



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

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TRICARE  
MANAGEMENT ACTIVITY

PCSIB

CHANGE 85  
7950.1-M  
SEPTEMBER 7, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE SYSTEMS MANUAL (TSM), AUGUST 2002**

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

**CHANGE TITLE:** NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FISCAL YEAR (FY)  
2010, SECTION 706, DUAL ELIGIBLE BENEFICIARIES

**CONREQ:** 14971

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

**SUMMARY OF CHANGE(S):** This change implements Section 706 of the NDAA FY 2010 that applies to disabled TRICARE beneficiaries under age 65 who were awarded Medicare Part B October 1, 2009 or later when Medicare Part A is effective at a minimum, six months prior to the Medicare Part B effective date. These beneficiaries remain eligible for TRICARE for the period in which they have Medicare Part A only. The benefit's effective date is October 28, 2009, but it applies to any timely claim submitted after that date, even if the date of care covered by the claim occurred prior to October 28, 2009.

**EFFECTIVE DATE:** October 28, 2009.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 105.



Jack Arendale  
Chief, Purchased Care Systems  
Integration Branch

**ATTACHMENT(S):** 4 PAGES  
**DISTRIBUTION:** 7950.1-M

**CHANGE 85**  
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**REMOVE PAGE(S)**

**CHAPTER 2**

Section 2.6, pages 5 through 8

**INSERT PAGE(S)**

Section 2.6, pages 5 through 8

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE (CONTINUED)</b>		
<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>		
	Q	Packaged services subject to separate payment based on payment criteria. See codes Q1 through Q3 listed below.
	R	Blood and blood products
	S	Significant procedures not subject to multiple procedure discounting.
	T	Significant procedures subject to multiple procedure discounting.
	U	Brachytherapy sources.
	V	Clinic or emergency department visits.
	W	Invalid HCPCS or invalid revenue code with blank HCPCS.
	X	Ancillary services.
	Z	Valid revenue code with blank HCPCS and no other SI assigned.
	TB	TRICARE reimbursement not allowed for CPT/HCPCS code submitted.
	Q1	STVX-packaged codes.
	Q2	T-packaged codes.
	Q3	Codes that may be paid through a composite APC.
<b>ALGORITHM N/A</b>		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>		
<b>SUBORDINATE</b>		<b>GROUP</b>
N/A		N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Required on all TED records reimbursed under Outpatient Prospective Payment System (OPPS).

Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 13, Section 3](#) for additional information and more complete definitions of the OPPTS Payment Status Indicator Codes. Must be left justified and blank filled.

The list of Payment Status Indicators For Hospital OPPTS and OPPTS Payment Status can be found at <http://www.tricare.mil/oppo>.

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CHAPTER 2, SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-132	1	Yes <sup>1</sup>
Non-Institutional	2-192	Up to 99	Yes <sup>1</sup>

**PRIMARY PICTURE (FORMAT)** One (1) alphanumeric character.

**DEFINITION** The code that indicates the reason that the person's period of eligibility for a non-DoD Other Government Program (OGP) began. The OGP begin reason code only applies to OGP type codes of 'A' or 'B' only. Download field from DEERS.

CODE/VALUE SPECIFICATIONS		
	A	Eligible for Medicare. Eligibility began after age 65 (the person did not have enough quarters of Social Security contributions to qualify at age 65). This value applies to Medicare Part A.
	B	Enrollment in Medicare Part B, C, or D; over or under age 65. Medicare Part B can only be obtained by payment of monthly premiums. This value applies to Medicare Part B, C, or D.
	D	Eligible for Medicare because of disability. This value applies to Medicare Part A.
	E	Eligible for Medicare at age 65. This value applies to Medicare Part A.
	F	Eligibility for Medicare defaulted at age 65; verification not received from Center for Medicare and Medicaid Services (CMS). Applies to Medicare Part A only.

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

If person not on DEERS but claim is payable (i.e., government liability), report 'W' in this field.

**NOTE:** For Mail Order Pharmacy use the data element Medicare Begin Reason Code from the DEERS inquiry/response to report this information. If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

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CHAPTER 2, SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (CONTINUED)

CODE/VALUE SPECIFICATIONS (CONTINUED)	G	Enrollment in Medicare Part B declined by beneficiary.
	N	Not eligible for Medicare. Under age 65 this is the default value. At age 65 this indicates eligibility could not begin because the person did not have enough quarters of Social Security contributions to qualify. This value applies to Medicare Part A.
	P	Eligible for Medicare at or after 65 because of purchase. This value applies to Medicare Part A.
	R	Eligible for Medicare because of end-stage renal disease. This value applies to Medicare Part A.
	V	Eligible for the Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA).
	W	Not applicable.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

<sup>1</sup> If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

If person not on DEERS but claim is payable (i.e., government liability), report 'W' in this field.

**NOTE:** For Mail Order Pharmacy use the data element Medicare Begin Reason Code from the DEERS inquiry/response to report this information. If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-131	1	Yes
Non-Institutional	2-191	Up to 99	Yes

PRIMARY PICTURE (FORMAT) One (1) alphanumeric character.

DEFINITION The code that represents what type of other government program the person has. Download field from DEERS.

CODE/VALUE SPECIFICATIONS A Medicare Part A

NOTES AND SPECIAL INSTRUCTIONS:

Instructions to submit the TED OGP TYPE CODE:

1. If the DEERS response returns only one OGP TYPE CODE segment report the DEERS OGP TYPE CODE in the TED OGP TYPE CODE; **unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' in the TED OGP TYPE CODE.**
2. If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and "B" report a 'C' in the TED OGP TYPE CODE.
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.
7. For Mail Order Pharmacy **and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

Contractors shall forward claims for beneficiaries who are age 65 or older to the TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC) when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TRICARE For Life or the response carries a Medicare Begin Reason Code of A, D, E, or R, indicating the patient has Medicare Part A.

Contractors shall forward claims for beneficiaries who are under 65 to the TDEFIC when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the TDEFIC shall determine if a benefit exists. The forwarding regional MCSCs shall determine if a dual eligible benefit exists.

If person not on DEERS but claim is payable (i.e., government liability), report 'N' in this field.