



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 36
7950.2-M
MAY 7, 2012

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM), FEBRUARY 2008**

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

CHANGE TITLE: ENROLLMENT FEES/PREMIUM SYSTEM CHANGES

CONREQ: 16000

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change adds the new process for managing fees and premiums collected and posted to Defense Enrollment Eligibility Reporting System (DEERS), adds language on how the paid-through dates are calculated by DEERS, adds the new Fiscal Year (FY) 2012 TRICARE Prime Enrollment Fees, and adds two categories of beneficiaries exempted from paying any future increases to the TRICARE Prime Fees: Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Service Members and their dependents.

EFFECTIVE DATE: October 1, 2011: For adding the new FY12 Enrollment Fee and the two categories of beneficiaries exempted.
October 1, 2012: For the new process and paid-through date.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TOM, Change No. 77 and Feb 2008 TRM, Change No. 67.


Jack Arendale
Chief, Purchased Care Systems
Integration Branch

ATTACHMENT(S): 73 PAGES
DISTRIBUTION: 7950.2-M

CHANGE 36
7950.2-M
MAY 7, 2012

REMOVE PAGE(S)

CHAPTER 2

Section 5.2, pages 25 and 26

Section 6.4, pages 13 and 14

Addendum L, pages 1 through 5

CHAPTER 3

Section 1.4, pages 7 through 41

APPENDIX A

pages 3 through 31

INSERT PAGE(S)

Section 5.2, pages 25 and 26

Section 6.4, pages 13 and 14

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)

022	TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR
023	TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR
028	TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS OR
029	TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS OR
409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR
410	TRS SURVIVOR CONTINUING FAMILY COVERAGE OR
411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
412	TRS SURVIVOR NEW FAMILY COVERAGE OR
413	TRS MEMBER-ONLY COVERAGE OR
414	TRS MEMBER AND FAMILY COVERAGE OR
418	TRR MEMBER-ONLY COVERAGE OR
419	TRR MEMBER AND FAMILY COVERAGE OR
420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
421	TRR SURVIVOR FAMILY COVERAGE OR
422	TYA STANDARD FOR ADFMS OR
423	TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS OR
424	TYA RESERVE SELECT OR
425	TYA RETIRED RESERVE OR
999	UNVERIFIED NEWBORN
AND PATIENT ZIP CODE MUST =	PHL PHILIPPINES
AND PROVIDER STATE OR COUNTRY CODE MUST =	PHL PHILIPPINES

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186)

VALIDITY EDITS

1-186-01V MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO [SECTION 2.5](#)).

RELATIONAL EDITS

NONE

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PRICING RATE CODE (1-190)

VALIDITY EDITS

1-190-01V VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.

RELATIONAL EDITS

1-190-01R	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	THEN PRICING RATE CODE MUST ≠	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER OR
		DD	DISCOUNTED DRG
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE OR
		DD	DISCOUNTED DRG
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT OR
		P	PER DIEM RATE AGREEMENT OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	OR AMOUNT ALLOWED (TOTAL) = ZERO		
1-190-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FS	TFL (SECOND PAYOR) OR
		MN	TSP - NON-NETWORK OR
		MS	TSP - NETWORK
	OR TYPE OF INSTITUTION =	70	HHA OR
		76	SNF
1-190-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE OR

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Chapter 2, Section 6.4

Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)

AND ENROLLMENT/HEALTH PLAN CODE MUST =			SR	SHCP - REFERRED CARE
AND AT LEAST ONE PROCEDURE CODE¹ MUST = 99456				
2-305-38R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PH	PHILIPPINES DEMONSTRATION PROJECT	
THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2013				
AND HCDP PLAN COVERAGE CODE MUST =			003	TRICARE STANDARD FOR ADFMS OR
			005	TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
			007	TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS OR
			009	TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS OR
			010	TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
			015	TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR
			017	TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR
			018	TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH OR
			020	TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
			021	TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
			022	TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR
			023	TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR
			028	TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS OR
			029	TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS OR
			409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR
			410	TRS SURVIVOR CONTINUING FAMILY COVERAGE OR
			411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
			412	TRS SURVIVOR NEW FAMILY COVERAGE OR
			413	TRS MEMBER-ONLY COVERAGE OR
			414	TRS MEMBER AND FAMILY COVERAGE OR
			418	TRR MEMBER-ONLY COVERAGE OR
			419	TRR MEMBER AND FAMILY COVERAGE OR

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² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)	
	420 TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421 TRR SURVIVOR FAMILY COVERAGE OR
	422 TYA STANDARD FOR ADFMS OR
	423 TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS OR
	424 TYA RESERVE SELECT OR
	425 TYA RETIRED RESERVE OR
	999 UNVERIFIED NEWBORN
AND PATIENT ZIP CODE MUST =	PHL PHILIPPINES
AND PROVIDER STATE OR COUNTRY CODE MUST =	PHL PHILIPPINES
¹ CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED. ² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.	

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)	
VALIDITY EDITS	
2-306-01V	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO SECTION 2.5)
RELATIONAL EDITS	
NONE	

Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
000	No health care coverage plan (transfer records only)
001	Direct Care for Active Duty Sponsors
002	Direct Care for Active Duty Family Members
003	TRICARE Standard for Active Duty Family Members
004	Direct Care for Survivors of Active Duty Deceased Sponsors
005	TRICARE Standard for Survivors of Active Duty Deceased Sponsors
006	Direct Care for Transitional Assistance Family Members
007	TRICARE Standard for Transitional Assistance Sponsors and Family Members
008	Direct Care for Retired Sponsors and Family Members
009	TRICARE Standard for Retired and Medal of Honor Sponsors and Family Members
010	TRICARE Standard for Transitional Survivors of Active Duty Deceased Sponsors
011	Direct Care for CONUS DoD Affiliates
012	TRICARE Standard for CONUS DoD Affiliates
013	Direct Care for OCONUS DoD Affiliates
014	Direct Care for Transitional Survivors of Active Duty Deceased Sponsors
015	TRICARE Standard for Transitional Survivors of Guard/Reserve Deceased Sponsors
016	Direct Care for Survivors of Guard/Reserve Deceased Sponsors
017	TRICARE Standard for Survivors of Guard/Reserve Deceased Sponsors
018	TRICARE for Life for Retired Sponsors and Family Members and Medal of Honor
019	Limited Direct Care with Line of Duty Injuries for Guard/Reserve Sponsors
020	TRICARE for Life for Transitional Survivors of Active Duty Deceased Sponsors
021	TRICARE for Life for Survivors of Active Duty Deceased Sponsors
022	TRICARE for Life for Transitional Survivors of Guard/Reserve Deceased Sponsors
023	TRICARE for Life for Survivors of Guard/Reserve Deceased Sponsors
024	Direct Care for Transitional Survivors of Guard/Reserve Deceased Sponsors
025	Direct Care Dental For Active Duty Sponsors
026	Direct Care Dental For Active Duty Foreign Military
027	Direct Care for Early Alert for Guard/Reserve Service Members
028	TRICARE Standard for Medically Retired Sponsors and Family Members
029	TRICARE for Life for Medically Retired Sponsors and Family Members
101	CHAMPUS Reform Initiative (CRI) - CHAMPUS Prime (history)
102	Fort Sill - Catchment Area Management (CAM) Program (history)
103	Fort Carson – Catchment Area Management (CAM) Program (history)
104	Bergstrom Air Force Base (AFB) - Catchment Area Management (CAM) program (history)

