Standard Insurance Table

and

Other Health Insurance

Business Rules

Version 2.5

TRICARE/Uniform Business Office

Revised: February 2008

Contents

Section **Page**

1.0 Objective

The purpose of these functional Business Rules is to ensure data quality by providing guidance in relation to data entry and data selection. With the new Standard Insurance Table and Other Health Insurance (SIT/OHI) Conversion, there is Global and bi-directional access between the Defense Eligibility Enrollment Reporting System (DEERS) and the Composite Health Care System (CHCS). New and expanded fields, along with newly created descriptors (Coverage Types), will support a more accurate picture of the Military Health System's (MHS) third party collections. User Actions and VPOC Options are also included to provide an overall view of the bi-directional access to DEERS.

2.0 General Rules for Health Insurance Carrier (HIC) Entry

1. When entering information for the SIT, please be sure that it is accurately entered to maintain data quality.

2. When entering a HIC (Health Insurance Carrier) do NOT include punctuation marks; i.e., periods, commas, hyphens or any symbols such as #, @,&, etc.

   Please note: A&I Benefit Plan, A&IOR0001, is the "grandfathered" exception. When the SIT was converted to DEERS, that SIT Short Name was loaded as a HIC ID.

3. The Health Insurance Carrier (HIC) ID is automatically assigned by DEERS when a request to add a new insurance company is received by DEERS. The HIC ID is based on the following convention: the first three (3) characters of the insurance company name, the two (2) character State or Country Code, and four (4) sequential numbers assigned by DEERS – for a total of nine (9) alpha numeric code.

   For Example, the HIC ID for the first Aetna entered into DEERS with a Virginia address is "AETVA0001."

   *** WHEN ADDING A NEW HEALTH INSURANCE CARRIER **ALWAYS** SPELL OUT THE ENTIRE NAME. This is important because whatever you enter as the first three letters of the insurance company name will become the first three characters of the HIC ID.

   There are some HIC IDs on the legacy system derived from acronyms, i.e., BCBS; however, in an effort to develop better data quality, DO NOT use acronyms when entering insurance company names.

   If you have a question about how to enter an insurance company name, please contact the VPOC (verification point of contact).

4. The “Point of Contact (POC)” on the DEERS HIC enter/edit screen and the “Last Update User Name” on the CHCS screen, is the person entering the data, not a Point of Contact at the insurance company.

   Note: On the CHCS HIC enter/edit screen, the “Last Update System Name” and the “Last Update User Name” is defaulted. You are required to enter your telephone number and your e-mail address before your request to add or update an insurance carrier will be sent to DEERS.

   The VPOC must be able to contact you. Please provide a valid telephone number and email address. Do not use the DSN. If the POC cannot be contacted, the entry will probably be rejected and the associated OHI will be terminated. (See rejected SITs later.)

   Managed Care Support Contractors must have a valid telephone number and provide a knowledgeable contact, should the person who entered the data not be available.

5. Enter the MTF site in the Local Comment Field. You may also include any additional telephone numbers for the insurer/payer, or other information that you would like to communicate to the VPOC. The VPOC will transfer that information into the Standard comment field for global communication. Standard Comments are distributed to all MTFs in the SIT Subscription. (Discussed later).

6. Entry of a valid Insurance Company telephone number is required. Try the number that is currently listed before entering another number. If it is not the right telephone number, try an Internet search using Google or any other publicly available search engine. Do not make up a number for this required field. A random number may pass system edits but it will not be accepted as a valid telephone number by the VPOC. An invalid telephone number may result in the SIT ADD being rejected by the VPOC.

7. Do not enter any insurance companies into CHCS that are billed only under MAC (Medical Affirmative Claim). MAC must continue to be manually entered in TPOCS, following service specific guidelines. MSA billing practices have not changed.

8. Do not enter JAG offices as Health Insurance Carriers. CHCS has a separate menu option under the Standard Insurance Company Maintenance option (STM) to enter/edit Attorneys.

