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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 40
7950.2-M
JUNE 8, 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: MAIL DELIVERY QUALITY CODE (MDQC)

CONREQ: 15806

PAGE CHANGE(S): See page 2.

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

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

This change is made in conjunction with Feb 2008 TOM, Change No. 79 and Feb 2008 TPM, Change No. 69.


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ATTACHMENT(S): 40 PAGES
DISTRIBUTION: 7950.2-M

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CHAPTER 3

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

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

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

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

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

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

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

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

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

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

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

1.2.8.3 Enrollment Fee Waivers

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

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

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

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

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

1.3.1 Addresses

1.3.1.1 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. These addresses shall not reflect unit, MTF, or MCSC addresses unless provided directly by the beneficiary. The mailing address captured on DEERS is primarily used to mail the enrollment card and other correspondence. The residential address is used to determine enrollment jurisdiction at the Zip Code level. DEERS uses a commercial product to validate address information received online and from batch sources.

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

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

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

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

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

1.3.2 Telephone Numbers

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

1.3.3 E-mail Addresses

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

1.4 Notifications

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

1.4.1 Notifications Resulting From Enrollment Actions

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

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

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

1.4.2 Unsolicited Notifications

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

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

1.5 Patient ID Merge

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

1.6 Enrollment Cards And Letter Production

The contractor is responsible for processing all mail returned for bad addresses and shall research the address, correct it on DEERS, and re-mail the correspondence to the beneficiary. **If the contractor cannot determine a valid address, the contractor shall update the MDQC in DEERS to prevent future mailings to that address (see paragraph 1.3.1, Addresses).**

1.6.1 DEERS is responsible for producing the TRICARE universal beneficiary card for both Continental United States (CONUS) and Outside the Continental United States (OCONUS). The cards are produced for beneficiaries enrolled in all TRICARE Prime programs or TRS. Enrollment cards are not produced for enrollments to USFHPs.

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

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

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

1.7 Claims, Catastrophic Cap, And Deductible Data

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

record for:

- Person Identification
- Eligibility
- Enrollment and PCM information
- Enrollment and FY to date totals for 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:

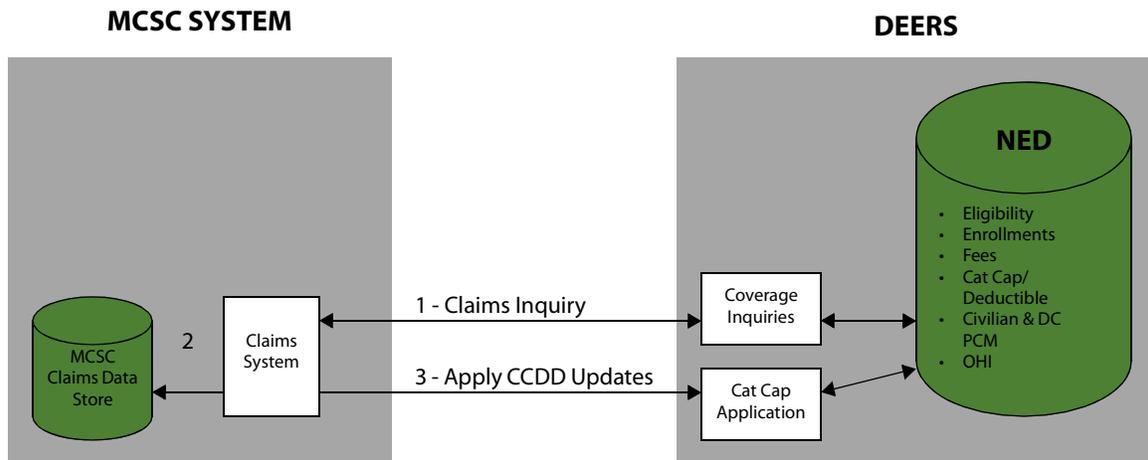
- HCC Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

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 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.
- OGP: Complete OGP information is provided in the response.

