

SOLICITATION/CONTRACT/ORDER FOR COMMERCIAL ITEMS				1. Requisition Number		PAGE 1 OF 393	
Offeror to Complete Blocks 12, 17, 23, 24, & 30				08-DPC-0074			
2. Contract No. H9400209C0003		3. Award/Effective Date Oct 1, 2008		4. Order Number		5. Solicitation Number	
7. For Solicitation Information Call:		a. Name SANDRA CLEVELAND sandra.cleveland.ctr@tma.osd.mil				b. Telephone Number (No collect calls) 303-676-3439	
9. Issued By Code H94002 DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/AM&S 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		10. This Acquisition is <input type="checkbox"/> Unrestricted <input type="checkbox"/> Set-Aside % for <input type="checkbox"/> Small Business <input type="checkbox"/> HubZone Small Business <input type="checkbox"/> 8(A) NAICS: _____ Size Standard: _____		11. Delivery for FOB Destination Unless Block is Marked. <input type="checkbox"/> See Schedule		12. Discount Terms Discount: 0% Net due: 30	
				<input checked="" type="checkbox"/> 13a. This contract is a rated order under DPAS (15 CFR 700)			
				13b. Rating DO-C9			
				14. Method of Solicitation <input type="checkbox"/> RFQ <input type="checkbox"/> IFB <input type="checkbox"/> RFP			
15. Deliver To Code H94002 DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/AM&S 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		16. Administered By Code H94002 DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/AM&S 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066					
17a. Contractor/Offeror Code 00003550 Facility Code JOHNS HOPKINS MEDICAL SERVICE CORPORATIO 6704 CURTIS COURT GLEN BURNIE MD 21060-6406 Telephone No. 410-424-4977 TIN: 96380409		18a. Payment Will Be Made By Code CRM DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY (CRM) 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066					
17b. Check if Remittance is Different and Put Such Address in Offer. <input type="checkbox"/>		18b. Submit Invoices to Address Shown in Block 18a Unless Box Below is Checked. <input type="checkbox"/> See Addendum.					
19. ITEM NO.		20. SCHEDULE OF SUPPLIES/SERVICES		21. QUANTITY		22. UNIT	
0001		Comprehensive Health Care Services and Associated Support Services (Health Care & Support) Base Year		(b)(4)		23. UNIT PRICE	
						24. AMOUNT	
25. Accounting and Appropriation Data See Schedule				26. Total Award Amount (For Govt. Use Only) US (b)(4)			
<input type="checkbox"/> 27a. Solicitation incorporates by reference FAR 52.212-1, 52.212-4, FAR 52.212-3 and 52.212-5 are attached. Addenda <input type="checkbox"/> are <input type="checkbox"/> are not attached				<input type="checkbox"/> 27b. Contract/Purchase Order incorporates by reference FAR 52.212-4, 52.212-5 is attached. Addenda <input checked="" type="checkbox"/> are <input type="checkbox"/> are not attached			
<input checked="" type="checkbox"/> 28. Contractor is required to sign this document and return 1 copies to Issuing Office. Contractor agrees to furnish and deliver all items set forth or otherwise identified above and on any additional sheets subject to the terms and conditions specified herein.				<input checked="" type="checkbox"/> 29. Award of Contract Reference. Offer Dated _____ Your offer on Solicitation (Block 5), including any additions or changes which are set forth herein, is accepted as to items:			
30a. Signature of Offeror/Contractor 		30b. Name and Title of Signer (Type or Print) PRESIDENT, JHMSC		30c. Date Signed 9/29/08		31a. United States of America (Signature of Contracting Officer) 	
				31b. Name of Contracting Officer (Type or Print) MARTIN A. MARTINEZ martin.martinez@tma.osd.mil		31c. Date Signed 09/30/08	
32a. Quantity in Column 21 Has Been <input type="checkbox"/> Received <input type="checkbox"/> Inspected <input type="checkbox"/> Accepted, and Conforms to the Contract, Except as Noted: _____							
32b. Signature of Authorized Government Representative		32c. Date		32d. Printed Name and Title of Authorized Government Representative			
32e. Mailing Address of Authorized Government Representative				32f. Telephone Number of Authorized Government Representative			
				32g. E-mail of Authorized Government Representative			
33. Ship Number		34. Voucher Number		35. Amount Verified Correct For		36. Payment <input type="checkbox"/> Complete <input type="checkbox"/> Partial <input type="checkbox"/> Final	
37. Check Number							
38. S/R Account Number		39. S/R Voucher Number		40. Paid By			
41a. I certify this account is correct and proper for payment				42a. Received By (Print)			
41b. Signature and Title of Certifying Officer				41c. Date			
				42b. Received At (Location)		42c. Date Rec'd (YY/MM/DD)	
				42d. Total Containers			

SCHEDULE Continued

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0002	(FY09) October 1, 2008 - September 30, 2009 Travel (FY09) Base Year (October 1, 2008 - 30 September 2009) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 10,000.00	10,000.00
0003	DIACAP (FY09) Base Year (October 1, 2008 - 30 September 2009) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 250,000.00	250,000.00
1001	Comprehensive Health Care Services and Associated Support Services (Health Care & Support) Option Period (Estimated Total Cost)	(b)(4)			
1002	(FY10) October 1, 2009 - September 30, 2010 Travel (FY10) Option Period (October 1, 2009 - 30 September 2010) (Estimated Total Cost) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 10,000.00	10,000.00
1003	DIACAP (FY10) Option Period (October 1, 2009 - 30 September 2010) (Estimated Total Cost) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 250,000.00	250,000.00
2001	Comprehensive Health Care Services and Associated Support Services (Health Care & Support) Option Period (Estimated Total Cost)	(b)(4)			
2002	(FY11) October 1, 2010 - September 30, 2011 Travel (FY11) Option Period (October 1, 2010 - 30 September 2011) (Estimated Total Cost) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 10,000.00	10,000.00
2003	DIACAP (FY11) Option Period (October 1, 2010 - 30 September 2011) (Estimated Total Cost) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 250,000.00	250,000.00
3001	Comprehensive Health Care Services and Associated Support Services (Health Care & Support) Option Period (Estimated Total Cost)	(b)(4)			
3002	(FY12) October 1, 2011 - September 30, 2012 Travel (FY12) Option Period (October 1, 2011 - 30 September 2012) (Estimated Total Cost) The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.	1	LT	NTE 10,000.00	10,000.00
3003	DIACAP (FY12) Option Period (October 1, 2011 -	1	LT	NTE 250,000.00	250,000.00

SCHEDULE Continued

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	30 September 2012) (Estimated Total Cost)				
4001	The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO. Comprehensive Health Care Services and Associated Support Services (Health Care & Support) Option Period (Estimated Total Cost)				(b)(4)
	(FY13) October 1, 2012 - September 30, 2013				
4002	Travel (FY13) Option Period (October 1, 2012 - 30 September 2013) (Estimated Total Cost)	1	LT	NTE 10,000.00	10,000.00
	The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.				
4003	DIACAP (FY13) Option Period (October 1, 2012 - 30 September 2013) (Estimated Total Cost)	1	LT	NTE 250,000.00	250,000.00
	The Contractor shall obtain authorization from the Contracting Officer prior to incurring any expenses under this cost type Sub-Clin. Payment for authorized expenses shall be approved by the COR and CO.				

SUPPLIES OR SERVICES AND PRICES/COSTS

1. This contract is for the provision, by the Designated Provider (DPs), of comprehensive health care services and associated support services, (excluding family planning and ethical and religious directives,) for persons eligible to enroll under the U.S. Family Health Plan Managed Care Plan. This contract award shall be a Fixed Price commercial contract for an initial period commencing October 1, 2008 through September 30, 2009 with four (4) option periods to be exercised at the Government’s discretion.

2. The negotiated contract ceiling price for this Base Period is (b)(4) of which (b)(4) is subject to the availability of funds as described in the table below. The total Award amount is (b)(4) which includes Travel and DIACAP costs. Funds may be adjusted based on reconciliations.

FY	FUND SITE	CLIN	AMOUNT	PR NUMBER
09	9709090130.1889.102000 (SAF FY09)	0001	(b)(4)	09-DPC-0074
09	97XXX5472.18D9.000000 (SAF FY09)	0001		09-DPC-0074
	9709090130.1889.102000 (SAF FY09)			09-DPC-0074
09	(SAF FY09)	0002		
09	97XXX5472.18D9.000000 (SAF FY09)	0002		09-DPC-0074
	9709090130.1889.102000 (SAF FY09)			09-DPC-0074
09	(SAF FY09)	0003		
09	97XXX5472.18D9.000000 (SAF FY09)	0003		09-DPC-0074

3. Availability of Funds: The resulting contract and options will be subject to FAR 52.232-18 Availability of Funds; and 52.232-19 Availability of Funds for the Next Fiscal Year.

4. Options: There will be four (4) separate twelve (12) month option periods under this contract. FAR Part 17.201 defines the term “Option” and the decision to exercise an option period will be made pursuant to FAR Part 17.207. Rates for the option periods shall be negotiated and adjusted based on the methodology stated in this contract award prior to exercising each of the option periods.

- Base Period October 1, 2008 through September 30, 2009
- Option 1 October 1, 2009 through September 30, 2010
- Option 2 October 1, 2010 through September 30, 2011
- Option 3 October 1, 2011 through September 30, 2012
- Option 4 October 1, 2012 through September 30, 2013

5. Public Law. Notwithstanding the terms and conditions in this contract, this contract will be subject to applicable Federal laws. The Contractor will comply with all Federal Laws and Regulations to include the terms and limitations contained in the National Defense Authorization Act for Fiscal Year 1997, Section 721 through 727.

6. Incorporation of Proposals. Proposals submitted by 9 June 2008, dated 5 June 2008 are hereby incorporated by reference with the same force and effect as if set forth in full text. If there is any inconsistency between the terms of this contract and the technical and/or cost proposal, the contract’s terms and conditions has priority over the terms contained in the technical and/or cost proposal. Email dated 19 September 2008, which acknowledges the agreements resulting from negotiations, is also incorporated by reference. This award document has been revised to include all negotiated changes.

7. Incorporation of Kennell Ceiling Rate Methodology Document dated 12 September 2008 is hereby incorporated by reference with the same force and effect as if set forth in full text.

**FY2009 CAPITATION RATES
(As identified in Attachment 11)**

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SECTION B 1

B.1 Statement of Objectives N:\DPC\Christus Health\Sections\Sec.B\Statement of Objectives
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B.1 Statement of Objectives**1.0. GENERAL:**

The General section includes performance based objectives which describes the general requirements of this contract. The "Objectives" represent the overall outcomes the Government is procuring. The objectives are supported by technical requirements. These requirements represent specific tasks, outcomes, and/or standards that must be achieved in support of the overall objectives. The purpose of this contract is to make available Designated Provider (DP) support to the Department of Defense (DoD) health care delivery system. The DP must operate a comprehensive health care delivery system to provide health care services in or through a managed care plan to eligible uniformed services beneficiaries who enroll. The DP plan must provide the TRICARE Prime uniform benefit and will be called the Uniformed Services Family Health Plan (USFHP).

2.0. BACKGROUND:

The Omnibus Reconciliation Act of 1981 (OBRA) mandated that eight hospitals and twenty-seven clinics operated by the Public Health Service (PHS) either (1) be closed by October 31, 1981, (2) be transferred to public or non-profit private entities or (3) become financially self-sufficient by September 30, 1982. After review of proposals submitted in September 1981 and after evaluation on criteria established in OBRA 1981, the Department of Health and Human Services (HHS) ultimately transferred five hospitals and five clinics to private ownership. The Military Construction Authorization Act of 1982, P.L. 97-99, (42 U.S.C. 248c), also known as the "Jackson Amendment", "deemed" ten former PHS facilities as facilities of the uniformed services for the purposes of 10 U.S.C., Chapter 55, and authorized the DoD, the HHS and the Department of Transportation (DOT) to reimburse the seven "Uniformed Services Treatment Facilities" (USTFs) for medical and dental care provided to eligible uniformed service beneficiaries at the ten sites. The National Defense Authorization Act (NDAA) for Fiscal Year 1997 repealed the "deemed" status of the USTFs and directed the Department to include the DPs (formerly called the USTFs or their legal successors in interest) in the health care delivery system of the uniformed services. Since 1982, each of the DPs have entered sole source contracts, with multiple year options to provide the TRICARE Prime benefit to beneficiaries of the uniformed services. Fairview Health System elected to discontinue providing services as a DP effective July 1, 2003. The resulting contracts from this Request for Proposal (RFP) are the legislated contracts to the USFHP.

2.1. Designated Providers:

The principal business locations of the six DPs are as follows:

Brighton Marine Health Center, Boston, Massachusetts
 CHRISTUS Health, Houston, Texas
 Johns Hopkins Medical Services Corporation, Baltimore, Maryland
 Martin's Point Health Care, Portland, Maine
 Pacific Medical Clinics, Seattle, Washington
 Saint Vincent Catholic Medical Centers of New York, NY, New York

The six DPs collaborate on a number of common issues through the US Family Health Plan Alliance"

3.0. STATEMENT OF OBJECTIVES:

There are three (3) objectives included in this contract. They are as follows:

3.1. OBJECTIVE 1: Operate a healthcare network for enrolled uniformed services members optimizing the delivery of the TRICARE Prime healthcare benefit through the combination of commercial best practices and Department of Defense (DoD) health care policy, promoting access, quality, referral management, satisfaction, and best value health care; through networks accredited by a national accrediting organization.

3.2. OBJECTIVE 2: Optimize patient outcomes and communication through the implementation of a patient safety program that will provide an evidence-based approach utilizing information, people, and resources to achieve the best clinical quality outcomes and the prevention of medical errors and patient harm. As an example, DoD currently uses a comprehensive set of evidence based and field-tested tools and strategies called Team Strategies & Tools to enhance Performance & Patient Safety (TeamSTEPPS™) that are applicable to any healthcare setting. The DPs can utilize DoD's TeamSTEPPS™ or propose their own Patient Safety program that meets the requirements.

3.3. OBJECTIVE 3: To ensure the proper allocation of health care resources and to improve the health care status of individuals under the care of the DP, the USFHP will design and implement a chronic care management system among the enrolled population. The approach must ensure resources are allocated to keeping well members healthy with a focus on healthy lifestyles, disease management, and health promotion, while maintaining an active disease management program for high-risk beneficiaries with chronic disease conditions.

3.4 PERFORMANCE CRITERIA

The Contractor's performance during the life of the resulting contract will be evaluated by criteria as follows:

3.4.1. Through evaluation of the overall healthcare program's effectiveness, the clinical quality, the access to health care services, and the ability of the USFHP to deliver the uniform TRICARE Prime health care benefit, as amended from time to time, to all enrollees during the period of performance.

3.4.2. TMA, through survey forms approved by the Office of Management and Budget (OMB), periodically surveys patient and provider satisfaction within the TRICARE Military Health Services (MHS), including Military Treatment Facilities (MTF) and through managed care support contractors, measured against similar results in the commercial

SECTION B

health plan sector. For the same periods covered by the TMA surveys, the DP may survey its enrollees and network providers and may provide its results to TMA to support its performance.

3.4.3. Through timely submission of complete and accurate enrollment, clinical, and pharmacy data to the designated provider data contractor as measured by reports of data submissions.

3.4.4. Through implementation of innovative performance programs during the base period and option periods of the contract, to include patient safety and population management of disease, and the continued administration of these performance issues during the contract period of performance.

4.0. DOCUMENTS:

The following documents are hereby incorporated by reference and form an integral part of this contract. Documentation incorporated into this contract by reference shall have the same force and effect as if set forth in full text for those chapters and sections that are identified herein:

TRICARE Policy Manual (TPM) 6010.54-M, August 1, 2002, through Change 74, dated April 7, 2008.

TRICARE Reimbursement Manual (TRM) 6010.55-M, August 1, 2002, through Change 73, dated April 7, 2008. (The following addendum applies to this contract: Chapter 2, Addendum B) through Change 41, dated May 22, 2006.

Changes 2 through 41 are not applicable to the Designated Providers and are incorporated for informational purposes and proper manual maintenance only.

TRICARE Systems Manual (TSM) 7950.1, August 1, 2002, through Change 57, dated March 6, 2008.

TRICARE Operations Manual (TOM) 6010.51-M, August 1, 2002, through Change 63, dated April 8, 2008.

Title 10, United States Code, Chapter 55

32 Code of Federal Regulations (CFR), Part 199. The following sections apply to this contract. 199.4, 199.5, 199.6, 199.8, 199.12, 199.17, 199.18, and 199.21.

DoD 5200.02 "Personnel Security Program" April 9, 1999

DoD 5200.02-R "Personnel Security Program" February 23, 1996

DoD 5400.11 "DoD Privacy Program" May 8, 2007

DoD 5400.11-R "DoD Privacy Program" as amended, May 14, 2007

DoD 6025.18-R "DoD Health Information Privacy Regulation" January 24, 2003

DoD 8500.2 "Information Assurance (IA) Implementation", February 6, 2003

DoD 8510.01 "DoD Information Assurance Certification and Accreditation Process (DIACAP) dated November 28, 2007

DoD 8580.02-R "DoD Health Information Security Regulation" July 12, 2007

"Privacy Act, as amended" P.L. 93-579, December 31, 1974

Health Insurance Portability and Accountability Act (HIPAA) of 1996

Federal Register - 60 FR 43775, 64 FR 22837, 65 FR 30966, 69 FR 50171, 71 FR 16127

Attachment 10 – TRICARE Manual Exceptions Table dated, April 11, 2008

4.1. Manuals Order of Precedence:

The TRICARE Policy Manual takes precedence over the other three TRICARE Manuals. The TRICARE Reimbursement Manual takes precedence over the TRICARE Systems Manual and the TRICARE Operations Manual. The TRICARE Systems Manual takes precedence over the TRICARE Operations Manual. Attachment 10 lists specific sections of the TRICARE manuals that do not apply to this contract.

Notwithstanding the foregoing, Attachment 10 will take priority over all of the Manuals in that it identifies those provisions of all the Manuals that are not applicable to this contract. In the event of any conflict between Attachment 10 and a Manual provision, Attachment 10 will govern.

4.2. Manual Updates:

TRICARE Management Activity (TMA) periodically incorporates changes in the various manuals relating to healthcare policy, operation, and system changes. TMA's Contracting Office will provide the Program Office, electronically, with Coordination Change Packages relating to TRICARE manual changes as they become available, and the Program Office will advise the DP, within ten (10) business days following the published distribution of each such Package, as to whether the particular Package is applicable, in whole or in part, to this contract. The Contracting Office will also notify the Program Office when the manual change resulting from a Coordination Change Package is issued in final form. For each such change that is applicable to this contract, the Program Office and the DP will negotiate and complete an appropriate modification to this contract, incorporating such change, within ten (10) business days following the publication of the manual change, and submit same to the Contracting Office; provided, however, said period may be extended by agreement of the Program Office and the DP's where a manual change requires additional preparation time for implementation and where the change may give rise to a request by the DP for an equitable adjustment. For each change that is not applicable to this contract, the Program Office and the DP will negotiate and complete an appropriate modification to Attachment 10 providing for an exception from such manual provision, within ten (10) business days following the publication of the manual change, and submit same to the Contracting Office.

Manual changes issued in final form prior to contract award will be reviewed in accordance with the preceding paragraph and will be incorporated into the contract, or included as an exception in Attachment 10, at the time of contract award.

Changes issued in final form following contract award will be subject to the provisions of the preceding paragraph.

To facilitate the modification process, the DP may access drafts of proposed changes in the TRICARE manual online. For access to the Coordination Manual Packages, the DP should contact William Orchard at William.Orchard@tma.osd.mil. The Program Office will notify the DP of an alternative contact point when relevant. The DP may also subscribe to a mailing list that will provide the latest information on manual updates and revisions, through the manual site: <http://manuals.tricare.osd.mil/>. TMA will assure DP access to this site.

4.3. Negotiated Changes:

Where modification to this contract are necessary, besides modifications resulting from TRICARE manual changes, which are governed by Section 4.2, such modifications will require bilateral agreement between the parties in accordance with FAR 52.212-4.

5.0. DEFINITIONS:

Definitions in manuals, attachments, or exhibits are incorporated by reference.

6.0. GOVERNMENT-FURNISHED PROPERTY AND SERVICES:

Government property furnished to the DP for the performance of this contract includes the Defense Online Enrollment System (DOES) production Compact Disks (CDs). The government will also be responsible for maintaining the Virtual Private Network (VPN) devices to access Defense Enrollment Eligibility Reporting System (DEERS) and the data contractor systems. Individual logon and passwords will be assigned for each DEERS user. A form will be supplied to the DP to request or delete users. This request must be submitted to the TMA DP Program Office.

7.0. CONTRACTOR-FURNISHED ITEMS:

The DP shall furnish all necessary items not provided by the Government for the satisfactory performance of this contract.

8.0. TECHNICAL REQUIREMENTS:

The DP must fulfill the technical requirements listed below in accomplishing the overall objectives of this contract.

8.1. Network Requirements:

The DP shall provide a managed, stable, high-quality network (s), of individual and institutional health care providers, sufficient to provide primary and specialty health care services covered by the TRICARE Prime benefit to all USFHP enrollees which promotes access, quality, beneficiary satisfaction, and best value health care.

8.1.1. The DP's network shall be accredited by a nationally recognized accrediting organization at the start of health care delivery and during contract performance. When this contract and the accrediting body both have a standard for the same activity, the higher standard shall apply.

8.1.2. Beginning with the start of health care delivery and during contract performance, the DP will ensure that all provider networks established in the DP's geographical service area meet the contract access standards.

8.1.3. The DP must inform the Government, within 24 hours of its obtaining any such information, of an instance of network inadequacy relative to its service area, and shall submit a corrective action plan with each notice of an instance of network inadequacy. (Network inadequacy is defined as any failure to meet the access standards.) The DP shall respond to any inquiries from Government representatives [Contracting Officer (CO), Procuring Contracting Officer (PCO) or Administrative Contracting Officer (ACO), Contracting Officer's Representative (COR), or Alternate Contracting Officer's Representative (ACOR)], concerning network adequacy, including provider turnover information. The response for this information shall be submitted within two business days from the DP's receipt of any such request.

8.1.4. Providers in the DP's network shall be sufficient in number, mix, and geographic distribution of fully qualified providers to provide the full scope of benefits for which all Prime enrollees are eligible under this contract, as described in 32 CFR 199.4, 199.5, and 199.17. The DP's provider network shall also support the requirements of special programs described in the applicable provisions of the TOM and TPM when included in the TRICARE Prime benefit. Catholic health care organizations are not permitted to provide certain services that are included as part of the TRICARE Health Care Services. CHRISTUS Health and Saint Vincent Catholic Medical Centers of New York are Designated Providers that can not provide family planning services or provide legend drugs to enrollees for family planning purposes without violating these Directives. Therefore, Brighton Marine Health Care Center will administer family planning benefits for enrollees of CHRISTUS Health and St. Vincent Catholic Medical Centers by arranging for a provider network to ensure that these enrollees continue to receive the full scope of the TRICARE Prime benefit. Payment for these services will be invoiced by Brighton Marine Health Center and paid directly to Brighton Marine Health Center.

8.1.5. The DP shall ensure that the standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time for various categories of services contained in 32 CFR 199.17(p)(5), are met. These standards shall be met in a manner which achieves beneficiary satisfaction with access to network providers and services as set forth in the contract.

8.1.6. All network providers who provide services and receive reimbursement under this contract shall be USFHP providers in accordance with the criteria set forth in 32 CFR 199.6. The DP shall obtain and maintain documentary evidence that each such provider meets the criteria set forth in 32 CFR 199.6 and subject to the exceptions identified in Attachment 10, the TPM, Chapter 11.

8.1.7. The DP shall ensure that all network providers and their support staffs gain a sufficient understanding of applicable USFHP program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner, which promotes beneficiary satisfaction. This requirement pertains to all

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network providers and their staff. The DP shall submit all educational materials used in conjunction with USFHP to the TRICARE Marketing Division, Falls Church, Virginia, for approval prior to use within the network. If no response is given by the TRICARE Marketing Division within 30 days of the receipt of such materials, the materials as submitted shall be deemed approved.

8.1.8. The DP shall have an active provider education program designed to enhance each network provider's awareness of USFHP requirements, to include emphasis on achieving the leading health care indicators of "Healthy People 2010", and encourage participation in the program. Additional information can be found at <http://www.healthypeople.gov/>

8.1.9. The DP shall ensure that no network provider requires payment from a beneficiary for any excluded or excludable service that the beneficiary received from a network provider (i.e., the beneficiary shall be held harmless) unless the beneficiary has been properly informed in writing such as in an Explanation of Benefit (EOB) or waiver of liability form, that the services are excludable and the provider has documentation that the beneficiary has agreed in advance of receiving the services to pay for such services. Any such understanding to pay must be evidenced by written records. A beneficiary who is informed that care is potentially excludable and proceeds with receiving the potentially excludable service, shall not, merely by receiving such care, be deemed to have agreed to pay for such care. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew that specific services he or she receives were excluded or excludable.

8.1.9.1. Under no circumstance will an enrollee EOB be issued to the parents/guardian of minors or incompetents when the care involve services related to abortion, AIDS/HIV, alcoholism, pregnancy, substance abuse, and/or Sexually Transmitted Diseases. (see TOM, Chapter 8 Section 8).

8.1.10. Effective with the start of healthcare services (October 1, 2008), the DP shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primary care manager within the commercial practice standard time. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's primary care manager within 24 hours by telephone, fax or other means, with a formal written report provided within the commercial practice standard time.

All consultation or referral reports, operative reports, and discharge summaries shall be provided to the primary care manager within 30 calendar days. If the accreditation standards organization referenced in Section 8.1.1 above has a more stringent specialty referral-reporting requirement, the DP shall adhere to that standard. The commercial practice standard time must be stated in the DP response to this RFP.

8.1.11. Effective with the start of healthcare services (October 1, 2008), the DP shall audit an adequate number of referrals to arrive at a statistically valid sample, quarterly, to validate the required specialty documentation within the standard set forth in Section 8.1.10 above. The sample shall be selected randomly. The DP shall report the results of the audit to the ACO (or designee) no later than 45 calendar days following the month from which the sample was selected. The DP shall develop and implement a corrective action plan when the audit discloses a failure to respond within commercial practice standards.

8.1.12. All acute-care medical/surgical hospitals in the DP's provider network are encouraged to become members of the National Disaster Medical System (NDMS). For more information, see <http://www.oep-ndms.dhhs.gov>

8.1.13. When the written agreements the DP has in place with its network providers at the start of health care delivery are re-contracted, the DP shall ensure that, for the remainder of the period of contract performance, such written agreements address required participation in the evidence-based patient safety program described in Objective 2 of this document. The DP shall also ensure that the written agreements it enters into with network providers following the start of health care delivery shall, for the remainder of the period of contract performance, address required participation in such evidence-based patient safety program.

8.2. Marketing:

Marketing materials include all written materials used to publicize, inform, educate, or otherwise influence reliant MHS beneficiaries. All marketing materials used by the DP must display the TRICARE logo and must be approved by the TRICARE Marketing Division, Falls Church, Virginia, prior to issuance by the DP. If no response is given by the TRICARE Marketing Division within 30 days of its receipt of any such materials, such materials shall be deemed approved.

8.2.1. The DP may market USFHP services to and enroll only those covered beneficiaries (a) who, except as noted below, do not have other primary health insurance (other than Medicare coverage) covering basic primary care and inpatient and outpatient services, or (b) who are enrolled in the direct care system under the TRICARE program, regardless of whether the covered beneficiaries were users of the healthcare delivery system of the uniformed services in prior years. Notwithstanding (a) above, in any federal fiscal year the DP may enroll new covered beneficiaries who have other primary health insurance coverage as long as the number of such new enrollees in any federal fiscal year does not exceed 10 percent of the excess (if any) of (i) the number of enrollees in the DP's US Family Health Plan as of the first day of such fiscal year over (ii) the number of such enrollees as of the first day of the immediately preceding fiscal year.

8.2.2. Beneficiaries that have other primary health insurance coverage through the Federal Employee Health Benefits Plan (FEHBP) may enroll when they elect to suspend their FEHBP coverage in accordance with 5 CFR 890.

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8.3. Enrollment:

The DP shall ensure that enrollment and transfers of enrollment, i.e. portability as described in the TOM, Chapter 6, are accomplished in a way that allows for uninterrupted coverage for the enrollee.

8.3.1. The DP shall use the current TRICARE Enrollment and Disenrollment forms found at:

<http://www.tricare.mil/mybenefit/Forms.do>. The DP shall reproduce the form as necessary to ensure ready availability to all potential enrollees. The DP shall implement enrollment processes that take advantage of current technology while ensuring access by and assistance to all beneficiaries.

8.3.2. The DP shall ensure that all eligible beneficiaries who reside in the geographic service area, as defined from time to time in accordance with the provisions of the contract, have the opportunity to enroll, add additional family members, or remain enrolled in the program. The DP shall adjust the capabilities and capacities of the network to compensate for enrollment changes when and where they occur throughout the term of the contract, including all option periods. On a quarterly basis, the ACOR (or designee) will provide a report to the DP of those beneficiaries enrolled that reside outside the approved geographic service area. To ensure that beneficiaries are educated on the TRICARE options available, the Government will provide the DPs with a listing of beneficiaries within the geographic service area on a monthly basis.

8.3.3. Enrollment in any given federal fiscal year may not exceed 110 percent (110%) of the total enrollment in the USFHP for all of the DPs as of the first day of the immediately preceding federal fiscal year. The government will issue direction as necessary to ensure that the statutory requirement on enrollment limitation is not violated.

8.3.4. All enrollments, re-enrollments, disenrollments, and transfers shall be in accordance with the provisions of the TOM, Chapter 6 and the TSM, Chapter 3.

8.3.5. The DP shall accomplish primary care manager (PCM) by name assignment in data provided to the DoD data collection contractor, including written notification to the beneficiary providing the name, location, and telephone number of the PCM.

8.3.6. The DP shall provide commercial practice payment methods for Prime enrollment fees that best meet the needs of beneficiaries. The DP shall accept payment of fees by payroll allotment or Electronic Funds Transfer (EFT) from a financial institution as well as other payment types (e.g., check, credit cards) with sufficient alternatives to achieve beneficiary satisfaction. The DP shall not require beneficiaries to pay an administrative fee of any kind for use of a particular payment option offered by the DP. The DP shall accept payment of enrollment fees on a monthly (by EFT or allotment only), quarterly, or annual basis. The DP shall provide beneficiaries with written notice of a payment due and when beneficiaries are delinquent.

8.3.7. Newborns shall be conditionally enrolled when the mother is a USFHP enrollee. The DP shall conditionally enroll the newborn to the data contractor's system for a 60-day (sixty) period. If the child is not enrolled in DEERS within the 60-day period, the child shall be disenrolled effective the 61st day.

8.3.8. Except as provided below, USFHP enrollees are locked out of the MTF system for healthcare services and pharmaceuticals. Medicare eligible beneficiaries with Part A coverage who elect to enroll are locked out of using Medicare for services covered under the USFHP. An enrollee's violation of the MHS or Medicare lockout could result in disenrollment of such enrollee. A USFHP enrollee may access an MTF for emergency services, for which the DP will be responsible for reimbursing the MTF, and the DP may refer enrollees to an MTF for the provision of care where it has a Memorandum of Agreement (MOA) in effect with the MTF, as provided in Section 8.5.3, under which the DP is responsible for the cost of the care.