9. When adding an insurer/payer from a different state to support out-of-state claims, the Attention line should include, “Out of State Claims”. The State code where the services were rendered becomes part of the HIC_ID.

   EXAMPLE:

   HIC Name: Blue Cross of Michigan
   Place of Service: Virginia
   HIC_ID: BLUVA 0001
   Attention Line: Out of State Claims

2.1 HIC Coverage Type Codes and HIC Payer Type Codes

HIC Coverage Types, in combination with HIC Payer Types define claims addresses.

HIC Coverage Type Codes: (Most commonly used are in boldface)

XM = Comprehensive Medical
MD = Medical Only
RX = Pharmacy
DN = Dental
VI = Vision
IP = Inpatient
OP = Outpatient
MH = Mental Health
LT = Long Term Care
SN = Skilled Nursing
PH = Partial Hospitalization

HIC Payer Type Codes:
B = Both Institutional and Professional (default)
I = Institutional Only
P = Professional Only
N = Non-billable

IMPORTANT: A HIC Coverage Type Code never stands alone – it is always considered in combination with the HIC Payer Type Code with which it is linked.

Rules for assigning HIC Coverage Type/HIC Payer Type Codes:

1. A HIC Coverage Type/Payer Type combination should be entered for each unique claims address for an insurance company + state code.

2. When selecting a HIC Coverage Type/HIC Payer Type to assign to a HIC ID, select the address which is applicable to the HIC ID, as opposed to being concerned about the HIC Coverage Type name.

3. The HIC Coverage Type(s)/Payer Type(s) assigned to a HIC ID should describe the types of claims to be sent to the address, but the name of the Coverage Type is less important than the address and attention line.

4. If the claims address supports multiple claim types, use the HIC Coverage Type Code “XM”.

5. If the claims address supports a specific service (i.e. Pharmacy only or Vision only) and no other claim types are accepted or processed at that address, use the HIC Coverage Type/HIC Payer Type Code combination that best describes the services processed at that address.

Example: PBM Caremark pays only pharmacy claims and thus should only have an “RX” Coverage Type Code.

2.2 Pharmacy Options

There are two (2) methods to enter Pharmacy into the Standard Insurance Table:

1. As a Coverage Type Code under an existing HIC_ID.

   First Choice as the carrier, with Pharmacy under the HIC_ID and a Coverage type of RX

   HIC_ID FIRPA0001
   HIC Name First Choice
   Coverage Types: XM Comprehensive Medical
   123 Capital Street
   Harrisburg, PA 19114

   RX Pharmacy
   658 Marymount Ave
   Hershey, PA

2. The Pharmacy Benefit Manager (PBM) as a new carrier with a new HIC_ID.

   New HIC_ID such as Caremark, Express Scripts (Pharmacy Benefit Manager)

   HIC_ID: CARAZ0001
   HIC Name: Caremark
   Coverage Type: RX

   All Pharmacy Benefit Managers (PBM) must be entered as a Health Insurance Carrier (HIC) with a coverage type of RX.

   OHI re-pointed to this HIC ID should have an RX Coverage Type Code.

2.3 User Actions for SIT – Add, Update, Cancel, Deactivate, and Subscribe

The SIT user actions include Add, Update, Cancel, Deactivate, and Subscribe.

These actions are available to authorized MTF users who hold the DOD SIT and DOD SIT MGR Security keys under the SIT menu option in CHCS.

When a CHCS user chooses one of these actions, enters the data associated with the action, and files the data in CHCS, the information is sent to DEERS via the SIT/OHI interface.

The data is reviewed by the VPOC and the VPOC makes the determination as to whether or not the data will be verified and loaded to DEERS or rejected.

2.3.1 ADD a HIC Carrier or Coverage

First, do a partial look-up:

Before adding a new Health Insurance Carrier (HIC) or HIC Coverage, perform a partial look-up by entering, at least the first four or five characters of the insurance company name. Review the partial look-up list and determine whether or not the carrier and/or Coverage that you wish to add, already exists. Remember to try known variations for names that may have been captured in the initial load, such as BLUE and BCBS, both referring to Blue Cross Blue Shield.