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Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
105	Luke/Williams Air Force base (AFB) - Catchment Area Management (CAM) Program (history)
106	TRICARE Prime Individual Coverage for Active Duty Sponsors
107	TRICARE Prime Individual Coverage for Active Duty Family Members
108	TRICARE Prime Family Coverage for Active Duty Family Members
109	TRICARE USFHP Direct Care Coverage for Active Duty Family Members
110	TRICARE Prime for Individual Coverage for Survivors of Active Duty Deceased Sponsors
111	TRICARE Prime Family Coverage for Survivors of Active Duty Deceased Sponsors
112	TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
113	TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
114	TRICARE USFHP Direct Care Individual Coverage for Survivors of Active Duty Deceased Sponsors
115	TRICARE USFHP Direct Care Family Coverage for Survivors of Active Duty Deceased Sponsors
116	TRICARE Prime Individual Coverage for Retired and Medal of Honor Sponsors and Family Members
117	TRICARE Prime Family Coverage for Retired and Medal of Honor Sponsors and Family Members
118	TRICARE USFHP Direct Care Individual Coverage for Retired Sponsors and Family Members
119	TRICARE USFHP Direct Care Family Coverage for Retired Sponsors and Family Members
120	TRICARE Senior Prime Individual Coverage for Retired Sponsors and Family Members
121	Continued Health Care Benefits Program Individual Coverage
122	Continued Health Care Benefits Program Family Coverage
123	Federal Employees Health Benefits Program (FEHBP) Individual Standard Coverage
124	Federal Employees Health Benefits Program (FEHBP) Family Standard Coverage
125	Federal Employees Health Benefits Program (FEHBP) Individual High Coverage
126	Federal Employees Health Benefits Program (FEHBP) Family High Coverage
127	TRICARE Senior Supplement
128	TRICARE Remote Individual Coverage for Active Duty Sponsors
129	TRICARE Remote Individual Coverage for Active Duty Family Members
130	TRICARE Remote Family Coverage for Active Duty Family Members
131	TRICARE Prime Individual Coverage for Transitional Survivors of Active Duty Deceased Sponsors
132	TRICARE Prime Family Coverage for Transitional Survivors of Active Duty Deceased Sponsors
133	TRICARE USFHP Direct Care Coverage for Transitional Survivors of Active Duty Deceased Sponsors
134	TRICARE Prime Individual Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
135	TRICARE Prime Family Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
136	TRICARE Prime Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors
137	TRICARE Prime Family Coverage for Survivors of Guard/Reserve Deceased Sponsors
138	TRICARE USFHP Direct Care Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors
139	TRICARE USFHP Direct Care Family Coverage for Survivors of Guard/Reserve Deceased Sponsors
140	TRICARE Plus with CHC Coverage for Active Duty Family Members
141	TRICARE Plus Coverage for Transitional Survivors of Active Duty Deceased Sponsors
142	TRICARE Plus with CHC Coverage for Transitional Survivors of Active Duty Deceased Sponsors
143	TRICARE Plus Coverage for Survivors of Active Duty Deceased Sponsors
144	TRICARE Plus with CHC Coverage for Survivors of Active Duty Deceased Sponsors
145	TRICARE Plus Coverage for Retired Sponsors, Family Members and Medal of Honor

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Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
146	TRICARE Plus with CHC Coverage for Retired Sponsors, Family Members and Medal of Honor
147	TRICARE Plus with CHC Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
148	TRICARE Plus Coverage for Survivors of Guard/Reserve Deceased Sponsors
149	TRICARE Plus Coverage with CHC for Survivors of Guard/Reserve Deceased Sponsors
150	TRICARE Plus Coverage for Active Duty Family Members
151	TRICARE Plus Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
152	TRICARE Overseas Prime Individual Coverage for Active Duty Sponsors
153	TRICARE Overseas Prime Individual Coverage for Active Duty Family Members
154	TRICARE Overseas Prime Family Coverage for Active Duty Family Members
155	TRICARE Global Remote Overseas Prime Individual Coverage for Active Duty Sponsors
156	TRICARE Global Remote Overseas Prime Individual Coverage for Active Duty Family Members
157	TRICARE Global Remote Overseas Prime Family Coverage for Active Duty Family Members
158	TRICARE Remote Individual Coverage for Transitional Survivors of Active Duty Deceased Sponsors
159	TRICARE Remote Family Coverage for Transitional Survivors of Active Duty Deceased Sponsors
160	TRICARE Prime Individual Coverage for Medically Retired Sponsors and Family Members
161	TRICARE Prime Family Coverage for Medically Retired Sponsors and Family Members
201	TRICARE Dental Plan Individual Coverage for Active Duty Family Members
202	TRICARE Dental Plan Family Coverage for Active Duty Family Members
203	TRICARE Dental Plan Individual Remote Coverage for Active Duty Family Members
204	TRICARE Dental Plan Family Remote Coverage for Active Duty Family Members
205	TRICARE Dental Plan Individual Coverage for Survivors of Active Duty Deceased Sponsors
206	TRICARE Dental Plan Family Coverage for Survivors of Active Duty Deceased Sponsors
207	TRICARE Dental Plan Individual Coverage for Selected Reserve (SelRes) Sponsors
208	TRICARE Dental Plan Individual Coverage for Selected Reserve (SelRes) Family Members
209	TRICARE Dental Plan family coverage for Selected Reserve (SelRes) family members
210	TRICARE Dental Plan Individual Remote Coverage for Selected Reserve (SelRes) Family Members
211	TRICARE Dental Plan Family Remote Coverage for Selected Reserve (SelRes) Family Members
212	TRICARE Dental Plan Individual Coverage for Survivors of Selected Reserve (SelRes) Deceased Sponsors
213	TRICARE Dental Plan Family Coverage for Survivors of Selected Reserve (SelRes) Deceased Sponsors
214	TRICARE Dental Plan Individual Coverage for Active Guard/Reserve (AGR) Family Members
215	TRICARE Dental Plan Family Coverage for Active Guard/Reserve (AGR) Family Members
216	TRICARE Dental Plan Individual Remote Coverage for Active Guard/Reserve (AGR) Family Members
217	TRICARE Dental Plan Family Remote Coverage for Active Guard/Reserve (AGR) Family Members
218	TRICARE Dental Plan Individual Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
219	TRICARE Dental Plan Family Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
220	TRICARE Dental Plan for Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
221	TRICARE Dental Plan Individual Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Member
222	TRICARE Dental Plan Family Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members

