PHARMACY (TRRx) AND PHARMACY DATA TRANSACTION SYSTEM (PDTS)

1.0. BACKGROUND

In the course of implementing the TRICARE Next Generation (T-NEX) contracts and the TRICARE Retail Pharmacy (TRRx) contract, it has been determined that the Managed Care Support Contractors (MCSCs) will be responsible for creating any and all Newborn Placeholder records on Defense Enrollment Eligibility Reporting System (DEERS). These placeholder records are necessary for posting copays and cost-shares to the family catastrophic cap totals.

The TRRx contractor processes claims and prescriptions which includes the application of copays and cost-shares. When a claim is received for a newborn and that newborn has not previously been entered onto DEERS, a request will be made to the MCSC to create a placeholder record on DEERS. The TRRx contractor will prepare and forward the request to the MCSC. Once the placeholder is created, the pharmacy claims processor (PDTS) can perform updates to the family totals through the Catastrophic Cap and Deductible Database (CCDD) interface.

2.0. GENERAL OVERVIEW

The following steps provide a high level view of the overall process. Each of these steps is documented in greater detail throughout this document. The process will consist of the following:

- TRRx determines that a placeholder needs to be created for a Newborn Claim
- TRRx prepares request using information from claim and/or DEERS query
- TRRx forwards the Newborn Placeholder Request Form to the appropriate MCSC
- MCSC completes request by creating the newborn placeholder on DEERS
- MCSC notifies TRRx that the request has been completed
- TRRx queries DEERS to obtain newborn information
- TRRx submits the claim which enables PDTS to perform the CCDD update to DEERS to record cost-shares.

3.0. PROCESS

3.1. Determination Of Need To Request Creation Of Newborn Placeholder

All reference to processing newborn claims refers to the receipt of a paper claim by TRRx, and the processing involved with that claim. The Point of Sale (POS) eligibility queries do not support newborn claim responses until the newborn is verified on DEERS. This will therefore require the beneficiary to submit a paper claim to recoup the prescription costs when appropriate. If a beneficiary contacts the TRRx to inquire on the ineligibility determination from the Point of Sale (POS) response, the beneficiary will be directed to enroll the newborn in DEERS and to submit a paper claim using form DD Form 2642.

Once a paper claim is submitted to TRRx, a Claims Eligibility inquiry is submitted by TRRx, through PDTS, to DEERS. The response returned to PDTS will be either an eligible response, a "person not found" response based on the information submitted, or the response will indicate that the individual does not have eligibility for the Pharmacy benefit.

For those responses in which the person is not found, or is deemed ineligible, TRRx will review the claim to determine if the beneficiary meets the requirements for consideration as an eligible newborn (see TRICARE Policy Manual (TPM), Chapter 10, Section 3.1, Prime and Status Changes). For those that are determined to meet the newborn eligibility requirements, the claim will be processed. For these claims that are processed, the following procedure will be followed in order to record any copay and cost-shares that the beneficiary is required to pay.

TRRx, through PDTS, will query DEERS via the Claims Eligibility interface using the Sponsor information. A Family inquiry is necessary to compare the dependent information on DEERS with that submitted on the claim. If PDTS determines that there exists a dependent record for this newborn, either verified or a placeholder, PDTS will use this information to inquire and update the CCDD totals.

If PDTS determines that this dependent record does not exist within the family, then a Newborn Placeholder Request will need to be executed in order to record the appropriate cost-shares.

3.2. Preparation Of The Newborn Request Form

TRRx will complete a Newborn Placeholder Request Form using information from both the paper claim, as well as the response record from the family inquiry submitted through the DEERS Claims Eligibility interface. TRRx is responsible for the accuracy and completeness of the content for the request. See Figure 3-F-1 for the required data elements and a sample Newborn Placeholder Request Form.

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 NEWBORN PLACEHOLDER REQUEST PROCESS FOR TRICARE RETAIL PHARMACY
 (TRRx) AND PHARMACY DATA TRANSACTION SYSTEM (PDTS)

FIGURE 3-F-1 SAMPLE NEWBORN PLACEHOLDER REQUEST FORM

NOTE: Request forms must be password protected prior to transmission.