Then compare data values:

To avoid adding duplicate entries, compare the following field values between the existing carriers and the carrier you wish to add:

Insurer's Name
Insurer's Telephone Number
Insurer's Address, City, State, Zip
Insurer's Attention Line

Decision Tree – When to ADD a New HIC

1. If you are looking for Cigna, and you find a Cigna Healthcare carrier when performing the partial look-up, consider that it may be a match. Do Not Add or Update the existing HIC entry until you have compared the remaining data associated with the HIC. If you have a specific name required by the insurance carrier for their claims, then Add a HIC entry.

2. If the following data match between the carrier you are considering adding, and the carrier that already exists in the SIT, DO NOT ADD your entry. Your entry will be considered a duplicate and will be rejected:

   Insurer's/payer's Name
   Attention Line, Address
   City
   State/Country
   Zip.

3. If the current Telephone Number is different from yours, try it. Most likely, it is another telephone line for the same company. Additional telephone numbers can be placed in Local Comments. If the telephone number is still unacceptable, ADD YOUR HIC ENTRY.

4. If the Address is acceptable but the Attention Line is empty or you would like a different attention line, please ADD YOUR HIC ENTRY with your Attention Line. Do NOT Update the existing HIC, as the address associated with the existing HIC may be correct for specific claims.

5. It is most important to share information with the VPOC to support your request, either via the local comment field or direct contact.

2.3.2 Update HIC Carrier or HIC Coverage Type

Please do not use the Update action at this time.

This function is on hold until further notice. Updating HIC entries during the transition to the new TNEX SIT/OHI functionality, may introduce data quality issues. If you believe that an existing HIC ID and/or Coverage requires updating (a small insurance company, one where claims address and the PO Box number are transposed, for example), please contact the VPOC. The VPOC will advise if a new HIC ID should be added or will authorize the update.

2.3.3 Cancel HIC Carrier or HIC Coverage Type

Using the "Cancel" action is appropriate when an insurance carrier (HIC ID) or a HIC Coverage Type was entered in error and should never have been entered in the first place.

The system allows cancellation for Temporary Unverified HIC IDs or HIC Coverage Types ONLY.

Only the MTF that originated or last updated a HIC ID or HIC Coverage Type is allowed to cancel that HIC ID or HIC Coverage Type.

Note: When a HIC ID or HIC Coverage is cancelled, ALL OHI policies associated with the cancelled HIC ID or HIC Coverage entry will be cancelled by the system.

2.3.4 Deactivate HIC Carrier or HIC Coverage Type

Do not use the "Deactivate" function.

To avoid deactivating a HIC that other MTF sites are still using, it is advised not to request deactivation of any HIC entry. A periodic sweep of the SIT Table will identify any HIC carriers that have zero to few OHI associated with it or any other automated process available that would demonstrate that a particular HIC is no longer being used. A list of these HIC carriers will be circulated via VPOChelpdesk@altarum.org email, to SIT Table users, for validation of the current status / usefulness of a HIC, prior to being removed from the SIT Table pick list.

The following information is for general knowledge only.

Deactivation is a method to terminate a HIC ID that is no longer in business or no longer accepts any health care claims.

When a CHCS user uses the "Deactivate" action, a REQUEST for deactivation of the carrier is sent to the VPOC via the SIT/OHI DEERS interface. At that point, the carrier remains in a deactivated/unverified status. You may no longer assign OHI to the carrier while it is in a deactivated/unverified status but the OHI currently associated with the carrier is not deactivated while the status is still "unverified."

The decision as to whether or not the carrier will be deactivated will be made by the VPOC.

Note: Deactivation occurs at the carrier level only. HIC Coverage Types cannot be deactivated individually. Use the Cancel option in such cases.