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Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
223	TRICARE Dental Plan Individual Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
224	TRICARE Dental Plan Family Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
225	TRICARE Dental Plan Individual Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
226	TRICARE Dental Plan Family Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
227	TRICARE Dental Plan for Non-Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
228	TRICARE Dental Plan Individual Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
229	TRICARE Dental Plan Family Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
230	TRICARE Dental Plan Individual Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
231	TRICARE Dental Plan Family Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
301	BRAC Pharmacy
302	Pharmacy Redesign Pilot Project (PRPP)
400	TRICARE Extended Care Health Option (ECHO) Program
401	TRICARE Reserve Select Tier 1 Member-Only Coverage (Contingency Operations)
402	TRICARE Reserve Select Tier 1 Member and Family Coverage (Contingency Operations)
403	Tobacco Cessation Demonstration Program
404	Weight Management Demonstration Program
405	TRICARE Reserve Select Tier 2 Member-Only Coverage (Certified Qualifications)
406	TRICARE Reserve Select Tier 2 Member and Family Coverage (Certified Qualifications)
407	TRICARE Reserve Select Tier 3 Member-Only Coverage (Service Agreement)
408	TRICARE Reserve Select Tier 3 Member and Family Coverage (Service Agreement)
409	TRICARE Reserve Select Survivor Continuing with Individual Coverage
410	TRICARE Reserve Select Survivor Continuing with Family Coverage
411	TRICARE Reserve Select Survivor New Individual Coverage
412	TRICARE Reserve Select Survivor New Family Coverage
413	TRICARE Reserve Select Member-Only Coverage
414	TRICARE Reserve Select Member and Family Coverage
415	Wounded, Ill, and Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))
416	Wounded, Ill, and Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))
417	Transitional Care For Service-Related Conditions (TCSRC)
418	TRICARE Retired Reserve Member-Only Coverage
419	TRICARE Retired Reserve Member and Family Coverage
420	TRICARE Retired Reserve Survivor Individual Coverage
421	TRICARE Retired Reserve Survivor Family Coverage
422	TRICARE Young Adult TRICARE Standard for Active Duty Family Members
423	TRICARE Young Adult TRICARE Standard for Retired and Medal of Honor Family Members

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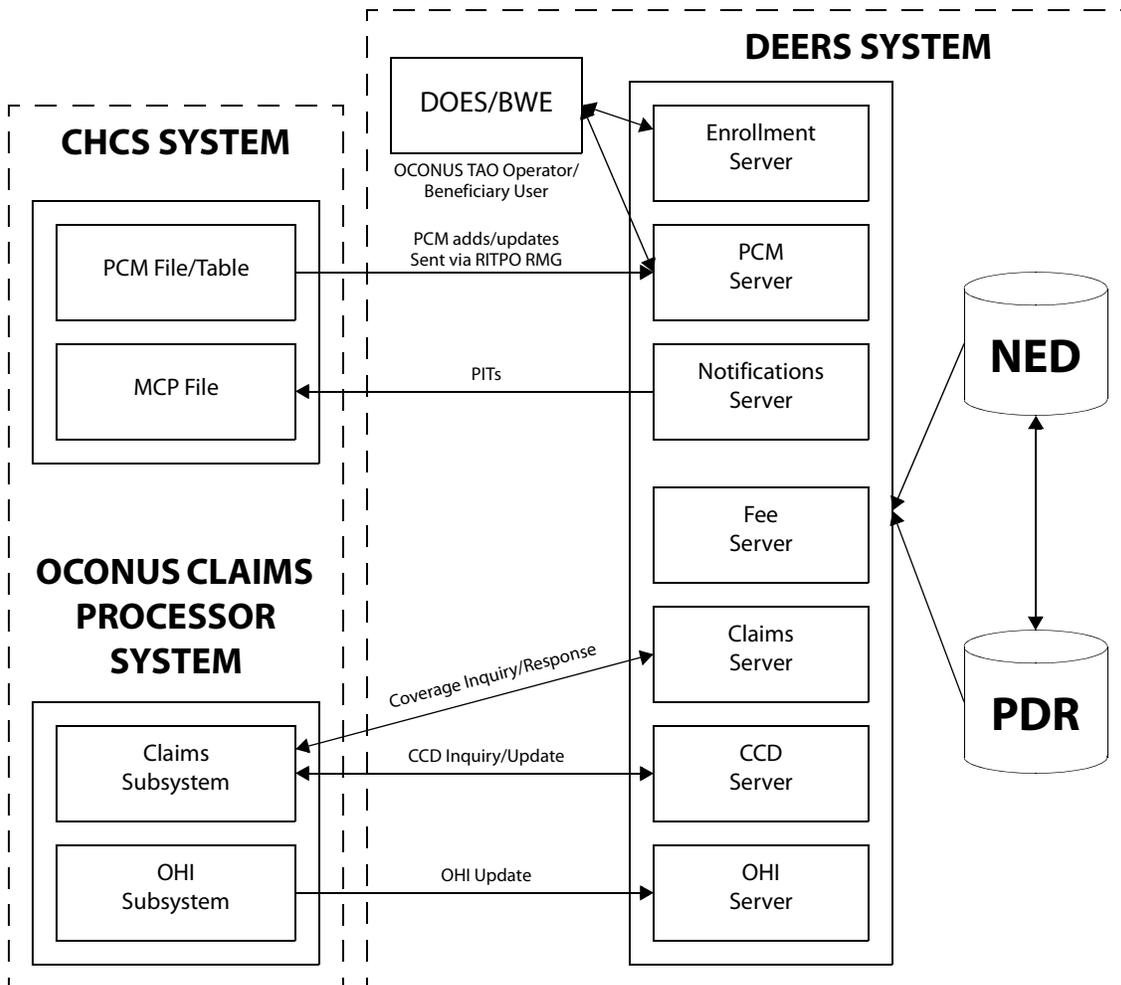
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Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
424	TRICARE Young Adult TRICARE Reserve Select
425	TRICARE Young Adult TRICARE Retired Reserve
426	TRICARE Young Adult TRICARE Prime for Active Duty Family Members
427	TRICARE Young Adult TRICARE Prime Remote for Active Duty Family Members
428	TRICARE Young Adult TRICARE Prime for Retired and Medal of Honor Family Members
429	TRICARE Young Adult TRICARE Overseas Prime for Active Duty Family Members
430	TRICARE Young Adult TRICARE Overseas Prime Remote for Active Duty Family Members
602	Direct Care and TRICARE Mail Order Pharmacy (TMOP) and Retail Pharmacies
603	Direct Care Only
999	Unverified Newborn

- END -

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



1.2.2 Defense Online Eligibility And Enrollment System (DOES)

DOES is a full function Government Furnished Equipment (GFE) application developed by Defense Manpower Data Center (DMDC) to support enrollment-related activity. DOES interacts with both the main DEERS database and the NED satellite database to provide enrolling organizations with eligibility and enrollment information, as well as the capability to update the NED with new enrollments and modifications to existing enrollments. The **contractors (Regional Contractors and Designated Provider (DP)/Uniformed Services Family Health Plan (USFHP))** and the TRICARE Overseas **Program (TOP)** contractor 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
- Beneficiary Update
- OHI Add
- Confirm Enrollment/PCM change (to support beneficiary web enrollment)
- Request new or replacement enrollment ID card
- Request PCM letter

