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TRICARE  
MANAGEMENT ACTIVITY

PCSIB

CHANGE 38  
7950.2-M  
MAY 25, 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:** PHARMACY PROCESSES FOR CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) BENEFICIARIES

**CONREQ:** 15707

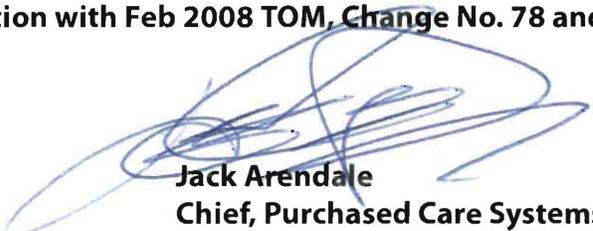
**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** The CHCBP Catastrophic Capitation and Deductible (CC&D) totals are maintained by the CHCBP contractor and are not available from the Defense Enrollment Eligibility Reporting System (DEERS). This modification will allow the pharmacy contractor to obtain and use CC&D information from the CHCBP contractor to calculate reimbursements of overpayments and charge appropriate copays.

**EFFECTIVE DATE:** November 4, 2009.

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

**This change is made in conjunction with Feb 2008 TOM, Change No. 78 and Feb 2008 TPM, Change No. 68.**

  
**Jack Arendale  
Chief, Purchased Care Systems  
Integration Branch**

**ATTACHMENT(S):** 17 PAGES  
**DISTRIBUTION:** 7950.2-M

**CHANGE 38**  
**7950.2-M**  
**MAY 25, 2012**

**REMOVE PAGE(S)**

**CHAPTER 3**

Section 1.4, pages 25 - 41

**INSERT PAGE(S)**

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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 TRICARE CC&D amounts
- Other Government Programs (OGP)

The contractor shall not override this data with information from other sources. **Continued Health Care Benefits Program (CHCBP) CC&D information shall be obtained from the CHCBP contractor.**

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

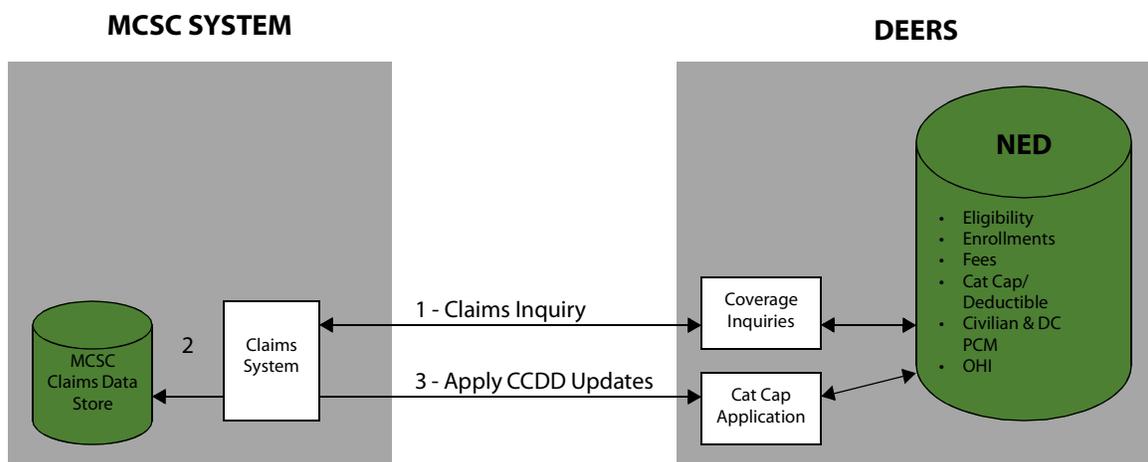
This section identifies the main events, including the inquiries and responses between the contractors and DEERS, associated with CCDD transactions. The main events to support processing this information include:

- 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

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DEERS Functions

Person Type Code is required to indicate if the SSN, Foreign ID, or Temporary ID is for the sponsor or family member. In such inquiries, DEERS returns both sponsor and family member information. If there is more than one person or family match, DEERS will return a partial match response. The contractor shall select the correct person and resend the coverage inquiry.

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

PERSONS TO RETURN	WHAT INFORMATION IS AVAILABLE FROM THE CLAIM	VALUES TO SET	USAGE
RETURN ONLY A SINGLE SPONSOR/FAMILY MEMBER (PNF_TXN_TYP_CD = P)	SPONSOR INFORMATION IS PROVIDED (INQ_PN_TYPE_CD=S)	<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.
- OGPs: Complete OGP information is provided in the response.

#### **1.7.1.2.3 HCC Copayment Factor For Coverage Inquiries**

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

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

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

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

#### **1.7.1.2.4 Special Entitlements**

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

Examples are:

- Special entitlement for participation in Operation Joint Endeavor. This code, when returned from a claims inquiry to DEERS, will waive or reduce the annual

deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the special entitlement section of the data returned.

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

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

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

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

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's 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 HCDDP.

#### **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 -