8.3.9. Eligible beneficiaries age 65 and over may elect to enroll in the USFHP. The DP must waive the enrollment fee for enrollees age 65 and over when the enrollee has Medicare Part B. Once the waived fee amount is equal to the TRICARE family enrollment fee maximum, the family enrollment fee requirement shall be considered satisfied. The DP shall not charge co-payments for services that would otherwise be covered by Medicare to enrollees with Medicare Part B.

8.3.10. The DP shall rely on the Defense Enrollment and Eligibility Reporting System (DEERS) as the official system of record for all eligibility and enrollment issues.

8.4. Customer/Member Services:

The DP shall provide comprehensive, readily accessible customer services that include multiple, contemporary avenues of access (for example, e-mail, Web site, telephone, facsimile, et cetera) for the beneficiary. Customer services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers.

8.4.1. All customer assistance provided by telephone shall be toll-free or without long distance charges to the beneficiary.

8.4.2. The DP shall perform all customer service functions with knowledgeable, courteous, and responsive staff.

8.4.3. The DP shall maintain an accurate, up-to-date list of network providers including their specialty, gender, work address, work fax number, and work telephone number, and whether or not they are accepting new beneficiaries. The DP shall provide easy access to this list for all beneficiaries, providers, and Government representatives. For the purposes of this requirement, "up-to-date" means by electronic, paper or telephone, or a combination of these approaches, that accurately reflects the name, specialty, gender, work address, and work telephone number of each

network provider and whether or not the provider is accepting new patients. The information contained on all electronic lists shall be current within the last 30 calendar days.

8.4.4. The DP shall encourage each USFHP member and provider to use Medline Plus® a web site developed and maintained by the U.S. National Library of Medicine (NLM) and the National Institutes of Health (NIH). This site will provide health professionals and USFHP members with information on diseases and conditions, clinical trials, drugs, and the latest health information. The use of this site is not intended to be a substitute for health care information provided by the plan, but may be used as resource to supplement the plans health care information. See, Medline Plus® site: <http://medlineplus.gov>

8.5. Medical Management:

The DP shall operate a medical management program for all MHS eligible beneficiaries who are enrolled and are receiving care that achieves the objectives of this contract.

8.5.1. The DP must provide comprehensive health care services to all enrollees for which the DP shall receive an annual capitation payment. Health care services for the DP program is defined by Public Law 104-201, Section 721, *et seq.*) as services known as the TRICARE Prime option. The referral management processes shall be included in the capitation payment and shall be the responsibility of the DP.

8.5.2. The DP shall operate programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which proven clinical management programs exist. These programs shall be available to enrolled eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 CFR 199 and active duty personnel in remote areas as defined by Chapter 17 of the TOM.

8.5.3. In Military Treatment Facility (MTF) catchment areas, the MTF has the right of first refusal for all out-of-network referrals, which shall be addressed in a Memorandum of Agreement (MOA) outlining agreed to terms, including payment. First right of refusal is defined as providing the MTF with an opportunity to review each out-of-network referral from a civilian provider to determine if the MTF has the capability and capacity to provide the treatment. The MOA shall address how the referrals are to be handled, with the intent being to use to the extent possible electronic referral arrangements entailing appropriate HIPAA-compliant transaction.

8.5.4. The DP will refer their USFHP enrollees to a non-network provider when the DP cannot provide the care within the contracted network, the MTF does not have the capability or capacity to provide the treatment and it is clearly in the best interest of the beneficiary clinically. The DP shall be financially responsible for the cost of care provided.

8.5.5. The DP shall ensure that care provided, including mental health care, is medically necessary and appropriate and encompasses the TRICARE benefits contained in 32 CFR 199.4 and 199.5. The DP shall use best practices in reviewing and approving care and establishing medical management programs to carry out this activity to the extent authorized by law (i.e. applicable TRICARE manual changes). Notwithstanding the DP's authority to utilize its best practices in managing, reviewing and authorizing health care services, the DP shall comply with the provisions of 32 CFR 199.4 and the TPM regarding review and approval of mental health services.

8.5.6. The DP shall establish twenty-four hour (24), seven (7) days a week, accessible telephone service, toll-free or without long distance charges, for enrolled beneficiaries seeking information and/or assistance with urgent or emergent care situations. This function shall be accomplished with live telephone personnel only.

8.5.7. The DP shall provide assistance in accessing information about other DoD programs and applicable community/state/federal health care and related resources for all MHS eligible beneficiaries who are enrolled in USFHP and require benefits and services beyond TRICARE.

8.5.8. The DP shall comply with the Appeals and Hearings Process per the TOM, Chapter 13.

8.6. Quality Management:

The DP shall establish and continuously operate an internal quality management/quality improvement program covering every aspect of the DP's operation, both clinically and administratively. A copy of the documents describing the internal quality management/quality improvement program shall be provided to the Contracting Officer within 30 days of award of this contract. A report listing problems identified by the DP's internal quality management/quality improvement program and the corrective actions planned/initiated shall be provided to the Contracting Officer within 10 days following the identification of the problem(s). The DP shall also comply with the Clinical Quality Management requirements of the TOM, Chapter 7, through on-site annual reviews. The DP must complete annually the vulnerability assessment required by TOM, Chapter 1, Section 4, Paragraph 6.2.

8.6.1. The DP shall comply with the provisions of the TOM, Chapter 7, regarding coordination and interaction with the TRICARE Quality Monitoring Contract (TMQC) contractor(s).

8.6.2. Quality Health Care Plan is due 1 October 2008 for Base Period and 45 days prior to start of each subsequent Option Period.

8.6.3. Contractor Operation Clinical Quality Report due 45 days after the start of the fiscal year.

8.7. Claims:

The DP's claims processing/encounter system shall correctly apply deductible, co-pay/coinsurance, cost shares, and catastrophic cap in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4, 199.5, 199.17, 199.18, and the TPM. Point-of-Service (POS) provisions do not apply to this contract.

8.7.1. The DP's claims/encounter processing system shall accurately coordinate benefits with other health insurances to which the beneficiary is entitled, as required by 32 CFR 199.8 and the applicable provisions of the TPM.

8.7.2. The DP shall ensure that enrollees have no liability for amounts billed, except for the appropriate co-payment, for referred care that constitutes covered services, including ancillary services from a non-network provider as a result of a medical emergency or as a result of the enrollee being referred to a non-network provider by the DP or DP's network provider.

8.7.3. The DP will be required to comply with Chapter 2 of the TOM. Chapter 2 does not require an electronic record keeping system. It does require that the DP keep paper copies of those records that relate to payment denial, appeals, peer review, or other specific issues that relate to payment or nonpayment of care on an individual basis. The provider's medical records, unless otherwise stated, are not DoD records that must be maintained by the contractor.

8.7.4. The DP or any of its subcontractors performing work on behalf of the DP that requiring access or an extraction of PHI under the provision of this contract must comply with OMB M-06-16, Protection of Sensitive Agency Information.

8.7.5. The DP shall provide to each beneficiary and each non-network participating provider an EOB that describes the action taken when care is denied or partially denied. If the denied care is related to a covered benefit, the EOB must provide the enrollee with his or her appeal rights. The DP may issue EOBs to network providers, as stipulated in the network provider agreement, provided an EOB is issued when care is denied or partially denied. The EOB must clearly describe the action taken, provide information regarding appeal rights, including the address for filing an appeal; information on the deductible and catastrophic cap status. The DP shall mail a requested EOB, without charge to the beneficiary, within 5 calendar days of receiving a request (written, verbal, and electronic) for an EOB from a beneficiary, regardless of his or her status. At the option of the providers, HIPAA-compliant electronic remittance advice shall be provided.

8.8. Management and Administration:

The DP shall establish and maintain sufficient staffing and management support to meet the requirements of this contract and comply with all management standards in the TOM, Chapter 1, Section 4.0.

8.8.1. The DP may be invited to participate in quarterly round table meetings with the Government, all other Managed Care Support contractors, and any other participants that the Government determines is necessary. The DP will arrange for high-level managerial participation in the round table (CEO, Medical Director, etc.) as well as participation, as appropriate based on the agenda, by the DP's technical and financial experts. The round table is tasked with reviewing current policies and procedures to determine where proven best practices from the participants, Government, and private sector operations can be implemented in the administration of TRICARE to continue TRICARE's leading role as a world-class health care delivery system.

8.8.2. The Government may develop major contract and program changes through Integrated Process Teams (IPTs) which is strictly voluntary for the DP to participate. This provision describes the contractor's opportunity to participate in this process. The contractor will be invited to participate in the IPT process and if acceptable, will provide appropriate personnel to serve on the IPTs to develop and/or improve the technical business, and implementation approach to proposed TRICARE processes, policy, business practices, and/or system architecture, possibly resulting in program changes. If electing to participate, the contractor may participate in the entire process with the government team from concept development through incorporating the change into the contract. This process includes developing budgetary cost estimates, requirement determination, developing Rough Order of Magnitude (ROM) cost estimates, and preparing specifications/statements of work. IPTs are generally formed for complex, system-wide issues within the Military Health System (MHS). Frequency and scheduling will vary depending upon the topic.

8.8.3. The DPs meet periodically to business through the US Family Health Plan Alliance. When the need arises, the USFHP Alliance will invite the Government DP Program Manager and appropriate staff to participate in specific topics of the USFHP Alliance meeting, as determined by the Alliance, for the purpose of furthering program objectives and maximizing healthcare business practices of the USFHP. The typically government attendees are the DP Program staff, the Contracting Officer, a representative from the Office of General Counsel, the government's actuarial representative, the Contracting Officer's Representative, and other subject matter experts in specific areas as invited.

8.8.4. The DP's shall provide Government personnel and/or their representatives during any site visit with private office space, a telephone with unrestricted capability, access to a printer and photocopier equipment.

8.8.5. Any MOA (drafted by the DP) between each MTF Commander and the DP shall be in writing and must be approved by the Contracting Officer. The DP shall initiate discussions related to and prepare the collaborative agreement. See, TOM, Chapter 16.

8.8.6. Information Systems (IS)/Networks Personnel Security: The DP shall achieve the same level of trustworthiness of personnel who have access to IS/Networks involved in the operation of the DP program systems of records as required for Government personnel requiring similar access to DoD information technology systems and networks containing sensitive information (SI) (See DoD 5200.2-R, February 1996 (Appendix 10)). See, TRICARE <http://www.tricare.mil/tmaprivacy/>.

a. To ensure the trustworthiness of personnel with access to DoD systems/data the contractor will classify Information Technology (IT) or related positions, submit appropriate paperwork for background investigations, ensure individuals

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- receive requisite training, and document compliance. Personnel background investigations and training must be initiated before access to DoD IS/networks or DoD SI is allowed for operation of contractor IS/Networks.
- b. All DP employees with access to SI that is maintained in contractor owned and operated IT systems that have no interconnection (including data feeds) with Government IT systems or networks, shall complete the appropriate background check for IT-III level personnel comparable to that described in the referenced Appendix 10 to DoD 5200.2-R unless the contractor proposes, and the Contracting Officer approves, other alternative safeguards appropriate to mitigate the risks associated with the loss/misuse or unauthorized access to or modification of the SI.
- c. Personnel to be assigned to an Automated Data Processing (ADP)/IT position must undergo a successful security screening before being granted access to DoD IT resources. The references and specific guidance provided herein to TMA by the Under Secretary of Defense for Intelligence (USDI) and the Office of Personnel Management (OPM) safeguard against inappropriate use and disclosure.
- d. The requirement above must be met by the DP, its' contractors, subcontractors and/or others who have access to DoD information systems containing information protected by the Privacy Act, as amended, and protected health information (PHI) under HIPAA. Background checks are required for all ADP/IT contractor personnel who receive, process, store, display, or transmit SI on a DoD IT system prior to being granted access.
- e. For the purposes of this contract, DoD/TMA data includes any information provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, capitation, fees, patient health information, as defined by DoD 6025.18-R, or any other information for which the source is the Government. Included in this definition is any data collected by or on behalf of the Government in the administration of TRICARE pursuant to the Privacy Act, as amended and DoD Regulation 5400.11-R. Any information developed or received by a contractor from a beneficiary, government employee, contractor or other functionary or system(s), whether Government owned or contractor owned, in the course of performing this contract is also DoD/TMA data. DoD/TMA data is any information, regardless of form or the media on which it may be recorded.
- f. For purposes of this contract, the DoD Information Assurance Certification and Accreditation Process (DIACAP) requirements apply to all activities of the DP contractors, regardless of the level of the contract organization.
- f.1. DIACAP requirements apply to DP subcontractors/business partners that perform functions such as program/business management, where the program/business management function requires access to DoD systems and/or the use of DoD/TRICARE data, beneficiary enrollment eligibility verification, claims processing, etc.
- f.2. The DIACAP requirements do not apply to providers who provide health care to CHAMPUS/TRICARE-eligible beneficiaries and who do not have access to DoD systems or use of DoD/TMA data, as that term is defined for purposes of this contract. Providers of health care are those hospitals, physicians, laboratories, pharmacies or other entities as defined by 32 CFR 199.6.
- f.3. It is expected that those institutional and/or non-institutional providers of health care under agreement or contract to the DP are covered by HIPAA.
- 8.8.7. The DP shall comply with DoD Information Assurance (DoD Directive 8500.1), Mission Assurance Category (MAC III), Sensitive Requirements found in DoD Information Assurance Implementation (DoD Instruction 8500.2), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (DoD 5200.2-R), the TSM, and the MHS IA Policy/Guidance Manual. The DP shall also comply with OMB M-06-16, Protection of Sensitive Agency Information
- 8.8.8. As a Covered Entity for the purpose of HIPAA, the DP shall comply with the HIPAA, as amended, requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS), the DoD Health Information Privacy Regulation (DoD 6025.18- R), the Health Insurance Portability and Accountability Act Security Compliance Memorandum (HA Policy 06-010), and the published TMA implementation directions. This includes the Standards for Electronic Transactions, the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information. The DP shall comply with all HIPAA-related rules and regulations as they are currently published.
- 8.8.9. DPs shall be treated as part of the DoD for purposes of section 8126 of title 38, United States Code. This code section authorizes the DP to be a DoD ordering activity for purposes of access to pharmaceuticals from contracts on the Federal Supply Schedule administered by the Department of Veterans Affairs. Therefore, the DP is eligible for Federal drug pricing through the Defense Supply Center, Philadelphia Pharmacy Prime Vendor Program, including Uniform Formulary Blanket Purchase Agreement (UF BPA) pricing, to order and obtain pharmaceuticals for covered enrollees of the USFHP.
- 8.8.10. Beneficiaries who are enrolled in USFHP may fill their prescriptions at a DP network pharmacy or through DP's mail order pharmacy program. The DP using its normal notification processes and procedures shall inform its enrolled beneficiary population that the USFHP utilizes the TRICARE Pharmacy Formulary and that co-payments will be consistent with TRICARE Prime Co-payments.
- 8.8.11. Under this co-payment structure, USFHP beneficiaries pay the pharmacy co-payment based on whether the prescription medication is classified as a formulary generic (Tier 1), formulary brand name (Tier 2), or non-formulary

(Tier 3) drug. That is, pharmaceutical agents not selected for the TRICARE UF are non-formulary. A covered enrollee of the USFHP may have access to such agents through prescriptions in the following ways: If there has been a review for medical necessity in accordance with the DP's procedures, with a determination made that the non-UF agent is medically necessary for the beneficiary in lieu of a pharmaceutical on the UF, then the beneficiary may receive the non-UF agent and pay the Tier 1 or Tier 2 co-payment, as applicable. If the beneficiary chooses not to have the medical necessity review, or if the medical necessity review concludes that access to the agent is not medically necessary for the beneficiary, the beneficiary may nonetheless obtain the agent with a prescription and shall be responsible for paying the Tier 3 co-payment.

8.8.12. In accordance with the provisions of Federal Acquisition Regulation 52.212-4, The DP will under go management control and diversion control audits for various programs, functions, administration, and/or payment process under the USFHP. The Contracting Officer will provide the DP with the general scope of any audit and a proposed time period to begin the audit process. All audits will be conducted in accordance with federal commercial contract procedures and regulation. TRICARE audits enrollment and capitation on a quarterly basis. Defense Contract Audit Agency (DCAA) conducts annual audits.

8.8.13. As a managed health plan, and in the absence of a TRICARE formulary, the DP has been allowed to establish a preferred drug list to promote clinically appropriate and cost-effective utilization of pharmaceuticals, rather than incurring the unnecessary expense of maintaining an inventory of drugs representing the full scope of pharmaceuticals approved by the FDA. However, even with a preferred drug list, DPs have been required to establish procedures for an eligible beneficiary to receive pharmaceutical agents not included on the preferred drug list when such agents are considered to be clinically necessary. The DP preferred drug list will be phased out as DoD completes implementation of the law requiring TRICARE to establish a Uniform Formulary (UF) which shall assure the availability of pharmaceutical agents in the complete range of therapeutic classes with inclusion of particular pharmaceutical agents in each therapeutic class based on the relative clinical and cost effectiveness of the agents in such class. Under the law, a DoD Pharmacy and Therapeutics (P&T) Committee has been established to review all therapeutic classes of pharmaceutical agents and to make recommendations concerning which pharmaceutical agents to include on the UF. Because the DP is required to provide the full TRICARE Prime scope of coverage, the DP is required to implement fully the TRICARE UF. During the transition period necessary for the DoD P&T Committee's review of all therapeutic classes of agents, the DP will be allowed to continue use of a preferred drug list for those therapeutic classes of agents not yet reviewed by the DoD P&T Committee. Such limited DP preferred drug list shall be established based on the local DP Pharmaceutical and Therapeutics (P&T) Committee's evaluation of the clinical and cost effectiveness of the agents in such class. Clinical effectiveness means that the DP P&T Committee has determined that a significant, clinically meaningful therapeutic advantage exists for the preferred agent(s) in terms of safety, effectiveness, or clinical outcome over the other agents in the class. Cost effectiveness means that the DP P&T Committee has evaluated the cost of the preferred agent(s) within the class in relation to the safety, effectiveness, and clinical outcomes of such agents. During this transition period, DPs will continue to have procedures for an eligible beneficiary to receive pharmaceutical agents not included on the preferred drug list when such agents are considered to be clinically necessary. As therapeutic classes are reviewed under the DoD formulary management process and pharmaceutical agents are designated for formulary/non-formulary status, the DP shall immediately discontinue any preferred drug list (even for limited educational or informational outreach to providers) which includes pharmaceutical agents from such therapeutic class.

8.8.14. Expansion of any USFHP service area requires the approval of TMA Senior leadership, consisting of the Chief of Health Plan Operations and the Deputy Director of TRICARE. The DP shall provide the program office information to support the proposed expansion with maps of the current service area and the area of proposed expansion. Service areas zip codes dropped, changed, or new that are or were in the DP service area can be added back to the service area by the program office without the approval of TMA senior leadership.

8.8.15. The DP shall comply with Office of the Secretary of Defense (OSD) Memorandum 12282-05 establishing a new Department-wide policy that requires contractors who collect, maintain, use, or disseminate protected personal information on behalf of a DoD Component, to notify Departmental personnel (Program Manager, Contracting Officer, and Contracting Officer's Representative), to include enrolled members affected, when their personal data has been lost, stolen, or compromised. OSD Memorandum 12282-05 will be incorporated in a future revision of DoD Directive 5400.11, "DoD Privacy Policy" incorporate the new policy.

<http://www.tricare.mil/tmaprivacy/hipaa/hipaacompliance/library/Policy-Memos.htm>

a. The Contractor shall comply with OSD Memorandum 12282-05 while current and with the appropriate revision of DoD 5400.11 regarding notification when protected personal information is lost, stolen, or compromised. Protected Personal Information (PPI) includes information about an individual that identifies, relates to, is unique to, or describes an individual, e.g., home address; date of birth; social security number; credit card or account numbers; etc. The policy provides that the Contractor, as part of the notification process, shall inform the individual of what protective actions the individual can take.

8.9. Information Systems and Data Sharing:

The DP shall provide information management and IT support as needed to accomplish the stated functional and operational requirement of the TRICARE program, in accordance with the TSM, Chapter 1 and MHS Enterprise Architecture guidance. For additional information see http://www.ha.osd.mil/mhscio/ea_reference_docs.htm.

8.9.1. Information System (IS)/Networks Certification And Accreditation:

The DoD Information Assurance Certification and Accreditation Process (DIACAP), November 28, 2007, was established for the authorization of the operation of DoD information systems.

- a. The DIACAP is the standardized approach to the Certification and Accreditation (C&A) process within DoD. Each IS/network that undergoes DIACAP must have required security controls in place, must have documented the security components and operation of the IS/network and must successfully complete testing of the required security controls. The DP shall ensure DIACAP documentation is available for review and is accurate
- b. Accreditation is the formal approval by the government for the contractors' IS' to operate in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS' to operate within the given operational environment with stated interconnections; and with appropriate levels of information assurance security controls.
- c. The DP network shall comply with the C&A process established under the DIACAP for safeguarding DoD SI accessed, maintained and used in the operation of systems of records under this contract.
- d. The DP shall implement the DIACAP by providing, for receipt by the Contracting Officer within sixty (60) calendar days following contract award, the required documentation necessary to receive an Approval to Operate (ATO), and making their IS(s)/networks available for testing and initiate testing 120 days in advance of accessing DoD data or interconnecting with DoD IS'. The DP shall ensure the proper DP, and/or subcontractor support staff is available to participate in all phases of the C&A process. They included, but are not limited to:
 - (i) attending and supporting C&A meetings with the government;
 - (ii) supporting/conducting the vulnerability mitigation process; and
 - (iii) supporting the C&A Team during system security testing.
- e. DP must confirm that their system baseline configuration remains static during the initial testing.
- f. Confirmation of system baseline configuration shall be agreed upon during the definition of the C&A boundary and be signed by the government and the DP and documented as part of the System Identification Profile (SIP) and artifacts.
- g. During the actual baseline and mitigation assessment scans, the information system must remain frozen. The freeze is only in place during the actual testing periods. Changes between baseline testing and mitigation testing must be coordinated and approved by the MHS IA Program Office prior to implementation. Any reconfiguration or changes in the system during the C&A testing process may require a rebaselining of the system and documentation of system changes. This could result in a negative impact to the C&A timeline.
- h. The DP shall be required to mitigate the vulnerabilities identified for correction during the C&A process. These requirements shall be met before interconnecting with any DoD IS/network or electronic access to DoD SI is authorized. The DP shall comply with the MHS DIACAP checklist. Reference material and DIACAP tools can be found at the TRICARE website and in the attachments. See, http://www.tricare.osd.mil/tmis_new/ia.htm
- i. After contract award date, and an ATO is granted to the DP, reaccreditation is required every three years or when significant changes occur that impact the security posture of the DPs' information system. An annual review shall be conducted by the MHS IA Program Office (or it's subcontractor/designee) that comprehensively evaluates existing contractor system security posture in accordance with DoD 8500.2, "Information Assurance (IA) Implementation," February 6, 2003.
- j. Each DP IS/network must also comply with the requirements for Information Assurance Vulnerability Management (IAVM) to ensure that the security posture is maintained. As part of the DP IAVM program the DP shall provide a primary and secondary point of contact for the MHS IAVM Monitor. The point of contact shall provide, upon receipt of a vulnerability message, an acknowledgment of receipt. The DP shall mitigate the vulnerability, and upon mitigation, report compliance. Receipt and compliance messages to the government shall occur within the stipulated window, as stated in the vulnerability message, and be directed to the MHS IAVM monitor. Mitigation compliance shall be assessed on an annual basis.

8.9.2. The DP shall ensure that all electronic transactions, for which a standard has been named, comply with HIPAA rules and regulations and TMA requirements. The Standards for Electronic Transactions apply to all health plans, all health care clearinghouses, and all health care providers that electronically transmit any of the electronic transactions for which a standard has been adopted by the Secretary, HHS. Electronic transmission includes transmission using all media, even when the transmission is physically moved from one location to another using magnetic tape, disk or CD media. Transmission over the Internet, Extranet, leased lines, dial-up lines and private networks are all included. Transmissions of covered data content via telephone conversations, fax machines, and voice response systems are not covered by the Standards for Electronic Transactions; however privacy and security requirements apply to these transmissions. Health plans and other covered entities conducting transactions through business associates must assure that the business associates comply with all HIPAA requirements that apply to the health plans or covered entities themselves.

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8.9.3. Consistent with the status of this contract as commercial items contract, the DP shall provide data to the Government at the beneficiary, institutional and non-institutional level, with the intent of providing the Government with the DP's full set of claims data, including, but not limited to, data concerning the participants in the DP's providers network, enrollment information, referrals, authorizations, claims processing, program administration, beneficiary satisfaction, services, availability of other health insurance (OHI) and fee payments.

8.9.4. The DP shall accurately capture and report all encounter data for all enrollees that received covered benefits and report that information to the DoD Data Contractor by the fifteenth (15) day of the following month. Encounter data reporting must comply with requirements outlined in Chapter 1, Section 4 of the TOM. Records shall comply with the information management requirements of this contract and shall be reported in compliance with the standards in the TOM. Encounter data will be used to validate experience data submitted by the DP for the contract option periods.

8.9.5. The DP shall accurately submit all medical and pharmacy encounters, provider, OHI, and enrollment fee data to the DoD Data Contractor by the fifteenth (15) day of each month. All data must be reported electronically using the file format and layout provided (Attachments 2). The DPs shall receive summary and error reports for their monthly submissions by the twentieth (20) of the month.

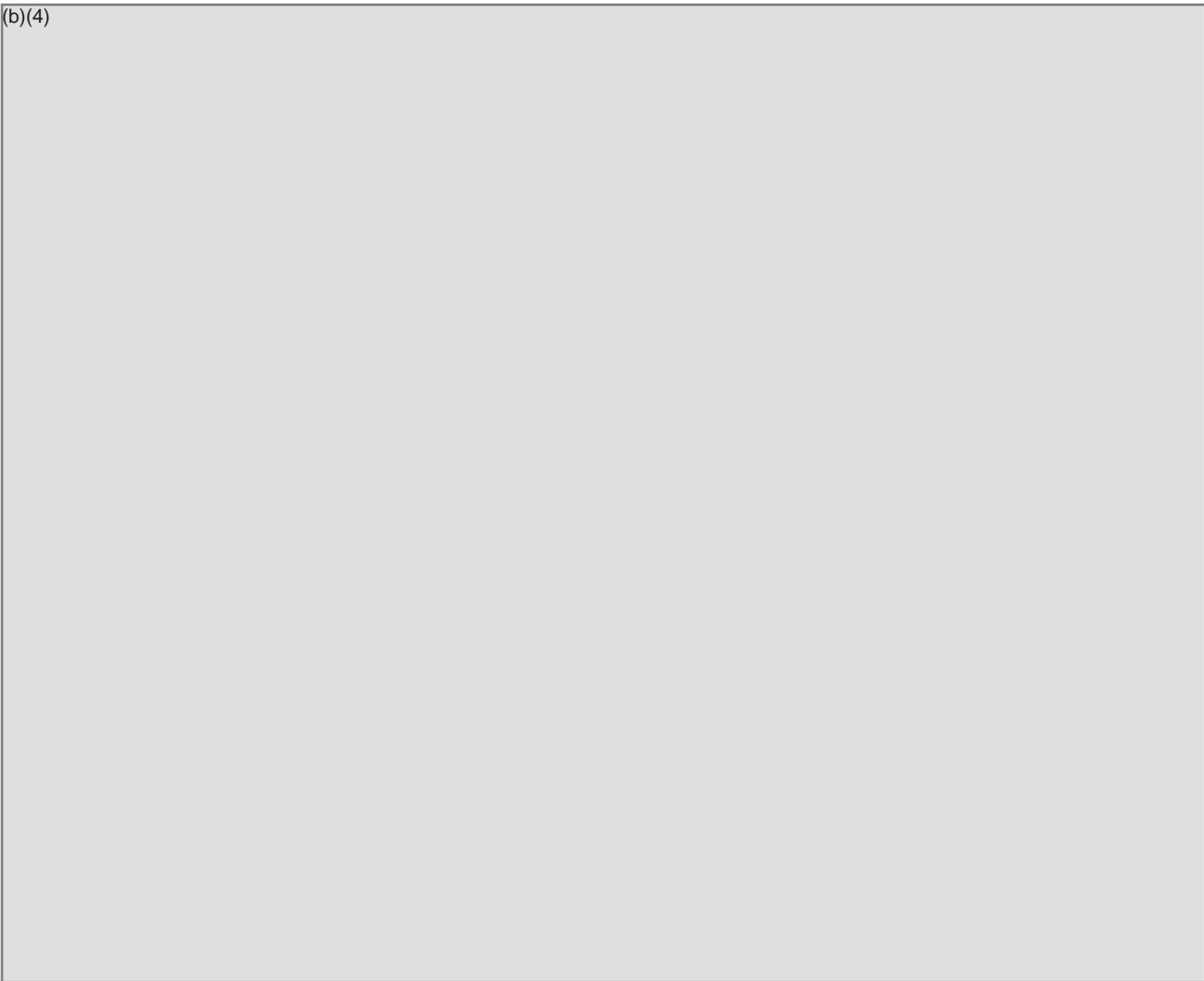
8.9.6. DP shall follow the DoD standards, procedures and use approved products to dispose of unclassified hard drives and other electronic media, as appropriate, in accordance with DoD Memorandum, "Disposition of Unclassified Computer Hard Drives," June 4, 2001. DoD guidance on sanitization of other internal and external media components are found in DoD 8500.2, "Information Assurance (IA) Implementation," February 6, 2003.

9.0. PROPOSAL INSTRUCTION - CAPITATION METHODOLOGY:

Each DP will be paid an amount that is the lesser of the amount that would be paid upon the "experience-based" rates or the "ceiling" rates. The government will determine annually which rates are used. The method to be used to set the "experience-based" rates is described in Section 9.1 and the method used to determine the "ceiling" rates is described in Section 9.2. The comparison of the ceiling and experience rates is described in Section 9.3 and the annual updating of the rates is described in Section 9.4.

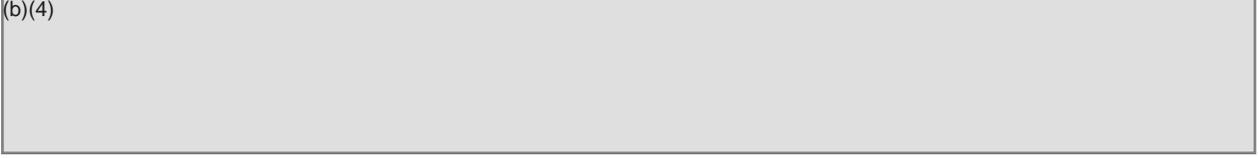
NOTE: Agreed to "Ceiling Rate Methodology" for the base period will be incorporated into the contract as Attachment 11.

