

DEERS Functions In Support Of The TRICARE Dental Program (TDP)

1.0 OPERATIONAL POLICIES AND CONSTRAINTS

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

- Standard Provider, Payer, and Patient IDs will be used, as legislated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when these IDs are mandated for implementation.

2.0 SYSTEM DESCRIPTION

2.1 DEERS Operational Environment and Characteristics

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

2.1.1 Web Requirements

2.1.1.1 All Defense Manpower Data Center (DMDC) web-based applications require Microsoft® Internet Explorer (MSIE) 6.0 or higher using Hypertext Transfer (Transport) Protocol Secure (https). They are all government furnished equipment. Contractors shall plan for system upgrades consistent with ongoing Microsoft releases, which shall be coordinated with DMDC through the TRICARE Management Activity (TMA).

2.1.1.2 The contractor shall use the applications for their intended use only. The contractor shall not utilize screen scraping, html stripping, and any other technology or approach to manipulate or alter the intended use of the application or the application architecture.

2.1.1.3 The DEERS Online Enrollment System (DOES) supports enrollment activities and allows entry of fee information. DOES will show the last fee payment for an existing policy.

2.1.1.4 General Inquiry of DEERS (GIQD) is used for research and customer service to display demographics and coverage information. It also allows address updates.

2.1.1.5 The DEERS Claims Service (DCS) is used to determine benefit coverage for a given period. Contractors must use the DCS for all claims processing. It is not intended to populate data in the contractor's system for customer service or beneficiary self-service purposes.

2.1.1.6 The Fee Research Application supports research and updates to the history of enrollment fee payment transactions posted to DEERS and stored on-line (two future, current plus previous four fiscal years).

2.1.1.7 The Security application is used by the TDP Site Security Managers (SSMs) to establish users and grant access to applications and other privileges. The TDP contractor is responsible for designating a primary SSM and one backup to manage all users and their access to DEERS applications. The appointed SSM and alternate are required to complete an on-line training certification at initial appointment and yearly thereafter. All SSMs are required to remove access to all DEERS systems immediately upon departure of an employee.

2.1.1.8 The DMDC Support Office (DSO) Web Request (DWR) application is used by the TDP to report potential data problems or request historical enrollment corrections that cannot be completed in DOES.

2.1.1.9 The DEERS Enrollment Reports application provides a number of reports at different intervals. These include:

- Enrollment and disenrollment reports.
- Management reports for fees.

2.1.2 System Maintenance/Downtime

See Section 1.3, paragraph 2.2.2, for System Maintenance/Downtime information for all TRICARE contractors.

2.1.3 DEERS System to System Interface/Interactions

See Section 1.3, paragraph 2.2.3, for DEERS System to System Interfaces/Interactions.

2.2 DEERS Major System Components

See Section 1.3, paragraph 2.3, for DEERS Major System Components.

2.3 External Systems

See Section 1.3, paragraph 2.4, for External System information.