Once the VPOC verifies deactivation of a HIC ID:

- All HIC Coverage Types associated with the deactivated HIC ID are deactivated; and
- All OHI policies associated with the deactivated HIC ID are terminated by the system.

2.3.5 Subscribe

The "Subscribe" action provides the authorized user (holder of DOD SIT MGR Security Key) with the ability to download a file from DEERS that includes all active insurance carrier records that currently exist on the DEERS database.

Note: This action is not often necessary because each CHCS host receives updates to DEERS SIT records in response to automatic hourly SIT queries from CHCS to DEERS. This process runs 24 hours a day to keep the update files smaller.

The "Subscribe" action would be used in the event that the CHCS SIT has become out of sync with the DEERS SIT. The action triggers a "partial subscription" inquiry when the site has not received a DEERS SIT update for less than 7 days. A "full subscription" inquiry will be triggered when the site has not received a DEERS SIT update for more than 7 days.

3.0 General Rules for Other Health Insurance (OHI)

1. Each policy is uniquely identified based on the following field values. If any one of these four data values is different, you must enter a separate policy.
   - Patient Identifier (EDI_PN) Electronic Data Interchange Personal Number
   - HIC ID (Health Insurance Carrier)
   - Policy Identifier (a.k.a. Policy Number)
   - Policy Effective Date

2. Insurance policies usually have only one Policy Identifier with multiple coverage types that support different types of care.

Example: One OHI policy with one Policy Identifier and multiple OHI Coverage Type/OHI Payer Type combinations = one OHI Entry

Carrier :	Aetna	Ins Type Code:	CI (Commercial)
Policy ID:	AE12345	Claim Filing Code:	12 (PPO)
Coverage Type:		XM	(Comprehensive Medical)
Coverage Payer Type:		B	(Both) Institutional and Professional
Coverage Precedence Code:		P	(Primary)
Coverage Type:		RX	(Pharmacy)
Coverage Payer Type:		B	(Both) Institutional and Professional

Coverage Precedence Code: P (Primary)

3. If a patient has a single policy for multiple coverage types, but different types of Claims are filed with different companies; you will need to enter a separate policy for each Policy Identifier and Health Insurance Carrier (HIC) combination.

Example: One OHI policy identifier, multiple OHI Coverage Type/OHI Payer Type, and multiple Health Insurance Carrier (HIC) combinations = one OHI Policy Entry for each OHI Policy Identifier/Health Insurance Carrier (HIC) combination.

A. Carrier: Blue Choice Ins Type Code GR (Group)
Policy ID: B958832 Claim Filing Code: 13 (Point of Service)

Coverage Type: MD (Medical Only)
Coverage Payer Type: B (Both - Institutional and Professional)
Coverage Precedence Code: 1 (Primary)

B. Carrier: MES Ins Type Code: HM (HMO)
Policy ID B958832 Claim Filing Code: 13 (Point of Service)

Coverage Type: VI (Vision)
Coverage Payer Type: B (Both - Institutional and Professional)
Coverage Precedence Code: 1 (Primary)

4. If a patient has a policy with multiple Policy Identifiers (ID'S) (e.g., a Policy Identifier for each OHI Coverage Type), you will need to enter a separate policy for each of the Policy Identifiers, even though the HIC ID and Policy Effective Date for each of the policies may be the same.

Example: One OHI policy with multiple Policy Identifiers = <u>one</u> OHI entry for <u>each</u> Policy Identifier

A. Carrier: Blue Cross Ins Type Code: HM (HMO)
Policy ID: B5674332 Claim filing Code: 13 (Point of Service)

Coverage Type: MD (Medical Only)
Coverage Payer Type: B (Both – Institutional and Professional)
Coverage Precedence Code: 1 (Primary)

B. Carrier: Blue Choice Insurance Type Code: HM (HMO)
Policy ID: Ph90832 Claim Filing Code: 13 (Point of Service)

Coverage Type: RX (Pharmacy Only)
Coverage Payer Type: B (Both – Institutional and Professional)
Coverage Precedence Code: 1 (Primary)

3.1 OHI Coverage Type Codes and OHI Payer Type Codes

The healthcare services covered by each policy are defined by the OHI Coverage Type/OHI Payer Type combinations assigned to the policy.