(b)(4)

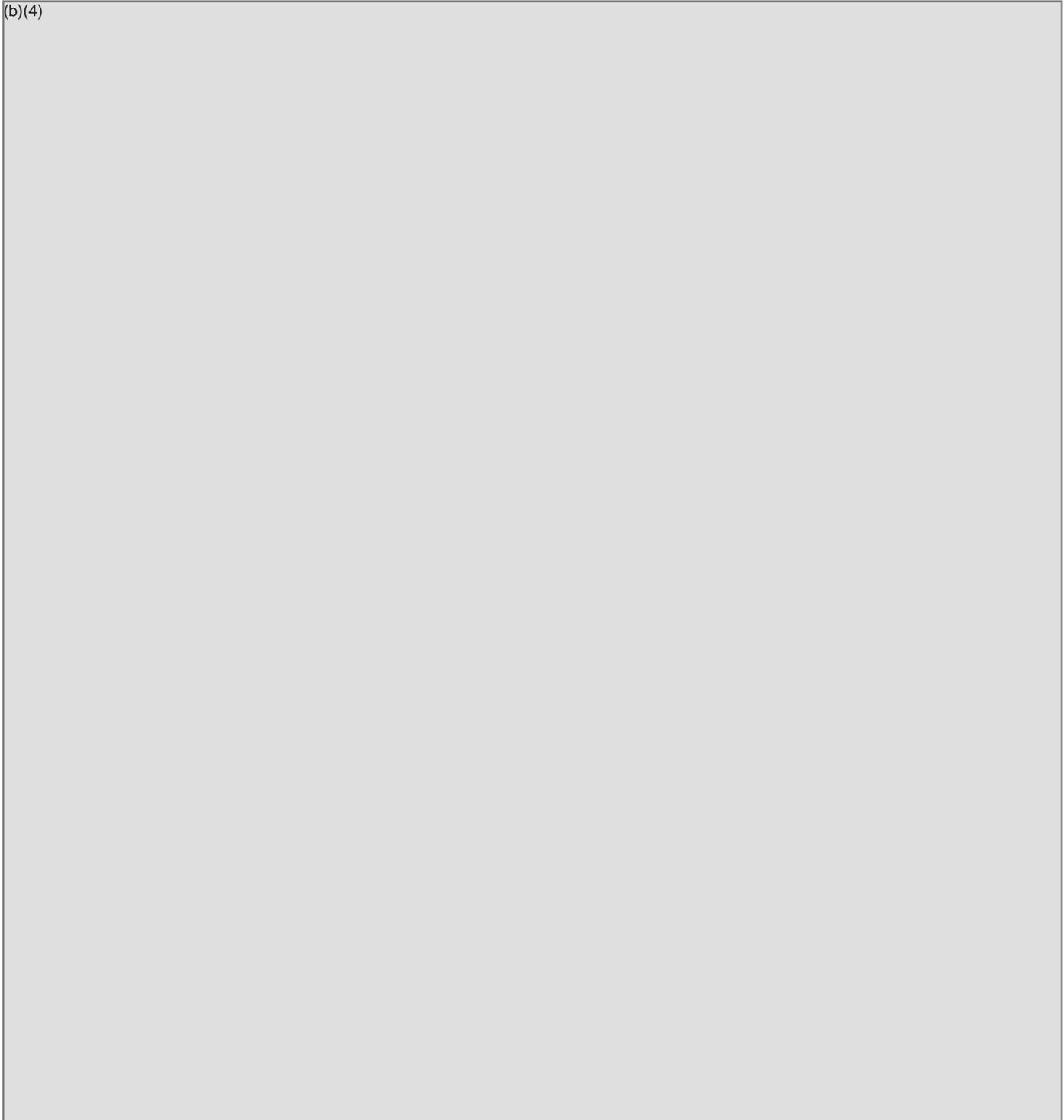


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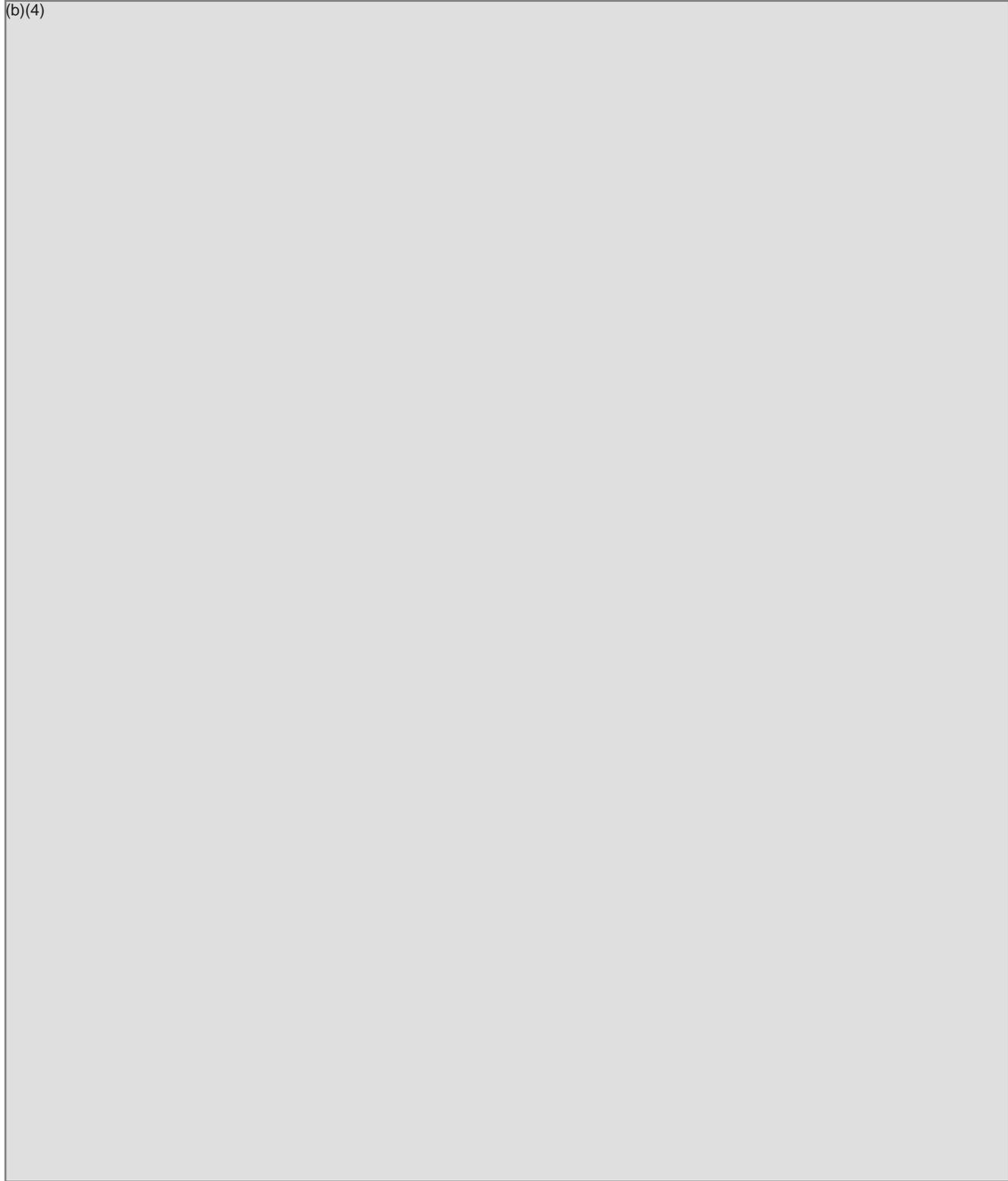
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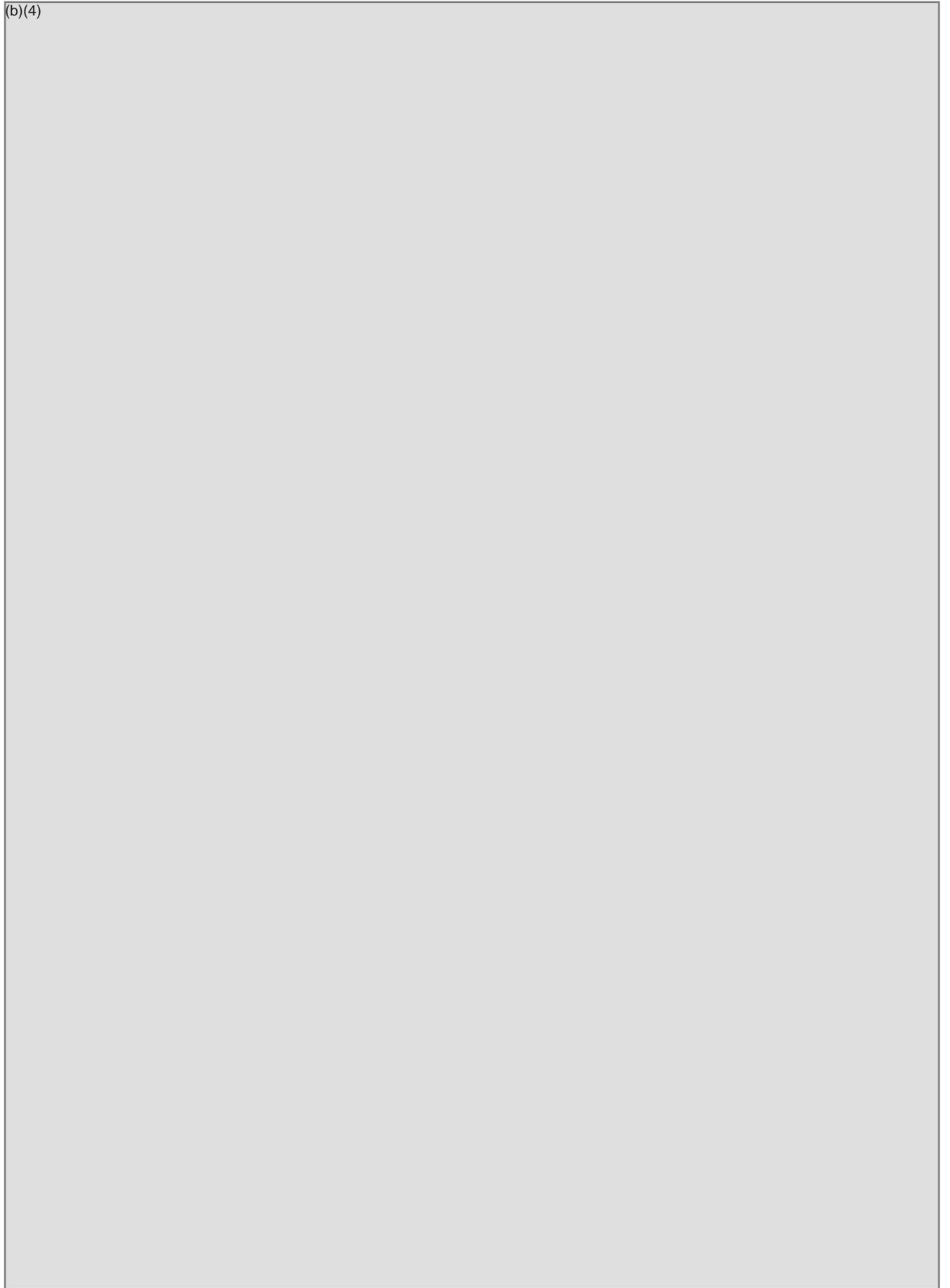


9.2. Ceiling Rates: Section 726(b) of the National Defense Authorization Act for Fiscal Year 1997 states that the capitation payments for health care services to a DP shall not exceed an amount equal to the cost that would have been incurred by the Government if the enrollee had received such health care services through a military treatment facility, the TRICARE program, or the Medicare program, as the case may be.

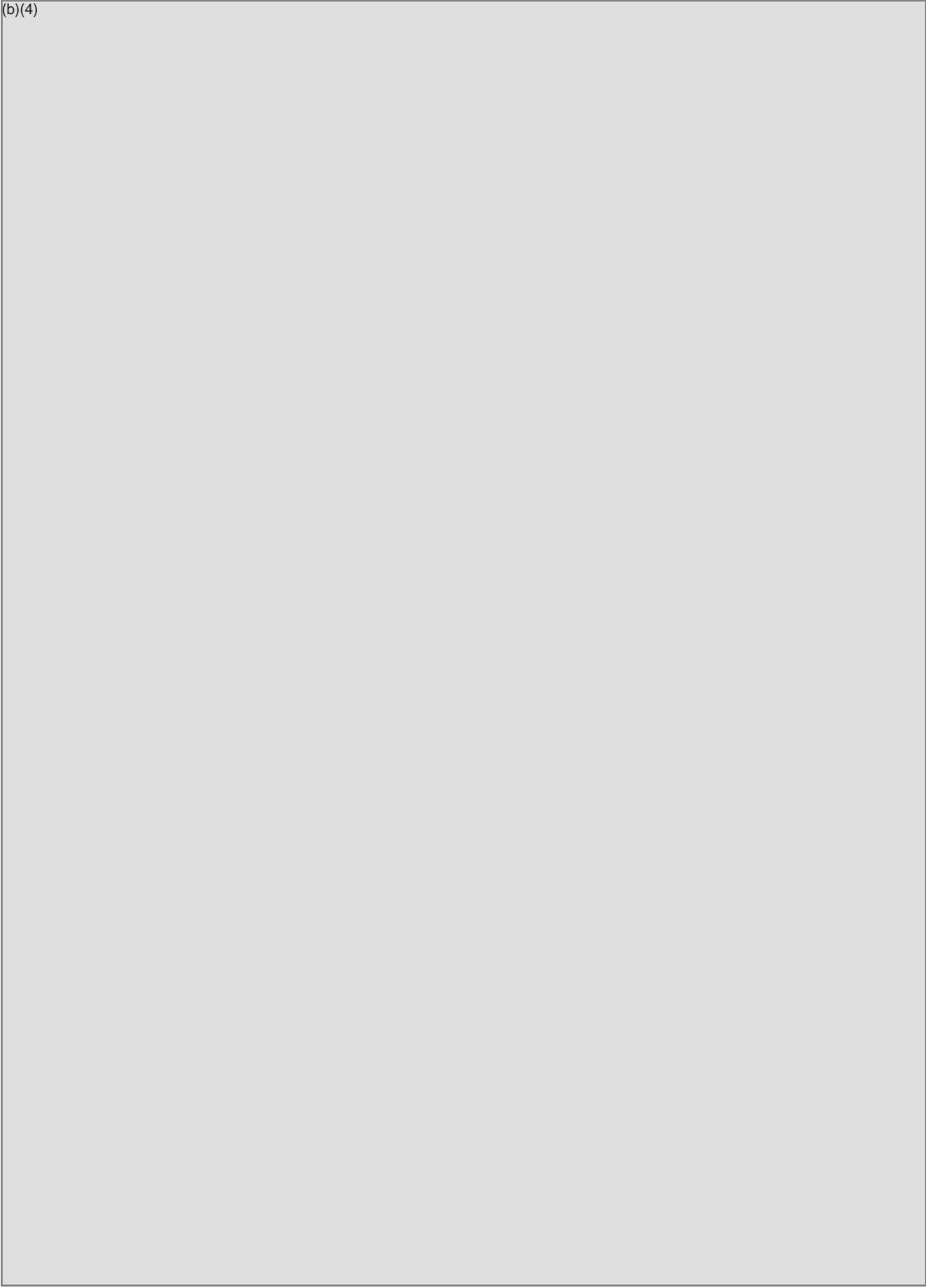
(b)(4)



(b)(4)



(b)(4)



(b)(4)

9.2.2.1. Medicare-Covered Service Portion: Section 726(b) of the FY97 National Defense Authorization Act indicates that the Government should pay the DP what the Government would have paid for the enrollees if they had received such services through an MTF, the TRICARE program, or Medicare. (b)(4)

(b)(4)

(b)(4)

10.0. PAYMENT PROCESSING:

Upon acceptance of a proper invoice, the COR will prepare a receiving report and forward it and the corresponding documentation to the paying office.

10.1. Capitation Invoices: The DP shall complete the payment invoice (DD Form 250) for health care Contract Line Item Number (CLIN 1001) forty-five (45) days prior to the requested payment date. The DP shall invoice for the current month's capitation amount of the eligible and enrolled beneficiary population, per data available at the time of invoicing. The DP's requested payment date shall be no earlier than the 10th of the payment month in which services are being provided. A complete DD Form 250 (including electronic signature) should be electronically forwarded to the DP Program Office.

10.2. Travel Invoices: Requests for travel costs (CLIN 1101) shall include a per person summary of the expenses being claimed along with their itineraries (including dates of travel), original airline tickets, original hotel receipts, original car rental receipts, and receipts for any other expenses over \$75 and the contracting officer's authorization for the trip. Costs associated with Government-authorized travel will be paid through the contract by the Government at rates authorized under the Joint Travel Regulation Volume 2, DoD Civilian Personnel, in accordance with FAR Section 31.205-46 Travel costs. Request for Travel reimbursement shall include a complete payment invoice (DD Form 250) along with all documents (i.e. to include but may not be limited to those documents as described above) supporting the total amount on the invoice.

10.3. DIACAP Invoices: Requests for DIACAP costs (CLIN's 1102) shall include a complete payment invoice (DD Form 250) along with all documents (i.e. expense reports, receipts, equipment invoices) supporting the total amount on the invoice.

10.4. Rejected Invoices: The COR or paying office may reject or require correction of any deficiencies found in the invoice. In the event of a rejected invoice, the DP must be notified in writing by the COR or paying office of the specific reasons for rejection.

10.5. Reconciliation: Reconciliation is made up of two separate sections, the enrollment reconciliation and the payment reconciliation. The Government will complete these combined reconciliation on a quarterly basis, and report to the DP no later than sixty (60) days following the end of each quarter. In the event of a correction requiring the Government to make payment to the DP, the Government will inform the DP of the amount due to them, and the DP shall invoice for that amount within thirty (30) days following the receipt of the quarterly reconciliation. In the event of a correction requiring the DP to refund money to the Government, the Government will inform the DP of the amount due to the Government and the DP shall submit a check to the Government within 60 days for the amount of the overpayment. At the time of reconciliation, the Government will recover overpayments in accordance with the TOM, Chapter 11, Section 4, Sub-section 6.1 Overpayments Recovery – Non-Financially Underwritten Funds. Reasonable care and precautions is evidenced by reliance on the DEERS file in accordance with Section 8.3.11.

11.0. ADDITIONAL PROVISIONS:

Nondiscrimination in Employment, Enrollment, Services, Benefits, and Facilities. Subject to the terms and conditions set forth herein relating to Medical Necessity and utilization review, the DP shall make no distinctions in employment, or in the provisions of services on the basis of age, sex, handicap, race, color, religion or national origin. Distinction on the grounds of age, sex, handicap, race, color, religion or national origin includes, but is not limited to, the following: denying an enrollee any services or benefit or availability of a provider on the basis of age, sex, handicap, race, color, religion or national origin; providing any service or benefit to an Enrollee which is different or is provided in a different manner or on a different schedule as provided to other Enrollees under this contract for any reason other than medical necessity and/or capacity; subjecting an Enrollee, on the basis of age, sex, handicap, race, color, religion or national origin to segregation or separate treatment in any manner related to the Enrollee's receipt of any service; restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; treating an Enrollee differently from others in determining whether the Enrollee satisfies any admission, enrollment,

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eligibility, or other requirement or condition which individuals must meet in order to be provided any service or benefit; the assignment of times or places for the provisions of services on the basis of the age, sex, handicap, race, color, religion or national origin of the Enrollees to be served; and discriminating against any employee or applicant for employment because of age, sex, handicap, race, color, religion or national origin.

11.1. Privacy Act:

Pursuant to FAR Part 24 the requirements of the Privacy Act (5 U.S.C. 552a), as amended, and the Department of Defense Privacy Program (DoD 5400.11-R) are applicable to this contract and the systems of records operated and maintained by the contractor on behalf of TMA. These systems of records are found at 65 Federal Register (FR) 30966 (Health Benefits Authorization Files, Medical/Dental Care and Claims Inquiry Files, Medical/Dental Claim History Files), 60 FR 43775 (USTF Managed Care System), 69 FR 50171 and 71 FR 16127 (Military Health Information System), and 64 FR 22837 (Health Affairs Survey Data Base). The records systems operated and maintained by TMA contractors are records systems operated and maintained by a DoD Component (TMA). (See TOM 6010.56-M, Chapter 1, Section 5, Chapter 2, Section 1, and Chapter 2, Section 2).

12.0. ADMINISTRATIVE POINTS OF CONTACT:

12.1. Contracting Officer's Representative: A Contracting Officer's Representative (COR) shall be designated in writing by the Contracting Officer.

12.2. Alternate Contracting Officer's Representative: An Alternate Contracting Officer's Representative (ACOR) shall be designated in writing by the Contracting Officer.

LIST OF ATTACHMENTS

ATTACHMENT 1	Service Area Zip Codes
ATTACHMENT 2	Designated Provider Final Specifications
ATTACHMENT 3	TRICARE DP Program Data Dictionary for the Ingenix Data Warehouse
ATTACHMENT 4	IAVM Program - MHS Information Assurance (IA) Implementation Guide
ATTACHMENT 5	DIACAP System Manual
ATTACHMENT 6	DIACAP Checklist
ATTACHMENT 7	DIACAP Artifact 9 PSA Report Template
ATTACHMENT 8	DIACAP Artifact 9 PSA Matrix
ATTACHMENT 9	Abbreviations, Acronyms and References
ATTACHMENT 10	TRICARE Manual Exemptions
ATTACHEMNT 11	Final Capitation Rates Used for the Base Period

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I.1 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available.

Also, the full text of a clause may be accessed electronically at this/these address(es):

<http://www.acqnet.gov> (End of Clause)

I.2 252.201-7000 CONTRACTING OFFICER'S REPRESENTATIVE (DEC 1991)

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I.7 52.204-4 PRINTED OR COPIED DOUBLE-SIDED ON RECYCLED PAPER (AUG 2000)
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I.8 52.204-7 CENTRAL CONTRACTOR REGISTRATION (JULY 2006) (Reference 4.1104)

I.9 52.204-9 PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL
(SEP 2007) (Reference 4.1303)

I.10 52.209-6 PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT (SEP 2006) (Reference 9.409)

I.11 52.212-4 CONTRACT TERMS AND CONDITIONS--COMMERCIAL ITEMS (FEB 2007)
(Reference 12.301)

I.12 52.212-5 CONTRACT TERMS AND CONDITIONS REQUIRED TO IMPLEMENT STATUTES OR EXECUTIVE ORDERS--COMMERCIAL ITEMS (SEP 2007)

(a) The Contractor shall comply with the following Federal Acquisition Regulation (FAR) clause, which is incorporated in this contract by reference, to implement provisions of law or Executive orders applicable to acquisitions of commercial items:

(1) 52.233-3, Protest after Award (Aug 1996) (31 U.S.C. 3553).

(2) 5.233-4, Applicable Law for Breach of Contract Claim (Oct 2004) (Pub. L.108-77, 108-78).

(b) The Contractor shall comply with the FAR clauses in this paragraph (b) that the Contracting Officer has indicated as being incorporated in this contract by reference to implement provisions of law or Executive orders applicable to acquisitions of commercial items:

✓ (1) ***52.203-6, RESTRICTIONS ON SUBCONTRACTOR SALES TO THE GOVERNMENT*** (Sep 2006), with Alternate I (Oct 1995)(41 U.S.C. 253g and 10 U.S.C. 2402).

___ (2) 52.219-3, Notice of Total HUBZone Set-Aside (Jan 1999) (15 U.S.C. 657a).

___ (3) 52.219-4, Notice of Price Evaluation Preference for HUBZone Small Business Concerns (July 2005) (if the offeror elects to waive the preference, it shall so indicate in its offer) (15 U.S.C. 657a).

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- ___ (4) [Reserved]
- ___ (5) (i) 52.219-6, Notice of Total Small Business Set-Aside (June 2003) (15 U.S.C. 644).
- ___ (ii) Alternate I (Oct 1995) of 52.219-6.
- ___ (iii) Alternate II (Mar 2004) of 52.219-6.
- ___ (6) (i) 52.219-7, Notice of Partial Small Business Set-Aside (June 2003) (15 U.S.C. 644).
- ___ (ii) Alternate I (Oct 1995) of 52.219-7.
- ___ (iii) Alternate II (Mar 2004) of 52.219-7.
- (7) **52.219-8, UTILIZATION OF SMALL BUSINESS CONCERNS** (May 2004) (15 U.S.C.637(d)(2) & (3)).
- (8) **(I) 52.219-9, SMALL BUSINESS SUBCONTRACTING PLAN** (Sep 2007) (15 U.S.C.637(d)(4)).
- ___ (ii) Alternate I (Oct 2001) of 52.219-9.
- ___ (iii) Alternate II (Oct 2001) of 52.219-9.
- ___ (9) 52.219-14, Limitations on Subcontracting (Dec 1996) (15 U.S.C.637(a)(14)).
- (10) **52.219-16, LIQUIDATED DAMAGES--SUBCONTRACTING PLAN** (Jan 1999) (15 U.S.C. 637(d)(4)(F)(i)).
- ___ (11) (i) 52.219-23, Notice of Price Evaluation Adjustment for Small Disadvantaged Business Concerns (Sept 2005) (10 U.S.C. 2323) (if the offeror elects to waive the adjustment, it shall so indicate in its offer).
- ___ (ii) Alternate I (June 2003) of 52.219-23.
- ___ (12) 52.219-25, Small Disadvantaged Business Participation Program - Disadvantaged Status and Reporting (Oct 1999) (Pub. L. 103-355, section 7102, and 10 U.S.C. 2323).
- ___ (13) 52.219-26, Small Disadvantaged Business Participation Program- Incentive Subcontracting (Oct 2000) (Pub. L. 103-355, section 7102, and 10 U.S.C. 2323).
- ___ (14) 52.219-27, Notice of Total Service-Disabled Veteran-Owned Small Business Set-Aside (May 2004) (15 U.S.C. 657 f).
- ___ (15) 52.219-28, Post Award Small Business Program Representation (June 2007) (15 U.S.C. 632(a)(2)).
- ___ (16) 52.222-3, Convict Labor (June 2003) (E.O. 11755).

✓ (17) 52.222-19, **CHILD LABOR COOPERATION WITH AUTHORITIES AND REMEDIES** (Aug 2006) (E.O. 13126).

✓ (18) 52.222-21, **PROHIBITION OF SEGREGATED FACILITIES** (Feb 1999).

✓ (19) 52.222-26, **EQUAL OPPORTUNITY** (Apr 2002) (E.O. 11246).

✓ (20) 52.222-35, **EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS, Veterans of the Vietnam Era, and Other Eligible Veterans** (Sept 2006) (38 U.S.C. 4212).

✓ (21) 52.222-36, **AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES** (Jun 1998) (29 U.S.C. 793).

✓ (22) 52.222-37, **EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, Veterans of the Vietnam Era, and Other Eligible Veterans** (Sept 2006) (38 U.S.C. 4212).

___ (23) 52.222-39, **Notification of Employee Rights Concerning Payment of Union Dues or Fees** (Dec 2004) (E.O. 13201).

✓ (24) (I) 52.222-50, **COMBATING TRAFFICKING IN PERSONS** (Aug 2007) (Applies to all contracts).

___ (ii) Alternate I (Aug 2007) of 52.222-50.

___ (25) (i) 52.223-9, **Estimate of Percentage of Recovered Material Content for EPA-Designated Products** (Aug 2000) (42 U.S.C. 6962(c)(3)(A)(ii)).

___ (ii) Alternate I (Aug 2000) of 52.223-9 (42 U.S.C. 6962(i)(2)(C)).

✓ (26) 52.225-1, **BUY AMERICAN ACT-SUPPLIES** (June 2003)(41 U.S.C. 10a-10d).

___ (27) (i) 52.225-3, **Buy American Act-Free Trade Agreements-Israeli Trade Act** (Aug 2007) (41 U.S.C. 10a-10d, 19 U.S.C. 3301 note, 19 U.S.C. 2112 note, Pub. L. 108-77, 108-78, 108-286, 109-53 and 109-169).

___ (ii) Alternate I (Jan 2004) of 52.225-3.

___ (iii) Alternate II (Jan 2004) of 52.225-3.

___ (28) 52.225-5, **Trade Agreements** (Nov 2006) (19 U.S.C. 2501, et seq. 19 U.S.C. 3301 note).

✓ (29) 52.225-13, **RESTRICTIONS ON CERTAIN FOREIGN PURCHASES** (Feb 2006) (E.O.S. proclamations, and statutes administered by the Office of Foreign Assets Control of the Department of the Treasury).

___ (30) 52.226-4, **Notice of Disaster or Emergency Area Set-Aside** (Aug 2006) (42 U.S.C. 5150).

___ (31) 52.226-5, **Restrictions on Subcontracting Outside Disaster or Emergency Area** (Aug 2006) (42 U.S.C. 5150).

___ (32) 52.232-29, Terms for Financing of Purchases of Commercial Items (Feb 2002) (41 U.S.C. 255(f), 10 U.S.C. 2307(f)).

___ (33) 52.232-30, Installment Payments for Commercial Items (Oct 1995) (41 U.S.C. 255(f), 10 U.S.C. 2307(f)).

✓ (34) **52.232-33, PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION** (Oct 2003) (31 U.S.C. 3332).

___ (35) 52.232-34, Payment by Electronic Funds Transfer-Other than Central Contractor Registration (May 1999) (31 U.S.C. 3332).

___ (36) 52.232-36, Payment by Third Party (May 1999) (31 U.S.C. 3332).

✓ (37) **52.239-1, PRIVACY OR SECURITY SAFEGUARDS** (Aug 1996) (5 U.S.C. 552a).

___ (38) (i) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. Appx 1241(b) and 10 U.S.C. 2631).

___ (ii) Alternate I (Apr 1984) of 52.247-64.

(c) The Contractor shall comply with the FAR clauses in this paragraph (c), applicable to commercial services, that the Contracting Officer has indicated as being incorporated in this contract by reference to implement provisions of law or Executive orders applicable to acquisitions of commercial items:

___ (1) 52.222-41, Service Contract Act of 1965, as Amended (July 2005) 41 U.S.C. 351, et seq.).

___ (2) 52.222-42, Statement of Equivalent Rates for Federal Hires (May 1989) 29 U.S.C. 206 and 41 U.S.C. 351, et seq.).

___ (3) 52.222-43, Fair Labor Standards Act and Service Contract Act - Price Adjustment (Multiple Year and Option Contracts) (May 1989) (29 U.S.C. 206 and 41 U.S.C. 351, et seq.).

___ (4) 52.222-44, Fair Labor Standards Act and Service Contract Act - Price Adjustment (Feb 2002) (29 U.S.C. 206 and 41 U.S.C. 351, et seq.).

___ (5) 52.237-11, Accepting and Dispensing of \$1 Coin (Aug 2007) (31 U.S.C. 5112(p)(1)).

(d) Comptroller General Examination of Record. The Contractor shall comply with the provisions of this paragraph (d) if this contract was awarded using other than sealed bid, is in excess of the simplified acquisition threshold, and does not contain the clause at 52.215-2, Audit and Records-Negotiation.

(1) The Comptroller General of the United States, or an authorized representative of the Comptroller General, shall have access to and right to examine any of the Contractor's directly pertinent records involving transactions related to this contract.

(2) The Contractor shall make available at its offices at all reasonable times the records, materials, and other evidence for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in FAR Subpart 4.7, Contractor Records Retention, of the other clauses of this contract. If this contract is completely or partially terminated, the records relating to the work terminated shall be made available for 3 years after any

resulting final termination settlement. Records relating to appeals under the disputes clause or to litigation or the settlement of claims arising under or relating to this contract shall be made available until such appeals, litigation, or claims are finally resolved.

(3) As used in this clause, records include books, documents, accounting procedures and practices, and other data, regardless of type and regardless of form. This does not require the Contractor to create or maintain any record that the Contractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e)

(1) Notwithstanding the requirements of the clauses in paragraphs (a), (b), (c), and (d) of this clause, the Contractor is not required to flow down any FAR clause, other than those in paragraphs (i) through (vii) of this paragraph in a subcontract for commercial items. Unless otherwise indicated below, the extent of the flow down shall be as required by the clause—

(i) 52.219-8, Utilization of Small Business Concerns (May 2004) (15 U.S.C. 637(d)(2) and (3)), in all subcontracts that offer further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds \$550,000 (\$1,000,000 for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(ii) 52.222-26, Equal Opportunity (Mar 2007) (E.O. 11246).

(iii) 52.222-35, Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (Sept 2006) (38 U.S.C. 4212).

