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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 97
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**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: MAIL DELIVERY QUALITY CODE (MDQC)

CONREQ: 15805

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change revises the referenced Manuals to require use of the Mail Delivery Quality Code (MDQC) when processing returned mail or verifying addresses. An updated MDQC will prevent mailings to the beneficiary such as enrollment cards and letters. The MDQC field automatically resets whenever the address is updated.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 142 and Aug 2002 TPM, Change No. 159.

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ATTACHMENT(S): 28 PAGES
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CHANGE 97
7950.1-M
JUNE 7, 2012

REMOVE PAGE(S)

CHAPTER 3

Section 1.5, pages 27 through 53

INSERT PAGE(S)

Section 1.5, pages 27 through 54

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 contractor 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 contractor 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 contractor 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 contractor 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 contractor system with the confirmed enrollment action. See [paragraph 1.4.](#) for more information about Notifications.

1.3. Address And Telephone Number Updates

1.3.1. Addresses

1.3.1.1. 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. The TRICARE enrollment form contains a mailing address and a residential address. **The contractor shall update the residential and mailing addresses in DEERS whenever possible. DEERS** uses a commercial product to validate address information online.

1.3.1.2. If the contractor cannot determine a valid address, the contractor shall update the Mail Delivery Quality Code (MDQC) in DEERS to indicate that mail is undeliverable to the address listed. The updated MDQC will prevent DEERS mailings to the beneficiary such as

enrollment cards and letters. The contractor shall also use the MDQC to prevent mailings to invalid addresses. The MDQC field shall be updated using one of two values:

- Value 1 = A post office rejected the mailing address as invalid.
- Value 2 = The mailing address is valid; however, the person no longer lives there.

1.3.1.3. If updated with Value 1 or 2, the DEERS applications will display the following message: "The U.S. Postal Service (USPS) returned mail to this address as undeliverable. Please check and update as needed."

1.3.1.4. The MDQC will automatically reset whenever an address update is processed.

1.3.2. Telephone Numbers

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

1.3.3. E-Mail Addresses

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 contractor. The home e-mail address is updated through the DOES application.

1.4. Notifications

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

1.4.1. Notifications Resulting From Enrollment Actions

1.4.1.1. DEERS sends notifications to contractors detailing any policy or PCM update performed in the DOES or BWE application. This includes address updates and some demographic changes made for enrollees, regardless of the update source. DEERS will also send notifications for fee updates the contractor makes in the Fee/CCDD Research

application. Additionally, DOES supports a feature for the contractor to request a notification to be sent without updating any address or enrollment information. The purpose of this request is to re-sync the contractor system with the latest DEERS policy data.

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

1.4.1.3. 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 contractor and result from updates to a sponsor or family member's information made by an entity other than the enrolling contractor. Unsolicited notifications may result from various types of updates made in DEERS, 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 contractor and to CHCS, if appropriate. One example of this type of notification is notification of loss of eligibility.
- Extended Eligibility. For example, in the case of a 21-year old child that shows proof of being a full-time student, eligibility 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 contractor.
- Address changes. The notification also includes information as to which type of entity made the update. Address changes performed by CHCS are also sent to the contractor.
- Data corrections made by DMDC Support Office (DSO) or the DOES Help Desk. If a contractor requests the DSO to make a data correction for a current or future enrollment that the contractor cannot make themselves, notification detailing the update is sent to the contractor, and to CHCS, if appropriate.
- Automatic approvals of BWE actions. DEERS will send unsolicited notifications for all BWE actions approved without contractor action in DOES.
- Fee waiver updates. Changes to an enrolled sponsor or beneficiary's fee waiver status will be sent via unsolicited notifications to the contractor.

NOTE: Fee waiver updates only apply when the contractor is using Web DOES.

- Changes to premium information as a result of a premium or fee recalculation by DEERS.

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 contractors. The contractor is responsible for retrieving and applying this information on a weekly basis. The merge brings the data gathered under the two IDs under only one of the IDs and discards the other. Although DEERS retains both IDs for an indefinite period, from that point on only the one remaining ID shall be used by the contractor for that person and for subsequent interaction with DEERS and other MHS systems. If there are enrollments under both records being merged that overlap, the enrolling organizations are responsible for correcting the enrollments. 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

1.5.1. 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 the contractors.