1.7.1.2.3 HCC Copayment Factor For Coverage Inquiries

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

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

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

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

1.7.1.2.4 Special Entitlements

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

Examples are:

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

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

1.7.1.3 Multiple Responses To A Single HCC Inquiry for Claims

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

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

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

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

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

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

1.7.1.4 CCDD Totals Inquiry

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

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

1.7.1.4.1 Information Required To Inquire For Totals

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

1.7.1.4.1.1 Person Information

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

1.7.1.4.1.2 CCDD Totals Inquiry Period

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

1.7.1.4.1.3 Lock Indicator

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

1.7.1.4.2 Response To CCDD Totals Inquiry

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

1.7.1.4.2.1 CCDD Totals

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

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

1.7.1.4.2.2 Lock Information

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

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

1.7.1.5 Updating CCDD Amounts

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

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

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

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

1.7.1.5.1 Information Required To Update CCDD Amounts

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

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

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

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

1.7.1.5.2 Types Of CCDD Updates

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

1.7.1.5.2.1 Adds

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

1.7.1.5.2.2 Adjustments

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

1.7.1.5.2.3 The 48-Hour Rule

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

1.7.1.5.2.4 Add Newborn

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

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

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

1.7.2 CCDD Transaction History Request

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

1.8 SIT Program

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

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

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

Field users perform five actions with the SIT:

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

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

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

1.8.1 SIT Inquiry

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

1.8.2 SIT Add

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

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

1.8.3 SIT Update

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

1.8.4 SIT Add Cancellation

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

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

1.8.5 Validation Of HIC Information

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

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

1.8.6 Deactivation of a HIC

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

1.9 OHI

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

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

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

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

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

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

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

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

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

Examples of OHI coverages are:

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

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

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

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

1.9.1 OHI Policy Inquiry

1.9.1.1 Person Identification For OHI Policy Inquiry

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

1.9.1.2 OHI Person Inquiry

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

1.9.1.3 OHI Information

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

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

1.9.1.4 Information Returned In The OHI Inquiry Response

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

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

1.9.2 OHI Policy Add

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

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

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

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

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

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

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

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

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

1.9.3 OHI Policy Update

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

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

1.9.4 OHI Policy Cancellation

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

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

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

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

1.10 Medicare Data

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

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

- END -

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

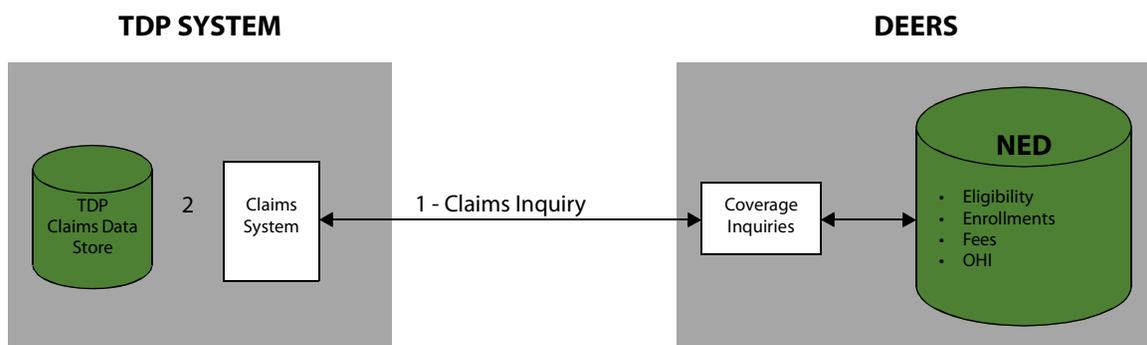
This section identifies the main events, including the inquiries and responses between the contractors and DEERS. The main event to support processing this information includes:

- 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.

3.2.9.3 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.

3.2.9.4 Disenrollment – Notification of Appropriate Systems

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

	WebDOES	DEERS (UNSOLICITED)
Enrollment	X	
Enrollment Cancellation	X	
Disenrollment	X	X
Disenrollment Cancellation	X	
Modify Enrollment Begin Date	X	X
Modify Prior Enrollment End Date	X	X
Modify Prior Enrollment End Reason	X	X

3.2.10 Modification Of Enrollment

WebDOES will be notified whenever there is a modification to an enrollment.

3.2.10.1 Change in Coverage

When a sponsor’s eligibility changes, requiring a move from one coverage plan to another, DEERS will automatically generate the disenrollment from the current plan and enrollment into the appropriate new plan. For example, when a reserve sponsor on active duty enrolled in RADDP coverage plan is released to the Selected Reserve, the sponsor will be disenrolled from RADDP coverage plan and enrolled into the appropriate TDP coverage plan if applicable.

When a sponsor’s eligibility changes to cause a move from one program to another program, DEERS will disenroll the sponsor from the first program. The sponsor must then initiate enrollment in the second. For example, if an active duty sponsor enrolled in RADDP is gained to the Selected Reserve, the sponsor will be disenrolled from the RADDP coverage plan and must submit an enrollment form for a new TDP coverage plan to continue.