(iv) 52.222-36, Affirmative Action for Workers with Disabilities (June 1998) (29 U.S.C. 793).

(v) 52.222-39, Notification of Employee Rights Concerning Payment of Union Dues or Fees (DEC 2004) (E.O. 13201).

(vi) 52.222-41, Service Contract Act of 1965, as Amended (July 2005), flow down required for all subcontracts subject to the Service Contract Act of 1965 (41 U.S.C. 351, et seq.).

(vii) 52.222-50, Combating Trafficking in Persons (Aug 2007) (22 U.S.C. 7104(g)). Flow down required in accordance with paragraph (f) of FAR clause 52.222-50.

(viii) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. Appx 1241 (b) and 10 U.S.C. 2631). Flow down required in accordance with paragraph (d) of FAR clause 52.247-64.

(2) While not required, the contractor may include in its subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(End of Clause)

I.13 52.215-8 ORDER OF PRECEDENCE--UNIFORM CONTRACT FORMAT (OCT 1997)
(Reference 15.209)

I.14 52.215-20 IV REQUIREMENTS FOR COST OR PRICING DATA OR INFORMATION OTHER THAN COST OR PRICING DATA (OCT 1997)--ALTERNATE IV (OCT 1997)

(a) Submission of cost or pricing data is not required.

(b) Provide information described below: _____

I.15 52.216-1 TYPE OF CONTRACT (APR 1984)

The Government contemplates award of a [Fixed Price \(Capitated Rate\) with Cost Reimbursable line item](#) contract resulting from this solicitation. (End of Provision)

I.16 52.217-8 OPTION TO EXTEND SERVICES (NOV 1999) (Reference 17.208)

I.17 52.217-9 OPTION TO EXTEND THE TERM OF THE CONTRACT (MAR 2000)
(Reference 17.208)

I.18 52.232-18 AVAILABILITY OF FUNDS (APR 1984) (Reference 32.705-1)

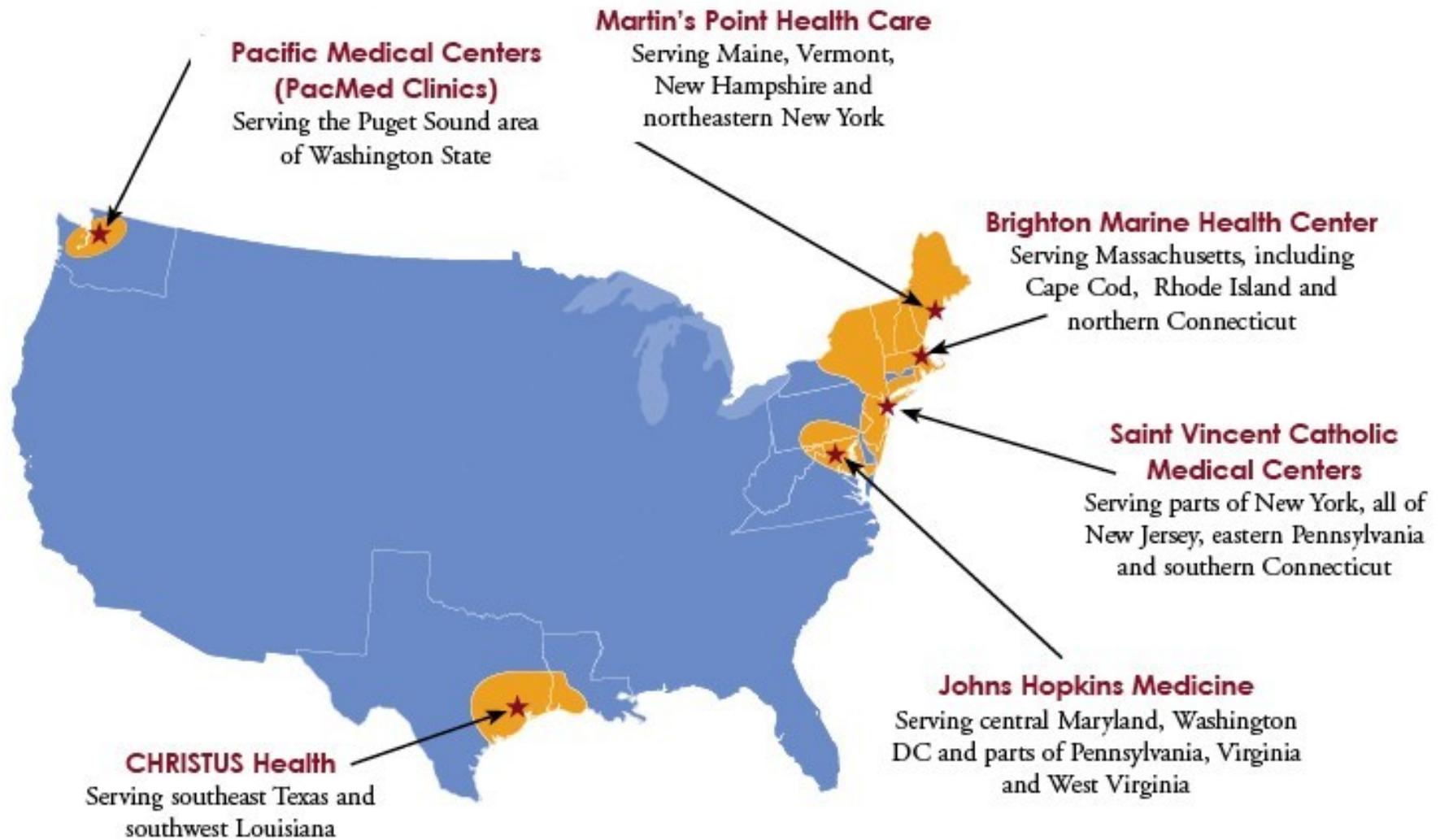
H94002-09-C-0003

I.19 52.232-19 AVAILABILITY OF FUNDS FOR THE NEXT FISCAL YEAR (APR 1984)
(Reference 32.705-1)

I.20 52.233-1 DISPUTES (JUL 2002) (Reference 33.215)

I.21 52.233-4 APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004)
(Reference 33.215)

I.22 52.253-1 COMPUTER GENERATED FORMS (JAN 1991) (Reference 53.111)



**Attachment 1
Johns Hopkins - Service Area**

| ZIP Code |
|----------|----------|----------|----------|----------|----------|----------|
| 15536 | 17247 | 17340 | 18231 | 20015 | 20176 | 20624 |
| 15559 | 17252 | 17342 | 19342 | 20016 | 20177 | 20625 |
| 15767 | 17257 | 17344 | 19362 | 20017 | 20178 | 20626 |
| 16022 | 17261 | 17346 | 19390 | 20018 | 20191 | 20627 |
| 16111 | 17263 | 17349 | 19709 | 20019 | 20317 | 20628 |
| 16316 | 17265 | 17350 | 19711 | 20020 | 20336 | 20629 |
| 16652 | 17266 | 17352 | 19713 | 20024 | 20424 | 20630 |
| 16689 | 17267 | 17353 | 19808 | 20026 | 19952 | 20632 |
| 16691 | 17268 | 17354 | 19810 | 20032 | 19973 | 20634 |
| 17013 | 17272 | 17355 | 19939 | 20036 | 20601 | 20635 |
| 17022 | 17301 | 17356 | 19952 | 20037 | 20602 | 20636 |
| 17067 | 17302 | 17360 | 19956 | 20038 | 20603 | 20637 |
| 17201 | 17304 | 17361 | 19958 | 20044 | 20604 | 20639 |
| 17212 | 17307 | 17362 | 19963 | 20052 | 20606 | 20640 |
| 17214 | 17308 | 17363 | 19966 | 20055 | 20607 | 20643 |
| 17215 | 17309 | 17366 | 19968 | 20057 | 20608 | 20645 |
| 17221 | 17311 | 17371 | 19970 | 20059 | 20609 | 20646 |
| 17222 | 17313 | 17375 | 20001 | 20064 | 20610 | 20650 |
| 17223 | 17314 | 17402 | 20002 | 20074 | 20611 | 20653 |
| 17224 | 17315 | 17403 | 20003 | 20111 | 20612 | 20656 |
| 17225 | 17320 | 17404 | 20004 | 20121 | 20613 | 20657 |
| 17228 | 17321 | 17407 | 20005 | 20122 | 20615 | 20658 |
| 17229 | 17322 | 17518 | 20006 | 20132 | 20616 | 20659 |
| 17233 | 17324 | 17530 | 20007 | 20146 | 20617 | 20660 |
| 17235 | 17325 | 17532 | 20008 | 20147 | 20618 | 20661 |
| 17236 | 17327 | 17536 | 20009 | 20152 | 20619 | 20662 |
| 17237 | 17329 | 17563 | 20010 | 20164 | 20620 | 20664 |
| 17238 | 17331 | 17602 | 20011 | 20165 | 20621 | 20667 |
| 17244 | 17332 | 17901 | 20012 | 20170 | 20622 | 20670 |
| 17246 | 17333 | 18017 | 20013 | 20175 | 20623 | 20674 |
| 20675 | 20715 | 20751 | 20788 | 20849 | 20886 | 21009 |
| 20676 | 20716 | 20752 | 20790 | 20850 | 20889 | 21010 |

**Attachment 1
Johns Hopkins - Service Area**

| ZIP Code |
|----------|----------|----------|----------|----------|----------|----------|
| 20677 | 20717 | 20753 | 20791 | 20851 | 20891 | 21011 |
| 20678 | 20718 | 20754 | 20792 | 20852 | 20892 | 21012 |
| 20680 | 20719 | 20755 | 20794 | 20853 | 20894 | 21013 |
| 20682 | 20720 | 20757 | 20795 | 20854 | 20895 | 21014 |
| 20684 | 20721 | 20758 | 20797 | 20855 | 20896 | 21015 |
| 20685 | 20722 | 20759 | 20799 | 20856 | 20897 | 21017 |
| 20686 | 20723 | 20762 | 20810 | 20857 | 20898 | 21018 |
| 20687 | 20724 | 20763 | 20811 | 20858 | 20899 | 21020 |
| 20688 | 20725 | 20764 | 20812 | 20859 | 20901 | 21021 |
| 20689 | 20726 | 20765 | 20813 | 20860 | 20902 | 21022 |
| 20690 | 20731 | 20768 | 20814 | 20861 | 20903 | 21023 |
| 20692 | 20732 | 20769 | 20815 | 20862 | 20904 | 21024 |
| 20693 | 20733 | 20770 | 20816 | 20866 | 20905 | 21025 |
| 20695 | 20735 | 20771 | 20817 | 20868 | 20906 | 21027 |
| 20697 | 20736 | 20772 | 20818 | 20871 | 20907 | 21028 |
| 20701 | 20737 | 20773 | 20824 | 20872 | 20908 | 21029 |
| 20702 | 20738 | 20774 | 20825 | 20874 | 20910 | 21030 |
| 20703 | 20740 | 20775 | 20827 | 20875 | 20911 | 21031 |
| 20704 | 20741 | 20776 | 20830 | 20876 | 20912 | 21032 |
| 20705 | 20742 | 20777 | 20832 | 20877 | 20913 | 21034 |
| 20706 | 20743 | 20778 | 20833 | 20878 | 20914 | 21035 |
| 20707 | 20744 | 20779 | 20837 | 20879 | 20915 | 21036 |
| 20708 | 20745 | 20781 | 20838 | 20880 | 20916 | 21037 |
| 20709 | 20746 | 20782 | 20839 | 20881 | 20918 | 21040 |
| 20710 | 20747 | 20783 | 20841 | 20882 | 20993 | 21041 |
| 20711 | 20748 | 20784 | 20842 | 20883 | 20997 | 21042 |
| 20712 | 20749 | 20785 | 20847 | 20884 | 21001 | 21043 |
| 20714 | 20750 | 20787 | 20848 | 20885 | 21005 | 21044 |
| 21045 | 21093 | 21154 | 21222 | 21275 | 21521 | 21612 |
| 21046 | 21094 | 21155 | 21223 | 21278 | 21522 | 21613 |
| 21047 | 21908 | 21156 | 21224 | 21279 | 21523 | 21617 |
| 21048 | 21101 | 21157 | 21225 | 21280 | 21524 | 21619 |

**Attachment 1
Johns Hopkins - Service Area**

| ZIP Code |
|----------|----------|----------|----------|----------|----------|----------|
| 21050 | 21102 | 21158 | 21226 | 21281 | 21525 | 21620 |
| 21051 | 21104 | 21160 | 21227 | 21282 | 21528 | 21622 |
| 21052 | 21105 | 21161 | 21228 | 21283 | 21529 | 21623 |
| 21053 | 21106 | 21162 | 21229 | 21284 | 21530 | 21624 |
| 21054 | 21107 | 21163 | 21230 | 21285 | 21531 | 21625 |
| 21055 | 21108 | 21201 | 21231 | 21286 | 21532 | 21626 |
| 21056 | 21111 | 21202 | 21232 | 21287 | 21536 | 21627 |
| 21057 | 21113 | 21203 | 21233 | 21288 | 21538 | 21628 |
| 21060 | 21114 | 21204 | 21234 | 21289 | 21539 | 21629 |
| 21061 | 21117 | 21205 | 21235 | 21290 | 21540 | 21631 |
| 21062 | 21120 | 21206 | 21236 | 21297 | 21541 | 21632 |
| 21065 | 21122 | 21207 | 21237 | 21298 | 21542 | 21634 |
| 21071 | 21123 | 21208 | 21239 | 21401 | 21543 | 21635 |
| 21074 | 21128 | 21209 | 21240 | 21402 | 21545 | 21636 |
| 21075 | 21130 | 21210 | 21241 | 21403 | 21550 | 21638 |
| 21076 | 21131 | 21211 | 21244 | 21404 | 21555 | 21639 |
| 21077 | 21132 | 21212 | 21250 | 21405 | 21556 | 21640 |
| 21078 | 21133 | 21213 | 21251 | 21409 | 21557 | 21641 |
| 21080 | 21136 | 21214 | 21252 | 21411 | 21560 | 21643 |
| 21082 | 21139 | 21215 | 21263 | 21412 | 21561 | 21644 |
| 21084 | 21140 | 21216 | 21264 | 21501 | 21562 | 21645 |
| 21085 | 21144 | 21217 | 21265 | 21502 | 21601 | 21647 |
| 21087 | 21146 | 21218 | 21268 | 21503 | 21606 | 21648 |
| 21088 | 21150 | 21219 | 21270 | 21504 | 21607 | 21649 |
| 21090 | 21152 | 21220 | 21273 | 21505 | 21609 | 21650 |
| 21092 | 21153 | 21221 | 21274 | 21520 | 21610 | 21651 |
| 21652 | 21684 | 21736 | 21778 | 21826 | 21890 | 22093 |
| 21653 | 21685 | 21737 | 21779 | 21829 | 21901 | 22101 |
| 21654 | 21686 | 21738 | 21780 | 21830 | 21902 | 22102 |
| 21655 | 21687 | 21740 | 21781 | 21835 | 21903 | 22124 |
| 21656 | 21688 | 21741 | 21782 | 21836 | 21904 | 22132 |
| 21657 | 21690 | 21742 | 21783 | 21837 | 21911 | 22134 |

**Attachment 1
Johns Hopkins - Service Area**

| ZIP Code |
|----------|----------|----------|----------|----------|----------|----------|
| 21658 | 21701 | 21746 | 21784 | 21838 | 21912 | 22150 |
| 21659 | 21702 | 21747 | 21787 | 21840 | 21913 | 22151 |
| 21660 | 21703 | 21748 | 21788 | 21841 | 21914 | 22172 |
| 21661 | 21704 | 21749 | 21790 | 21842 | 21915 | 22181 |
| 21662 | 21705 | 21750 | 21791 | 21843 | 21916 | 22190 |
| 21663 | 21707 | 21754 | 21792 | 21849 | 21917 | 22192 |
| 21664 | 21709 | 21755 | 21793 | 21850 | 21918 | 22201 |
| 21665 | 21710 | 21756 | 21794 | 21851 | 21919 | 22202 |
| 21666 | 21711 | 21757 | 21795 | 21852 | 21920 | 22203 |
| 21667 | 21713 | 21758 | 21797 | 21853 | 21921 | 22204 |
| 21668 | 21714 | 21759 | 21798 | 21856 | 21922 | 22205 |
| 21669 | 21715 | 21762 | 21801 | 21857 | 21930 | 22302 |
| 21670 | 21716 | 21765 | 21802 | 21861 | 22003 | 22303 |
| 21671 | 21717 | 21766 | 21803 | 21862 | 22015 | 22304 |
| 21672 | 21718 | 21767 | 21804 | 21863 | 22027 | 22308 |
| 21673 | 21719 | 21768 | 21807 | 21864 | 22032 | 22309 |
| 21675 | 21720 | 21769 | 21810 | 21865 | 22033 | 22310 |
| 21676 | 21721 | 21770 | 21811 | 21866 | 22039 | 22311 |
| 21677 | 21722 | 21771 | 21813 | 21867 | 22042 | 22312 |
| 21678 | 21723 | 21773 | 21814 | 21869 | 22046 | 22314 |
| 21679 | 21725 | 21774 | 21817 | 21871 | 22066 | 22315 |
| 21681 | 21727 | 21775 | 21821 | 21872 | 22075 | 22520 |
| 21682 | 21733 | 21776 | 21822 | 21874 | 22080 | 22553 |
| 21683 | 21734 | 21777 | 21824 | 21875 | 22090 | 22554 |
| 22601 | 25425 | 22625 | 25432 | 22728 | 25446 | 23117 |
| 22603 | 25427 | 22645 | 25438 | 22736 | 26147 | 23228 |
| 22611 | 25428 | 22655 | 25442 | 22835 | 26288 | 23336 |
| 22624 | 25430 | 22656 | 25443 | 22901 | 26354 | 23417 |
| 23503 | 25401 | 25414 | 26719 | 24701 | 25413 | 26710 |
| 23518 | 25402 | 25419 | 26722 | 23803 | 25411 | 25422 |
| 23601 | 25410 | 25420 | 26726 | 26757 | | |



Designated Provider (DP) Reporting Specifications

CDRL-74 Version 1.4

04.17.2008

Designated Provider Data

W74V8H-04-D-0023 Order B307

Prepared For:

Tricare Management Activity
5111 Leesburg Pike, Suite 810
Falls Church VA 22041

Submitted By:

Apptis, Inc.
4800 Westfields Blvd.
Chantilly, VA 20151

INGENIX.



1.0 Task Order Information

Task Order No./DO:	W74V8H-04-D-0023-B307
Task Order Title:	Designated Provider Data Contract
Apptis Project Manager:	Jennifer Brown
COR for the Task Order:	Danielle McCammon

Document Identification

Title:	Designated Provider (DP) Reporting Specifications
CDRL ID: (If applicable)	CDRL-74
Doc ID:	11456-74-200804-v1.4
File Name:	Apptis DP Reporting Specifications V1.4 Final.doc
Version No.:	v1.4
Date:	4/17/2008
Contact:	Jennifer Brown

Revision History

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
1	.0 Draft	<ul style="list-style-type: none"> Initial Draft 	Ingenix Apptis	Sharon Neborsky	03/20/2006
1	.2 Draft	<ul style="list-style-type: none"> Section 2.4.3 - OHI – confirmed primary key to include Policy ID. Section 2.5.3 – Clarification to Fee Payments (payments can only be positive and Fee Action Code = C, updated language) Added Document Control Log – Section 11 Update to 2.5.4 – Fee Error handling, duplicate payments will be processed and reported to DEERs given the inability to identify unique records. Section 4.1.2 - Procedure Code – removed default to ZZZZZ, blanks are accepted. Section 4.6/4.7 - Added data types to capitation/enrollment output files. Section 4 - Updated data formats of header records. Section 9 - Update to file names Section 2.2.3 - Encounters – added chronological processing order. 	DefenseWeb Ingenix Apptis	Sharon Neborsky	04/14/2006
1	.0 Final	<ul style="list-style-type: none"> Final 	Apptis TMA	Jennifer Brown	04/17/2006
1	.3 Draft	<ul style="list-style-type: none"> Section 2.5.3 – Fee Payments - removed 8 char field requirement. Limited to 6 Char with no decimal or dollar sign. Changed Unique Key to include Enrollment Fee Transaction ID. Section 2.2.3 - MCD – removed Patient ID from key. OHI Layout – removed validation from OHI End Date. Rx Encounters – added unique key (DMIS ID, NDC Number, Unique Patient Reference, Date Dispensed) Submission Period – changed to MMYYYY Header Records – Added Valid Values/Descriptions of fields. Reports – NOTIF02 and NOTIF04 changed to Daily reports. 	Ingenix Apptis	Sharon Neborsky	04/20/2006

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
1	.1 Final	<p>Revisions made to SECTION ONE:</p> <ul style="list-style-type: none"> • Paragraph 2.5.3 – Fee Payments - removed 8 char field requirement. Limited to 6 Char with no decimal or dollar sign. Changed Unique Key to include Enrollment Fee Transaction ID. • Paragraph 2.2.3 - MCD – removed Patient ID from key. • OHI Layout – removed validation from OHI End Date. • Rx Encounters – added unique key (DMIS ID, NDC Number, Unique Patient Reference, Date Dispensed) • Submission Period – changed to MMYYYYY • Header Records – Added Valid Values/Descriptions of fields. • Reports – NOTIF02 and NOTIF04 changed to Daily reports. 	Ingenix Apptis TMA	Jennifer Brown	04/21/2006
1	.2 Final	<p>Revisions made to SECTION ONE:</p> <ul style="list-style-type: none"> ▪ Paragraph 3. – Removed x.x and added SECTION FOUR, 4.2. ▪ Paragraph 4.1.2 – Changed heading in column to “Appropriate for Encounter Setting” • Paragraph 4.4 – Removed the record 	TMA	Danielle McCammon	04/25/2006

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
1	.3 Draft	<p>Revisions made to SECTION ONE:</p> <ul style="list-style-type: none"> ▪ Updated the Monthly DP Submission date to the 15th of each month ▪ Updated the date for posting error reports to the DP Website to the 20th of each month. ▪ Moved the Data File Record Layouts for MCD, Pharmacy, Provider, OHI, and Fee to follow the description of each type of file. ▪ Revised error codes in the Data File Record Layouts for MCD, Pharmacy, Provider, OHI, and Fee to reflect overall error code changes. ▪ Revised Section 2.5.3 (Enrollment Fee) to include the following: <ul style="list-style-type: none"> ○ Revised the unique key for the enrollment fee submission standards to remove Patient ID of Subscriber from the Key and added Fee Collected Amount ○ Added more detail regarding the Payment Exception Reason Codes. ○ Added more detail regarding the Request to Begin EFT/Allotments. ○ Added Fee Action Code “H” - Credit, and associated business rules. ○ Added example scenarios of the following Transaction Types – “A”, “B” and “H” ○ Removed Fee Action Code “D” ○ Removed Payment Exception Reason Code “T” – Policy Transfer from another contractor ○ Added Payment Exception Reason Code “W” – Enrollment fee for this payment period has been affected by individual family member fee waiver(s) • Added a fee error crosswalk that details the fee errors that are reported from Ingenix and from DEERS and a description of what may have caused the error. 	<p>Ingenix Apptis</p>	<p>Jennifer Brown</p>	<p>4/25/2007</p>

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
1	.3 Draft	<ul style="list-style-type: none"> • Corrected general editing issues. <p>Revisions made to SECTION ONE:</p> <ul style="list-style-type: none"> ▪ Revised Section 2.5.3 (Enrollment Fee) to include the following: <ul style="list-style-type: none"> ○ Added an Enrollment Fee Unique Identifier field to the Enrollment Fee layout. ▪ Revised Error Codes Section to include Error Codes and Sequences. Included the master list of error code changes and error codes and sequences for PNT, MCD, Rx, Provider, OHI, and Fee. Removed Error Code 020 and added Error Codes 034, 035, and 036. ▪ Added a new section for PNT End Reason Codes ▪ Updated the output file layouts ▪ Removed the Document Control section and incorporated it into the Revision History table. <p>Revisions made to SECTION TWO:</p> <ul style="list-style-type: none"> ▪ Updated Pip-Delimited File Layouts to reflect current processing <p>Revisions made to SECTION THREE:</p> <ul style="list-style-type: none"> ▪ Updated the DP sample reports to reflect current processing <p>Revisions made to SECTION FIVE:</p> <ul style="list-style-type: none"> • Updated the e-mail address for problem form submissions to dpsupport@tma.osd.mil. 	Ingenix Apptis TMA	Jennifer Brown	5/15/2007
1	.3 Final	<p>Corrected general editing issues.</p> <p>Revisions made to SECTION ONE:</p> <ul style="list-style-type: none"> ▪ Revised Section 2.2.7 (MCD Detail Data Record File Specifications) to include the following: <ul style="list-style-type: none"> ○ Removed Error Code 004 – early service date error. ○ Updated the Hospital Service Patient Procedure Code fields to include the following valid values: Valid CPT, HCPCS, Revenue and ICD 9 Procedure code. ▪ Revised Section 2.5.3 (Enrollment Fee) to keep the Patient ID of Subscriber as part of the unique key for enrollment fee submission. ▪ Added Section 4.5 Enrollment Fee Errors File Format – (SUMRY15 – Output to DPs), which includes the SUMRY 15 .dat file layout. ▪ Revised Section 8.1.2 (Medical Error Codes and Sequence) to remove the error produced for the erly_srvc_dt (Early Service Date) field. <ul style="list-style-type: none"> • Removed Claims Eligibility Requirements from Website Specs 	Ingenix Apptis TMA	Jennifer Brown	6/20/2007

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
1	.4 Draft	<ul style="list-style-type: none"> ▪ Revised Section 2.2.7 (MCD Detail Data Record File Specifications) to include the following: <ul style="list-style-type: none"> ○ Removed Error Code 004 – early service date error. ▪ Revised Section 2.2.7 (MCD Detail Data Record File Specifications) to include the following: <ul style="list-style-type: none"> ○ Field "Blank," start position 248: Length Field is changed to "8" ○ Field "Service 5 End Date," start position 492: Under "Appropriate for Encounter Setting," added an "X" in Column "O" ○ Field "DEERS Family Identifier," start position 16, added an "N" under column headed "REQ'D" ▪ Revised Section 2.5.3 (Enrollment Fee Submission Standards) to include additional clarification regarding the Payment Exception Reason Codes, Fee Waivers, and additional Example Scenarios. ▪ Revised Section 2.5.4 (Enrollment Fee Error/Reject Handling) to include the following additional DEERS errors: <ul style="list-style-type: none"> ○ Error Reported: HCDP_FPMT_THRU_DT and HCDP_FY_ID must match, Business Rule: The HCDP_FPMT_THRU_DT and HCDP_FY_ID must be in the same fiscal year. Correct and Resubmit. ○ Error Reported: Credit is not allowed in a prior fiscal year, Business Rule: Credits are only allowed on the current and up to 2 fiscal years in the future. Correct and resubmit. ▪ Revised Section 2.5.7 (Enrollment Fee Collections Detail Data Record File Specifications) to reflect the following changes: <ul style="list-style-type: none"> ○ Removed the value "S" for Split enrollment situation ("free rider") in the Field "HEALTH CARE DELIVERY PROGRAM ENROLLMENT FEE PAYMENT EXCEPTION REASON CODE", start position 130. ○ Updated Field type from Char to Num in the Field "QUANTITY DISPENSED", start position 116. ▪ Updated Section 4.5 (Enrollment Fee Errors File Format – (SUMRY15 – Output to DP's) to include the "Enrollment Fee Unique ID" with start position 160 and end position 171 and renumbered subsequent field positions. ▪ Updated Section 9 (PNT End Reason Codes) to 	Ingenix Apttis TMA	Jennifer Brown	03/19/2008

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
		include the current approved codes and added a column to note recoupable status. <ul style="list-style-type: none"> ▪ Updated Section 10 (Naming Conventions – Output to Designated Providers) to include Enrollment 12 – Medicare B Change Report. Revisions made to SECTION TWO <ul style="list-style-type: none"> ▪ Updated ENROL 3 & ENROL 4 Reports to include the PNT Transaction Date • Added New Report ENROL 12 			
1	.4 Final	<ul style="list-style-type: none"> ▪ Updated Cover and Document Description Sections ▪ Revised Section 2.5.3 (Enrollment Fee Submission Standards) to include a summary of Batch Fee scenarios and five additional Scenarios ▪ Final 	Ingenix Apptis TMA	Jennifer Brown	4/17/2008

Distribution

This document is distributed to:

- TRICARE Management Activity (TMA), TRICARE Operations Directorate (for dissemination to designated reviewers, and for project control)
- Apptis PM (for dissemination to the Apptis Team)
- Apptis CM Library

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Referenced Documents

To prepare the Designated Provider Data Dictionary, the DP Project Team relied upon information received from a number of sources.

These reference documents, and their associated versions, are shown in the table that follows.

Document or Information Description	Source
N/A	

Key Stakeholders

The stakeholders identified in this section are responsible for reviewing and approving the Final Designated Provider Specifications at inception and after any changes made at a later time.

Ms. Jennifer Brown		
_____	_____	_____
Apptis Program Manager	Signature	Date
Mr. David Osmek		
_____	_____	_____
Ingenix Project Manager	Signature	Date
Ms. Maria Gaboury		
_____	_____	_____
DefenseWeb Program Manager	Signature	Date
Ms. Danielle McCammon		
_____	_____	_____
DP Data Contract COR	Signature	Date

1. INTRODUCTION

The DP project consists of Data Management support to include: collecting DP submitted data monthly, interfacing with the Defense Enrollment and Eligibility Reporting System (DEERS) for the purpose of collecting enrollment and eligibility data and to send enrollment fee and catastrophic capitation information on DP beneficiaries, reporting monthly results for enrollment and capitation, maintaining a database of all enrollment demographics for the DP population, performing audits and reviews, and reporting results of the data collection and comparison. This project supports the following six DP facilities;

- Pacific Medical Clinics; Seattle, Washington
- CHRISTUS Health; Houston, Texas
- Martin’s Point Health Care; Portland, Maine
- Brighton Marine Health Center; Boston, Massachusetts
- Johns Hopkins Medical Services Corporation; Baltimore, Maryland
- St. Vincent Catholic Medical Centers of New York; New York City, New York

Apptis is the prime vendor who maintains overall responsibility for the DP data contract. The Apptis Team consists of Apptis, DefenseWeb, and Ingenix. Apptis provides the program management, overall oversight, and management of the DP support desk. DefenseWeb provides the “customer facing” website and serves as the communication hub for the project with real-time interfaces to DEERS and connections to TMA, the DPs, the Military Data Repository (MDR), Apptis, and Ingenix. Ingenix provides the data warehousing and reporting capabilities.

2. OBJECTIVE

The purpose of the DP Specifications is to provide the DPs with a consolidated document that details the interfaces, specifications, file layouts, data dictionary, website specifications, and problem resolution process, that will be used to support this program.