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

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

1.2.3 Beneficiary Self-Service Enrollment

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

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

- Enrollment
- PCM change
- Address update
- Transfer of enrollment (as a result of address update)
- Disenrollment
- Limited cancellation events
- Submit an initial enrollment application, **including any required fee payment**
- Add limited OHI
- Request replacement enrollment card
- **Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card (RCC) payment election**
- **Allotment payment election (Prime only)**

The web application contains checks for beneficiary eligibility and hard edits requiring the beneficiary to fulfill established DEERS business rules and enrollment criteria. Upon completion of the web process, the beneficiary is informed that the enrollment actions will be reviewed by the appropriate contractor for accuracy and compliance with established Regional requirements, and that they will be contacted if additional information is needed. DEERS will send the contractor a Policy Notification Transaction (PNT), informing the contractor that a pending enrollment exists for the beneficiary. The contractor shall apply all PNTs for pending enrollments and/or PCMs and use the pending status to create workload reports. Using DOES, the contractor shall review or modify all pending enrollment-related activities within six calendar days of submission to DEERS, including

any necessary contact with the beneficiary. DEERS will perform a daily process to finalize enrollment actions after six calendar days. DEERS will send a policy notification indicating the approval. If the enrollment is not accepted, the contractor shall cancel the enrollment using DOES, and send the beneficiary an explanatory letter within five calendar days. The contractors shall consider beneficiary provided data from BWE as having the same validity as beneficiary provided data on paper enrollment forms. DEERS will not provide support or interfaces to contractor web applications that perform any enrollment-related functions.

1.2.4 Eligibility For Enrollment

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

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

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

- A sponsor is assigned TRICARE Prime for Active Duty Service Members (ADSMs), No PCM Selected in which he or she is the subscriber and the insured. The dates on the coverage represent the dates determined by the eligibility rules.
- A sponsor with family members is listed as the subscriber under the TRICARE Standard for Active Duty Family Members (ADFMs) assigned plan. The sponsor is not insured under this coverage plan.
- Eligible family members are assigned TRICARE Standard for ADFMs plan as insured with both Direct Care (DC) and Civilian Health Care (CHC) coverage. The coverage plan dates are determined by the eligibility rules. There are no enrollment dates, since this option requires no enrollment.

1.2.5 Prime Enrollment

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

- TRICARE Prime for ADSMs. This plan requires the assignment of a PCM.
- TRICARE Prime Remote (TPR) for ADSMs. This plan requires a PCM if one is available.
- TRICARE Overseas Prime for ADSMs. This plan requires a PCM to be assigned.

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

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

Enrollments are at the individual or family level, depending on the number of family members wishing to enroll. DEERS creates a policy that encompasses all enrollments for a family and a HCDP. DEERS automatically switches enrollment policies from individual to family or family to individual when required. It is the contractor's responsibility to correct the fees based on the policy notification of the plan change. DEERS will adjust fees for a policy to '\$0' any time a policy is systematically cancelled. Some HCDP's, such as TRICARE Plus, only offer enrollment on an individual basis. For these plans, DEERS does not limit the number of individual policies that a family may have.

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

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

Enrollments may be backdated up to 18 months.

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

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

For enrollees that pay fees on a quarterly basis, the contractor shall collect a prorated fee covering the period until the next FY quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30 of the current FY. For enrollees that pay fees on a monthly basis (by EFT or monthly allotments), contractors must collect and post an amount equal to three months of fees at the time of enrollment with monthly EFwT or allotments beginning on the first day of the fourth month following the enrollment anniversary date.

- **Enrollments Effective Prior to October 1, 2012:** If the first three month payment crosses into the next FY, the contractor shall send DEERS the three month payment amount, indicating the applicable paid-through date and a payment plan type of "Request to begin allotment". DEERS will apply one or two months of the three month

payment (whichever is applicable) to the enrollment ending in the current FY and the remaining one or two months of fees to the beginning of the new enrollment beginning on October 1 of the next FY.

Note: If the first three month payment crosses into FY 2013, the contractor shall send DEERS the portion that applies to FY 2012, indicating the applicable paid-through date and a payment plan type of "Request to begin allotment"; and shall send a second transaction containing the dollar amount of payment that applies to FY 2013 to DEERS with a payment plan type of "Request to begin allotment" and DEERS will calculate the paid-through date and notify the contractor.

- Enrollments Effective On Or After October 1, 2012: The contractor will send the fee amount collected for the first three month payment and a payment type of "Request to begin allotment" to DEERS and DEERS will calculate the paid-through date and notify the contractor.

1.2.5.1 Prime Enrollment Fees

1.2.5.1.1 Enrollment Year To FY Alignment

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

1.2.5.1.2 Prorated Enrollment Fees

For new Prime enrollments that do not begin on October 1, DEERS will establish abbreviated (less than 12 months) policies ending September 30 and the contractor shall **collect** the enrollment fees **necessary to align the policy with the FY**. The monthly prorated enrollment fee is 1/12 of the **respective** annual enrollment fee (**rounded down**). **DEERS will** apply any fee overage from the abbreviated enrollment year to the next FY enrollment policy and shall set the paid **period end** dates in accordance with those amounts. At the end of the abbreviated enrollment (end of the current FY), the contractor shall renew the policy for the next FY with a begin date of October 1 and resume collecting the full enrollment fees.

1.2.5.1.3 Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Services Members and their Dependents

Effective FY 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime.

The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

1.2.5.1.4 Prorated Catastrophic Cap Amounts

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

1.2.5.2 PCM Assignment Within The DOES Application

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

1.2.5.2.1 DC PCM Assignment

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

1.2.5.2.2 Civilian PCM Assignment

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

1.2.6 Disenrollment

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

1.2.6.1 Disenrollment - Loss Of Eligibility

A loss of eligibility refers to any loss or change in eligibility for DoD health care benefits in accordance with the current DoDI 1000.13 or additional legislation authorizing benefits or for a specific health coverage plan. At the time of enrollment, DEERS provides the end of eligibility date to the contractors via the notification. If that end date does not change, DEERS will provide no additional notifications. If the end date changes, DEERS will provide another notification with the new end date. DEERS also cancels any future actions for that beneficiary, including future enrollments, PCM changes, etc. If a contractor has applied fees to a policy that DEERS is cancelling, DEERS will adjust the fees to '\$0'.

1.2.6.2 Retroactive Eligibility/Enrollment Maintenance

There may be instances where DEERS receives notice of a loss of eligibility from the Uniformed Services, only to later be informed of the immediate reinstatement. Upon the receipt of the initial loss of eligibility, DEERS terminates the enrollment. Upon receipt of the notice of reinstatement, DEERS reinstates the eligibility and enrollment as long as there are no gaps in eligibility. DEERS will reinstate eligibility and enrollments only if DEERS receives new personnel information reinstating eligibility within 90 days of the initial loss of eligibility and only if the plan does not require fee payment.