3.2.10.2 Enrollment Period Change

This event is used to update an enrollee’s begin or end date. Modifications can only be performed by DEERS or the enrolling organization managing the enrollment. The enrollment end date may only be changed 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. The enrollment period can only be changed for the policy currently in effect or to a future enrollment.

When changing the enrollment period, the dates must not precede the beginning of eligibility or exceed the end of eligibility. If a person's eligibility in DEERS changes and affects an enrollment because the eligibility period is less than originally stated or an update to a medical TPR coverage plan, DEERS will update the RADDP enrollment period.

3.2.10.3 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 using the WebDOES application.

3.2.10.4 Enrollment/Disenrollment Cancellation

3.2.10.4.1 DEERS will accept enrollment cancellations with appropriate reason code by changing the enrollment period. Enrollment cancellations can only be performed by the enrolling organization through the WebDOES application. The enrollment can only be cancelled for the coverage plan currently in effect.

3.2.10.4.2 Disenrollment cancellations can only be performed by the entity that performed the disenrollment through the WebDOES application, and the disenrollment cancellation can only be performed for the last enrollment period. Upon receiving a disenrollment cancellation, DEERS will reinstate the original enrollment period.

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, MTF, or ADDP 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 medical enrollment jurisdiction at the zip code level. **DEERS** uses a commercial product to validate address information received online and from batch sources.

Note: Changing an ADSM's residence address will not cause an automatic disenrollment. DEERS will not disenroll an ADSM from RADDP based on an address update.

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 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 ADDP 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).**

3.4.1 DEERS is responsible for producing and mailing the TRICARE dental card for the RADDP ADSMs.

3.4.2 New enrollment cards are automatically sent upon a new enrollment unless the enrollment operator specifies in WebDOES not to send an enrollment card. A contractor may request a replacement enrollment card for a RADDP ADSM at any time via WebDOES.

3.4.3 DEERS also sends a letter to a beneficiary upon disenrollment. If an ADSM has been disenrolled within the past 18 months, a disenrollment letter may be regenerated upon request through WebDOES. The contractor shall not send additional letters that duplicate those already provided by DEERS.

3.5 Claims Data

3.5.1 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

3.5.1.1 The contractor shall not override this data with information from other sources, with the exception of a DSPOC determination. The contractor can contact the DSPOC to verify eligibility for those individuals who are indicated on DEERS as not eligible (e.g., not on active duty but who may have a LOD condition, FFM). DSPOC's are the final decision authority for eligible ADSMs.

3.5.1.2 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. If a change of address is noted, the contractor shall validate that the change has been made in DEERS, if it hasn't then the contractor shall submit the update through WebDOES.

3.5.2 Data Event: Inquiry And Response

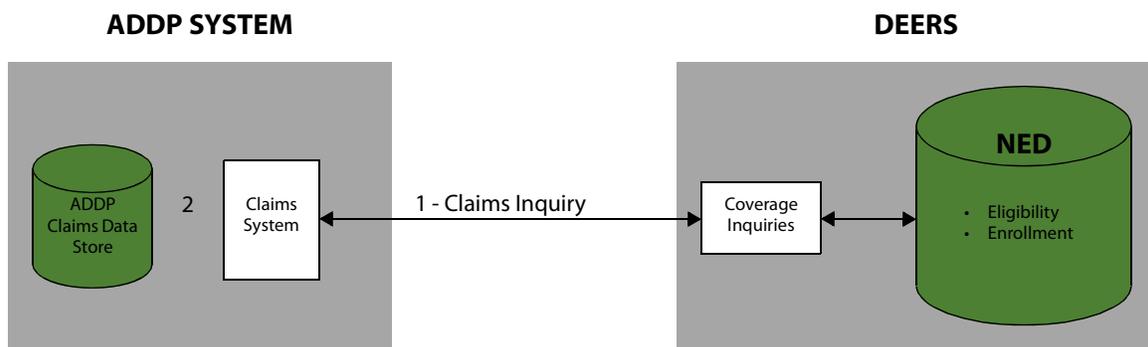
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The contractor shall install a prepayment eligibility verification system into its TRICARE operation that results in a query against DEERS for TRICARE claims and adjustments. The interface should be conducted early in the claims processing cycle to 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 3.1.6-1 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 as stated in [paragraph 3.5.1.2](#).

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), Chapter 2.

Unless authorized by the contracting officer, the contractor may not bypass the query/response process. If either DEERS or the contractor is down for more than 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.

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Appendix A

Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

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