3. DOCUMENT ORGANIZATION

The DP Specifications document is organized into the following sections:

- SECTION ONE – DATA REPORTING SPECIFICATIONS
 1. Purpose of Input/Output Data Reporting Specifications
 2. Data Identification and Description
 - Enrollment Data - Policy Notification Transfers (PNTs)
 - Medical/Clinical (MCD) and Pharmacy Encounters
 - Provider
 - Other Health Insurance/Primary Care Manager (OHI/PCM)
 - Enrollment Fee Collections
 3. Method for Submitting Data
 4. Data File Formats
 5. Assessing Data Quality
 6. Recovery
 7. Control Total Reporting
 8. Error Codes and Sequences
 9. PNT End Reason Codes
 10. Naming Conventions
 11. Glossary of Terms
- SECTION TWO – PIPE-DELIMITED OUTPUT FILES
- SECTION THREE – DP SAMPLE REPORTS
- SECTION FOUR – DP WEBSITE SPECIFICATIONS
- SECTION FIVE – PROBLEM RESOLUTION PROCESS

SECTION ONE – DATA REPORTING SPECIFICATIONS

1. PURPOSE OF INPUT/OUTPUT DATA REPORTING SPECIFICATIONS

This document describes the timing, content, and sources of Enrollment (supplied by DEERS), Enrollment Fee, Other Health Insurance (OHI), Provider, and Clinical and Pharmacy encounter data to be reported to the TRICARE Management Activity (TMA) Designated Provider's (DP) Program Office. The documentation also includes the output files which will be supplied to the DP's including the Clinical and Pharmacy encounter errors, enrollment and payment files. This data will be used to support the evaluation and monitoring of this DP contract. The following information is provided:

- Identification and purpose of input and output data, including source and type
- Parties responsible for reporting
- Timing and frequency of reporting requirements
- Data element specifications
- Guidelines and rules for reporting
- Control total submissions
- Error codes

The following sections describe the various files, business rules, and formats that are required. All input files need to be submitted to Ingenix by the 15th of each month. Detailed field definitions and valid values for all fields can be found in alphabetical order in the DP Data Dictionary Section. Each data format contains a listing of the corresponding error codes. Definitions of all error codes are defined on the table and are also available in the Error Code section.

The data files submitted by the DP's contain two (2) types of records: header record and the detailed data records. One header is required for each file and should be the first record in the file. Multiple detail records will be submitted on each file.

2. DATA IDENTIFICATION AND DESCRIPTION
2.1. Enrollment Data (Policy Notification Transfers):
2.1.1.PNTs Description and Purpose

The DP Program employs the concept of voluntary enrollment for non-active-duty Military Health System (MHS) beneficiaries and active duty dependents. The DPs will be paid to provide a comprehensive set of health care benefits to verified enrollees based on capitation rates in each of the age/gender beneficiary categories adjusted by geographical location.

The DP's will be provided a complete list of all beneficiaries who are enrolled and eligible in the DP program based on data from Defense Enrollment Eligibility Reporting System (DEERS).

DefenseWeb will distribute to each DP a copy of the eligibility file received from DEERS, along with the standard enrollment reports each month from Ingenix as stated in the Data Contractor's contract. Each DP will have the ability to retrieve only records for their facility.

Refer to the DEERS Policy Notification Transfer (PNT) specifications for the file layout of the transfer of enrollment data from DEERS to Ingenix.

Policy Notification Transfers (PNTs). Notifications are received daily when current enrollment or specific demographic information regarding beneficiary changes in DEERS. These notifications are sent real-time from DEERS. Ingenix shall apply them in their database. The notifications shall be displayed real-time on DefenseWeb's web application and available for printing. (These were previously known as EITs).

Ingenix will provide each DP with two (2) specific files related to the processing of these PNTs. The two files are described below as The Enrollment Output file and the Capitation Payment Data Output file.

2.1.2. Payment Data Output File for DP's (ENROL11)

1. File containing detailed data on beneficiaries paid capitation for the specific month, including the capitation amount paid – Males and Females will be included in the same file. (Refer to Section 4.6 for the format of this file)

2.1.3. Enrollment Output File for DP's Capitation (FINAN04)

2. Enrollment records for all the beneficiaries that are enrolled and eligible to have capitation calculated for them based on the 1st of the current month. This file will be available to the DP's by the 10th of the month. (Refer to Section 4.7 for the format of this file)

2.2. Medical/Clinical (MCD) and Pharmacy Encounter Data:**2.2.1. Encounters Description and Purpose**

Encounter data will include the records for all services provided to each enrollee during the previous month. Earlier services provided are reported in the monthly submission, regardless of how much delay the DP experiences in collecting the information. For evaluation purposes, it is important to capture all care provided to enrollees. Incomplete data may impact capitation rates when they are recalibrated.

Reported services will cover all encounter settings, including hospital, related professional services for admitted patients and outpatient care – this includes all laboratory, mental health, and radiology services. This file will be uploaded through the web interface by the 15th of each month.

Encounter summary and error reports will be posted on DefenseWeb's website and will be available on or before the 20th of the month of submission.

2.2.2. Encounters History

Encounter records will be retained for the length of the contract beginning 6/1/03.

2.2.3. Encounters Submission Standards

Since MCD can be submitted as Hospital Services data, Inpatient Professional Services data, or Outpatient Professional Services data, the encounter setting field will indicate the type of care reported. A grid, to the right of the data elements, indicates which elements are used for the encounter setting reported. If the grid indicates the field is not reported for an encounter setting, the field should be left blank.

Encounters need to be submitted in a chronological order by processing time of the claim. This will ensure that all change and delete records will be processed correctly and with minimal processing errors.

UNIQUE KEY:

The unique key used to identify each MCD submission is DMIS ID and Unique Patient Reference Number.

TRANSACTION TYPE:

A single submitted record must contain exactly ONE of the following:

1. An "Initial" encounter record, transaction type "I". If two initial records are submitted with the exact same information in ALL the fields then the second record will be rejected as a duplicate. Otherwise, if any fields are different the record will be treated as a change record.

2. A “Change” encounter record, transaction type “C”. If a corresponding Initial record (matched by the unique key fields) is not found, the record will be processed as an “Initial” record. All fields on this type of record will be considered to be authoritative and not dependent on any previous submission as of the submission date and time.
3. An “Extension” encounter record, transaction type “F”. This type must follow an existing Initial or Change record and is matched to the Initial record by the unique key fields. This type is used to report additional services (beyond the initial six services). If a Change record is submitted for an Extension record, all corresponding Extension records must also be resubmitted.
4. A “Delete” encounter record, transaction type “D”. All non-key fields on this record will be ignored and all corresponding records, matched by the unique key fields, will be marked invalid in the warehouse.

MATCH TO ENROLLMENT:

Patient ID and Sponsor SSN will be used to identify DEERS Family ID and DEERS Beneficiary ID on the enrollment master. If a successful match can not be made the record will be rejected. Ingenix will retain the reported values for DEERS Family ID and Beneficiary ID as submitted on the claim. However, when reporting back to the DP’s Ingenix will use the ID’s matched from enrollment. The match to Enrollment will also contain a match to DMIS with corresponding date logic, the earliest date of service must fall within the HCDP Policy Enrollment Begin and End Dates otherwise the claim will be rejected as not matching to enrollment. Ingenix will also report all co-pay information submitted on a rejected and accepted claim to DEERS on the Cat Cap file. In order for a cat cap adjustment to take place a delete or adjustment record must be submitted for this original record (even if it was rejected).

MATCH TO PROVIDER:

The Unique Provider ID and DMIS ID of the Provider Entity will be used to identify the provider of the clinical encounter. The corresponding provider records are to be submitted on the monthly provider file.

DIAGNOSIS AND PROCEDURE CODE GUIDELINES:

When coding diagnosis(es) and procedure(s) for encounter data all codes must be the full complement of digits as required by the appropriate coding manuals (ICD-9-CM, CPT, and HCPCS). Revenue Center codes are not to be submitted except for a few valid Home Health Revenue Center Codes. These acceptable Revenue Center codes should be submitted in the Service 1-6 procedure code fields.

ICD-9-CM annually updates codes (new codes, revised texts, and/or revised code titles). These code changes are effective October 1 of each year. There will be a three (3) month “grace period” (October 1 through December 31) for these updates for dates of service October 1 through December 31. The grace period applies to claims received prior to January 1 2002 and subsequent contract years that include the updated codes for dates of service October 1 through December 31. During this time period the claims processors are to accept both the old and new codes. Claims received after January 1 of each year are to be returned by the claims processor. Each year Ingenix will accept both the old and new codes through the January 15th clinical and pharmacy data submissions. After that submission, all clinical and pharmacy claims, with the old codes, will be placed in the pend file. Grace periods are only effective with the new contract that began June 1, 2001.

CPT and HCPCS annually update codes (additions, deletions and revisions). These code changes are effective January 1 of each year. There will be a three-month “grace period” (January 1 through March 31) for these updates for dates of service January 1 through March 31. The grace period applies to claims received prior to April 1 of 2002 and subsequent contract years that include the updated codes for dates of service January 1 through March 31. During this time period the claims processors are to accept both the old and new codes. Claims received after April 1 of each year are to be returned by the claims processor. Each year Ingenix will accept both the old and new codes through the April 15th clinical and pharmacy data submissions. After that submission, all clinical and pharmacy claims with the old codes will be placed in the pend file. CPT and HCPCS may have periodic updates throughout the year. A three-month “grace period” will be based on the effective date or deletion date of the code.

2.2.4. Encounters Error/Reject Handling

All records will be loaded to the warehouse, including all fatal/rejected records, except when a patient ID is not found. This is due to the fact that the co-payment amounts are still submitted to DEERS regardless if a record is rejected or not. Either a delete or corrected record will need to be submitted to the warehouse to fix the previous errors. Fatal records will be identified by a data warehouse processing status code.

2.2.5. MANAGEMENT CLINICAL DATA (MCD) FORMAT (Input from DP's)

The DP will report all clinical services provided for all DP enrollees. This file format and data elements are required for each encounter setting (Hospital, Inpatient Professional or Outpatient Professional services) when reporting the monthly clinical workload for DP enrollees. This file will be uploaded through DefenseWeb's web application by the 15th of each month.

The unique key used to identify each MCD submission is DMIS ID and Unique Patient Reference Number.

2.2.6. MCD Header Record File Specifications

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	VALID VALUES/DESCRIPTION	CORRESPONDING ERROR CODE	
1	3	FILE TYPE	3	Char	EFC	002, 007	
					Enrollment Fee Collections		
					NDC		Pharmacy Data
					PRV		Provider Data
					MCD		Management Clinical Data
OHI	OHI/PCM Update Data						
4	9	SUBMISSION PERIOD	6	Char (MMYYYY)	The month and year of the actual data being submitted (example: 052006 is all May data)	008	
10	17	CREATION DATE	8	Date (CCYYMMDD)	The date the file is created (example the May submission period will have a creation date > 5/31/06)	008	
18	21	DMIS ID	4	Char	See valid values listed below	002, 007	
22	28	TOTAL RECORDS	7	Num	Must be numeric – can be right justified zero filled if DP's prefer or just left as a number	008	

2.2.7. MCD Detail Data Record File Specifications

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
					H	I	O					
1	4	DMIS ID	4	Char	X	X	X	0190	DD Valid Lookup	002	Required field is blank/NULL	
								Johns Hopkins Medical Services Corporation				
								0191				Brighton Marine Health Care
								0192				CHRISTUS Health – St. John's
0193	Saint Vincent Catholic Medical	007	Data value not found in DP table									
										034	DMIS ID/Patient/Sponsor not found in DP table	

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O					
									Centers of NY			
								0194	Pacific Medical Clinics			
								0196	CHRISTUS Health – St. Joseph’s			
								0197	CHRISTUS Health – St. Marys			
								0198	Martin’s Point Health Care			
5	13	DEERS FAMILY IDENTIFIER	9	Char	X	X	X	Any		No Validation	N/A	N/A
14	15	DEERS BENEFICIARY IDENTIFIER	2	Char	X	X	X	Any		No Validation	N/A	N/A
16	25	PATIENT IDENTIFIER	10	Char	X	X	X	Patient ID match to enrollment		Valid match to enrollment	002 008 034	Required field is blank/NULL Invalid data value Patient/Sponsor not found in DP Table
26	52	PATIENT’S LAST NAME	27	Char	X	X	X	Any		Non Blank	002	Required field is blank/NULL
53	72	PATIENT’S FIRST NAME	20	Char	X	X	X	Any		Non Blank	002	Required field is blank/NULL
73	92	PATIENT’S MIDDLE NAME	20	Char	X	X	X	Any		No Validation	N/A	N/A
93	96	PATIENT’S CADENCY NAME	4	Char	X	X	X	Any		No Validation	N/A	N/A
97	104	PATIENT’S DATE OF BIRTH	8	Date	X	X	X	Date		Valid date	002 035	Required field is blank/NULL Field has invalid date format
105	109	PATIENT’S ZIP CODE	5	Char	X	X	X	Any Numeric		No Validation	N/A	N/A
110	110	PATIENT’S GENDER	1	Char	X	X	X	M	Male	DD Valid Lookup	002	Required field is blank/NULL Data value not found in DP table
								F	Female			
								Z	Unknown			
111	119	SPONSOR SOCIAL SECURITY NUMBER (SSN)	9	Char	X	X	X	SSN matching to enrollment		Valid match to enrollment	002 008	Required field is blank/NULL Invalid data value

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
					H	I	O					
										034	Patient/Sponsor not found in DP Table	
120	121	LEGACY DEERS DEPENDENT SUFFIX	2	Char	X	X	X	Any	No Validation	N/A	N/A	
122	122	MEMBER CATEGORY CODE	1	Char	X	X	X	See DD	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table	
123	123	SERVICE BRANCH CLASSIFICATION CODE	1	Char	X	X	X	See DD	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table	
124	135	UNIQUE PATIENT REFERENCE NUMBER	12	Char	X	X	X	Any	Must be populated with alpha/numeric	002	Required field is blank/NULL	
136	136	ENCOUNTER SETTING	1	Char	X	X	X	H	Hospital Services	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
								I	Inpatient Professional Services			
								O	Outpatient Professional Services			
137	143	PATIENT PRINCIPAL/ PRIMARY DIAGNOSIS	7	Char	X	X	X	Valid Diagnosis Code	Code Table Valid Lookup	030	Dx code not valid on DOS in DP table	
144	150	PATIENT DIAGNOSIS 2	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table	
151	157	PATIENT DIAGNOSIS 3	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table	
158	164	PATIENT DIAGNOSIS 4	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table	
165	171	PATIENT DIAGNOSIS 5	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table	
172	178	PATIENT DIAGNOSIS 6	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table	
179	185	PATIENT DIAGNOSIS 7	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table	
186	192	PATIENT DIAGNOSIS	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to	030	Dx code not valid on DOS	

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O				
			8						Diagnosis Code		in DP table
193	199	PATIENT DIAGNOSIS 9	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table
200	206	PATIENT DIAGNOSIS 10	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table
207	213	PATIENT DIAGNOSIS 11	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table
214	220	PATIENT DIAGNOSIS 12	7	Char	X	X	X	Valid Diagnosis Code	If populated, lookup to Diagnosis Code	030	Dx code not valid on DOS in DP table
221	229	TAX ID OF PROVIDER ENTITY	9	Char	X	X	X	Any	No Validation	N/A	N/A
230	247	UNIQUE PROVIDER ID NUMBER/PHARMACY NCPDP NUMBER	18	Char	X	X	X	Valid Provider ID	Valid match to Provider	002 021	Required field is blank/NULL Provider not found in DP table
248	255	BLANK	8								
256	257	MAJOR SPEC/INSTITUTION TYPE	2	Char	X	X	X	See DD	DD Valid Lookup	007	Data value not found in DP table
258	266	PROVIDER ZIP CODE	9	Char	X	X	X	Any	No Validation	N/A	N/A
267	284	ORDERING PHYSICIAN	18	Char		X	X	Valid Provider ID	Valid match to Provider	002 021	Required field is blank/NULL Provider not found in DP table
285	295	COST DATA	11	Num	X	X	X	Any	No Validation	N/A	N/A
296	301	CO-PAYMENT AMOUNT COLLECTED	6	Num	X	X	X	Any numeric or blank	Numeric or Blank	008	Invalid data value
302	302	EMERGENCY FLAG	1	Char		X	X	Y N	Yes No	002 007	Required field is blank/NULL Data value not found in DP table
303	310	DATE OF RELATED ADMISSION	8	Date		X		Date	No Validation	N/A	N/A
311	318	DATE OF RELATED DISPOSITION	8	Date		X		Date	No Validation	N/A	N/A
319	319	NUMBER OF SERVICES	1	Char		X	X	Number (0-6)	Valid Number 0-6	002	Required field is blank/NULL

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O				
										003	Nbr srvc's doesn't=nbr srvc's populated
320	327	SERVICE 1 START DATE	8	Date		X	X	Date (no blanks, zero's)	Valid Date – Date must be > or = DOB and Enrollment Date as defined from DEERS	002 035 004	Required field is blank/NULL Field has invalid date format Date not>=DOB and Enroll date in DEERS
328	335	SERVICE 1 END DATE	8	Date		X	X	Date (no blanks, zero's)	Valid Date – Date must be > or = service start date and < enrollment end date	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
336	337	SERVICE 1 PLACE OF SERVICE	2	Char		X	X	See DD	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
338	350	SERVICE 1 PROCEDURE CODE	13	Char		X	X	Valid CPT, HCPC, or HomeHealth Rev Code as defined in DD.	Valid match to Procedure Code and/or Revenue Code	031	Proc/Rev Cd not valid on DOS in DP table
351	357	SERVICE 1 RELATED DIAGNOSIS CODE	7	Char		X	X	Valid Diagnosis Code.	Valid match to Diagnosis Code	030	Dx code not valid on DOS in DP table
358	360	SERVICE 1 QUANTITY	3	Char		X	X	Any	N/A	N/A	N/A
361	368	SERVICE 2 START DATE	8	Date		X	X	Date (if >1 Service)	Valid Date – Date must be > or = DOB and Enrollment Date as defined from DEERS	002 035 004	Required field is blank/NULL Field has invalid date format Date not>=DOB and Enroll date in DEERS
369	376	SERVICE 2 END DATE	8	Date		X	X	Date (if >1 Service)	Valid Date – Date must be > or = service start date and < enrollment end date	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
377	378	SERVICE 2 PLACE OF	2	Char		X	X	See DD	DD Valid Lookup	002	Required field is

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O				
		SERVICE								007	blank/NULL Data value not found in DP table
379	391	SERVICE 2 PROCEDURE CODE	13	Char		X	X	Valid CPT, HCPC, or HomeHealth Rev Code as defined in DD.	Valid match to Procedure Code and/or Revenue Code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
392	398	SERVICE 2 RELATED DIAGNOSIS CODE	7	Char		X	X	Valid ICD9 Code.	Valid match to Diagnosis Code	030	Dx code not valid on DOS in DP table
399	401	SERVICE 2 QUANTITY	3	Char		X	X	Any	N/A	N/A	N/A
402	409	SERVICE 3 START DATE	8	Date		X	X	Date (if >2 Services)	Valid Date – Date must be > or = DOB and Enrollment Date as defined from DEERS.	002 035 004	Required field is blank/NULL Field has invalid date format Date not >= DOB and Enroll date in DEERS
410	417	SERVICE 3 END DATE	8	Date		X	X	Date (if >2 Services)	Valid Date – Date must be > or = service start date and < enrollment end date.	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
418	419	SERVICE 3 PLACE OF SERVICE	2	Char		X	X	See DD	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
420	432	SERVICE 3 PROCEDURE CODE	13	Char		X	X	Valid CPT, HCPC, or HomeHealth Rev Code as defined in DD.	Valid match to Procedure Code and/or Revenue Code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
433	439	SERVICE 3 RELATED DIAGNOSIS CODE	7	Char		X	X	Valid ICD9 Code.	Valid match to Diagnosis Code	030	Dx code not valid on DOS in DP table
440	442	SERVICE 3 QUANTITY	3	Char		X	X	Any	N/A	N/A	N/A
443	450	SERVICE 4 START	8	Date		X	X	Date (if >3 Services)	Valid Date – Date must be	002	Required field is

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O				
		DATE						> or = DOB and Enrollment Date as defined from DEERS	035 004	blank/NULL Field has invalid date format Date not>=DOB and Enroll date in DEERS	
451	458	SERVICE 4 END DATE	8	Date		X	X	Date (if >3 Services)	Valid Date – Date must be > or = service start date and < enrollment end date	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
459	460	SERVICE 4 PLACE OF SERVICE	2	Char		X	X	See DD	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
461	473	SERVICE 4 PROCEDURE CODE	13	Char		X	X	Valid CPT, HCPC, or HomeHealth Rev Code as defined in DD.	Valid match to Procedure Code and/or Revenue Code – if no procedure was performed use ZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
474	480	SERVICE 4 RELATED DIAGNOSIS CODE	7	Char		X	X	Valid ICD9 Code.	Valid match to Diagnosis Code	030	Dx code not valid on DOS in DP table
481	483	SERVICE 4 QUANTITY	3	Char		X	X	Any	N/A	N/A	N/A
484	491	SERVICE 5 START DATE	8	Date		X	X	Date (if >4 Services)	Valid Date – Date must be > or = DOB and Enrollment Date as defined from DEERS	002 035 004	Required field is blank/NULL Field has invalid date format Date not>=DOB and Enroll date in DEERS
492	499	SERVICE 5 END DATE	8	Date		X	X	Date (if >4 Services)	Valid Date – Date must be > or = service start date and < enrollment end date	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
500	501	SERVICE 5 PLACE OF SERVICE	2	Char		X	X	See DD	DD Valid Lookup	002	Required field is blank/NULL

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O				
										007	Data value not found in DP table
502	514	SERVICE 5 PROCEDURE CODE	13	Char		X	X	Valid CPT, HCPC, or HomeHealth Rev Code as defined in DD.	Valid match to Procedure Code and/or Revenue Code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
515	521	SERVICE 5 RELATED DIAGNOSIS CODE	7	Char		X	X	Valid ICD9 Code.	Valid match to Diagnosis Code	030	Dx code not valid on DOS in DP table
522	524	SERVICE 5 QUANTITY	3	Char		X	X	Any	N/A	N/A	N/A
525	532	SERVICE 6 START DATE	8	Date		X	X	Date (if >5 Services)	Valid Date – Date must be > or = DOB and Enrollment Date as defined from DEERS	002 035 004	Required field is blank/NULL Field has invalid date format Date not >= DOB and Enroll date in DEERS
533	540	SERVICE 6 END DATE	8	Date		X	X	Date (if >5 Services)	Valid Date – Date must be > or = service start date and < enrollment end date	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
541	542	SERVICE 6 PLACE OF SERVICE	2	Char		X	X	See DD	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
543	555	SERVICE 6 PROCEDURE CODE	13	Char		X	X	Valid CPT, HCPC, or HomeHealth Rev Code as defined in DD.	Valid match to Procedure Code and/or Revenue Code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
556	562	SERVICE 6 RELATED DIAGNOSIS CODE	7	Char		X	X	Valid ICD9 Code.	Valid match to Diagnosis Code	030	Dx code not valid on DOS in DP table
563	565	SERVICE 6 QUANTITY	3	Char		X	X	Any	N/A	N/A	N/A
566	573	HOSPITAL SERVICE ADMISSION DATE	8	Date	X			Date (no blanks, zero's)	Date - admission date can not be > 3 years from the	002	Required field is blank/NULL

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O					
										submission period and must be > DOB	035 036	Field has invalid date format Adm dt cannot be >3 yrs from submit per
574	574	HOSPITAL SERVICE ADMISSION TYPE	1	Char	X			1 2 3 4 5 6 9	Emergency Urgent Elective Newborn Trauma center Inpatient mental health Info not available	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
575	575	HOSPITAL SERVICE ADMISSION SOURCE	1	Char	X			1 2 3 4 5 6 7 8 9	Physician Referral Clinic Referral HMO Referral Transfer from a Hospital Transfer from a Skilled Nursing Facility Transfer from Another Health Care Facility Emergency Court/ Law Enforcement Information Not Available	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
576	577	HOSPITAL SERVICE DISPOSITION STATUS	2	Char	X			01 02 03	Discharge to home or self-care Discharged/Transfer red to another short-term general hospital Discharged/Transfer red skilled nursing facility (SNF)	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O					
								04	Discharged/Transferred to an intermediate care facility (ICF)			
								05	Discharged/Transferred to another type of institution			
								06	Discharged/Transferred to home under care of organized home health service organization			
								07	Left against medical advice			
								08-09	Reserved for national assignment			
								10-19	Discharged to be defined at state level, if necessary			
								20	Deceased			
								21-29	Deceased to be defined at state level, if necessary			
								30	Still a patient			
								31-39	Still a patient to be defined at state level, if necessary			
								*40	Expired at home			
								*40, *41	Expired in a medical facility; e.g., hospital, SNF, ICF, free standing hospice			
								*42	Expired - Place Unknown			
								43-99	Reserved for			

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O				
								National Assignment *For use only on Medicare claims for hospital care			
578	585	HOSPITAL SERVICE DISPOSITION DATE	8	Date	X			Date	Date must be > or = to admission date	002 035 006	Required field is blank/NULL Field has invalid date format Date not>=Adm Date
586	588	DIAGNOSIS RELATED GROUP (DRG)	3	Char	X			Valid DRG	Required when reporting acute hospital (DRG), Acute Hospital or Sole Community Hospital (777) Skilled Care (888) and Observation (999) encounters	032	DRG code not valid on DOS in DP table
589	595	HOSPITAL SERVICE PATIENT PRINCIPAL PROCEDURE	7	Char	X			Valid CPT, HCPCS, Revenue and ICD 9 Procedure code.	Validate to procedure code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
596	602	HOSPITAL SERVICE PATIENT PROCEDURE 2	7	Char	X			Valid CPT, HCPCS, Revenue and ICD 9 Procedure code.	Validate to procedure code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
603	609	HOSPITAL SERVICE PATIENT PROCEDURE 3	7	Char	X			Valid CPT, HCPCS, Revenue and ICD 9 Procedure code.	Validate to procedure code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
610	616	HOSPITAL SERVICE PATIENT PROCEDURE 4	7	Char	X			Valid CPT, HCPCS, Revenue and ICD 9 Procedure code.	Validate to procedure code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
617	623	HOSPITAL SERVICE PATIENT PROCEDURE 5	7	Char	X			Valid CPT, HCPCS, Revenue and ICD 9 Procedure code.	Validate to procedure code – if no procedure was performed use ZZZZZ or leave blank	031	Proc/Rev Cd not valid on DOS in DP table
624	630	HOSPITAL SERVICE PATIENT	7	CHAR	X			Valid CPT, HCPCS, Revenue and ICD 9 Procedure code.	Validate to procedure code – if no procedure was	031	Proc/Rev Cd not valid on DOS in DP table

ST	END	DATA ELEMENT NAM	LENGTH	FIELD TYPE	APPROPRIATE FOR ENCOUNTER SETTING			VALID VALUES		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
					H	I	O					
		PROCEDURE 6								performed use ZZZZ or leave blank		
631	631	TRANSACTION TYPE	1	CHAR	X	X	X	I	Initial submission	DD Valid Lookup	002	Required field is blank/NULL Data value not found in DP table
								F	Further episode submission		007	
								C	Correction submission			
								D	Delete submission			

2.2.8. PHARMACY ENCOUNTER DATA FORMAT (Input from DP's)

The DP will report all pharmacy services provided for all DP enrollees. This file format and data elements are required for each pharmacy encounter when reporting the monthly pharmacy workload for DP enrollees. This file will be uploaded through DefenseWeb's web application by the 15th of each month.

The unique key used to identify each individual service provided is the DMIS ID, Patient ID, Sponsor SSN, NDC Number, Unique Patient Reference and Date Dispensed.

The unique National Council Prescription Drug Program (NCPDP) identification number will identify each pharmacy site. Grouping of numerous sites is not authorized. A corresponding record will be submitted on the monthly Provider File.

2.2.9. Pharmacy Header Record File Specifications

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	VALID VALUES/DESCRIPTION	CORRESPONDING ERROR CODE	
1	3	FILE TYPE	3	Char	EFC	002, 007	
					Enrollment Fee Collections		
					NDC		Pharmacy Data
					PRV		Provider Data
					MCD		Management Clinical Data
OHI	OHI/PCM Update Data						
4	9	SUBMISSION PERIOD	6	Char (MMYYYY)	The month and year of the actual data being submitted (example: 052006 is all May data)	008	
10	17	CREATION DATE	8	Date (CCYYMMDD)	The date the file is created (example the May submission period will have a creation date > 5/31/06)	008	
18	21	DMIS ID	4	Char	See valid values listed below	002, 007	
22	28	TOTAL RECORDS	7	Num	Must be numeric – can be right justified zero filled if DP's prefer or just left as a number	008	

2.2.10. Pharmacy Detail Data Record File Specifications

ST	END	DATA ELEMENT NAME	LENGT H	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
1	4	DMIS ID	4	Char	Y	0190	DD Valid Lookup	002	Required field is blank/ NULL	
						Johns Hopkins Medical Services Corporation				
						0191				Brighton Marine Health Care
						0192				CHRISTUS Health – St. John's
						0193				Saint Vincent Catholic Medical Centers of NY
						0194				Pacific Medical Clinics
						0196				CHRISTUS Health – St. Joseph's
						0197				CHRISTUS Health – St. Marys
0198	Martin's Point Health Care									
5	13	DEERS FAMILY	9	Char	N	Any	No Validation	N/A	N/A	

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
		IDENTIFIER								
14	15	DEERS BENEFICIARY IDENTIFIER	2	Char	N	Any		No Validation	N/A	N/A
16	25	PATIENT IDENTIFIER	10	Char	Y	Patient ID match to enrollment		Valid match against enrollment table	002 008 034	Required field is blank/NULL Invalid data value DMIS ID/Patient/Sponsor not found in DP table
26	34	SPONSOR SOCIAL SECURITY NUMBER (SSN)	9	Char	Y	Sponsor SSN match to enrollment		Valid match against enrollment table	002 008 034	Required field is blank/NULL Invalid data value DMIS ID/Patient/Sponsor not found in DP table
35	36	LEGACY DEERS DEPENDENT SUFFIX	2	Char	N	Any		No Validation	N/A	N/A
37	62	PATIENT'S LAST NAME	26	Char	N	Any		Non Blank	002	Required field is blank/NULL
63	82	PATIENT'S FIRST NAME	20	Char	N	Any		Non Blank	002	Required field is blank/NULL
83	102	PATIENT'S MIDDLE NAME	20	Char	N	Any		No Validation	N/A	N/A
103	106	PATIENT'S CADENCY NAME	4	Char	N	Any		No Validation	N/A	N/A
107	114	PATIENT'S DATE OF BIRTH	8	Date	Y	Date		Valid Date	002 035	Required field is blank/NULL Field has invalid date format
115	115	PATIENT'S GENDER	1	Char	Y	M	Male	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						F	Female			
						Z	Unknown			
116	121	QUANTITY DISPENSED	6	Num	Y	Number		>0	008	Invalid data value
122	129	DATE DISPENSED	8	Date	Y	Date		Valid Date	002 035 005	Required field is blank/NULL Field has invalid date format Date is outside enrollment dates
130	140	NATIONAL DRUG	11	Char	Y	Valid NDC Number		Match to NDC table	033	NDC not found in DP table

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
		CODE NUMBER								
141	151	COST DATA	11	Num	N	Any		No Validation	N/A	N/A
152	154	BASIS FOR COST DETERMINATION	3	Char	N	Any		No Validation	N/A	N/A
155	166	UNIQUE PATIENT REFERENCE NUMBER	12	Char	Y	Any		Must be populated with alpha/numeric	002	Required field is blank/NULL
167	172	CO-PAYMENT AMOUNT COLLECTED	6	Num	Y	Any numeric or blank		Numeric or Blank	008	Invalid data value
173	190	PHARMACY NCPDP NUMBER	18	Char	Y	Valid Provider ID		Valid match to Provider	002 021	Required field is blank/NULL Provider not found in DP table
191	193	NUMBER OF DAYS PROVIDED	3	Num	Y	001-999		Must be in valid value range	002 008	Required field is blank/NULL Invalid data value
194	211	PROVIDER PRESCRIBING MEDICATION	18	Char	N	Any		No Validation	N/A	N/A
212	212	DISPENSED AS WRITTEN INDICATOR	1	Char	Y	0	Not Product Selection Indicated	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						1	Substitution NOT Allowed. Brand Drug Mandated by Prescriber.			
						2	Substitution Allowed. Patient Requested Brand Drug			
						3	Substitution Allowed. Pharmacist Selected Brand Drug.			
						4	Substitution Allowed. Generic Not in Stock.			
						5	Substitution Allowed. Brand Drug Dispensed as Generic.			
						6	Override			
						7	Substitution NOT Allowed. Brand Drug Mandated by Law.			
						8	Substitution Allowed. Generic Not Available in Marketplace.			
9	Other									
213	213	TRANSACTION TYPE	1	Char	Y	I	Initial submission	DD Valid Lookup	002	Required field is

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
								007	blank/NULL Data value not found in DP table
						F Further episode submission			
						C Correction submission			
						D Delete submission			

2.3. **Provider Data:**

2.3.1. **Provider Description and Purpose**

As part of the monitoring and evaluation function, the TMA DP Program Office requires provider information detailing the location, type, and affiliation of each provider in the managed-care network. Each DP will create a file containing provider data records for every provider delivering care to DP enrollees. This file will be submitted to Ingenix by the 15th of each month. Only those providers delivering care to DP enrollees will be on this data file.