- An OHI Coverage Type Code never stands alone – it is always considered in combination with the OHI Payer Type Code to which it is linked.
- Each OHI Policy must have, at least one OHI Coverage Type/OHI Payer Type combination – but may have as many OHI Coverage Type/OHI Payer Type combinations as required to completely describe the scope of services covered by the policy.

OHI Coverage Type Codes: (Most commonly used are in boldface)

XM = Comprehensive Medical (limit use, unless RX coverage is certain)
MD = Medical Only
RX = Pharmacy
DN = Dental
VI = Vision
IP = Inpatient
OP = Outpatient
MH = Mental Health
LT = Long Term Care
SN = Skilled Nursing
PH = Partial Hospitalization

OHI Payer Type Codes:

B = Both Institutional and Professional (default)
I = Institutional Only
P = Professional Only
N = Non-billable

Rules for Assigning OHI Coverage Type/OHI Payer Type Codes:

1. An appropriate OHI Coverage Type/OHI Payer Type combination should be entered for <u>each</u> type of healthcare service that is covered by the policy.
   a. Immediately after the SIT/OHI activation conversion, you will see "XM/B" as the OHI Coverage Type/OHI Payer Type in most of the OHI policies on your CHCS database. The activation conversion automatically assigns the default of "XM/B" to previously existing OHI policies.
   b. The one exception is the OHI policies that were associated with the RX SITs, which existed prior to the conversion. The old RX carriers were mapped to valid carriers and policies associated with the RX carriers were created in the new OHI file with a Coverage Type/Payer Type of "RX/B."
   c. After the activation conversion, "XM" should be used only when the details of a patient's OHI policy is not known and the MTF wants to load a placeholder OHI policy while the policy is being developed. You should assign the OHI Coverage Type/OHI Payer Type combination to accurately describe the patient's coverage as you begin to work with the new policies.

2. OHI Coverage Type/OHI Payer Type combinations assigned to an OHI policy DO NOT HAVE TO MATCH the HIC Coverage Type/HIC Payer Type for the carrier with which the policy is associated.

   For Example, An OHI policy might have an OHI Coverage Type/OHI Payer Type of "MD/B" and the carrier associated with that OHI policy might have a HIC Coverage Code/HIC Payer Type of "XM/B.

NOTE: OHI DATA ENTERED BY MTFs AFFECT PATIENT'S BENEFITS

All OHI is now retained in DEERS. It is accessible to all Military Treatment Facilities, TRICARE Pharmacy Point of Sale and Managed Care Support Contractors.

- **The OHI data is used by the MTFs to bill for services at the facility. Ensuring that data is correct for CHCS and TPOCS billing is a priority.**
- **TRICARE uses the OHI data to verify if they (TRICARE) are the Primary or Secondary payer for services received in the civilian sector. OHI data entered by the MTFs now affects patient's benefits in the civilian sector, both in network Pharmacy and in other TRICARE claims.**
- **For example, if a policy is set up as "XM", but has no pharmacy benefits and the patient goes to a civilian pharmacy, the system will show OHI as the primary payer and TRICARE as secondary. The patient will have to pay cash and file a claim for the cost, until the system is updated.**

3.2 Insurance Type Code

The Insurance Type Code is a value assigned to the OHI Policy to describe the type of insurance policy. This field has a drop down option. Do not bypass this field thereby accepting the default, but rather select the appropriate Insurance type code that represents the OHI being added.

- The Insurance Type Code is a required field.
- The default value is "CI" (Commercial).