1.5.2. New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new contractor, 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.

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

1.5.4. 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.

1.5.5. The contractor 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 contractor due to a bad address, the contractor researches the address, corrects it on DEERS, and re-mails the correspondence to the beneficiary. **If the contractor cannot determine a valid address, the contractor shall update the MDQC in DEERS to prevent future mailings to that address (see paragraph 1.3.1., Addresses).**

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

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

Upon receipt of this data from DEERS, the contractor 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 contractor has evidence of additional or more current OHI information they shall process claims using the additional or more current information. After the claims adjudication process is complete, the contractor shall send the updated or additional OHI information to DEERS 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 contractors and DEERS, associated with CCDD transactions. The main events to support processing this information include:

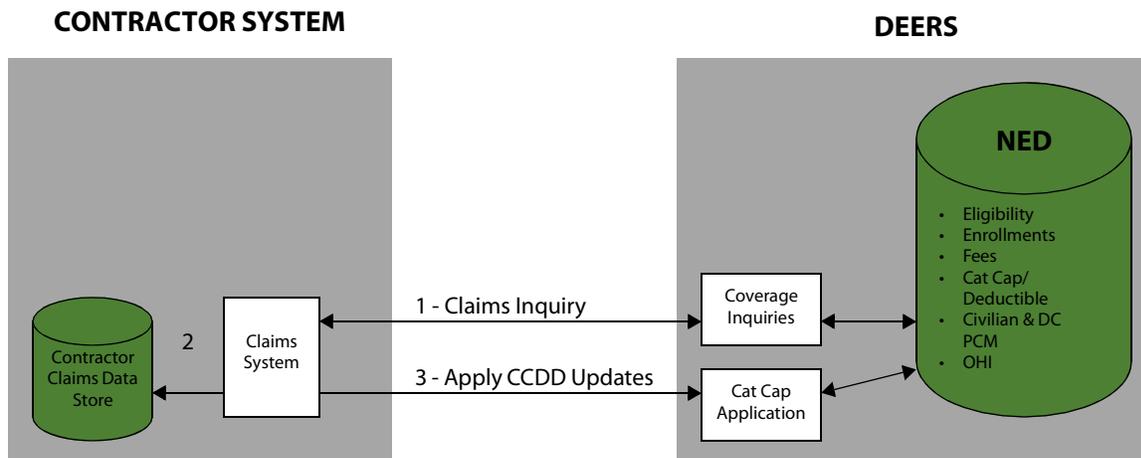
- Health Care Coverage Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

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 contractor must use the eligibility, enrollment, OHI, OGP's (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 contractor 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 contractor is required to store the Patient ID. The Patient ID provides uniform person identification and patient identification across the MHS. The contractor 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 contractor 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 contractor 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

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1.5

DEERS FUNCTIONS

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	CONTRACTOR 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.
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.

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

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

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

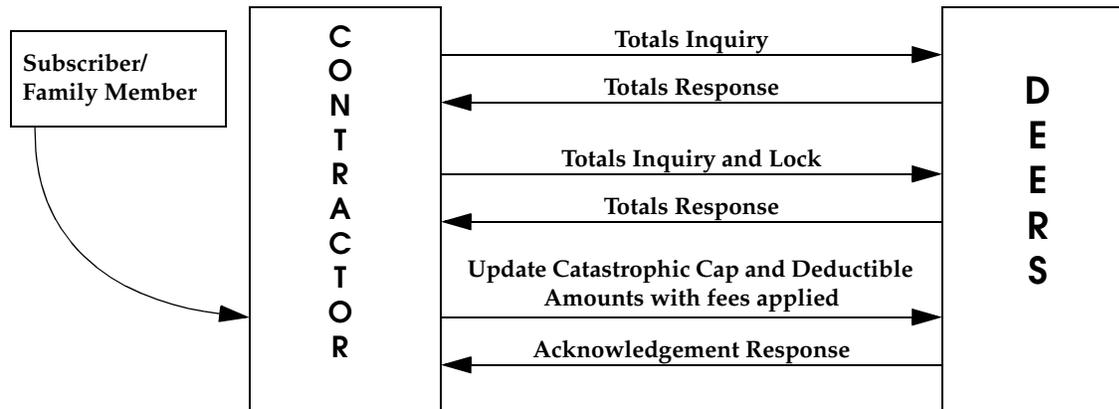
October 25, 2003, there would be two sets of fiscal year totals, one for FY 2003 and one for FY 2004.