The implementation of a managed-care approach for providing health care to beneficiaries is expected to result in a more comprehensive DP health care delivery system, because enrollees are only able to seek care at any clinic or hospital participating in the network of DP providers. DP networks consist of a combination of multiple institutions and staff or contracted providers and clinics.

Provider error and summary reports will be posted on DefenseWeb's website on or before the 20th of each month for the DP to access.

2.3.2. **Provider History**

No history will be maintained on the provider file. Full refreshes are submitted each month, if any information changes within an existing provider the record will be updated with the new information. If a previously submitted provider is not on a submission, the existing record will remain as is in the database. The only way a provider will no longer be active is based on the location end date.

2.3.3. **Provider Submission Standards**

UNIQUE KEY:

The unique key used to identify each clinical and pharmacy provider is the DMIS ID and Unique Provider ID Number.

The monthly submissions will contain all institutional and non-institutional providers that have given care to DP enrollees. Staffs, contracted and other providers, are to be included. This file will be uploaded through DefenseWeb's web application by the 15th of each month.

Each institutional provider will have a unique record specified by *Unique Provider ID*. Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) data processing rules state that "multiple records will be required for institutional providers with both Diagnosis Related Group (DRG)-exempt and DRG-nonexempt units" (reference - OCHAMPUS 6007.50-M, *Automated Data Processing and Reporting Manual*, pages 1-17). A separate record will be generated for each financially independent entity, even if it is within the same physical plant.

Each non-institutional provider will have a unique record specified by *Unique Provider ID Number*. *The Provider ID Number* is the unique number assigned to each Physician/Clinic by the DP and uniquely identifies each Physician/Clinic.

Institution type for a hospital is either non-institutional or institutional, depending on the type of services rendered. If the hospital provides inpatient care, a provider record will be coded with Institutional/Non-Institutional code as "I" for inpatient hospital services it provides. If the hospital also provides emergency room services, ambulatory surgeries, or other outpatient facility services, then another provider record will be created with Institutional/Non-Institutional code value of "N" for non-institutional, along with a value of "99" (Facility Charges) for Provider Major Specialty.

Each Pharmacy provider will have a unique key defined by specifying the NCPDP number assigned to each pharmacy in the unique provider ID number field.

The monthly Provider file will be submitted in the format outlined in the Data Specifications layout.

2.3.4. Provider Error/Reject Handling

A provider record will be rejected if the required fields are either not filled in or there are invalid values for the fields which validation is being performed on. Rejected records will not be loaded into the tab

2.3.5. PROVIDER-RELATED DATA FORMAT (Input from DP's)

This file format and data elements are required when reporting the monthly provider-related data. The monthly submissions will contain all institutional and non-institutional providers that have given care to DP enrollees. Staffs, contracted and other providers, are to be included. This file will be uploaded through DefenseWeb's web application by the 15th of each month.

The unique key used to identify each clinical and pharmacy provider is the DMIS ID and Unique Provider ID Number.

2.3.6. Provider Header Record File Specifications

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	VALID VALUES/DESCRIPTION	CORRESPONDING ERROR CODE	
1	3	FILE TYPE	3	Char	EFC	002,007	
					Enrollment Fee Collections		
					NDC		Pharmacy Data
					PRV		Provider Data
					MCD		Management Clinical Data
OHI	OHI/PCM Update Data						
4	9	SUBMISSION PERIOD	6	Char (MMYYYY)	The month and year of the actual data being submitted (example: 052006 is all May data)	008	
10	17	CREATION DATE	8	Date (CCYYMMDD)	The date the file is created (example the May submission period will have a creation date > 5/31/06)	008	
18	21	DMIS ID	4	Char	See valid values listed below	002,007	
22	28	TOTAL RECORDS	7	Num	Must be numeric – can be right justified zero filled if DP's prefer or just left as a number	008	

2.3.7. Provider Detail Data Record File Specifications

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
1	4	DMIS ID	4	Char	Y	0190	DD Valid Lookup	002	Required field is blank/NULL	
						Johns Hopkins Medical Services Corporation				
						0191				Brighton Marine Health Care
						0192				CHRISTUS Health – St. John's
						0193				Saint Vincent Catholic Medical Centers of NY
						0194				Pacific Medical Clinics
						0196				CHRISTUS Health – St. Joseph's
						0197				CHRISTUS Health – St. Marys
0198	Martin's Point Health Care									
								007	Data value not found in DP table	

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
5	22	UNIQUE PROVIDER ID NUMBER/ PHARMACY NCPDP NUMBER	18	Char	Y	Any non-blank or non-zero	No Blanks or all 0's accepted, no duplicates accepted	002 008 010	Required field is blank/NULL Invalid data value Dup value where dups are not allowed	
23	23	PROVIDER TYPE CODE	1	Char	Y	C	Civilian network	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						D	Direct Care network			
						N	None			
						U	Uniformed Services Family Health Plan (USFHP)			
24	47	PROVIDER LICENSE IDENTIFER	24	Char	N	Any	No Validation	N/A	N/A	
48	87	PROVIDER FULL NAME	40	Char	Y	Must be populated	Must be non-blank	002	Required field is blank/NULL	
88	127	PROVIDER GROUP NAME	40	Char	N	Any	No Validation	N/A	N/A	
128	136	TAX ID OF PROVIDER ENTITY	9	Char	N	Any	No Validation	N/A	N/A	
137	137	PROVIDER AFFILIATION CODE	1	Char	N	Any	No Validation	N/A	N/A	
138	138	INSTITUTION/NON-INSTITUTION	1	Char	Y	I	Institutional	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						N	Non-institutional			
139	152	PROVIDER TELEPHONE NUMBER	14	Num	N	Any Number	No Validation	N/A	N/A	
153	192	PROVIDER STREET ADDRESS	40	Char	Y	Must be populated	Must be non-blank	002	Required field is blank/NULL	
193	212	PROVIDER CITY	20	Char	Y	Must be populated	Must be non-blank	002	Required field is blank/NULL	
213	214	PROVIDER STATE	2	Char	Y	Must be populated with valid 2 digit State abbreviation.	Must be non-blank	002	Required field is blank/NULL Data value not found in DP table	
								007		
215	223	PROVIDER ZIP CODE	9	Char	Y	Must be populated	Must be non-blank	002	Required field is blank/NULL	

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
224	225	1 ST MAJOR SPECIALTY/ INSTITUTION TYPE	2	Char	Y	See DD		DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
226	227	2 ND MAJOR SPECIALTY	2	Char	Y	See DD		DD Valid Lookup	007	Data value not found in DP table
228	229	3 RD MAJOR SPECIALTY	2	Char	Y	See DD		DD Valid Lookup	007	Data value not found in DP table
230	231	4 TH MAJOR SPECIALTY	2	Char	Y	See DD		DD Valid Lookup	007	Data value not found in DP table
232	233	5 TH MAJOR SPECIALTY	2	Char	Y	See DD		DD Valid Lookup	007	Data value not found in DP table
234	241	PROVIDER LOCATION BEGIN DATE	8	Date	Y	Date		Valid Date	002 035	Required field is blank/NULL Field has invalid date format
242	249	PROVIDER LOCATION END DATE	8	Date	Y	Date		Valid Date	002 035	Required field is blank/NULL Field has invalid date format
250	250	PROVIDER GENDER CODE	1	Char	N	F	Female	No Validation	N/A	N/A
					M	Male				
					Z	Unknown				
251	251	REMOTE ENROLLEE ASSIGNMENT INDICATOR CODE	1	Char	N	Y	Yes	No Validation	N/A	N/A
					N	No				
252	331	PROVIDER ASSIGNMENT REMARKS TEXT	80	Char	N	Any		No Validation	N/A	N/A
332	332	PROVIDER ACCREDITATION INDICATOR	1	Char	N	Y	Yes	No Validation	N/A	N/A
					N	No				
333	333	GUARD/RESERVE STATUS	1	Char	Y	G	Guard	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
					R	Reserve				
					N	Not Applicable				

2.4. Other Health Information/Primary Care Manager (OHI/PCM) Information:

2.4.1. OHI/PCM Description and Purpose

The DP's will report Other Health Insurance (OHI) and Primary Care Manager (PCM) information by the 15th of each month to Ingenix. This information will be used to monitor OHI and PCM information for each enrollee of the DP. One record should be submitted for each enrollee within the DP. If the enrollee has more than one OHI policy, additional records should be submitted to report each OHI policy.

OHI/PCM Information summary and error reports will be posted on DefenseWeb's website on or before the 20th of each month for the DP to access.

The monthly OHI/PCM information will be submitted in the format outlined in the Data Specifications layout.

2.4.2. OHI/PCM History

No history will be maintained for OHI/PCM. The most current values are what will be maintained and reported on.

2.4.3. OHI/PCM Submission Standards

UNIQUE KEY:

The unique key used to identify each OHI/PCM record is Patient ID and OHI Begin Date. An enrollee could have more than one OHI record.

2.4.4. OHI/PCM Error/Reject Handling

OHI/PCM records will be rejected if the required fields are either not filled in or there are invalid values for the fields which validation is being performed on. Rejected errors are not loaded into the table.

2.4.5. OHI/PCM INFORMATION DATA FORMAT (Input from DP's)

This file format will be used by the DP when reporting the monthly enrollee OHI/PCM information. The DP will provide a record for those beneficiaries with OHI. This file will be uploaded through DefenseWeb's web application by the 15th of each month.

The unique key used to identify each OHI/PCM record is Patient ID and OHI Begin Date. An enrollee could have more than one OHI record.

The patient's PCM number will be used to identify the Primary Care Manager for the enrollee. Corresponding records are to be submitted on the monthly Provider file.

2.4.6. OHI/PCM Information Update Header Record File Specifications

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	VALID VALUES/DESCRIPTION	CORRESPONDING ERROR CODE	
1	3	FILE TYPE	3	Char	EFC	002,007	
					Enrollment Fee Collections		
					NDC		Pharmacy Data
					PRV		Provider Data
					MCD		Management Clinical Data
OHI	OHI/PCM Update Data						
4	9	SUBMISSION PERIOD	6	Char (MMYYYY)	The month and year of the actual data being submitted (example: 052006 is all May data)	008	
10	17	CREATION DATE	8	Date (CCYYMMDD)	The date the file is created (example the May submission period will have a creation date > 5/31/06)	008	
18	21	DMIS ID	4	Char	See valid values listed below	002,007	
22	28	TOTAL RECORDS	7	Num	Must be numeric – can be right justified zero filled if DP's prefer or just left as a number	008	

2.4.7. OHI/PCM Information Update Detail Data Record File Specifications

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
1	4	DMIS ID	4	Char	Y	0190	DD Valid Lookup	002	Required field is blank/NULL	
						Johns Hopkins Medical Services Corporation				
						0191				Brighton Marine Health Care
						0192				CHRISTUS Health – St. John's
						0193				Saint Vincent Catholic Medical Centers of NY
						0194				Pacific Medical Clinics
						0196				CHRISTUS Health – St. Joseph's
						0197				CHRISTUS Health – St. Mary's
0198	Martin's Point Health Care									
5	13	SPONSOR SOCIAL SECURITY NUMBER (SSN)	9	Char	Y	Any SSN with a match to enrollment	Valid match to enrollment (Sponsor SSN, Patient ID)	002	Required field is blank/NULL	

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
								and DMIS_ID must match to enrollment)	008 034	Invalid data value DMIS ID/Patient/Sponsor not found in DP table
14	15	LEGACY DEERS DEPENDENT SUFFIX	2	Char	N	Any		No Validation	N/A	N/A
16	24	DEERS FAMILY IDENTIFIER	9	Char	N	Any		No Validation	N/A	N/A
25	26	DEERS BENEFICIARY IDENTIFIER	2	Char	N	Any		No Validation	N/A	N/A
27	36	PATIENT IDENTIFIER	10	Char	Y	Any Patient ID with a match to enrollment		Valid match to enrollment (Sponsor SSN, Patient ID and DMIS_ID must match to enrollment)	002 008 034	Required field is blank/NULL Invalid data value DMIS ID/Patient/Sponsor not found in DP table
37	63	PATIENT'S LAST NAME	27	Char	N	Any		No Validation	N/A	N/A
64	83	PATIENT'S FIRST NAME	20	Char	N	Any		No Validation	N/A	N/A
84	103	PATIENT'S MIDDLE NAME	20	Char	N	Any		No Validation	N/A	N/A
104	107	PATIENT'S CADENCY NAME	4	Char	N	Any		No Validation	N/A	N/A
108	115	OTHER HEALTH INSURANCE (OHI) BEGIN DATE	8	Date	Y	Any Valid Date		Valid Date	002 035	Required field is blank/NULL Field has invalid date format
116	123	OTHER HEALTH INSURANCE (OHI) END DATE	8	Date	N	Any Valid Date		No Validation	N/A	N/A
124	163	OTHER HEALTH INSURANCE (OHI) CARRIER NAME	40	Char	Y	Any		Non Blank	002	Required field is blank/NULL
164	165	OTHER HEALTH INSURANCE (OHI) COVERAGE INDICATOR TYPE CODE	2	Char	Y	C	TRICARE Supplement	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						GR	Group/Employee			
						M	Medicare/Medicaid Supplement			
						NG	Non-group (Private)			
						SD	Student			
166	182	OTHER HEALTH INSURANCE (OHI) POLICY IDENTIFIER	17	Char	N	ANY		No Validation	N/A	N/A

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
183	222	OTHER HEALTH INSURANCE (OHI) SUBSCRIBER NAME	40	Char	Y	Any		Non Blank	002	Required field is blank/NULL
223	230	OTHER HEALTH INSURANCE (OHI) SUBSCRIBER'S DATE OF BIRTH	8	Char	N	Any		No Validation	N/A	N/A
231	231	OTHER HEALTH INSURANCE (OHI) STATUS CODE	1	Char	Y	A	Active	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						B	Inactive			
232	239	OTHER HEALTH INSURANCE (OHI) DATE RECEIVED	8	Date	N	Any		No Validation	N/A	N/A
240	240	POLICY PRIORITY CODE	1	Char	Y	1	Primary	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
						2	Secondary			
						3	Tertiary			
241	258	PATIENT'S PCM NUMBER	18	Char	N	Any		No Validation	N/A	N/A
259	338	PRIMARY CARE MANAGER SELECTION PREFERENCE TEXT	80	Char	N	Any		No Validation	N/A	N/A

2.5. Enrollment Fee Collections:

2.5.1. Enrollment Fee Description and Purpose

The DP's will report all enrollment fees collected to Ingenix no later than the 15th of each month. This information is used to report and monitor enrollment fees paid for each family unit. This data will be submitted detailing all enrollment fees received from the enrollees during the previous month.

This file should contain all fee payment transactions for enrollees including routine transactions, adjustments, and credits.

The DP will report enrollment fees collected in a timely manner. The DP's will report all collection information received, (regardless of the length of delay between reporting the data and when the collection was actually received). Ingenix will report enrollment fee information to DEERS. Reporting fee information to DEERS is a key component in timely portability for beneficiaries. No fee information should be reported to DOES as this information is also sent to DEERS and would be duplicative information if these payment records are also sent to Ingenix.

Enrollment Fee Collection error and summary reports will be posted on DefenseWeb's web application on or before the 20th of each month for the DP to access.

2.5.2. Enrollment Fee History

All records will be maintained for enrollment fee history except the fatal/reject records.

2.5.3. Enrollment Fee Submission Standards

UNIQUE KEY:

Each submission will include records uniquely identified by the Patient ID of Subscriber, Sponsor Social Security Number, Fee Payment Date, FY ID, Fee Payment Paid Thru Date, Payment Plan Type Code, Fee Action Code, and Fee Collected Amount.

Matching to Enrollment:

Sponsor SSN and FY Identifier will be used to find the family the payment is being made to. The Family ID, Beneficiary ID and HCDP Plan Coverage Codes will be retrieved in order for this information to be reported to DEERS.

A single submitted record must be exactly one of the following:

1. A routine (New Payment) Transaction, Fee Action Code "A".

Business Rules

- Fee Payment Amount (ENROLLMENT FEE COLLECTED) – Payment amounts must be positive values or zero. The maximum amount in a single payment transaction is \$999.99 (Ingenix/DEERS will reject if it is more than this amount).
- Payment Thru Date must be greater than the Payment Thru Date on the most recent payment record.
- If there is a positive credit balance on the policy then the new payment will be rejected with an error indicating that the payment is not allowed due to an existing credit.
- If there is an existing duplicate payment in the system this record will be rejected. A duplicate is determined based on Fee Payment Date, FY ID, Fee Payment Paid Thru Date, Payment Plan Type Code, and Fee Action Code.
- The Payment Thru Date must be in the same fiscal year as the identified FY ID. EXCEPTIONS: The request to begin EFT or Allotment w/in 3 months of the end of the fiscal year which would

either be 10/31 or 11/30 of the following fiscal year. In this case, the Payment Thru Date should either be October 31 or November 30 of the following fiscal year.

- **Fee Waivers:** Fee waivers are used to identify individuals that have Medicare Part B and do not require a fee. Ingenix will work with DMDC on an annual basis to automatically place fee waivers on those individuals that have Medicare Part B.
- **Payment Exception Reason Codes:** These codes are used to indicate the reason that an enrollment fee payment was either partially paid or if there was no payment included at all. Valid codes are “C” – Catastrophic Cap and Deductible have been met for this payment period, “F” – Fees waived due to End of Year to Fiscal Year realignment, “L” – Fee waiver exists for an individual, “M” – Multiple fee waivers in family, “N” – No fee waiver exception, “W” – Enrollment fee for this payment period has been affected by individual family member fee waiver(s). You **MUST** submit a Payment Exception Reason Code of “L” or “M” for any beneficiary that has a Fee Waiver to ensure that DEERS is not expecting a fee.
- Payments made in future fiscal years require:
 - That previous fiscal years be paid in full **or**
 - That the payment exception code is not equal to “N” **and**
 - That the latest payment through date equals the end of the specified previous fiscal year (XXXX0930).
- If the Plan Type Code is “A” or “Q” then the only accepted Payment Type Codes are 3(check), 2(credit card), 4(money order), 1(cash), and 0 (no payment). If the Plan Type Code is “M” then the only accepted Payment Type Codes are 5(allotment) or 6(electronic funds transfer).
- If the Plan Type Code (HCDP Plan Type Code) is Q and the Fee Payment Thru Date (Fee Payment Paid Thru Date) does not fall on one of the following fiscal year quarter end dates: December 31st, March 31st, June 30th, or September 30th.
- **Request to begin EFT/Allotments** (When Fee Payment Type Code = R (request to begin EFT/Allotment) the additional restrictions apply):
 - For monthly EFT or monthly allotments, the DP must collect and post a quarterly amount at the time of enrollment with monthly EFT or allotments beginning on the first day of the fourth month following the enrollment anniversary date (beginning of the next quarter). Regardless of the date the DP receives the monthly EFT or allotment, the payment must be posted through the end of the next applicable payment period. If during the transition from enrollment year to fiscal year, the first three month payment crosses into the next fiscal year, a three month payment amount should be submitted indicating the applicable Paid Thru and a Payment Plan Type of “R” - Request to begin EFT or allotment.
 - Fee Payment Type Code must equal 3 (check), 2 (credit card), 4 (money order), 1 (cash), and 0 (no payment)
 - Fee Payment Thru Date must be exactly 3 months from the last fee payment on the database if one exists or otherwise must be the date specified in the Policy Begin Date.
 - The Fee Payment Amount must be at least 3 months of the annual fee if the Payment Exception Reason Code is “N”.
 - DEERS will apply one or two months of the three month payment (whichever is applicable) to the enrollment ending in the current fiscal year and the remaining one or two months of fees to the beginning of the new enrollment beginning on October 1 of the next fiscal year. When a three month fee is paid and a request for a monthly allotment or EFT is indicated and there are less than 90 days but more than 45 days remaining on the policy ending September 30, DEERS will create the new policy (beginning October 1) and apply the one or two remaining fee payments from the previous policy.
 - Example: If a beneficiary’s enrollment policy anniversary date is August 1 and they request to pay by monthly allotment or EFT, three months of enrollment fees will be submitted. Two months of the fee will be applied to the enrollment period, August 1 through September 30, and the remaining one-month’s fees will be applied to the new (fiscal year aligned) policy beginning October 1. In this example, the Payment Thru Date should be October 31. The monthly allotments or EFT payments should start by November 1 (first day of the fourth month following the previous enrollment anniversary date of August 1).
- After transactions have been validated against the above rules, the following additional checks will be made that show that there may be an abnormal condition on the record. In this case, the payment is still applied:
 - When the payment exception reason code is equal to “N”, the payment total is compared to the annual plan fee prorated for the number of months that have elapsed. If the Total Payment is not equal to the expected amount – over/under warning is generated.

2. An Adjustment to routine (New Payments) Transaction, Fee Action Code “B”.

Business Rules

- Fields used to identify a policy are Patient ID of Subscriber and Sponsor SSN, FY Identifier, Plan Coverage Code
- All business rules and field restrictions that apply to routine(new payments) also apply to adjustments with the following exceptions:
 - The identified fiscal year and the Fee Payment Thru Date can be different if the Fee Payment Thru Date is Sept. 30 of the prior year (fiscal year – 1)
 - Enrollment Fee Collected can be a negative, zero or positive amount.
 - **Positive adjustments:** The Fee Payment Thru Date should be greater than or equal to the Fee Payment Paid Thru Date of the most recent fee payment on the policy per fiscal year.
 - **Negative adjustments:** The Fee Payment Thru Date has to be less than or equal to the Fee Payment Thru Date of the most recent fee payment on the policy per fiscal year, or one day prior to the HCDP Policy Begin Date or Sept. 30 of the prior year ; can only be one day prior if the cumulative amount = \$0.
 - **Zero adjustments:** The Fee Payment Through Date must be within the identified fiscal year, or one day prior to the HCDP Policy Begin Date or Sept. 30 of the prior year; can only be one day prior if the cumulative amount = \$0.

3. Other transaction, Fee Action Code “C”.

Business Rules

- Match to Enrollment - Patient ID of Subscriber, Sponsor SSN, Plan Coverage Code, and FY Identifier – the fields needed to make a unique record include FY Identifier, Payment Received Date, Fee Payment Paid Thru Date, Payment Plan Type Code, Fee Payment Type Code, and Enrollment Fee Collected.
- If this Action Code is used the information will be processed as submitted and no interpretation will be done on the record within the warehouse. Negative amounts will be processed as negatives and positive amounts as positive.

4. Credit Fee transaction, Fee Action Code “H”.

Business Rules

- A routine (new payment) transaction must accompany and precede the “H” credit transaction, and comply with Section 2.5.3.1, Fee Action Code A (above).
- The fee action code “H” is used to provide credit information for payments credited outside the transaction period identified in the accompanying “A” Fee Action code record.
- The Fee Payment Thru Date should be the date through which the credit pays.
- The maximum amount in a single credit transaction is \$999.99
- Credits are only allowed on the current fiscal year and up to two fiscal years in the future.
- The Fee Payment Thru Date must be within the identified fiscal year, or one day prior to the Policy Begin Date or September 30 of the prior year, whichever is later.
- Credits are only applied if the existing duplicate credit is not found in DEERS.
- Data for the required fields for the “A” and “H” Fee Action Code records will be identical, with the following exceptions:
 - For Quarterly payments with a fee credit:
 - Credit payments using the “H” transaction codes may NOT exceed the assigned full quarterly payment value.
 - For Annual payments with a fee credit:
 - In the case of an annual payment where a credit crosses fiscal years, the Policy Begin Date and FY ID fields must reflect the differing policy years.

Batch Enrollment Fee Scenarios

This section illustrates some sample scenarios. In each scenario, the table shows the values of the fee information segment of the fee payment record. The fields in the other segments are omitted here for brevity. The following scenarios are included:

Type	#	SCENARIO DESCRIPTION
Payments	1	Annual
	2	Quarterly
	3	Request to Begin EFT/Allotment Payment within 90 Days of Fiscal Year End
	4	Monthly
	5	Payment on a Terminated Policy that Spans the Termination Date
	6	Policy that Begins Mid Year
Adjustments	7	Regular
	8	Adjustment to a Request to begin EFT/Allotment Payment
Credits	9	Add New Credit When No Prior Credits Exist
	10	Annual Payment with Overpayment
	11	Quarterly Payment with Overpayment
	12	Modify an Existing Credit
	13	Modify an Existing Credit on a Policy that Begins Mid-Year
	14	Removing an Existing Credit and Applying a Payment in DEERS
Fee Exceptions	15	Removing a Fee Exception from a record when NO enrollment fee payments have been posted to the current Fiscal Year in order to correctly post Quarterly or Annual Payments
	16	Removing a Fee Exception from a record when NO enrollment fee payments have been posted to the current Fiscal Year in order to correctly post Monthly Payments
	17	Removing a Fee Exception from a record when enrollment fee payments have been posted to the current Fiscal Year
Split Enrollments	18	Submitting Enrollment Fee Payments by Subscriber of an Enrolled Health Plan

Payments

Payments are applied to policies using the identifying information in the input record. A payment transaction is identified by having a HCDP_FEE_ACTN_CD of A in the input record. Payment amounts are accumulated on a fiscal year basis. The Cat Cap totals are updated with the payment amounts. For payments, the HCDP_EY_FPMT_AM field is restricted to be a positive value. Since payments are only applied to individual fiscal years, if a payment spans a fiscal year end, it is up to the contractor to send two transactions with the appropriate paid-through dates in order to direct the payments to the appropriate fiscal years. Payments may be made up to two fiscal years in the future and as far back in the past as the policy begin date. Payments made on future fiscal years are only accepted if the prior fiscal years are paid in full and if the sum of the credits on the policy is zero. The HCDP_FPMT_PLN_TYP_CD identifies the payment plan type (A-Annual, Q-Quarterly, M-Monthly, or R-Request to begin EFT/Allotment). Monthly payments are only accepted after a previous request to begin EFT/Allotment payment transaction has been received. R payments must have payment amounts equal to three (3) months of the annual premium.

SCENARIO 1: ANNUAL PAYMENT

An annual payment is made on a 2005 fiscal year policy and ends on 09/30/2005. The plan coverage code for the policy is 117, which requires a premium of \$460/yr. The payment is made by check. The date of the payment is 09/05/2004.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20040905	The date of the transaction
HCDP_FPMT_THRU_DT	20050930	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	A	An "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$460.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

SCENARIO 2: QUARTERLY PAYMENT

The first quarterly payment is to be made on a policy that begins on 10/01/2004 and ends on 09/30/2005. The plan coverage code for the policy is 117, which requires a premium of \$460/yr. The payment is an exact quarter amount and is made by check. The date of the payment is 09/05/2004.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The year that identifies the policy
HCDP_FPMT_DT	20040905	The date of the transaction
HCDP_FPMT_THRU_DT	20041231	The date that the payment pays through. For the first quarterly payment, this is three months after the policy begin date.
HCDP_FPMT_PLN_TYP_CD	Q	A "Q" indicates a quarterly payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$115.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

SCENARIO 3: REQUEST TO BEGIN EFT/ALLOTMENT PAYMENT WITHIN 90 DAYS OF FISCAL YEAR END

A policy with a plan coverage code of 117 has a begin date of 11/01/2004 and has been paid in quarterly payments until 08/31/2005. On 08/15/2005, a request to begin EFT/Allotment is made along with a check for \$115.00 to cover the three months' premiums. In this case, the HCDP_FPMT_THRU_DT that is specified is three months after the last paid-through date. Only one fee transaction should be sent.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041101	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050815	The date of the transaction
HCDP_FPMT_THRU_DT	20051130	The date that the payment pays through. For the first quarterly payment, this is three months after the policy begin date.
HCDP_FPMT_PLN_TYP_CD	R	An "R" indicates a Request to begin EFT or Allotment
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$115.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no exception reason code
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

SCENARIO 4: MONTHLY PAYMENT

HCDP_FPMT_PLN_TYP_CD cannot be “monthly” (“M”) if this is the initial fee payment or if there is not a previous HCDP_FPMT_PLN_TYP_CD (HCDP Enrollment Fee Payment Plan Type Code) of “R” (Request to begin EFT/Allotment) or “M”. We will use the same policy as the example above which has a request to begin EFT/Allotment payment with the paid through date of 11/30/2005. The plan coverage code for the policy is 117, which requires a monthly premium of \$38.33. The date of the payment is 11/05/2005. For monthly payment (“M”), the field HCDP_FPNT_TYP_CD can only be “A” (Allotment) or “E” (EFT).

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20051001	The date the policy began
HCDP_FY_ID	2006	The fiscal year identifier of the policy
HCDP_FPMT_DT	20051105	The date of the transaction
HCDP_FPMT_THRU_DT	20051231	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	M	An “M” indicates a Monthly payment
HCDP_FPMT_TYP_CD	5	A “5” indicates an “Allotment”. This field can only be “5” or “6”.
HCDP_EY_FPMT_AM	\$38.33	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An “N” indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An “A” indicates a payment

SCENARIO 5: PAYMENT ON A TERMINATED POLICY THAT SPANS THE TERMINATION DATE

A payment needs to be made to a policy that has been terminated. The paid through date extends past the termination date. The policy has a coverage code of 117 and occurs in fiscal year 2005. The current date is 08/20/2005 and the termination date is 08/31/2005. The paid through date of the payment is 09/30/2005. The total payment amount is \$115.00 and amount payable to the terminated policy is \$76.67. This scenario is handled using two transactions: one is a regular payment with a paid through date equal to the termination date of the policy. The second is a credit transaction for 38.33 on the same policy.

The first payment is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050820	The date of the transaction
HCDP_FPMT_THRU_DT	20050831	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	\$76.67	This is the payment amount
HCDP_FPMT_EXC_RSN_CD	N	An “N” indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An “A” indicates a payment.

The second payment is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050820	The date of the transaction
HCDP_FPMT_THRU_DT	20050831	The date that the credit pays through. This date can be between 20040930 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	\$38.33	This is the balance of the payment after subtracting 76.67
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit

SCENARIO 6: PAYMENT ON A POLICY THAT BEGINS MID-YEAR

A payment is made on a policy that begins in the middle of a fiscal year. The policy begin date is 04/01/2005. The policy has a coverage code of 117 and occurs in fiscal year 2005. The current date is 03/20/2005. Payments are made quarterly by check and paid through date of the payment is 06/30/2005. The total payment amount is \$115.00 and the amount payable to the policy is \$115.00.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20050401	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050320	The date of the transaction
HCDP_FPMT_THRU_DT	20050630	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	\$115.00	This is the payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no exception reason code
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

Adjustments

Adjustments are used to modify values sent in prior payment transactions. An adjustment transaction is identified with a HCDP_FEE_ACTN_CD=B. Adjustments made on future fiscal year payments are only accepted if the prior fiscal years are paid in full and if the sum of the credits on the policy is zero.