Insurance Type Code Table (the most commonly used are in bold)

CI = Commercial (default)
HM = HMO
GP = Group Policy
MP = Medicare Primary
MC = Medicaid
AP = Auto Insurance Policy
CP = Medicare Conditionally Primary
IP = Individual Policy
LD = Long Term Policy
LT = Litigation
MB = Medicare Part B
MI = Medigap Part B
PP = Personal Payment
SP = Supplemental Policy
OT = Other

CI = Commercial which includes: BCB, Aetna, Cigna, etc.
GR = Group Policy is used when an Employer's address must be entered. Group policy information is required if you enter GP as the Insurance Type Code. It can be associated with Third Party Administrators or Self-Funded plans

3.3 Coverage Precedence Code (a.k.a. "Ranking")

The Coverage Precedence Code Is used to define rank.

- Ranking is set at the OHI Coverage Type/OHI Payer Type level now, rather than at the policy level, as was the case in previous versions of SIT/OHI.

- A Coverage Precedence Code must be entered for each OHI Coverage Type/OHI Payer Type. It is a required field.

Coverage Precedence Code Table

P = Primary (default)
S = Secondary
T = Tertiary
N = Non-Ranked

There are no system restrictions on Ranking. There may be multiple OHI Coverage Types within each policy that are ranked as Primary, so it is up to the user to correctly define each OHI Coverage Type within each policy held by a single patient.

EXAMPLES:

- If a patient has two policies in which there are MD/B OHI Coverage Type/Payer Type(s), the user would want to rank one as Primary and one as Secondary, in order for claims to be logically processed.

- If a patient has one policy and it has an MD/B OHI Coverage Type/Payer Type ranked as Primary and an RX/I OHI Coverage Type ranked as Primary, there would be no logic conflict.

Note: The system has basic logic built in to handle these conflicts when billing within CHCS and TPOCS but, in order to be sure that the system logic billing as intended by the billing office, it is incumbent upon the responsible users to screen claims and make corrections, as applicable.

3.4 Claim Filing Code

The Claim Filing Code is a descriptive value assigned to each OHI policy.

Although, the field value defaults to "09," that value needs to be changed to the appropriate value for the selected OHI policy.

- Always stop at this field, click on the drop down and select the Claim Filing Code that corresponds to the OHI.

- Self Pay (09) should not be used for the Military Health Service (MHS).

OHI Claim Filing Codes Table: (Most common choices are bolded)

09 = Self Pay (default)
12 = Preferred Provider Organization (PPO)
13 = Point of Service (POS)
14 = Exclusive Provider Organization (EPO)
BL = Blue Cross/Blue Shield
CI = Commercial Insurance
HM = Health Maintenance Organization (HMO)
MC = Medicaid
10 = Central Certification
OF = Other Federal Program – Example: Medicare
11 = Other Non Federal Programs
MB = Medicare Part B
15 = Indemnity Insurance
TV = Title V Maternal/Child program
16 = HMO/Medicare Risk
VA = Veteran's Plan
AM = Automobile Medical
WC = Worker's Comp
CH = CHAMPUS (TRICARE) not supported by DEERS

4.0 Re-pointing OHI

4.1 Host and Child sites – Shared OHI and HIC

One site may be, unknowingly, re-pointing OHI and affecting another site's billing.

To avoid confusion on this issue, the following procedure is recommended:

- Print and view OHI list first, with attention to the coverage types
- Do any changes manually. Review coverage types of OHI and coordinate them with the appropriate HICs.
- Establish a Point of Contact at all sites on the Host
- Email all POCs of any re-pointing to be done
- Preferably, one site on the Host should do the re-pointing

NOTE: When re-pointing, it is important to think through the process since what is being changed may affect another site's business.

4.2 Review of DG Re-point OHI Batch Utility

The DG REPOINT OHI BATCH UTILITY is an existing secondary menu option.

The secondary menu option, “REP Re-Point OHI Batch Utility” [DG REPOINT OHI BATCH UTILITY], allows a user to re-point all Other Health Insurance (OHI) policies associated with a user-selected Standard Insurance Table (SIT) entry to a different user-selected SIT entry.