2.4 Data Sequencing

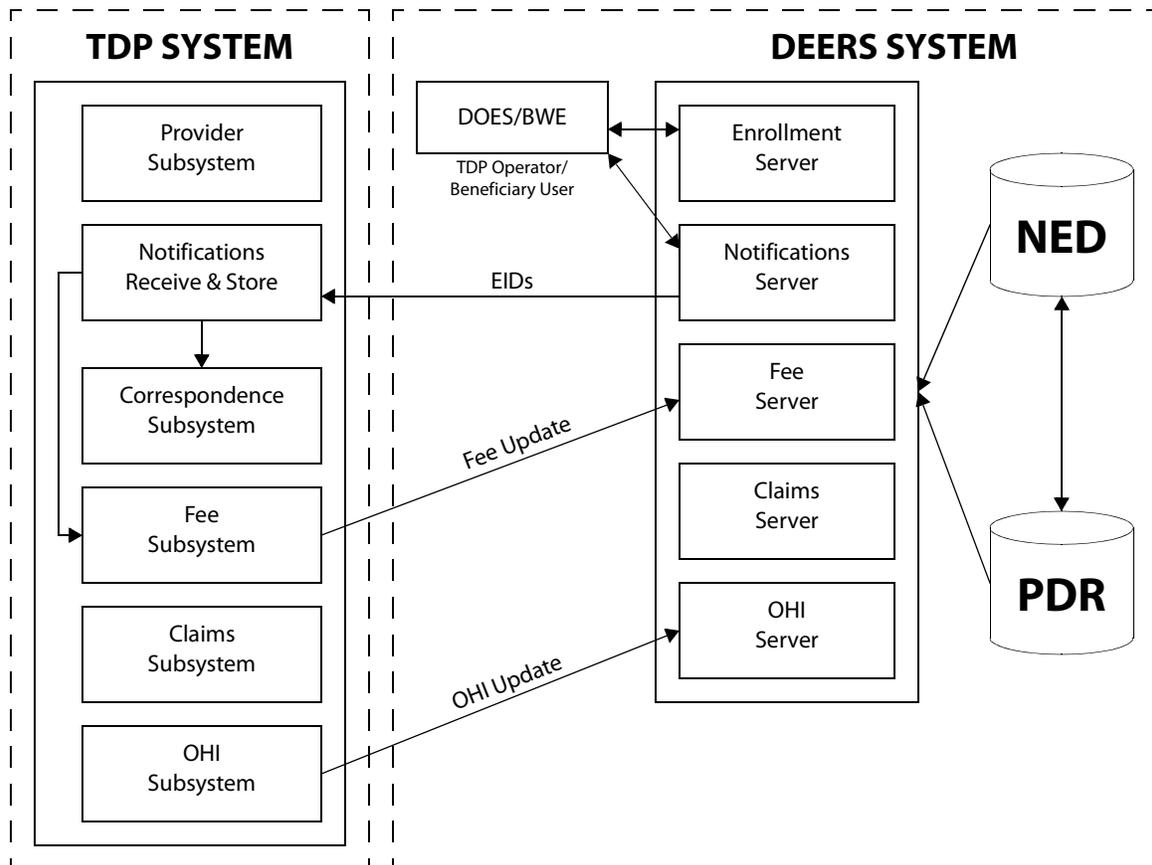
See Section 1.3, paragraph 2.5, for Data Sequencing information.

3.0 DEERS FUNCTIONS

As the person-centric centralized data repository of DoD personnel and medical data and the National Enrollment Database (NED) for the portability of the Military Health System (MHS) worldwide TRICARE program, DEERS is designed to provide benefits eligibility and entitlements, TRICARE enrollments, and claims coverage processing.

This chapter will detail the events to verify eligibility, perform enrollments, perform a claims inquiry, and the associated updates of address information, enter fees, Other Health Insurance (OHI), and the Standard Insurance Table (SIT). The expected data stores for the contractor are illustrated in Figure 3.1.5-1. Deviation from the intended concept of operations between the contractor and DEERS shown in the figure below is at the contractor's technical and financial risk.

FIGURE 3.1.5-1 DEERS CLAIMS INTERACTION - TRICARE DENTAL PROGRAM (TDP)



3.1 Partial Match

A partial match response may be returned for any inquiry where sufficient identification information is not provided (person ambiguity). There will be a separate listing for each person or family matching the requested Social Security Number (SSN) or DoD Benefits Number (DBN). The listing includes the sponsor and family member identification information needed to determine the correct beneficiary or family including the DEERS ID, the Patient ID, or possibly both. The requesting organization must select which of the multiple listings is correct based on documents or information at hand. After this selection, the requesting organization would use the additional information returned (e.g., Date Of Birth (DOB), Name) "to resend the inquiry."

3.2 Health Care Delivery Program (HCDP) Eligibility and Enrollment

The rules for determining a beneficiary's entitlement to dental benefits are applied by rules-based software within DEERS. DEERS is the sole repository for these DoD rules, and no other eligibility determination outside of DEERS is considered valid. Whenever data about an individual sponsor or a family member changes, DEERS reapplies these rules. DEERS receives daily, weekly, and monthly updates to this data, which is why organizations must query DEERS for eligibility information before taking action. This ensures that the individual is still eligible to use the benefits and that the contractor has the most current information.

A beneficiary who is considered eligible for DoD TDP benefits in accordance with [32 CFR 199.13](#) is required to enroll for TRICARE dental benefits. If an authorized organization inquires about that beneficiary's eligibility, DEERS reflects if he or she is eligible to use the benefits.

3.2.1 Enrollment-Related Business Events

Enrollment related business events include:

3.2.1.1 Eligibility for enrollment identifies current enrolled coverage plans and eligibility for enrollment into other coverage plans.