SCENARIO 7: REGULAR ADJUSTMENT

In this scenario, an adjustment needs to be made so that \$20 is subtracted from the total payments to a policy. In this case, the paid-through date is not changed from the existing 02/28/2005. The fiscal year of the policy is 2005. The date of this adjustment is 01/20/2005. The values of the most recent payment are as follows: HCDP_FPMT_PLN_TYP_CD=Q, HCDP_FPMT_TYP_CD=C, HCDP_FPMT_EXC_RSN_CD=N.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050120	The date of the transaction
HCDP_FPMT_THRU_DT	20050228	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	Q	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	-\$20.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no exception reason code
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	B	A "B" indicates an adjustment

SCENARIO 8: ADJUSTMENT TO A REQUEST TO BEGIN EFT/ALLOTMENT PAYMENT

In this scenario, a payment with a HCDP_FPMT_PLN_TYP_CD of R (Request to begin EFT or Allotment) needs to be reversed. The payment to be reversed had a paid through date of 06/30/2005. The policy begin date is 01/01/2005 and is a family policy. The previous HCDP_FPMT_PLN_TYP_CD was Q (quarterly). To reverse this payment an adjustment needs to be sent with a negative value of the amount that was initially sent in the payment. The HCDP_FPMT_PLN_TYP_CD of the adjustment should be set to previous payment type, which in this case is Q.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20050101	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050315	The date of the transaction
HCDP_FPMT_THRU_DT	20050331	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	-\$115.00	This is a negative amount of the payment that is being reversed
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	B	A "B" indicates an adjustment.

Credits

Credit transactions are used to indicate overpayments to a policy and are applied on a fiscal year basis. An HCDP_FEE_ACTN_CD of "H" is used to identify a credit transaction. The HCDP_EY_FPMT_AM field contains the amount of the credit. The credit amount may be a positive or negative value; however, there are some restrictions that the application enforces. The sum of a new credit and existing credits for the fiscal year cannot be negative. A positive credit amount will not be allowed if the sum of the existing credits for the fiscal year is a positive amount. In order to apply a new credit when there are existing credits, the existing credit amount must first be reversed by sending a negative credit transaction so that the credit sum becomes zero. Once this is done, the new credit amount can be sent.

SCENARIO 9: ADD NEW CREDIT WHEN NO PRIOR CREDITS EXIST

A \$9.00 overpayment is received for a quarterly payment that is paid through 06/30/2005 on a policy with a begin date of 10/01/2004.

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050402	The date of the transaction
HCDP_FPMT_THRU_DT	20050630	The date that the credit pays through. This date can be between 20040930 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	This is the value of the payment plan type code
HCDP_FPMT_TYP_CD	3	This is the or value of the fee payment type code
HCDP_EY_FPMT_AM	\$9.00	This is the credit amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit.

SCENARIO 10: ANNUAL PAYMENT WITH OVERPAYMENT

A beneficiary sends an annual payment that exceeds the annual fee amount. The fiscal year of the policy is 2005 and ends on 09/30/2005. The plan coverage code for the policy is 117, which requires a premium of \$460/yr. The payment is for \$500.00 and is made by check. The date of the payment was 09/05/2004.

To apply the payment to DEERS, this scenario requires two fee transactions. The first transaction is a payment that pays to the end of the end of the 2005 fiscal year. The overage is then made as a credit transaction to the 2006 fiscal year policy. The HCDP_FPMT_THRU_DT on the second transaction can be anything between 20050930 and 20060930.

The first transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20040905	The date of the transaction
HCDP_FPMT_THRU_DT	20050930	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	A	An "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$460.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

The second transaction to apply the overage is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20051001	The date the policy began
HCDP_FY_ID	2006	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050905	The date of the transaction
HCDP_FPMT_THRU_DT	20050930	The date that the credit pays through. This date can be between 20050930 and 20060930
HCDP_FPMT_PLN_TYP_CD	A	An "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$40.00	The credit amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used **
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit

The first payment should be accepted without any warnings or errors.

SCENARIO 11: QUARTERLY PAYMENT WITH OVERPAYMENT

A beneficiary sends the first quarterly payment that exceeds the quarterly fee amount. The fiscal year of the policy is 2005 and ends on 09/30/2005. The plan coverage code for the policy is 117, which requires a premium of \$460/yr. The payment is for \$150.00 and is made by check. The date of the payment was 10/15/2004. Since the payment period does not span a fiscal year, a single payment transaction is used. The overpayment amount is \$35.00. Since this amount is less than a full quarterly payment, the paid-through date is the quarter end date, which in this case would be 12/31/2004.

To apply the payment to DEERS, this scenario requires two fee transactions. The first transaction is a payment that pays to the end of the end of the first fiscal quarter. The overage is then made as a credit transaction to the 2005 fiscal year policy. The HCDP_FPMT_THRU_DT on the second transaction can be anything between 20040930 and 20050930.

The first transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20041015	The date of the transaction
HCDP_FPMT_THRU_DT	20041231	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	Q	A "Q" indicates a quarterly payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$115.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

The second transaction to apply the overage is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20041015	The date of the transaction
HCDP_FPMT_THRU_DT	20041231	The date that the credit pays through. This date can be between 20040930 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	A "Q" indicates a quarterly payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$35.00	The credit amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used **
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit

SCENARIO 12: MODIFY AN EXISTING CREDIT

A credit amount exists in fiscal year 2005 in the amount of \$10.00. The policy begin date is 10/01/2004. The date of the transaction is 02/20/2005. The credit needs to be changed to be \$15.00 instead. In order to do this, two credit transactions need to be sent. The first transaction has a -\$10.00 amount in order to reverse the existing credit. The second transaction is then sent for the \$15.00.

The first transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050220	The date of the transaction
HCDP_FPMT_THRU_DT	20050331	The date that the credit pays through. This date can be between 20040930 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	This is the value of the payment plan type code
HCDP_FPMT_TYP_CD	3	This is the or value of the fee payment type code
HCDP_EY_FPMT_AM	-\$10.00	This is the credit amount to reverse the existing credit in DEERS
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit.

The second transaction to apply the new credit amount is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20041001	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050220	The date of the transaction
HCDP_FPMT_THRU_DT	20050331	The date that the credit pays through. This date can be between 20040930 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	This is the value of the payment plan type code
HCDP_FPMT_TYP_CD	3	This is the or value of the fee payment type code
HCDP_EY_FPMT_AM	\$15.00	This is the corrected credit amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit.

SCENARIO 13: MODIFY AN EXISTING CREDIT ON A POLICY THAT BEGINS MID-YEAR

We will use the same scenario as the above example (13.3.2), except the policy begin date is 04/01/2005. A credit amount exists in fiscal year 2005 in the amount of \$10.00. The policy begin date is 04/01/2005. The date of the transaction is 05/20/2005. The credit needs to be changed to \$15.00 instead. In order to do this, two credit transactions need to be sent. The first transaction has a -\$10.00 amount in order to reverse the existing credit. The second transaction is then sent for the \$15.00.

Scenario 14: Removing an Existing Credit and Applying a Payment in DEERS

A new policy with the TRICARE Prime Family Cvg has an enrollment begin date of 03/01/2008. A credit exists of \$76.67 and a new quarterly payment of \$115.00 was submitted in the current fiscal year. The credit needs to be backed out before the payment can be applied. In order to do this, you must first submit a negative credit transaction to reverse the credit and then submit a payment transaction.

Identify the credit amount, fiscal year and Healthcare Delivery Plan coverage code (HCDP) the credit is attached to. Submit an H/Adjustment with a negative dollar amount and paid through date equal to the last payment paid thru date submitted to remove the credit.

The first transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20080520	The date of the transaction
HCDP_FPMT_THRU_DT	20080331	The date that the credit pays through.
HCDP_FPMT_PLN_TYP_CD	Q	This is the value of the payment plan type code
HCDP_FPMT_TYP_CD	3	This is the or value of the fee payment type code
HCDP_EY_FPMT_AM	-\$76.67	This is the credit amount to reverse the existing credit in DEERS
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit.

Submit A/Payment record according to normal fee specifications. The amount should include the credit adjustment total and the remaining payment that makes the quarter/annual payment whole (i.e. \$38.33 credit + \$76.67 payment = \$115.00). The HCDP_FPMT_THRU_DT must fall on the end of a quarter or the end of the current FY.

The second transaction to apply the payment is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20080520	The date of the transaction
HCDP_FPMT_THRU_DT	20080630	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	Q	A "Q" indicates a quarterly payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$115.00	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

When submitting the credit adjustment and payment postings in one batch, set the H credit adjustment as primary and the quarterly payments in paid through date order – oldest to newest. This will ensure proper posting of paid through dates in DEERS without causing an error of paid through date not greater than latest paid through date.

The first transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20050401	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050520	The date of the transaction
HCDP_FPMT_THRU_DT	20050331	The date that the credit pays through. This date can be between 20050331 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	This is the value of the payment plan type code
HCDP_FPMT_TYP_CD	3	This is the or value of the fee payment type code
HCDP_EY_FPMT_AM	-\$10.00	This is the credit amount to reverse the existing credit in DEERS
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit

The second transaction to apply the new credit amount is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	117	
HCDP_PLCY_BGN_DT	20050401	The date the policy began
HCDP_FY_ID	2005	The fiscal year identifier of the policy
HCDP_FPMT_DT	20050520	The date of the transaction
HCDP_FPMT_THRU_DT	20050331	The date that the credit pays through. This date can be between 20050331 and 20050930
HCDP_FPMT_PLN_TYP_CD	Q	This is the value of the payment plan type code
HCDP_FPMT_TYP_CD	3	This is the or value of the fee payment type code
HCDP_EY_FPMT_AM	\$15.00	This is the corrected credit amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	H	An "H" indicates a credit

Fee Exceptions

Scenario 15: Removing a Fee Exception from a record when NO enrollment fee payments have been posted to the current Fiscal Year in order to correctly post Quarterly or Annual Payments

A policy with the plan USFHP DC Family Cvg has a begin date of 10/01/2007 and has one fee exception “L – fee waiver exists for an individual” and one fee paying family member. The current fee exception is through 9/30/2008 and quarterly/annual payments need to be posted for the fee paying family member.

OPTION 1:

Submit a B/Adjustment record including: N – no fee waiver exception, Annual payment plan, \$0 payment and HCDP_FPMT_THRU_DT equals the last day of the prior fiscal year (i.e. 20070930).

The first transaction to remove the fee exception is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20070930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	A	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	\$0.00	No payment is being applied
HCDP_FPMT_EXC_RSN_CD	N	An “N” indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	B	A “B” indicates an adjustment.

Once the Fee Exception is removed from the record, submit payments placing the fee exception “L – fee waiver exists for individual” in addition to the Quarterly or Annual payments.

The second transaction to apply **one** quarterly or annual payment is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20071231	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q or A	A "Q" indicates a quarterly payment plan or an "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates payment by check
HCDP_EY_FPMT_AM	\$57.50 or \$230	Quarterly or Annual payment is being applied
HCDP_FPMT_EXC_RSN_CD	L	An "L" indicates fee waiver exists for an individual
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

OPTION 2:

Without removing the existing Fee Exception, update the HCDP_FPMT_THRU_DT to end of current FY (i.e. 20080930) for all current Fee submissions. Make sure the HCDP_FPMT_DT (payment received date) is not duplicate to previous payments or it will error out as a duplicate payment by DEERS. This transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20080930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q or A	A "Q" indicates a quarterly payment plan or an "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates payment by check
HCDP_EY_FPMT_AM	\$57.50 or \$230	Quarterly or Annual payment is being applied
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

Scenario 16: Removing a Fee Exception from a record when NO enrollment fee payments have been posted to the current Fiscal Year in order to correctly post Monthly Payments

A policy with the USFHP DC Family Cvg has a begin date of 10/01/2007 and has one fee exception "L – fee waiver exists for an individual" and one fee paying family member. The fee exception is through 9/30/2008 and the member wants to pay via Monthly EFT/Allotment. Monthly payments need to be posted for the fee paying family member.

OPTION 1:

Submit a B/Adjustment record including: N – no fee waiver exception, Annual payment plan, \$0 payment and HCDP_FPMT_THRU_DT equals the last day of the prior fiscal year (i.e. 20070930).

The first transaction to remove the fee exception is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20070930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	A	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	\$0.00	No payment is being applied
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	B	A "B" indicates an adjustment.

Once the Fee Exception is removed from the record, first submit an R/Request for EFT/Allotment record to include a quarterly payment of \$57.50 for the first three months and HCDP_FPMT_THRU_DT equals 12/31/07. Including the "L – fee waiver exists for an individual" with the payment.

The second transaction to apply the "R" transaction and initial quarterly payment is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20071231	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	R	An "R" indicates a Request to begin EFT or Allotment
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$57.50	The payment amount
HCDP_FPMT_EXC_RSN_CD	L	An "L" indicates fee waiver exists for an individual
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

Submit a monthly payment with a paid through date of 1/31/08 with an "L" exception for each transaction to maintain the exception.

The final transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20080131	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	M	An "M" indicates a monthly payment
HCDP_FPMT_TYP_CD	5	A "5" indicates an "Allotment". This field can only be "5" or "6".
HCDP_EY_FPMT_AM	\$19.17	Monthly payment is being applied
HCDP_FPMT_EXC_RSN_CD	L	An "L" indicates fee waiver exists for an individual
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

Scenario 17: Removing a Fee Exception from a record when enrollment fee payments have been posted to the current Fiscal Year

A policy with the USFHP DC Family Cvg has a begin date of 10/01/2007 and has one fee exception "L – fee waiver exists for an individual" and one fee paying family member. There is \$115.00 in fees posted to the record. Mid fiscal year, the fee exception is placed in DEERS paid through 9/30/2008 and additional quarterly payments need to be posted for the fee paying family member.

OPTION 1:

Submit a B/Adjustment record including: N – no fee waiver exception, total amount paid for the current FY as a negative payment (i.e -\$115.00) and HCDP_FPMT_THRU_DT equal to the last day of the prior fiscal year (i.e. 20070930). This will result in \$0 fees paid for the current FY and no fee exception on file.

The first transaction to remove the fee exception and fees is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20070930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	A	This is the prior value of the plan type code
HCDP_FPMT_TYP_CD	3	This is the prior value of the fee payment type code
HCDP_EY_FPMT_AM	-\$115.00	This is a negative payment to remove the fees
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	B	A "B" indicates an adjustment.

Once the Fee Exception and fees are removed from the record, submit A/Payment records according to normal fee specifications including the addition of the fee exception "L – fee waiver exists for individual". This will ensure the payment for the fee paying member(s) and the fee exception for the non-fee paying member are updated in DEERS correctly.

The second transaction to apply **one** quarterly payment is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20071231	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q	A "Q" indicates a quarterly payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$57.50	Quarterly payment is being applied
HCDP_FPMT_EXC_RSN_CD	L	An "L" indicates fee waiver exists for an individual
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

OPTION 2:

Without removing the existing Fee Exception, update the HCDP_FPMT_THRU_DT to end of current FY (i.e. 20080930) for all current Fee submissions. You must continue to input the fee exception with the payment because the payment expected is less than the family rate. This transaction is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20080930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	Q	A "Q" indicates a quarterly payment plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$57.50	Quarterly payment is being applied
HCDP_FPMT_EXC_RSN_CD	L	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

Scenario 18: Submitting Enrollment Fee Payments by Subscriber of an Enrolled Health Plan

When a Fee Exception member enrolled in USFHP DC Individual Cvg with Medicare B and a Fee paying member enrolled in Prime Individual Cvg are enrolled in the same Designated Provider, transmit the following two transactions:

The first transaction is for the USFHP Individual Cvg w/Medicare B Subscriber:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	118	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20080520	The date of the transaction
HCDP_FPMT_THRU_DT	20080930	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	A	A "A" indicates a annual plan
HCDP_FPMT_TYP_CD	0	A "0" indicates a payment of other
HCDP_EY_FPMT_AM	\$0	The payment amount
HCDP_FPMT_EXC_RSN_CD	L	An "L" indicates fee waiver applies for individual
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

To submit the Fee Payment for the Subscriber of the enrolled TRICARE Prime Individual plan, identify the subscriber of the enrolled health plan (usually the spouse/eldest child). Transmit one quarterly payment as follows:

The second transaction is for the TRICARE Prime Individual Subscriber:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	116	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20071015	The date of the transaction
HCDP_FPMT_THRU_DT	20071231	The date that the payment pays through
HCDP_FPMT_PLN_TYP_CD	Q	A "A" indicates a annual plan
HCDP_FPMT_TYP_CD	3	A "3" indicates a payment made by check
HCDP_EY_FPMT_AM	\$57.50	The payment amount
HCDP_FPMT_EXC_RSN_CD	N	An "N" indicates no fee waiver exception
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment

These methods apply to all current payment types.

When two or more enrollees with USFHP DC Family plan with Medicare Part B and one fee paying member are enrolled in TRICARE Prime Individual plan, with begin dates of 10/01/2007. Fee exceptions need to be placed under each enrolled plan for the current FY. Submit an A/Payment record including: M – multiple fee waivers in a family under the subscriber of USFHP DC Family Cvg. Then submit an A/Payment record including: L – individual fee waiver exists under the subscriber of the TRICARE Prime Individual for the current fiscal year.

The first transaction to apply the fee exception to the USFHP DC Family Cvg plan is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	119	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20080930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	A	An "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	0	A "0" indicates other payment
HCDP_EY_FPMT_AM	\$0.00	No payment is being applied
HCDP_FPMT_EXC_RSN_CD	M	An "M" indicates multiple fee waivers in a family
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

The second transaction to apply the fee exception to the TRICARE Prime Individual plan is as follows:

Fee Information		
System Name	Expected Value	Notes
HCDP_PLN_CVG_CD	116	
HCDP_PLCY_BGN_DT	20071001	The date the policy began
HCDP_FY_ID	2008	The fiscal year identifier of the policy
HCDP_FPMT_DT	20070314	The date of the transaction
HCDP_FPMT_THRU_DT	20080930	The date that the payment pays through.
HCDP_FPMT_PLN_TYP_CD	A	An "A" indicates an annual payment plan
HCDP_FPMT_TYP_CD	0	A "0" indicates other payment
HCDP_EY_FPMT_AM	\$0.00	No payment is being applied
HCDP_FPMT_EXC_RSN_CD	L	An "L" indicates fee waiver exists for an individual
EMC_LKOT_PERD_CD	*blank*	** Not Used ** Can be blank
HCDP_FEE_ACTN_CD	A	An "A" indicates a payment.

2.5.4. Enrollment Fee Error/Reject Handling

Enrollment fees will be rejected when the required fields are not populated according to the above documented business rules. Ingenix will send a single error file that will include errors that failed both Ingenix and DEERS validation checks. A summary of the reported errors that will be returned along with the associated business rules are as follows:

SOURCE	ERROR REPORTED	BUSINESS RULE
Ingenix	DMIS_ID	As defined in the data dictionary
Ingenix	SPSR_SSN/DMIS_ID	Sponsor SSN/DMIS ID (SPSR_SSN/DMIS_ID) must exist
Ingenix	EMC_POL_ENRL_PRD_BEGN_DT	The Enrollment Begin Date (EMC_POL_ENRL_PRD_BEGN_DT) must be provided
Ingenix	ENRL_FEE_CLCTED_AMT	When Fee Action is "A" - New Payment Transaction (ACT_CD = A) , the Enrollment Fee Collected Amount must be positive and cannot exceed \$999.99
Ingenix	ENRL_FEE_PYMT_PD_THRU_DT	1) The Fee Payment Thru Date (ENRL_FEE_PYMT_PD_THRU_DT) must be provided 2) The Fee Payment Thru Date must be greater than or equal to the Enrollment Begin Date (EMC_ENRL_BEGN_DT) and less than or equal to the Enrollment End Date (EMC_ENRL_END_DT)+730 3) If the Plan Type Code is Q - Quarterly (PLN_TYP_CD = Q), then the Fee Paid Thru Date (ENRL_FEE_PYMT_PD_THRU_DT) must have an end date of December 31, March 31, June 30, or September 30 4) If the Plan Type Code is A - Annually, M - Monthly, or R - Request to begin EFT or allotment (PLN_TYP_CD = A, M or R), the Fee Payment Thru Date (ENRL_FEE_PYMT_PD_THRU_DT) must be the last day of the month
Ingenix	ENRL_FEE_PYMT_RECV_DT	The Fee Payment Received Date (ENRL_FEE_PYMT_RECV_DT) must be provided
Ingenix as of May 2007	HCDP_FEE_ACTN_CD	Valid values for the Fee Action Code are "A" - Payment, "B" - Adjustment, "C" - Other, and "H" - Credit
Ingenix	HCDP_FISC_YR_ID	The Fiscal Year (HCDP_FISC_YR_ID) must be provided
Ingenix	HCDP_POL_ENRL_PRD_BEGN_DT	The Policy Begin Date (HCDP_POL_ENRL_PRD_BEGN_DT) must be provided
Ingenix	PLN_TYP_CD	Valid values for the Plan Type Code are "A" - Annually, "M" - Monthly, "Q" - Quarterly, and "R" - Request to begin Electronic Funds Transfer or allotment (3 month payment)
Ingenix	PRD_BEGN_DT/PYMT_PD_THRU_DT	The Fee Payment Thru Date (ENRL_FEE_PYMT_PD_THRU_DT) must be after the Policy Begin Date (HCDP_POL_ENRL_PRD_BEGN_DT)
Ingenix	PYMT_TYP_CD	Valid values for the Payment Type Code are "0" - No Payment, "1" - Cash, "2" - Credit Card, "3" - Check, "4" - Money Order, "5" - Allotment (only for "M" Transactions), and "6" - Electronic Funds Transfer
Ingenix	PYMT_TYP_CD/PLN_TYP_CD	1) Payments with Plan Type Codes (PLN_TYP_CDs) of "A" - Annually and "Q" - Quarterly can only have Payment Type Codes PYMT_TYP_CDs of "0" - No Payment, "1" - Cash, "2" - Credit Card, "3" - Check, or "4" - Money Order 2) Payments with Plan Type Codes (PLN_TYP_CDs) of "M" -

SOURCE	ERROR REPORTED	BUSINESS RULE
		Monthly can only have Payment Type Codes (PYMT_TYP_CDs) of "5" - Allotment or "6" - Electronic Funds Transfer
Ingenix	PYMT_XCPT_RSN_CD	Valid values for the Payment Exception Reason Code are: "C" - Catastrophic cap and deductible have been met for this payment period, "F" - Fees waived due to EY to FY realignment, "L" - Fee waiver exists for an individual, "M" - Multiple fee waivers in a family, "N" - No fee waiver exception, and "W" - Enrollment fee for this payment period has been affected by individual family member fee waiver(s)
Ingenix	SPSR_SSN	Sponsor SSN (SPSR_SSN) must be provided and must be 9 digits
DEERS	3 month payment required for HCDP_PLN_TYP_CD of R	Plan Type Codes of "R" - Request to begin EFT require a 3 month payment
DEERS	Credit/Payment not applied due to existing credit	The existing credit must be reversed before the new credit or payment can be applied. Send one or more credit transactions with negative amounts to reverse the existing credit.
DEERS	Duplicate fee payment	Indicates that there is a payment already in the database with the same Fee Payment Date, Fiscal Year Indicator, Fee Payment Thru Date, Fee Payment Plan Type Code, End of Year Fee Payment Amount, and Fee Action Code (EHCDP_FPMT_DT, HCDP_FY_ID, HCDP_FPMT_THRU_DT, HCDP_FPMT_PLN_TYP_CD, HCDP_EY_FPMT_AM, and HCDP_FEE_ACTN_CD)
DEERS	HCDP_PLCY_BGN_DT is not the correct date	The Policy Begin Date must be the date that the policy began or October 1st of the year that the payment is to be applied, whichever is later.
DEERS	HCDP_FPMT_THRU_DT and HCDP_FY_ID must match	The HCDP_FPMT_THRU_DT and HCDP_FY_ID must be in the same fiscal year. Correct and Resubmit.
DEERS	Credit is not allowed in a prior fiscal year	Credits are only allowed on the current and up to 2 fiscal years in the future. Correct and resubmit.

SOURCE	ERROR REPORTED	BUSINESS RULE
DEERS	Incorrect HCDP_FPMT_THRU_DT	<p>1) The Fee Payment Thru Date (HCDP_FPMT_THRU_DT) of the payment transaction specifies a date that is prior to an existing payment in the database. The Fee Payment Thru Date HCDP_FPMT_THRU_DT must be later than the current paid-through date.</p> <p>2) The Fee Payment Thru Date (HCDP_FPMT_THRU_DT) should be in the same fiscal year as that identified by the Fiscal Year Indicator (HCDP_FY_ID). The exception to this rule is for payments that have a Plan Type Code of "R" - Request to begin EFT or Allotment that are within three months of the end of the fiscal year. In this case, the Fee Payment Thru Date HCDP_FPMT_THRU_DT should be either October 31 or November 30 of the following fiscal year.</p> <p>3) For Plan Type Codes of "R" - Request to begin EFT or Allotment, (HCDP_FPMT_PLN_TYP_CD = "R"), the Fee Payment Thru Date (HCDP_FPMT_THRU_DT) must be exactly 3 months from the last fee payment on the DEERS database if one exists or otherwise the date specified in Policy Begin Date (HCDP_PLCY_BGN_DT).</p> <p>4) This date must be the last day of the month and must be within two fiscal years in the future of the current fiscal year.</p>
DEERS	Invalid HCDP_FY_ID	Invalid Fiscal Year Indicator
DEERS	No fee required for plan	No fee required for plan
DEERS	No policy record found	The fields that are used to identify a policy on DEERS are the DEERS Family ID, Plan Coverage Code, and Policy Begin Date (DEERS_FAM_ID, HCDP_PLN_CVG_CD, and HCDP_PLCY_BGN_DT).
DEERS	Plan type code 'M' requires prior 'R' payment	Indicates that a monthly payment requires a prior Plan Type Code of "R" - Request to begin EFT or allotment (HCDP_FPMT_PLN_TYP_CD = "R").
DEERS	Pmt not allowed due to prior FY not paid in full	<p>1) The payment was rejected because the previous fiscal year policy was not paid in full.</p> <p>2) Payments made in future fiscal years require that previous fiscal years be paid in full or the Fee Payment Exception Reason Code cannot be "N" - No Fee Waiver Exception (HCDP_FPMT_EXC_RSN_CD not equal to "N") and the latest Fee Payment Thru Date (HCDP_FPMT_THRU_DT) must be the end of the specified previous fiscal year (XXXX0930)</p>

2.5.5. ENROLLMENT FEE COLLECTIONS DATA FORMAT (Input from DP's)

This file format will be used by the DP when reporting monthly Enrollment Fee data. This file will be uploaded through DefenseWeb's web application by the 15th of each month. Each submission will include records uniquely identified by the Sponsor Social Security Number, Fee Payment Date, FY ID, Fee Payment Paid Thru Date, Health Care Delivery Program Enrollment Fee Payment Plan Type Code, Fee Action Code, and Fee Collected Amount.

Each submission will include records uniquely identified by the Patient ID of Subscriber, Sponsor Social Security Number, Fee Payment Date, FY ID, Fee Payment Paid Thru Date, Payment Plan Type Code, Fee Action Code, and Fee Collected Amount.

2.5.6. ENROLLMENT FEE COLLECTIONS HEADER RECORD FILE SPECIFICATIONS

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	VALID VALUES/DESCRIPTION	CORRESPONDING ERROR CODE	
1	3	FILE TYPE	3	Char	EFC	002,007	
					Enrollment Fee Collections		
					NDC		Pharmacy Data
					PRV		Provider Data
					MCD		Management Clinical Data
OHI	OHI/PCM Update Data						
4	9	SUBMISSION PERIOD	6	Char (MMYYYY)	The month and year of the actual data being submitted (example: 052006 is all May data)	008	
10	17	CREATION DATE	8	Date (CCYYMMDD)	The date the file is created (example the May submission period will have a creation date > 5/31/06)	008	
18	21	DMIS ID	4	Char	See valid values listed below	002, 007	
22	28	TOTAL RECORDS	7	Num	Must be numeric – can be right justified zero filled if DP's prefer or just left as a number	008	

2.5.7. Enrollment Fee Collections Detail Data Record File Specifications

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION	
1	4	DMIS ID	4	Char	Y	0190	DD Valid Lookup	002 007 034	Required field is blank/NULL Data value not found in DP table DMIS ID/Patient/Sponsor not found in DP table	
						Johns Hopkins Medical Services Corporation				
						0191				Brighton Marine Health Care
						0192				CHRISTUS Health – St. John's
						0193				Saint Vincent Catholic Medical Centers of NY
						0194				Pacific Medical Clinics
						0196				CHRISTUS Health – St. Joseph's
0197	CHRISTUS Health – St. Marys									

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
						0198 Martin's Point Health Care			
5	13	DEERS FAMILY IDENTIFIER	9	Char	N	Any	No Validation	N/A	N/A
14	15	DEERS BENEFICIARY IDENTIFIER	2	Char	N	Any	No Validation	N/A	N/A
16	25	PATIENT IDENTIFIER of Subscriber	10	Char	Y	Any	Valid match to enrollment	002 008 034	Required field is blank/NULL Invalid data value DMIS ID/Patient/Sponsor not found in DP table
26	34	SPONSOR SOCIAL SECURITY NUMBER (SSN)	9	Char	Y	Any	Valid match to enrollment	002 008 034	Required field is blank/NULL Invalid data value DMIS ID/Patient/Sponsor not found in DP table
35	36	SUBSCRIBER LEGACY DEERS DEPENDENT SUFFIX	2	Char	N	Any	No Validation	N/A	N/A
37	63	SUBSCRIBER PERSON LAST NAME	27	Char	N	Any	No Validation	N/A	N/A
64	82	SUBSCRIBER PERSON FIRST NAME	19	Char	N	Any	No Validation	N/A	N/A
83	101	SUBSCRIBER PERSON MIDDLE NAME	19	Char	N	Any	No Validation	N/A	N/A
102	104	SUBSCRIBER PERSON CADENCY NAME	3	Char	N	Any	No Validation	N/A	N/A
105	112	SUBSCRIBER DATE OF BIRTH	8	Date	N	Date	No Validation	N/A	N/A
113	120	ENROLLMENT FEE PAYMENT RECEIVED DATE	8	Date	Y	Date	Valid date	002 035	Required field is blank/NULL Field has invalid date format
121	128	HEALTH CARE DELIVERY PROGRAM ENROLLMENT FEE PAYMENT	8	Date	Y	Date	Valid Date – see validation rules in section 2.5.3	002 035 008 005	Required field is blank/NULL Field has invalid date format Invalid data value Date is outside enrollment dates

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION		TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION
		PAID-THROUGH CALENDAR DATE								
129	129	HEALTH CARE DELIVERY PROGRAM ENROLLMENT FEE PAYMENT PLAN TYPE CODE	1	Char	Y	A	Annually	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
					M	Monthly (payroll deduction) (this value will not be in use until monthly fee payment allotments are implemented)				
					Q	Quarterly				
					R	Request to begin ELECTRONIC FUNDS TRANSFER or allotment (3 month payment)				
130	130	HEALTH CARE DELIVERY PROGRAM ENROLLMENT FEE PAYMENT EXCEPTION REASON CODE	1	Char	Y	C	Catastrophic cap and deductible have been met for this payment period	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
					F	Fees waived due to EY to FY realignment				
					L	Fee waiver exists for an individual				
					M	Multiple fee waivers in a family				
					N	No fee waiver exception				
					W	Enrollment fee for this payment period has been affected by individual family member fee waiver(s)				
131	136	ENROLLMENT FEE COLLECTED	6	Num	Y	Numeric and Non-Blank		DEERS Validation	002 008	Required field is blank/NULL Invalid data value
								DEERS		Value must be between -999.99 and 999.99 Must be non duplicate based on HCDP Fee Payment Date, HCDP Payment Thru Date, HCDP Fee Payment Plan Type Code, HCDP Enrollment Year Fee Payment Amount
137	137	ENROLLMENT FEE PAYMENT	1	Char	Y	0	No Payment	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table
					1	Cash				

ST	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	REQ'D	VALID VALUES WITH DESCRIPTION	TYPE OF VALIDATION	ERROR CODE	ERROR CODE DESCRIPTION										
		TYPE CODE				<table border="1"> <tr><td>2</td><td>Credit Card</td></tr> <tr><td>3</td><td>Check</td></tr> <tr><td>4</td><td>Money Order</td></tr> <tr><td>5</td><td>Allotment</td></tr> <tr><td>6</td><td>Electronic Funds Transfer</td></tr> </table>	2	Credit Card	3	Check	4	Money Order	5	Allotment	6	Electronic Funds Transfer		DEERS	No Fee required for plan (payment exception reason code)
2	Credit Card																		
3	Check																		
4	Money Order																		
5	Allotment																		
6	Electronic Funds Transfer																		
138	138	CREDIT CARD TYPE	1	Char	N	Any	No Validation	N/A	N/A										
139	139	ENROLLMENT FEE PAYMENT ACTION CODE	1	Char	Y	<table border="1"> <tr><td>A</td><td>Payment</td></tr> <tr><td>B</td><td>Adjustment</td></tr> <tr><td>C</td><td>Other</td></tr> <tr><td>H</td><td>Credit</td></tr> </table>	A	Payment	B	Adjustment	C	Other	H	Credit	DD Valid Lookup	002 007	Required field is blank/NULL Data value not found in DP table		
A	Payment																		
B	Adjustment																		
C	Other																		
H	Credit																		
140	147	ENROLLMENT MANAGEMENT CONTRACTOR POLICY ENROLLMENT PERIOD BEGIN CALENDAR DATE	8	Date	Y	Date (This is the Enrollment Begin Date)	Valid Date	002 035	Required field is blank/NULL Field has invalid date format										
148	155	HEALTH CARE DELIVERY PROGRAM POLICY ENROLLMENT PERIOD BEGIN CALENDAR DATE	8	Date	Y	Date (This is the Policy Begin Date)	Valid Date	002 035 001	Required field is blank/NULL Field has invalid date format Date is > enrollment date										
156	159	FISCAL YEAR INDICATOR	4	Char	Y	CCYY	Fiscal year (up to two years after the current fiscal year)	002 008	Required field is blank/NULL Invalid data value										
160	171	ENROLLMENT FEE UNIQUE IDENTIFIER	12	Char	N	Any	No Validation	N/A	N/A										

3. METHOD FOR SUBMITTING DATA:

Electronic submission of data using DefenseWeb's upload process on their website will be the only method to submit data. Please refer to the data submission section of these specifications for more information (SECTION Four, 4.2).