1.2.6.3 Disenrollment - Voluntary

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

1.2.6.4 Disenrollment - Involuntary

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

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 3, Section 1.4

DEERS Functions

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

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

	DOES	BWE	FEE INTERFACE	PCM PANEL REASSIGNMENT	CCD FEE	DEERS (UNSOLICITED)
Enrollment	X	X				
Enrollment Cancellation	X	X (if pending)				
Disenrollment	X	X	X (failure to pay fees only)			X
Disenrollment Cancellation	X					
PCM Change	X	X		X		
PCM Cancellation	X	X (if pending)				
PCM Panel Reassignment				X		
Modify Enrollment Begin Date	X					X
Modify Prior Enrollment End Date	X					X
Modify Prior Enrollment End Reason	X					X
Modify PCM Effective Date	X					
Transfer	X	X				
Transfer Cancellation	X	X				X (if loss of eligibility before transfer)
Apply Enrollment Fee/ TRICARE Reserve Select (TRS)/TRICRE Retired Reserve (TRR)/TYA Premium		X (initial)	X		X	

1.2.7 Modification Of Enrollment

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

1.2.7.1 PCM Change And Cancellation

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

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

1.2.7.2 PCM Panel Reassignment

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

1.2.7.2.1 DC Care PCM Panel Reassignment

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

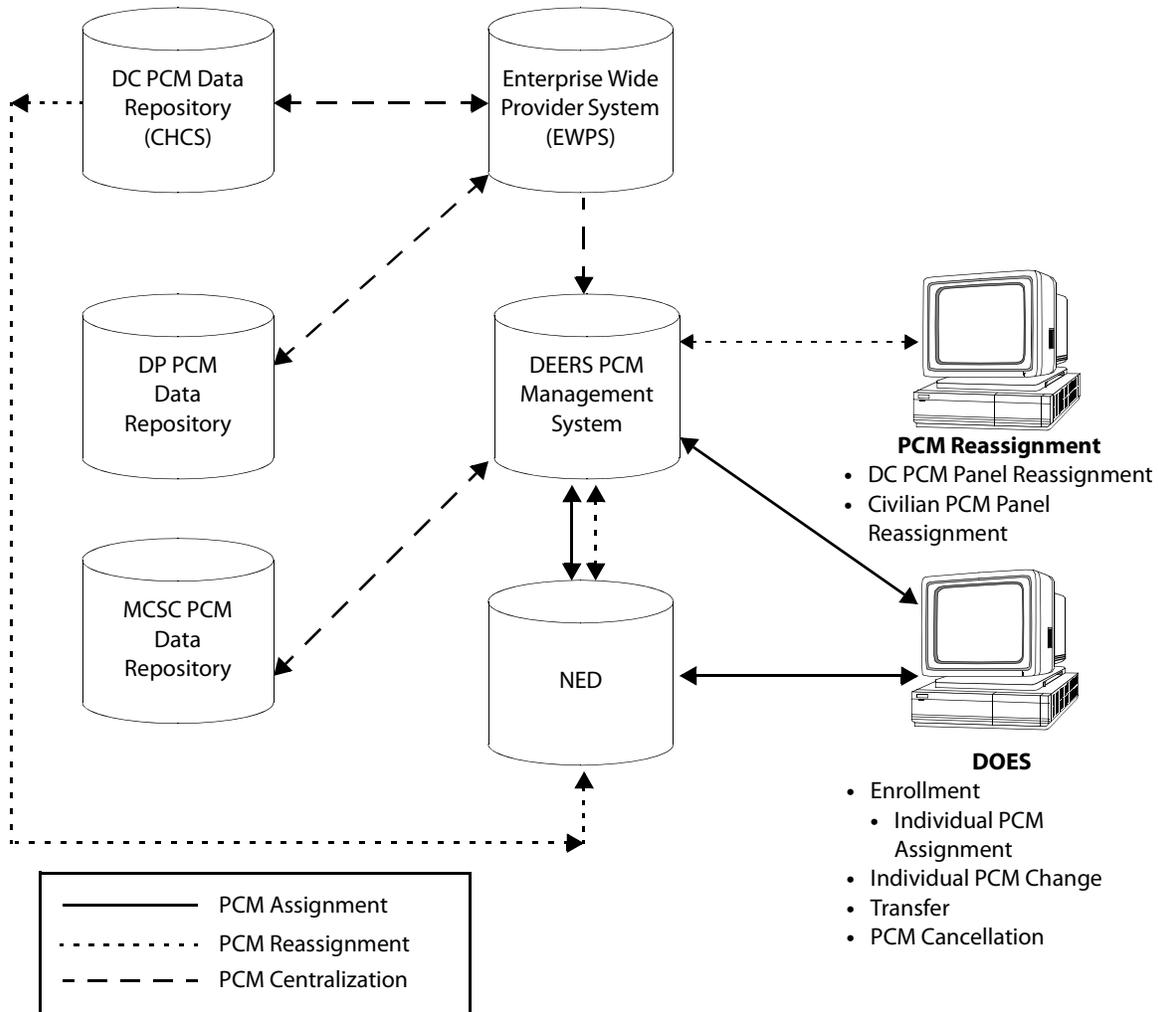
Panel changes that cross Composite Health Care System (CHCS) platforms must be coordinated not only with the contractor but with the designated TRICARE Management Activity (TMA) Representative and DEERS.