3.2.1.2 New enrollments are used for enrolling eligible sponsors and family members into a HCDP coverage plans or for adding family members to an existing family policy. Enrollments begin on the date specified by the enrolling organization and extend through the beneficiaries' end of eligibility for the HCDP. New enrollments may also perform the following functions:

- Update address, e-mail address, and/or telephone number
- Record that the enrollee has OHI

3.2.1.3 Modifications of the current enrollment (updates) are used to change some information in the current enrollment plan. Modifications of the current enrollment include the following functions:

- Change enrollment begin date
- Cancel enrollment/disenrollment
- Change prior enrollment end date
- Change prior enrollment end reason
- Request an enrollment card replacement
- Add OHI information for an enrollee
- Request a replacement letter for disenrollment

3.2.1.4 Enrollment fee payments are used to indicate payment of enrollment fees. The Fee Web Research is used to view and update this detailed information for a specified policy.

3.2.1.5 Disenrollments are used to terminate the specified beneficiary's enrollment. Disenrollments are used for disenrolling a beneficiary only when he or she has lost eligibility, voluntarily disenrolls (e.g., chooses not to re-enroll) or involuntarily disenrolls (e.g., fails to pay enrollment fees).

3.2.1.6 DOES will display the last enrollment fee payment that applies to the policy.

3.2.2 Defense Online Eligibility And Enrollment System (DOES)

3.2.2.1 WebDOES is a full function Government Furnished Equipment (GFE) application developed by 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 TDP is required to perform enrollment related functions through DOES, including:

- Enrollment
- Disenrollment
- Enrollment Period Change
- Enrollment End Reason Code Change
- Enrollment/Disenrollment Cancellation
- Enrollment Fee Payment
- Beneficiary Update
- OHI Add
- Confirm Enrollment (to support beneficiary web enrollment)
- Request new or replacement enrollment ID card

3.2.2.2 DOES will display the last enrollment fee payment for the policy.

3.2.2.3 The DOES application meets the HIPAA guidelines for a direct data entry application, and is data-content compliant for enrollment and disenrollment functions.

3.2.3 Beneficiary Self-Service Enrollment

3.2.3.1 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
- Address update
- Disenrollment
- Limited cancellation events
- Submit an initial enrollment application
- Add limited OHI
- Request replacement enrollment card
- Fee Payment

3.2.3.2 The web application contains checks for beneficiary eligibility and hard edits requiring the beneficiary to fulfill established DEERS business rules and enrollment criteria. DEERS will send an Enrollment Information for Dental (EID) for the completed enrollment. The contractor 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.

3.2.4 Eligibility For Enrollment

The DoD provides assigned HCDPs and plans when a person joins the DoD. DEERS determines coverage plans for which a beneficiary is eligible to enroll by using the DoD-assigned coverage in conjunction with additional eligibility information. The Eligibility for Enrollment Inquiry in DOES is used to view a person's or family's eligibility to enroll.

Note: The Eligibility For Enrollment Inquiry in DOES should not be used for other eligibility determinations.

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 dental benefits in accordance with [32 CFR 199.13](#).

3.2.5 Enrollment

3.2.5.1 Enrollment in TDP is optional.

3.2.5.1.1 Enrollments are at the individual and/or family level, depending on the number of family members enrolled and/or the status of the sponsor. 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 receipt of the EID for the plan change.

3.2.5.1.2 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, TDP for family members requires the following data elements:

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

3.2.5.1.3 Enrollments may be backdated up to 18 months.

3.2.5.1.4 Initial enrollment policies are established for a 12 month period. Enrollment premiums are paid on a monthly basis. After the initial 12 month period, the enrollment may be continued on a month to month basis.

3.2.5.2 Enrollment Fees

The contractor shall collect enrollment premiums for the initial 12 month enrollment period. Enrollment premiums shall be collected for each month of continuous enrollment following the initial enrollment period.

3.2.5.2.1 Monthly enrollment fees must be paid through an allotment from a military pay account or through Electronic Funds Transfer (EFT) from the enrollee's designated financial institution.

3.2.5.2.2 TDP enrollees who elect the monthly fee payment option must pay the first month's installment at the time the enrollment application is submitted to allow time for the allotment or EFT to be established. The contractor shall accept payment of the first month's installment by personal check, cashier's check, traveler's check, money order, or credit card (e.g., Visa/MasterCard).

3.2.5.2.3 The contractor shall be responsible for verifying the information necessary to initiate monthly allotments and EFTs.

3.2.5.2.4 The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT.

3.2.6 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.

3.2.6.1 Disenrollment - Loss Of Eligibility

A loss of eligibility refers to any loss or change in eligibility for TRICARE dental benefits in accordance with the current [32 CFR 199.13](#) or additional legislation authorizing benefits. At the time of enrollment, DEERS provides the end of eligibility date to the contractors via the EID. If that end date does not change, DEERS will provide no additional EIDs. If the end date changes, DEERS will provide another EID with the new end date. DEERS also cancels any future actions for that beneficiary, including future enrollments.