DG REPOINT OHI BATCH UTILITY is locked by the existing DG OHI MGMT Security Key. Users need to contact their local CHCS administrator in order to be “assigned” this security key.

After the system has finished re-pointing all of the selected policies, the replacement occurs only in the selected OHI records in OHI file # 8074. There is no change in the Standard Insurance Company file # 8192 without further user action as described below.

DO NOT DEACTIVATE HIC! When prompted on the Screen in CHCS, accept the default of “NO”. If “yes” is answered, it will send a deactivation request message to DEERS. This would affect the entire HIC and all sites linked to the DEERS SIT.

See section 10.12 for the STEP-BY-STEP PROCEDURE for running the OHI Batch Utility, if you need more instructions. See pp 114-121 in SIT/OHI Post Conversion Guide on the UBO website.
http://tricare.osd.mil/ocfo/mcfs/ubo/index.cfm

5.0 Verification Point of Contact (VPOC) Options

The following information is for your general knowledge of the VPOC options and how those options may affect your business practices.

5.1 Verify

The VPOC will verify all electronic requests for SIT adds, updates, and deactivates. When the VPOC verifies a request for deactivation, all OHI associated with the HIC ID or HIC Coverage will be terminated. Please ensure that your add, update and deactivate transaction requests are complete, including Point of Contact (POC) information, to ensure timely verification.

5.2 Update

Requesting an “update” for a HIC is on hold until further notice. Not all OHI associated with a particular HIC may be affected by the claims address change. To avoid confusion, it is advised to create a new HIC and re-point any of the affected OHI only.

The VPOC will correct any SIT “add” or “update” requests for obvious typographical errors prior to verification. For any further discussion regarding updates, MTFs may contact the VPOC.

5.3 Restore

If during VPOC review, it is determined that an update or deactivate request is not valid, the VPOC may restore the previous values, rather than accepting (verifying) the requested update or deactivation.

The restore option does not affect any OHI associated with the HIC ID or HIC Coverage Type.

Consider Restore as a “soft” rejection.

5.4 Reject

The VPOC will reject an add or update request if the information is incorrect or incomplete and the Point of Contact is unavailable for consult.

The VPOC will make reasonable efforts to contact, resolve, or clarify issues with an unverified add or update request in order to avoid rejecting a HIC.

If the VPOC is unable to verify an entry and it is rejected, the VPOC will provide a reason in the Standard Comment field. The rejection and comment is only seen when the user actually goes into the entry again.

When a HIC ID or HIC Coverage is rejected, all OHI associated with a rejected HIC ID or HIC Coverage is terminated by the system.

VPOC REJECTION CRITERIA:

1. RX Health Insurance Carriers entered with an RX prefix in the HIC Name, i.e., RX Aetna.

2. Invalid Carrier telephone number. The VPOC uses the phone number provided; contact the insurance company to validate the SIT information. If the number is invalid, the carrier and coverage information cannot be verified.

3. Entry is an obvious duplicate – the same HIC Name and address.

   EXAMPLE: A new HIC ID with the name Aetna is added where Aetna Health Care or Aetna Health already exist with the same address information. The VPOC will enter a written response in the Standard Comment field. (If possible, the VPOC will contact the POC to discuss and provide the opportunity for the POC to re-point their OHI associated to the existing verified HIC).

5.5 Cross-Reference

No HICs will be cross-referenced.

The following information is for general knowledge only.

The VPOC can cross reference one HIC ID to another HIC ID to avoid rejecting an obvious duplicate add.

Once the VPOC cross-references a HIC ID to another HIC, CHCS systematically cancels all OHI policies and Coverage Type(s) that were assigned to the cross-referenced HIC ID.

CHCS, then automatically adds replacement OHI policies, using the HIC ID to which the obsolete carrier was cross-referenced, using the same Coverage Types as existed in the obsolete policies

Once a HIC ID is cross-referenced, OHI will always be booked to the new HIC ID in CHCS. There may be some HICs on the SIT table that are currently cross-referenced. Contact the VPOC to discuss if this status is affecting your billing process.