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

1.2.7.2.2 Civilian Panel Reassignment

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

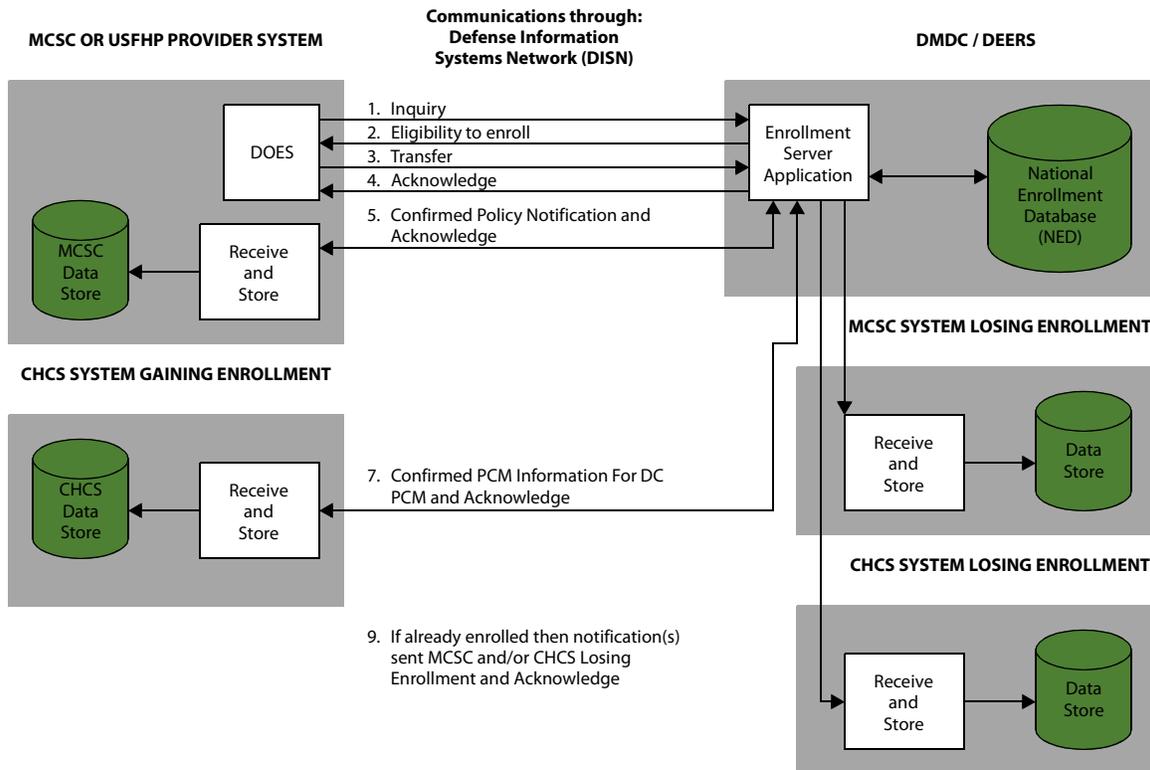
FIGURE 3.1.4-6 PCM ASSIGNMENT PROCESS



1.2.7.3 Transfer Of Enrollment And Transfer Cancellation

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

FIGURE 3.1.4-7 ENROLLMENT TRANSFER PROCESS



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

1.2.7.4 Enrollment Period Change

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

If a person's eligibility in DEERS changes and affects an enrollment because the eligibility period is either greater or less than originally stated, DEERS updates the enrollment period and pushes the PCM and policy changes to the appropriate systems managing the enrollment.

1.2.7.5 Enrollment End Reason Change

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

precedes the date of loss of eligibility.

1.2.7.6 Enrollment/Disenrollment Cancellation

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

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

1.2.8 Enrollment Fees, Premiums, And Enrollment Fee Waivers

DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment year in the Fee/CCD Web Research application.

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

- Enrollment Fee Payment (Fee/CCD Web Research application and Fee Interface)
- Update an enrollee's free-rider code (DOES)
- Terminate Policy For Failure To Pay Fees (DOES and Fee Interface)
- Premium Billing Service (for policies in effect on or after October 1, 2012)

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

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

Fee waivers are stored at the family level. DEERS will provide the reason for fee waiver and the begin and end dates, a status code, and status date associated to that waiver on the PNT. The status code indicates whether the waiver is active or inactive. Inactive waivers reflect waiver information that is no longer applicable because there has been a change to the fee waiver entitlement. Inactive waivers do not have an effect on the determination of fees due for the policy and are for audit purposes only. A fee waiver that indicates that a family has met their fiscal year catastrophic cap limit will be considered inactive if the fee waiver end date is not September 30th of the fiscal year for which the waiver exists. All waiver data is displayed in the Fee/CCD Web Research application and DOES (limited to only current fee waivers and those effective within the past two years).

1.2.8.1 Enrollment Fee and Premium Payment Processing (For Enrollment Periods Prior to October 1, 2012)

1.2.8.1.1 Prime Enrollment Fee Payment (For Enrollment Periods Prior to October 1, 2012)

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

1.2.8.1.1.2 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 family contribution towards the catastrophic cap. If the catastrophic cap is locked at the time the fee payment is sent, DEERS will reject the fee payment. The contractor shall resend the fee amount to DEERS daily until it is accepted. If the record remains locked longer than 48 hours, the contractor should contact the claims processor that placed the lock to determine the reason for the lock and when it will be released.

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

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

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

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

1.2.8.1.1.7 Credits extending into FY 2013, have to be removed prior to initialization of the new premium fee model and then later sent to DEERS if those funds apply to an FY 2013 payment. For

payments effective October 1, 2012 and later, DEERS will not post credits amounts to the catastrophic cap.

1.2.8.1.2 Fee Payments Interface (For Enrollment Periods Prior to October 1, 2012)

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

1.2.8.1.3 Premium Payment Programs: TRS, TRR, and TYA (Payments For Enrollment Periods Prior to October 1, 2012)

For the TRS, TRR, and TYA programs, DEERS will accept premium payment paid-through dates.

1.2.8.1.3.1 Contractors are required to submit paid-through dates to DEERS upon receipt of premium payments. Contractors will refund all overpayments of premiums to the member. In the event the member moves from one region to another region, billings for premiums shall be initiated on the next month with coverage effective the first day following the previous paid-through date. Transfers shall be made per the TRICARE Operations Manual (TOM), Chapter 22, Sections 1 and 2 and Chapter 25, Section 1.

1.2.8.1.3.2 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/TRR/TYA premium payments are not applicable to the FY catastrophic cap.

1.2.8.2 Enrollment Fee and Premium Payment Processing (For Enrollment Periods On or After October 1, 2012)

1.2.8.2.1 Prime Enrollment Fee Payment (For Enrollment Periods On or After October 1, 2012)

1.2.8.2.1.1 Enrollment fees may be paid monthly, quarterly, or annually. The beneficiary specifies this payment option during enrollment and the contractor shall enter the dollar amount received from the beneficiary in the Premium/Fee Interface or the Fee/CCD Web Research application. DEERS will calculate the policy paid period end date and return the information to the enrolling contractor. Contractors shall send the dollar amount of all subsequent enrollment fee transactions to DEERS within one business day. With the exception of claims recoupments and NSF fees, all monetary receipts from beneficiaries must be treated as premium/fee payments and be reported to DEERS as premium/fee payments, unless they are refunded to the beneficiary or forfeited by the beneficiary. The contractor's system shall be able to process fee refunds as necessary.

1.2.8.2.1.2 The contractor will send premium/fee payment information to DEERS through a system-to-system interface. This interface includes new payments and payment adjustments. DEERS will calculate the new paid period end date based on the amount submitted by the contractor. Contractors must correct and resubmit enrollment premium/fee payments rejected by

DEERS or research, correct and resubmit premium/fee payments for which DEERS has provided a warning within three business days of the error.

1.2.8.2.1.3 If applicable, DEERS will automatically apply fee transactions 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 family contribution towards the catastrophic cap. If the catastrophic cap is locked at the time the fee payment is sent, DEERS will reject the fee payment. The contractor shall resend the fee amount to DEERS daily until it is accepted. If the record remains locked longer than 48 hours, the contractor should contact the claims processor that placed the lock to determine the reason for the lock and when it will be released.

1.2.8.2.1.4 The Premium/Fee Interface performs edits against the submitted fee data. The contractor shall research and correct any data discrepancies identified by DEERS (both warnings and errors) within three business days.

1.2.8.2.1.5 DEERS calculates paid period end dates based on the premium/fee amounts collected and entered into DEERS by the contractor. It does not determine the date of the next premium/fee payment, send premium/fee payment due notifications, or identify which entity is responsible for premium/fee payments. These actions are the responsibility of the contractors. Additionally, the contractors must be able to accommodate policies that are less than 12 months in length, and collect only the enrollment fees due.