3.2.6.2 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.

3.2.6.3 Disenrollment - Voluntary

An enrollee may choose to terminate his or her current enrollment prior to the end date. If voluntary disenrollment occurs prior to the end of the initial 12 month enrollment period, the beneficiary incurs a 12 month lockout. Contractors must set the lockout manually, and may cancel the lockout and disenrollment in accordance with established administrative procedures. This transaction is performed in DOES. DEERS then terminates the enrolled coverage plan for the beneficiary. If additional systems need notification of the disenrollment, DEERS sends

disenrollment EIDs as necessary, notifying them of the termination of coverage benefits.

3.2.6.4 Disenrollment - Involuntary

3.2.6.4.1 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.

3.2.6.4.2 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.

3.2.6.4.3 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 | DEERS (UNSOLICITED) |
|------------------------------------|------|-------------------|---------------------------------|---------------------|
| Enrollment | X | X | | |
| Enrollment Cancellation | X | X (if pending) | | |
| Disenrollment | X | X | X (failure to pay fees only) | X |
| Disenrollment Cancellation | X | | | |
| Modify Enrollment Begin Date | X | | | X |
| Modify Prior Enrollment End Date | X | | | X |
| Modify Prior Enrollment End Reason | X | | | X |

3.2.7 Modification Of Enrollment

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

3.2.7.1 Enrollment Period Change

3.2.7.1.1 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.

3.2.7.1.2 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 policy changes to the appropriate systems managing the enrollment.

3.2.7.2 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.

3.2.7.3 Enrollment/Disenrollment Cancellation

3.2.7.3.1 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 will be reinstated if there was a contiguous change of plan (family to individual).

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

3.2.8 Enrollment Fees

DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment year in DOES. DEERS provides a number of applications to support enrollment-fee-related transactions:

- Enrollment Fee Payment (Fee/Web Research application and Fee Interface)
- Terminate Policy For Failure To Pay Fees (DOES and Fee Interface)

3.2.8.1 Enrollment Fee Payment

3.2.8.1.1 Enrollment fees are paid on a monthly basis. 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, 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.

3.2.8.1.2 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.

3.2.8.1.3 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.

3.2.8.1.4 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.

3.2.8.2 Fee Payments Interface

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.

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

3.3.1 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 in DEERS, whenever possible. **If the contractor cannot determine a valid address, the contractor shall update the Mail Delivery Quality Code (MDQC) in DEERS to prevent future mailings to that address (see Section 1.4, paragraph 1.3.1, Addresses).** These addresses shall not reflect unit, Military Treatment Facility (MTF), or TDP contractor 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. DEERS uses a commercial product to validate address information received online and from batch sources.

3.3.2 Telephone Numbers

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

3.3.3 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.

3.4 Notifications (EIDs)

Notifications (EIDs) are sent to the 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 (EIDs) 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 application or use of information contained in notifications sent from DEERS is determined by the Government and shall not be used to build beneficiary history. The following information details examples of events that trigger DEERS to send notifications to a contractor.

3.4.1 Notifications (EIDs) Resulting From Enrollment Actions

DEERS sends notifications (EIDs) 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.

3.4.2 Unsolicited Notifications (EIDs)

Unsolicited notifications (EIDs) 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. 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 DOB changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or DOB are communicated via unsolicited notification to the contractor.
- Address changes. The notification also includes information as to which type of entity made the update. Address changes performed by Composite Health Care System (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.

3.5 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. DEERS merges OHI by assigning the last updates of OHI active policies (not cancelled or systematically terminated) to the remaining Patient ID.

3.6 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. The return address on the envelope mailed by DMDC will be that of the TDP contractor and will also include the statement: "Address Service Requested". The contractor will be responsible for paying the United States Postal Service (USPS) for this service. **If the contractor cannot determine a valid address, the contractor shall update the MDQC in DEERS to prevent future mailings to that address (see Section 1.4, paragraph 1.3.1, Addresses).**

3.6.1 DEERS is responsible for producing the TRICARE dental card for both Continental United States (CONUS) and Outside the Continental United States (OCONUS).

3.6.2 New enrollment cards are automatically sent upon a new enrollment 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 an EID to the contractor indicating the last date an enrollment card was generated for the enrollee.

3.6.3 DEERS also sends a letter to a beneficiary upon disenrollment. 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.

3.7 Claims Data

3.7.1 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 Information

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

3.7.1.2 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.