1.6.1.4.1.7. Lock Information

If an contractor 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 a contractor inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that contractor's lock information, including their lock organization, lock date, and lock time. If an contractor 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 contractor may choose not to remove the lock. In this case, the record would remain locked until the 48-hour time period expires, or the lock is removed, whichever comes first.

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

- DEERS ID: This identifies the beneficiary for whom the update is applied.
- Catastrophic cap, deductible, and/or Point of Service (POS) dollar amount

The contractor sends DEERS the CCDD amount for the beneficiary. DEERS knows to which family the beneficiary belongs and rolls up the totals for the correct family using the DEERS ID.

- Identifier for the claim, enrollment fee, or adjustment

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

- Claim extension identifier

When a claim spans 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 contractor 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 contractor utilizes the CCDD update to add new CCDD amounts to the DEERS CCDD repository.

1.6.1.5.2.2. Adjustments

The contractor utilizes the CCDD update to adjust posted CCDD amounts. The same claim identifier as the original claim must be provided for the adjustment. A negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, a contractor must provide the same information for updating a claim as outlined in the previous section. For example, a contractor updates a claim with a \$50 catastrophic cap amount, then two weeks later discovers that the claim was incorrectly adjudicated and the catastrophic cap amount should have been \$35. The contractor would then update the beneficiary's catastrophic cap for the same claim number with an amount of -\$15. The DEERS catastrophic cap balance would then show \$35 for that claim.

1.6.1.5.2.3. Canceling A Catastrophic Cap Or Deductible Amount

The contractor 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, a contractor 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 contractor 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 a contractor places a lock on a record and fails to update that record within the specified 48-hour time period, the contractor will be unable to update CCDD amounts, because the lock will have expired.

1.6.1.5.2.5. Removing A Lock

If a contractor 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 contractor 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 contractor 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). Contractors 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 contractor 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'.

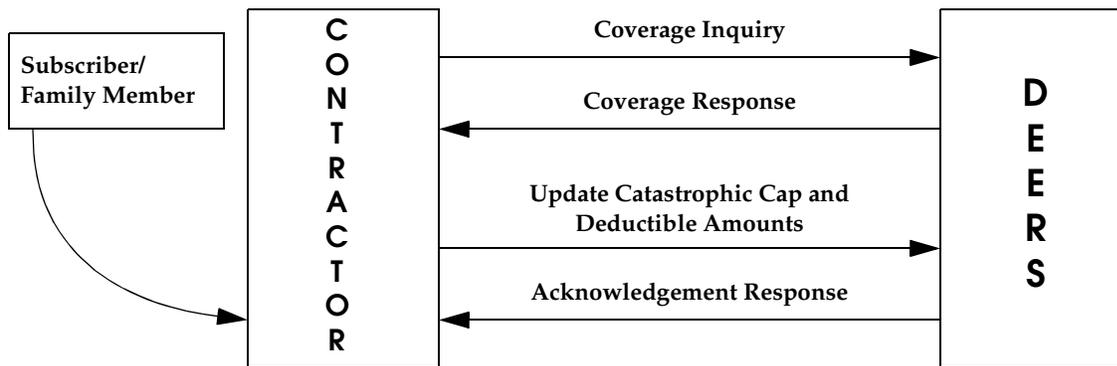
Adding the newborn in DEERS via CCDD updates will not generate eligibility for the newborn, but the newborn will show in GIQD and in claims responses. Once the sponsor "adds" the newborn in DEERS through RAPIDS, the newborn will be eligible like any other beneficiary.

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 contractor during transition. It is the responsibility of the new 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 contractor'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 TED 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 contractor will determine the existence of OHI. The contractor can add or update minimal OHI data through the DOES application used by the contractor to enter enrollments into DEERS. 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 contractor, the contractor 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 contractor to perform an OHI Inquiry before attempting to add or update an OHI policy. The MHS organizations are reliant on the individual beneficiary to provide accurate OHI information and DEERS is reliant on the MHS organizations for the accurate assignment of policy information to the individual record. DEERS is not the system of record for OHI information. Performing an OHI Inquiry on a person before adding or

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

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

- Patient ID
- HIC 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 contractor 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 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.