1.2.8.2.1.6 DEERS records both the enrollment fee payment date and the enrollment fee paid. The enrollment fee payment date reflects the date the fee was received by the contractor. The enrollment fee paid will be used by DEERS to calculate the paid period end date. DEERS includes the last fee information from the enrollee's policy on notifications to the contractors. DEERS calculates and reports credits to all policies.

1.2.8.2.1.7 Contractors must remove all existing credits on DEERS prior to the initialization of the new premium model. Credits not refunded to the beneficiary must be re-posted as a FY 2012 credit or a FY 2013 payment after initialization. Any credits remaining on or after October 1, 2012, must be removed from FY 2012 and either refunded to the beneficiary or posted as a payment for FY 2013. Effective October 1, 2012 and later, DEERS will not post credit amounts to the catastrophic cap.

1.2.8.2.2 Premium Payment Programs: TRS, TRR, and TYA (For Enrollment Periods On or After October 1, 2012)

1.2.8.2.2.1 For the TRS, TRR, and TYA programs, the contractor will enter into DEERS the premium amount collected for the policy and DEERS will calculate and return to the contractor the paid period end date.

1.2.8.2.2.2 Contractors are required to submit all premium payments collected to DEERS upon receipt. Contractors will refund all overpayments of premiums to the member at termination of coverage. In the event the member moves from one region to another region, billings for premiums shall be initiated the next month with coverage effective the first day following the previous paid period end date. Transfers shall be made per the TRICARE Operations Manual (TOM), [Chapter 22, Sections 1 and 2](#) and [Chapter 25, Section 1](#).

1.2.8.2.2.3 As with any other enrollment fee or premium payment, overpayments not refunded to the beneficiary are considered part of the fee or premium amount that must be reported to DEERS.

Note: TRS/TRR/TYA premium payments are not applied to the FY catastrophic cap.

1.2.8.3 Enrollment Fee Waivers

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

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

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

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

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

1.3.1 Addresses

DEERS receives address information from a number of source systems. Although most systems only update the residence address, DEERS actually maintains multiple addresses for each person. The contractor shall update the residential and mailing addresses through DOES or other DEERS applications (e.g., GIQD) whenever possible. These addresses shall not reflect unit, MTF, or MCSC addresses unless provided directly by the beneficiary. The mailing address captured on DEERS is primarily used to mail the enrollment card and other correspondence. The residential address is used to determine enrollment jurisdiction at the Zip Code level. DOES uses a commercial product to validate address information received online and from batch sources.

1.3.2 Telephone Numbers

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

1.3.3 E-mail Addresses

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

1.4 Notifications

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

1.4.1 Notifications Resulting From Enrollment Actions

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

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

During transfers in BWE, one non-pending disenrollment notification is sent to the losing contractor. There is no subsequent notification sent to the losing contractor when the enrollment information is confirmed in DOES. If the transfer is cancelled before the gaining contractor approves it, the losing contractor will receive a cancellation of the disenrollment.

1.4.2 Unsolicited Notifications

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

- Change to eligibility. As updates are made in DEERS that affect a beneficiary's entitlements to TRICARE benefits, DEERS modifies policy data based on those

changes and sends notifications to the contractor and to CHCS, if appropriate. One example of this type of notification is notification of loss of eligibility.

- Extended Eligibility. For example, in the case of a 21-year old child that shows proof of being a full-time student, eligibility may be extended until the 23rd birthday.
- SSN, name, and date of birth changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or date of birth are communicated via unsolicited notification to the contractor.
- Address changes. The notification also includes information as to which type of entity made the update. Address changes performed by CHCS are also sent to the contractor.
- Data corrections made by the DMDC Support Office (DSO) or the DOES Help Desk. If a contractor requests the DSO to make a data correction for a current or future enrollment that the contractor cannot make themselves, notification detailing the update is sent to the contractor, and to CHCS, if appropriate.
- Automatic approvals of BWE actions. DEERS will send unsolicited notifications for all BWE actions approved without contractor action in DOES.
- Fee waiver updates. Changes to an enrolled sponsor or beneficiary's fee waiver status will be sent via unsolicited notifications to the contractor.
- **Changes to premium information as a result of a premium or fee recalculation by DEERS.**

1.5 Patient ID Merge

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

1.6 Enrollment Cards And Letter Production

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

1.6.1 DEERS is responsible for producing the TRICARE universal beneficiary card for both Continental United States (CONUS) and Outside the Continental United States (OCONUS). The cards

are produced for beneficiaries enrolled in all TRICARE Prime programs or TRS. Enrollment cards are not produced for enrollments to USFHPs.

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

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

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

1.7 Claims, Catastrophic Cap, And Deductible Data

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

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

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

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

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

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

1.7.1 Data Events: Inquiries And Responses

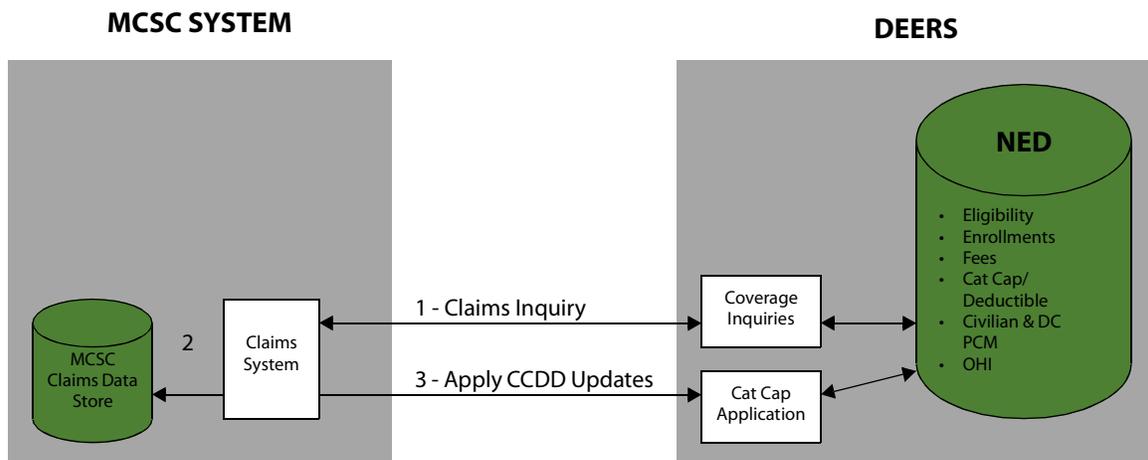
This section identifies the main events, including the inquiries and responses between the contractors and DEERS, associated with CCDD transactions. The main events to support processing this information include:

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

1.7.1.1 HCC Inquiry For Claims

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

FIGURE 3.1.4-8 CLAIMS INQUIRY TO DEERS



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

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

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

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

1.7.1.1.1 Exceptions To The DEERS Eligibility Query Process

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

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

1.7.1.1.2 Information Required For A HCC Inquiry For Claims

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

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

1.7.1.1.3 Person Identification

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

1.7.1.1.4 Inquiry Options: Person Or Family

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

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contractor shall select the correct person and resend the coverage inquiry.