3.7.1.3 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.

3.7.2 Data Event: Inquiry And Response

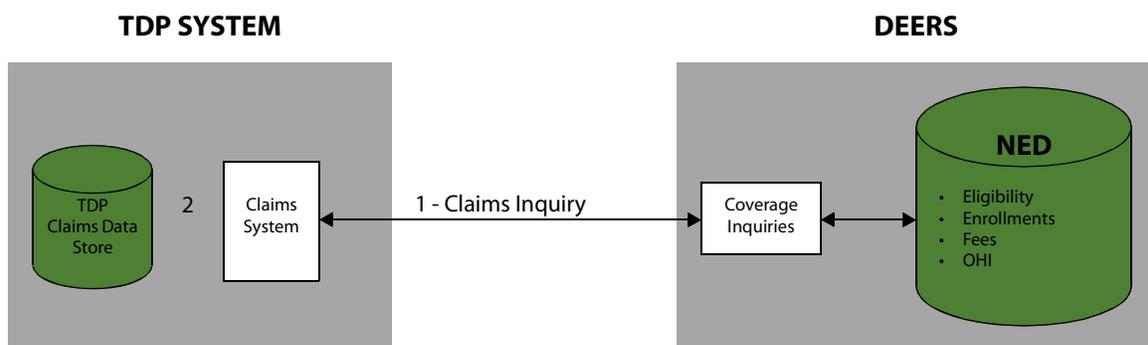
This section identifies the main events, including the inquiries and responses between the contractors and DEERS. The main event to support processing this information includes:

- DEERS Claims Web Service (DCWS) Inquiry for Claims

3.7.2.1 DCWS 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 DCWS Inquiry for Claims supports business events associated with DCWS data for processing dental claims. This inquiry may also be used for general customer service requests or for predeterminations.

FIGURE 3.1.5-2 CLAIMS INQUIRY TO DEERS



The contractor must use the eligibility and enrollment information returned on the DEERS response to process the claim. The contractor may use address information from any source but must update DEERS with any differing information within two business days if the information is more current.

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 Operations Manual (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.

3.7.2.1.1 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. 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

3.7.2.1.2 Information Required For A DCWS 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

3.7.2.1.3 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.

3.7.2.1.4 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, DBN, 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 3.1.5-3 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).

3.7.2.1.5 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.

3.7.2.2 Information Returned In The DCWS 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 transactions for the claim. In addition, the Patient ID is returned in the coverage response. The contractor shall also store the Patient ID for use in subsequent transactions.

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.

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

In response to a DCWS 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 (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.

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

3.7.2.2.2.1 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.
- Person information including the mailing address.
- The residential zip code will be returned for jurisdiction purposes.

3.7.2.2.2.2 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.

- OHI: Limited OHI information is returned.

3.7.2.2.3 DCWS Copayment Factor For Coverage Inquiries

3.7.2.2.3.1 The DCWS 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.

3.7.2.2.3.2 The different factors are determined by legislation, which considers factors such as pay grade. Although the rates are based on the population to which they pertain, these rates also apply to a sponsor's family members. Examples of cost-share factors are:

- Pay Grade E-1 to E-4
- Pay Grade E-5 and above
- Command Sponsored

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

3.7.2.2.4 Special Entitlements

Congressional legislation may affect 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. An example of a Special Entitlement plan is the Survivor Benefit Plan.

3.7.2.3 Multiple Responses To A Single DCWS Inquiry for Claims

3.7.2.3.1 DEERS may need to send multiple responses to a single DCWS 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.

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

3.7.2.3.3 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.

3.7.2.3.4 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](#).

3.7.2.3.5 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.

3.8 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 and dental 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.

3.8.1 SIT Inquiry

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

3.8.2 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."

3.8.3 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."

3.8.4 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.

3.8.5 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.

3.8.6 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.

3.9 OHI

OHI identifies non-DoD health insurance held by a beneficiary. The requirements for OHI are

validated by the TMA 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 (LTC) 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 TDP contractor must develop the OHI within 15 days but is not responsible for development of medical or pharmacy. The medical or pharmacy contractors are expected to develop medical or 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.

3.9.1 OHI Policy Inquiry

3.9.1.1 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.

3.9.1.2 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.

3.9.1.3 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.

3.9.1.4 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.

3.9.2 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 medical or pharmacy contractors, regardless of which organization created the placeholder. Dental placeholder policies will be developed by the TDP 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.

3.9.3 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.

3.9.4 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

3.10 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 Other Government Programs (OGPs) 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 -