6.0 OHI Placeholder's

Placeholder Policy – A placeholder policy is an OHI policy in a temporary state. It is created with preliminary information with the intent of being completed at a later time.

With the implementation of the SIT / OHI conversion, which enabled global access to information, there has been a noticeable increase in visibility of OHI placeholder policies at the local MTF level. Placeholder policies are not encouraged and most MTFs do not create them. The issue arose as an increase of OHI placeholder policies began coming down from DEERS during a typical, routine OHI inquiry.

Workload for MTF staff began to increase as the placeholder OHI policies were investigated, completed or cancelled.

6.1 MTF Guidance

- There is a **60 day window** for MTFs to either complete or cancel an OHI placeholder policy
- The CHCS OHI report is to be run monthly, then quarterly as compliance improves, or as directed by your service specific UBO manager, to monitor compliance

The Menu path to run the OHI report is as follows:

- (MSA) MSA System Menu > (IFM) Insurance Processing Menu > (IOR) Insurance and OHI Report Menu > (OHI) Other Health Insurance Report

- Select the DMIS

- You can print the OHI report by (S) Sponsor SS, (P) Patient name, or (I) Insurance company
- Select Placeholder (not expired)

  A Placeholder is defined in the HIC file by having a "P" in the HIC Status code field. That is how the system knows it is a placeholder.
  A Placeholder policy has either one or several 9's; 9, or 99, or 99999 in the Policy ID field.

NOTE: Although the OHI is now centralized on DEERS through the SIT/OHI Conversion, the above OHI report identifies OHI on your LOCAL CHCS database.

Plan: An SCR is planned that will automatically cancel a placeholder policy in 60 days

TMA/UBO will monitor OHI placeholder policy compliance for all entities

7.0 TMA and UBO Service Points of Contact

TRICARE Management Activity (TMA)

Jim Frank
TMA
James.Frank@tma.osd.mil
303- 676-3950

TMA UBO

Tom Sadauskas
TMA UBO
Thomas.sadauskas@tma.osd.mil
703-681-3492 x4069

Army UBO

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8.0 CHCS and DEERS Helpdesk Information

Users needing support with CHCS should contact the MHS Helpdesk at the following telephone numbers

- (800) 600-9332 (CONUS)
- (210) 767-5250 (Direct)
- (866) 637-8725 (OCONUS)

or by email at help@mhs-helpdesk.com or by fax (210) 767-0449.

Users needing support with Access issues for the DEERS MTF SIT Online Application should contact DMDC DEERS by calling 1-800-372-7437.

9.0 TMA/UBO Web Site

http://tricare.osd.mil/rm/index.cfm?pageId=10

10.0 TMA/UBO Helpdesk

VPOC (Verification Point of Contact)

TMA/UBO Contract Support

TMA/UBO Helpdesk
Functional Support
UBO.helpdesk@altarum.org or VPOChelpdesk@altarum.org

703-575-5385

11.0 List of Acronyms

AMEDD Army Medical Department

BUMED	Bureau of Medicine and Surgery
CHCS	Composite Health Care System
DEERS	Defense Enrollment Eligibility Reporting System
DMDC	Defense Manpower Data Center
DoD	Department of Defense
EDIPN	Electronic Data Interchange Person Number
HIC	Health Insurance Carrier
MAC	Medical Affirmative Claim
MSA	Medical Services Account
MTF	Military Treatment Facility
OHI	Other Health Insurance
OIB	Outpatient Itemized Billing
SCM	Site Conversion Manager
SIT	Standard Insurance Table
SSM	Site Security Manager
TAMC	Tripler Army Medical Center
TMA	TRICARE Management Activity
TPCP	Third Party Collection Program
TPOCS	Third Party Outpatient Collection System
UBO	Uniform Business Office
VPOC	Verification Point of Contact