FIGURE 3.1.4-9 INQUIRY PERSON TYPE CODE

PERSONS TO RETURN	WHAT INFORMATION IS AVAILABLE FROM THE CLAIM	VALUES TO SET	USAGE
RETURN ONLY A SINGLE SPONSOR/FAMILY MEMBER (PNF_TXN_TYP_CD = P)	SPONSOR INFORMATION IS PROVIDED (INQ_PN_TYPE_CD=S)	<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).

1.7.1.1.5 Inquiry Period

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

1.7.1.1.6 Lock indicator

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

1.7.1.2 Information Returned In The HCC Inquiry For Claims

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

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

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

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

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

Note: Newborn coverage information will only be reflected after the newborn is added to DEERS. See TOM, [Chapter 8, Section 1](#) and TPM, [Chapter 10, Section 3.1](#).

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

The DEERS coverage response will always return:

- Sponsor Personnel Information: All current personnel segments will be returned, including dual eligible segments. The contractor shall not use this information for claims processing. This information is intended to be used for the TED only.
 - Person information including the mailing address.
 - The residential zip code will be returned for jurisdiction purposes.
- CCDD totals: Both family and individual CCDD accumulations are provided in the coverage response.

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

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

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

1.7.1.2.3 HCC Copayment Factor For Coverage Inquiries

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

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

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

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

1.7.1.2.4 Special Entitlements

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

Examples are:

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

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

1.7.1.3 Multiple Responses To A Single HCC Inquiry for Claims

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

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

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

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

A list of key DSO personnel and the Joint Uniformed Services Personnel Advisory Committee (JUSPAC) and the Joint Uniformed Services Medical Advisory Committee (JUSMAC) Members is provided at the TMA web site at <http://www.tricare.osd.mil>. These individuals are designated by the TMA to assist DoD beneficiaries on issues regarding claims payments. In extreme cases the DSO may direct the claims processor to override the DEERS information; however, in most cases the DSO is able to correct the database to allow the claim to be reprocessed appropriately. The procedure the contractor shall use to request data corrections is in [Section 1.7](#).

Any overrides issued by the DSO will be in writing detailing the information needed to process the claim. Overrides cannot be processed verbally, and overrides are not allowed in cases where correction of the data is the appropriate action. Only in cases of aged data that can not be corrected will DSO authorize an override. The contractor will provide designated Point Of Contact (POC) for the DSO personnel and the JUSPAC/JUSMAC members identified on the TMA web site.

1.7.1.4 CCDD Totals Inquiry

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

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

1.7.1.4.1 Information Required To Inquire For Totals

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

1.7.1.4.1.1 Person Information

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

1.7.1.4.1.2 CCDD Totals Inquiry Period

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

1.7.1.4.1.3 Lock Indicator

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

1.7.1.4.2 Response To CCDD Totals Inquiry

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

1.7.1.4.2.1 CCDD Totals

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

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

1.7.1.4.2.2 Lock Information

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

- If a contractor inquires for totals with a request to lock and the totals were not already locked, DEERS would return the accumulated totals and the lock information, including the locking organization, the lock date, and the lock time.
- If an contractor inquires and requests a lock for a beneficiary whose totals are already locked, only the locking organization, the lock date, and the lock time will be returned. No totals will be returned in this situation.

1.7.1.5 Updating CCDD Amounts

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

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

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

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

1.7.1.5.1 Information Required To Update CCDD Amounts

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

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

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

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

1.7.1.5.2 Types Of CCDD Updates

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

1.7.1.5.2.1 Adds

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

1.7.1.5.2.2 Adjustments

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

1.7.1.5.2.3 The 48-Hour Rule

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

1.7.1.5.2.4 Add Newborn

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

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

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

1.7.2 CCDD Transaction History Request

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

1.8 SIT Program

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

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

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

Field users perform five actions with the SIT:

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

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

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

1.8.1 SIT Inquiry

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

1.8.2 SIT Add

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

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

1.8.3 SIT Update

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

1.8.4 SIT Add Cancellation

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

cancellations to all local holders of the SIT through the daily subscription process.

1.8.5 Validation Of HIC Information

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

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

1.8.6 Deactivation of a HIC

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

1.9 OHI

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

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

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

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

- Policy Identifier (policy number)
- OHI Effective Date
- HIPAA Insurance Type Code

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

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

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

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

Examples of OHI coverages are:

- Comprehensive Medical coverage (Plans with multiple coverage types)
- Medical coverage
- Inpatient coverage
- Outpatient coverage
- Pharmacy coverage
- Dental coverage
- Long-term care coverage
- Mental health coverage
- Vision coverage
- Partial hospitalization coverage
- Skilled nursing care coverage

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

In addition, each OHI policy carries a code indicating whether the policy is active, inactive, or deactivated. The deactivation of an OHI policy only occurs when the DoD VPOC at TMA deactivates

the HIC on the SIT. DEERS retains OHI policy data for five years after an OHI policy expires or is deactivated or terminated.

1.9.1 OHI Policy Inquiry

1.9.1.1 Person Identification For OHI Policy Inquiry

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

1.9.1.2 OHI Person Inquiry

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

1.9.1.3 OHI Information

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

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

1.9.1.4 Information Returned In The OHI Inquiry Response

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

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

1.9.2 OHI Policy Add

DEERS allows the MHS and contractor systems to add an OHI policy for a person when information is presented to them. An OHI Inquiry should be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Inquiry, the OHI data can be added as necessary. OHI data can be added during an enrollment via the DOES application. OHI can be updated any time after enrollment through the web application provided by DEERS, or through the system to system interface. The presence of an OHI Policy

discovered during routine claims processing shall be entered on DEERS within two business days. Within 15 business days, the contractor shall provide all OHI data not initially entered.

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

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

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

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

A person can have multiple types of OHI coverage for one policy. For example, to add an OHI policy that covers medical and vision, two OHI coverage types, one for medical coverage and one for vision coverage, would be sent to DEERS.

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

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

1.9.3 OHI Policy Update

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

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

1.9.4 OHI Policy Cancellation

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

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

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

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

1.10 Medicare Data

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

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

- END -

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Appendix A

Acronyms And Abbreviations

ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BH	Behavioral Health
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation

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BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)

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CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf

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CIF	Central Issuing Facility Common Intermediate Format
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMR	Cardiovascular Magnetic Resonance
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation

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CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive

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DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center

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DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders

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DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory

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EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy

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ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSO	Facility Security Officer
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year

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GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management

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HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with

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IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio

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INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base

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KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository

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MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®

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MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLCL	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard

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NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set

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OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier

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PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool

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PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine

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PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice

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RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder

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SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community

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SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol

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TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M

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TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation

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TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility

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UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	DEERS Online Enrollment System Web (application)
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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