Date of Request:		
TRRx POC:		
Telephone No:		
DATA ELEMENTS	VALUES	R = REQUIRED O = OPTIONAL
SPONSOR INFORMATION		
Sponsor Identifier		R
Sponsor Identifier Type Code		R
Sponsor Last Name		R
Sponsor First Name		R
Sponsor Date of Birth		R
Sponsor Telephone Number		R
Sponsor Address		O
NEWBORN INFORMATION		
Newborn Last Name		R
Newborn First Name		R
Newborn Middle Name		O
Newborn Cadency Name		O
Newborn Date of Birth		R
Newborn Sex Code		R
FOR MCSC USE:		
Date Request Completed		
Request Completed By		

3.3. Forward Newborn Placeholder Request To The MCSC

Based on the sponsor information, TRRx will determine which MCSC should receive the request form. The request will be saved in the form of a Microsoft Word document. The document will be password protected using an agreed upon standard password.

The file naming convention will include the text "Newborn" and the date of the request. If there is more than one request made on a specific day, then a sequence number can be added to the file name for any subsequent requests sent on the same day. The following format will be used: "Newborn_MMDDYYYY.doc".

For example, a request sent on December 5, 2004 would have a name of, "Newborn_12052004.doc". A second request for that same date would include a sequence number such as, "Newborn_12052004_2.doc."

TRRx will forward this password protected document to the Point of Contact (POC) for the MCSC via e-mail.

3.4. MCSC Processes The Newborn Placeholder Request

Upon receipt of the request from TRRx, the MCSC will validate the need to create a placeholder record for the newborn. This will include performing a Claims Eligibility request for a family query. The response received will be evaluated to determine whether or not a record exists for this newborn. This will reduce the possibility of a duplicate placeholder being introduced. This would most likely occur as a result of timing between the request made and the request performed. The MCSC will also review claims history to determine whether or not the newborn is a grandchild. If it is determined that the newborn is a grandchild, the MCSC will not enter a placeholder on DEERS.

Once the MCSC verifies the requirement to create a placeholder record for the newborn, the MCSC will use the data provided in the request form and will execute the appropriate transaction in the CCDD interface. The response record will be evaluated to ensure that the newborn information is returned which indicates that the newborn was added successfully. The MCSC processing of the Newborn Placeholder Request will occur within one business day of receipt.

3.5. MCSC Notifies TRRx Of Completed Processing Of Newborn Placeholder Request

Once the request has been processed, the MCSC will send an e-mail to the POC at TRRx to notify them of the outcome. The e-mail will let TRRx know whether the placeholder has been created, or if not, why the placeholder was not created.

The e-mail will reference the original file name of the request so that TRRx can track any and all outstanding requests (see file naming convention above). It is not necessary to return the original file itself.

3.6. TRRx Queries (Through PDTS) To DEERS For Newborn Information

For those requests that did not have a Placeholder record added by the MCSC, such as for a grandchild, PDTS will reject the claim.

For those requests that did have a Placeholder, either created or pre-existing, TRRx through PDTS, will requery DEERS via the Claims Eligibility interface using sponsor information. A family inquiry is necessary to compare the dependent information on DEERS with the information submitted on the claim. TRRx should now be able to determine that there exists a placeholder record for the newborn. The Claims Eligibility Response record will confirm the addition of the newborn placeholder record with an HCDP Plan Coverage Code value of "999".

3.7. PDTS Performs Catastrophic Cap Inquiry And Update

PDTS will then use the identifier information returned in the Claims Response to inquire and update the CCDD totals. Once the appropriate update is made to the CCDD database, the request is considered complete.

3.8. Maintenance Of POCs

Each organization is responsible for coordinating and providing updates to POC information for their organization with other contractors. POC information should include the following information: Name of POC; telephone number, and e-mail address.