4. DATA FILE FORMATS (Output to DPs):

The following sections show the file format for all data returned to the DP's. Detailed field definitions and valid values for all fields can be found in alphabetical order in the DP Data Dictionary Section.

On a monthly basis, Ingenix will provide an electronic copy of the records received for each DP. This information is placed on DefenseWeb's site as well as on the TMA DP Program Office Information System Web Application in a downloadable format. Reports are also generated and available for downloading from DefenseWeb's web application.

4.1 CAPITATION PAYMENT DATA FORMAT – (FINAN04 - Output to DP's)

This file format will be used when Ingenix is producing the file containing detailed data on beneficiaries paid capitation for the specific month, including the capitation amount paid. Males and Females will be included in the same file. This file will be available to the DP's by the 10th of the month.

FIELD	START	END	LENGTH	TYPE	DESCRIPTION
PCM EDVSN DMIS ID	1	4	4	CHAR(4)	Primary Care Manager Enrolling Division DMIS Identifier
Delimiter	5	5	1		Pipe () delimiter
SPN PN ID	6	14	9	CHAR(9)	Sponsor Person Identifier
Delimiter	15	15	1		Pipe () delimiter
PN LST NM, PN 1ST NM	16	42	27	CHAR(27)	Beneficiary Name (Last Name, First Name)
Delimiter	43	43	1		Pipe () delimiter
SVC CD	44	44	1	CHAR(1)	Service Branch Classification Code
Delimiter	45	45	1		Pipe () delimiter
MBR CAT CD	46	46	1	CHAR(1)	Member Category Code (MBR CAT CD)
Delimiter	47	47	1		Pipe () delimiter
PN BRTH DT	48	57	10	DATE	Person Birth Date
Delimiter	58	58	1		Pipe () delimiter
Calculated Enroll Age	59	61	3	NUMBER(3)	Calculated age (based on first day of contract year)
Delimiter	62	62	1		Pipe () delimiter
PN SEX CD	63	63	1	CHAR(1)	Person Gender
Delimiter	64	64	1		Pipe () delimiter
EMC ENRL BGN DT	65	74	10	DATE	Enrollment Management Contract Enrollment Begin Calendar Date
Delimiter	75	75	1		Pipe () delimiter
EMC ENRL END DT	76	85	10	DATE	Enrollment Management Contract Enrollment End Calendar Date
Delimiter	86	86	1		Pipe () delimiter
RPT ENRL END DT	87	96	10	DATE	Calculated Report Enrollment End Date
Delimiter	97	97	1		Pipe () delimiter
EMC ENRL ERSN CD	98	98	1	CHAR(1)	Enrollment Management Contractor Enrollment End Reason Code
Delimiter	99	99	1		Pipe () delimiter
PMT MNTHLY CAPIT PMT	100	106	7	DECIMAL(7,2)	Monthly calculated capitation amount (\$\$\$\$cc)
Delimiter	107	107	1		Pipe () delimiter
PAYMENT DATE	108	117	10	DATE	Date capitation was calculated

FIELD	START	END	LENGTH	TYPE	DESCRIPTION
Delimiter	118	118	1		Pipe () delimiter
MA LN1 TX	119	158	40	CHAR(40)	Person's mailing address
Delimiter	159	159	1		Pipe () delimiter
MA CITY NM	160	179	20	CHAR(20)	Person's mailing address city name
Delimiter	180	180	1		Pipe () delimiter
MA ST CD	181	182	2	CHAR(2)	Person's mailing address state code
Delimiter	183	183	1		Pipe () delimiter
MA PR ZIP CD, MA PR ZIPX CD	184	192	9	CHAR(9)	Person's mailing address 9-digit zip code
Delimiter	193	193	1		Pipe () delimiter
DEERS FAM ID	194	202	9	CHAR(9)	DEERS Family Identifier
Delimiter	203	203	1		Pipe () delimiter
DEERS BNFRY ID	204	205	2	CHAR(2)	DEERS Beneficiary Identifier
Delimiter	206	206	1		Pipe () delimiter
PTNT ID	207	216	10	CHAR(10)	Patient Identifier
Delimiter	217	217	1		Pipe () delimiter
HCDP PLN CVG CD	218	220	3	CHAR(3)	Health Care Delivery Program Plan Coverage Code
Delimiter	221	221	1		Pipe () delimiter
ACCUMULATED CAT CAP AMT (Current Year)	222	228	7	DECIMAL(7,2)	Accumulated Catastrophic Capitation Amount (\$\$\$\$\$cc)
ACCUMULATED CAT CAP AMT (Prior Year)	229	235	7	DECIMAL(7,2)	Accumulated Catastrophic Capitation Amount (\$\$\$\$\$cc)
ACCUMULATED CAT CAP AMT (Two Years Prior)	236	242	7	DECIMAL(7,2)	Accumulated Catastrophic Capitation Amount (\$\$\$\$\$cc)

4.2 ENROLLMENT FORMAT – (ENROLL11 - Output to DP's)

This file format will be used when Ingenix is producing the file containing enrollment records for all the beneficiaries that are enrolled and eligible to have capitation calculated for them based on the 1st of the current month. This file will be available to the DP's by the 10th of the month.

START	END	LENGTH	TYPE	DESCRIPTION	LABEL	VALUE
1	9	9	CHAR(9)	DEERS FAMILY IDENTIFIER	DEERS_FAM_ID	
10	10	1		Pipe () delimiter	Delimiter	
11	12	2	CHAR(2)	DEERS BNFYR IDENTIFIER	DEERS_BNFYR_ID	
13	13	1		Pipe () delimiter	Delimiter	
14	23	10	CHAR(10)	PATIENT IDENTIFIER	PTNT_ID	
24	24	1		Pipe () delimiter	Delimiter	
25	33	9	CHAR(9)	SPONSOR PERSON IDENTIFIER	SPN_PN_ID	
34	34	1		Pipe () delimiter	Delimiter	
35	60	26	CHAR(26)	PERSON LAST NAME	PN_LST_NM	
61	61	1		Pipe () delimiter	Delimiter	
62	81	20	CHAR(20)	PERSON FIRST NAME	PN_1ST_NM	
82	82	1		Pipe () delimiter	Delimiter	
83	102	20	CHAR(20)	PERSON MIDDLE NAME	PN_MID_NM	
103	103	1		Pipe () delimiter	Delimiter	
104	107	4	CHAR(4)	PERSON CADENCY NAME	PN_CDNCY_NM	
108	108	1		Pipe () delimiter	Delimiter	
109	109	1	CHAR(1)	PERSON SEX CODE	PN_SEX_CD	
110	110	1		Pipe () delimiter	Delimiter	
111	120	10	DATE	PERSON BIRTH CALENDAR DATE	PN_BRTH_DT	YYYY-MM-DD
121	121	1		Pipe () delimiter	Delimiter	
122	131	10	DATE	MAILING ADDRESS EFFECTIVE CALENDAR DATE	MA_DT	YYYY-MM-DD
132	132	1		Pipe () delimiter	Delimiter	
133	172	40	CHAR(40)	MAILING ADDRESS LINE 1 TEXT	MA_LN1_TXT	
173	173	1		Pipe () delimiter	Delimiter	
174	213	40	CHAR(40)	MAILING ADDRESS LINE 2 TEXT	MA_LN2_TXT	
214	214	1		Pipe () delimiter	Delimiter	
215	234	20	CHAR(20)	MAILING ADDRESS CITY NAME	MA_CITY_NM	
235	235	1		Pipe () delimiter	Delimiter	
236	237	2	CHAR(2)	MAILING ADDRESS US POSTAL REGION STATE CODE	MA_ST_CD	
238	238	1		Pipe () delimiter	Delimiter	

START	END	LENGTH	TYPE	DESCRIPTION	LABEL	VALUE
239	243	5	CHAR(5)	MAILING ADDRESS US POSTAL REGION ZIP CODE	MA_PR_ZIP_CD	
244	244	1		Pipe () delimiter	Delimiter	
245	249	4	CHAR(4)	MAILING ADDRESS US POSTAL REGION ZIP EXTENSION CODE	MA_PR_ZIPX_CD	
250	250	1		Pipe () delimiter	Delimiter	
251	252	2	CHAR(2)	MAILING ADDRESS COUNTRY CODE	MA_CNTRY_CD	
253	253	1		Pipe () delimiter	Delimiter	
254	279	26	CHAR(26)	SPONSOR PERSON LAST NAME	SPN_PN_LST_NM	
280	280	1		Pipe () delimiter	Delimiter	
281	300	20	CHAR(20)	SPONSOR PERSON FIRST NAME	SPN_PN_1ST_NM	
301	301	1		Pipe () delimiter	Delimiter	
302	321	20	CHAR(20)	SPONSOR PERSON MIDDLE NAME	SPN_PN_MID_NM	
322	322	1		Pipe () delimiter	Delimiter	
323	326	4	CHAR(4)	SPONSOR PERSON CADENCY NAME	SPN_PN_CDNCY_NM	
327	327	1		Pipe () delimiter	Delimiter	
328	328	1	CHAR(1)	SERVICE BRANCH CLASSIFICATION CODE	SVC_CD	
329	329	1		Pipe () delimiter	Delimiter	
330	335	6	CHAR(6)	RANK CODE	RANK_CD	
336	336	1		Pipe () delimiter	Delimiter	
337	346	10	DATE	SPONSOR PERSON DEATH CALENDAR DATE	SPN_PN_DTH_DT	YYYY-MM-DD
347	347	1		Pipe () delimiter	Delimiter	
348	348	1	CHAR(1)	SPONSOR PERSON DEATH CODE	SPN_PN_DTH_CD	
349	349	1		Pipe () delimiter	Delimiter	
350	353	4	CHAR(4)	PRIMARY CARE MANAGER ENROLLING DIVISION DMIS IDENTIFIER	PCM_EDVSN_DMIS_ID	
354	354	1		Pipe () delimiter	Delimiter	
355	356	2	CHAR(2)	PRIMARY CARE MANAGER REGION CODE	PCM_RGN_CD	
357	357	1		Pipe () delimiter	Delimiter	
358	367	10	DATE	HEALTH CARE DELIVERY PROGRAM POLICY ENROLLMENT PERIOD BEGIN CALENDAR DATE	HCDP_PEP_BGN_DT	YYYY-MM-DD
368	368	1		Pipe () delimiter	Delimiter	

START	END	LENGTH	TYPE	DESCRIPTION	LABEL	VALUE
369	378	10	DATE	HEALTH CARE DELIVERY PROGRAM POLICY ENROLLMENT PERIOD END CALENDAR DATE	HCDP_PEP_END_DT	YYYY-MM-DD
379	379	1		Pipe () delimiter	Delimiter	
380	382	3	CHAR(3)	HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE	HCDP_PLN_CVG_CD	
383	383	1		Pipe () delimiter	Delimiter	
384	393	10	DATE	ENROLLMENT MANAGEMENT CONTRACTOR ENROLLMENT BEGIN CALENDAR DATE	EMC_ENRL_BGN_DT	YYYY-MM-DD
394	394	1		Pipe () delimiter	Delimiter	
395	404	10	DATE	ENROLLMENT MANAGEMENT CONTRACTOR ENROLLMENT END CALENDAR DATE	EMC_ENRL_END_DT	YYYY-MM-DD
405	405	1		Pipe () delimiter	Delimiter	
406	406	1	CHAR(1)	ENROLLMENT MANAGEMENT CONTRACTOR ENROLLMENT END REASON CODE	EMC_ENRL_ERSN_CD	
407	407	1		Pipe () delimiter	Delimiter	
408	417	10	DATE	EARLIEST CONTINUOUS BEGIN DATE	NEW_ENROL_BEG_DT	YYYY-MM-DD
418	418	1		Pipe () delimiter	Delimiter	
419	419	1	CHAR(1)	Other Government Program Type Code (Part A)	OGP_TYP_CD	
420	420	1		Pipe () delimiter	Delimiter	
421	421	1	CHAR(1)	Other Government Program Begin Reason Code (Part A)	OGP_BEGN_RSN_CD	
422	422	1		Pipe () delimiter	Delimiter	

START	END	LENGTH	TYPE	DESCRIPTION	LABEL	VALUE
423	423	1	CHAR(1)	Other Government Program Type Code (Part B)	OGP_TYP_CD	
424	424	1		Pipe () delimiter	Delimiter	
425	425	1	CHAR(1)	Other Government Program Begin Reason Code (Part B)	OGP_BEGN_RSN_CD	
426	426	1		Pipe () delimiter	Delimiter	
427	428	2	CHAR(2)	PERSON ASSOCIATION REASON CODE	PNA_RSN_CD	
429	429	1		Pipe () delimiter	Delimiter	
430	430	1	CHAR(1)	PERSON TYPE CODE		
431	431	1		Pipe () delimiter	Delimiter	
432	432	1	CHAR(1)	Member Category Code	MBR CAT CD	

4.3 MANAGEMENT CLINICAL DATA (MCD) ERROR FILE FORMAT – (SUMRY13/SUMRY13A - Output to DP's)

Ingenix will report all clinical services provided by the DP which contained errors. This file will be posted on DefenseWeb's website and will be available on or before the 20th of the Month of submission.

4.3.1 MCD Error Header Record File Specifications

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	CORRESPONDING ERROR CODE
1	3	FILE TYPE	3	Char	002, 007
4	9	SUBMISSION PERIOD	6	Char	008
10	17	CREATION DATE	8	Date	008
18	21	DMIS ID	4	Char	002, 007
22	28	TOTAL RECORDS	7	Num	008

4.3.2 MCD Error Detail Data Record File Specifications

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		DMIS ID	4	Char
		DEERS FAMILY IDENTIFIER	9	Char
		DEERS BENEFICIARY IDENTIFIER	2	Char
		PATIENT IDENTIFIER	10	Char
		PATIENT'S LAST NAME	27	Char
		PATIENT'S FIRST NAME	20	Char
		PATIENT'S MIDDLE NAME	20	Char
		PATIENT'S CADENCY NAME	4	Char

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		PATIENT'S DATE OF BIRTH	8	Date
		PATIENT'S ZIP CODE	5	Char
		PATIENT'S GENDER	1	Char
		SPONSOR SOCIAL SECURITY NUMBER (SSN)	9	Char
		LEGACY DEERS DEPENDENT SUFFIX	2	Char
		MEMBER CATEGORY CODE	1	Char
		SERVICE BRANCH CLASSIFICATION CODE	1	Char
		UNIQUE PATIENT REFERENCE NUMBER	1 2	Char
		ENCOUNTER SETTING	1	Char
		PATIENT PRINCIPAL/ PRIMARY DIAGNOSIS	5	Char
		PATIENT DIAGNOSIS 2	5	Char
		PATIENT DIAGNOSIS 3	5	Char

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		PATIENT DIAGNOSIS 4	5	Char
		PATIENT DIAGNOSIS 5	5	Char
		PATIENT DIAGNOSIS 6	5	Char
		PATIENT DIAGNOSIS 7	5	Char
		PATIENT DIAGNOSIS 8	5	Char
		PATIENT DIAGNOSIS 9	5	Char
		PATIENT DIAGNOSIS 10	5	Char
		PATIENT DIAGNOSIS 11	5	Char
		PATIENT DIAGNOSIS 12	5	Char
		TAX ID OF PROVIDER ENTITY	9	Char
		UNIQUE PROVIDER ID NUMBER/PHARMACY NCPDP NUMBER	18	Char
		BLANK		

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		MAJOR SPEC/INSTITUTION TYPE	2	Char
		PROVIDER ZIP CODE	9	Char
		ORDERING PHYSICIAN	18	Char
		COST DATA	11	Num
		CO-PAYMENT AMOUNT COLLECTED	6	Num
		EMERGENCY FLAG	1	Char
		DATE OF RELATED ADMISSION	8	Date
		DATE OF RELATED DISPOSITION	8	Date
		NUMBER OF SERVICES	1	Char
		SERVICE 1 START DATE	8	Date
		SERVICE 1 END DATE	8	Date
		SERVICE 1 PLACE OF SERVICE	2	Char

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		SERVICE 1 PROCEDURE CODE	7	Char
		SERVICE 1 RELATED DIAGNOSIS CODE	5	Char
		SERVICE 1 QUANTITY	3	Char
		SERVICE 2 START DATE	8	Date
		SERVICE 2 END DATE	8	Date
		SERVICE 2 PLACE OF SERVICE	2	Char
		SERVICE 2 PROCEDURE CODE	7	Char
		SERVICE 2 RELATED DIAGNOSIS CODE	5	Char
		SERVICE 2 QUANTITY	3	Char
		SERVICE 3 START DATE	8	Date
		SERVICE 3 END DATE	8	Date
		SERVICE 3 PLACE OF SERVICE	2	Char
		SERVICE 3 PROCEDURE CODE	7	Char

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		SERVICE 3 RELATED DIAGNOSIS CODE	5	Char
		SERVICE 3 QUANTITY	3	Char
		SERVICE 4 START DATE	8	Date
		SERVICE 4 END DATE	8	Date
		SERVICE 4 PLACE OF SERVICE	2	Char
		SERVICE 4 PROCEDURE CODE	7	Char
		SERVICE 4 RELATED DIAGNOSIS CODE	5	Char
		SERVICE 4 QUANTITY	3	Char
		SERVICE 5 START DATE	8	Date
		SERVICE 5 END DATE	8	Date
		SERVICE 5 PLACE OF SERVICE	2	Char
		SERVICE 5 PROCEDURE CODE	7	Char

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		SERVICE 5 RELATED DIAGNOSIS CODE	5	Char
		SERVICE 5 QUANTITY	3	Char
		SERVICE 6 START DATE	8	Date
		SERVICE 6 END DATE	8	Date
		SERVICE 6 PLACE OF SERVICE	2	Char
		SERVICE 6 PROCEDURE CODE	7	Char
		SERVICE 6 RELATED DIAGNOSIS CODE	5	Char
		SERVICE 6 QUANTITY	3	Char
		HOSPITAL SERVICE ADMISSION DATE	8	Date
		HOSPITAL SERVICE ADMISSION TYPE	1	Char
		HOSPITAL SERVICE ADMISSION SOURCE	1	Char
		HOSPITAL SERVICE DISPOSITION STATUS	2	Char

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		HOSPITAL SERVICE DISPOSITION DATE	8	Date
		DIAGNOSIS RELATED GROUP (DRG)	3	Char
		HOSPITAL SERVICE PATIENT PRINCIPAL PROCEDURE	5	Char
		HOSPITAL SERVICE PATIENT PROCEDURE 2	5	Char
		HOSPITAL SERVICE PATIENT PROCEDURE 3	5	Char
		HOSPITAL SERVICE PATIENT PROCEDURE 4	5	Char
		HOSPITAL SERVICE PATIENT PROCEDURE 5	5	Char
		HOSPITAL SERVICE PATIENT PROCEDURE 6	5	Char
		TRANSACTION TYPE	1	Char
		ERROR COUNT	2	Num
		ERROR CODE 1	3	Num
		ERROR DATA FIELD NAME 1	30	Char
		ERROR CODE 2	3	Num

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		ERROR DATA FIELD NAME 2	30	Char
		ERROR CODE 3	3	Num
		ERROR DATA FIELD NAME 3	30	Char
		ERROR CODE 4	3	Num
		ERROR DATA FIELD NAME 4	30	Char
		ERROR CODE 5	3	Num
		ERROR DATA FIELD NAME 5	30	Char
		ERROR CODE 6	3	Num
		ERROR DATA FIELD NAME 6	30	Char
		ERROR CODE 7	3	Num
		ERROR DATA FIELD NAME 7	30	Char
		ERROR CODE 8	3	Num

		DATA ELEMENT DESCRIPTION	LENGTH	FIELD TYPE
		ERROR DATA FIELD NAME 8	30	Char
		ERROR CODE 9	3	Num
		ERROR DATA FIELD NAME 9	30	Char
		ERROR CODE 10	3	Num
		ERROR DATA FIELD NAME 10	30	Char

4.4 PHARMACY ENCOUNTER ERROR FILE FORMAT – (SUMRY14/SUMRY14A - Output to DP's)

Ingenix will report all pharmacy services provided by the DP which contained errors. This file will be posted on DefenseWeb's website and will be available on or before the 20th of the Month of submission.

4.4.1 Pharmacy Error Header Record File Specifications

START	END	DATA ELEMENT NAME	LENGTH	FIELD TYPE	CORRESPONDING ERROR CODE
1	3	FILE TYPE	3	Char	002, 007
4	9	SUBMISSION PERIOD	6	Char	008
10	17	CREATION DATE	8	Date	008
18	21	DMIS ID	4	Char	002, 007
22	28	TOTAL RECORDS	7	Num	008

4.4.2 Pharmacy Error Detail Data Record File Specifications

	DATA ELEMENT NAME	Length	Field Type
	DMIS ID	4	Char
	DEERS FAMILY IDENTIFIER	9	Char
	DEERS BENEFICIARY IDENTIFIER	2	Char
	PATIENT IDENTIFIER	10	Char
	SPONSOR SOCIAL SECURITY NUMBER (SSN)	9	Char
	LEGACY DEERS DEPENDENT SUFFIX	2	Char
	PATIENT'S LAST NAME	26	Char
	PATIENT'S FIRST NAME	20	Char
	PATIENT'S MIDDLE NAME	20	Char
	PATIENT'S CADENCY NAME	4	Char

		DATA ELEMENT NAME	Length	Field Type
		PATIENT'S DATE OF BIRTH	8	Date
		PATIENT'S GENDER	1	Char
		QUANTITY DISPENSED	6	Char
		DATE DISPENSED	8	Date
		NATIONAL DRUG CODE NUMBER	11	Char
		COST DATA	11	Num
		BASIS FOR COST DETERMINATION	3	Char
		UNIQUE PATIENT REFERENCE NUMBER	12	Char
		CO-PAYMENT AMOUNT COLLECTED	6	Num
		PHARMACY NCPDP NUMBER	18	Char
		NUMBER OF DAYS PROVIDED	3	Num
		PROVIDER PRESCRIBING MEDICATION	18	Char
		DISPENSED AS WRITTEN INDICATOR	1	Char

		DATA ELEMENT NAME	Length	Field Type
		TRANSACTION TYPE	1	Char
		ERROR COUNT	2	Num
		ERROR CODE 1	3	Num
		ERROR DATA FIELD NAME 1	30	Char
		ERROR CODE 2	3	Num
		ERROR DATA FIELD NAME 2	30	Char
		ERROR CODE 2	3	Num
		ERROR DATA FIELD NAME 3	30	Char
		ERROR CODE 4	3	Num
		ERROR DATA FIELD NAME 4	30	Char
		ERROR CODE 5	3	Num
		ERROR DATA FIELD NAME 5	30	Char
		ERROR CODE 6	3	Num

		DATA ELEMENT NAME	Length	Field Type
		ERROR DATA FIELD NAME 6	30	Char
		ERROR CODE 7	3	Num
		ERROR DATA FIELD NAME 7	30	Char
		ERROR CODE 8	3	Num
		ERROR DATA FIELD NAME 8	30	Char

4.5 ENROLLMENT FEE ERRORS FILE FORMAT – (SUMRY15 - Output to DP's)

Ingenix will report all enrollment fee records provided by the DP which contained errors. This file will be posted on DefenseWeb's website and will be available on or before the 20th of the Month of submission.

FILE LAYOUT FOR SUMRY15 REPORT (.DAT)					FILE LAYOUT FOR SUMRY 15 REPORT (.DAT) COMPREHENSIVE REPORT				
START	END	FIELD	LENGTH	TYPE	START	END	FIELD	LENGTH	TYPE
1	4	DMIS_ID	4	char			same		
5	13	DEERS_FAM_ID	9	char			same		
14	15	DEERS_BNFY_ID	2	char			same		
16	25	PTNT_ID	10	char			same		
26	34	SPSR_SSN	9	char			same		
35	36	SBSCR_LGCY_DEERS_DEPN_SUFIX_NBR	2	char			same		
37	63	PERS_LST_NM	27	char			same		
64	82	PERS_FST_NM	19	char			same		
83	101	PERS_MIDL_NM	19	char			same		
102	104	PERS_CDNCY_NM	3	char			same		
105	112	PERS_BTH_DT	8	date			same		
113	120	ENRL_FEE_PYMT_RECV_DT	8	date			same		
121	128	ENRL_FEE_PYMT_PD_THRU_DT	8	date			same		
129	129	ENRL_FEE_PYMT_PLN_TYP_CD	1	char			same		
130	130	ENRL_FEE_PYMT_XCPT_RSN_CD	1	char			same		
131	136	ENRL_FEE_CLCTED_AMT	6	char			same		
137	137	ENRL_FEE_PYMT_TYP_CD	1	char			same		
138	138	ENRL_FEE_CRDT_CRD_TYP	1	char			same		
139	139	ENRL_FEE_PYMT_ACT_CD	1	char			same		
140	147	EMC_POL_ENRL_PRD_BEGN_DT	8	date			same		
148	155	HCDP_POL_ENRL_PRD_BEGN_DT	8	date			same		
156	159	HCDP_FISC_YR_ID	4	char			same		
160	171	ENRL_FEE_UNIQ_ID	12	char			same		
172	306	RESPONSE_CD_DESC	35	char			same		
307	309	ERR_CD_1	3	char			same		
310	349	ERROR_DESCRIPTION	50	char			same		
350	384	RESPONSE_CD_DESC2	35	char	248	253	run date	6	char
385	387	ERR_CD_2	3	char					
388	437	ERROR_DESCRIPTION2	50	char					
438	472	RESPONSE_CD_DESC3	35	char					

FILE LAYOUT FOR SUMRY15 REPORT (.DAT)					FILE LAYOUT FOR SUMRY 15 REPORT (.DAT) COMPREHENSIVE REPORT				
473	475	ERR_CD_3	3	char					
476	525	ERROR_DESCRIPTION3	50	char					
526	560	RESPONSE_CD_DESC4	35	char					
561	563	ERR_CD_4	3	char					
564	613	ERROR_DESCRIPTION4	50	char					
614	648	RESPONSE_CD_DESC5	35	char					
649	651	ERR_CD_5	3	char					
652	601	ERROR_DESCRIPTION5	50	char					

5. ASSESSING DATA QUALITY

Quality of submitted data is assessed via a series of screening programs. A number of checks are performed on the DP data received by DefenseWeb and Ingenix. Data errors are now only classified as Fatal. Fatal errors require the DP to resubmit all records that have fatal error codes. Records with fatal errors will not be in standard reports until the DP has resubmitted corrected data.

Data collected for the Designated Provider Program will be submitted by the Ingenix to the Military Data Repository (MDR) system. Selected clinical and provider encounter data and related provider information will be sent the National Quality Monitoring Committee (NQMC) for review.

6. RECOVERY

Once data files are received from appropriate sources, Ingenix will create backup files of all data. Two backups are created, one for storage on-site and one for storage off-site, away from the main computer facility. Data can be recovered from one (1) of these two (2) backup files.

7. CONTROL TOTAL REPORTING

The number of records submitted on each file will be contained within a field on the header record called Total Records. This field will need to be populated on each header file of each submission.

8.ERROR CODES & SEQUENCE

8.1 ERROR CODES AND DESCRIPTIONS MASTER LIST

Error Number	Current Error Description	Proposed Error Description
001	Date < Begin Date	Date is > enrollment date
002	Required Field. Field is blank or invalid	Required field is blank/NULL
003	Total number of services does not match the number of services populated	Nbr srvcs doesn't = nbr srvcs populated
004*	Date must be > or = DOB and Enrollment Date as defined from DEERS.	Date not >= DOB and Enroll date in DEERS
005*	Date must be > or = service start date and < enrollment end date.	Date is outside enrollment dates
006	Date must be > or = to admission date and in a valid date format	Date not >= Adm Date
007	Not defined as a valid value in DP Data Dictionary	Data value not found in DP table
008	Invalid value	Invalid data value
009	Date must be > than an existing paid through date record and must end on a fiscal quarter.	Thru dt < pd thru dt or not ending on FQ
010	Duplicate Record	Dup value where dups are not allowed
020	No matching enrollment record found on enrollment file.	Removed
021	No matching provider record found on provider file.	Provider not found in DP table
030	Invalid ICD9 Code for date of service.	Dx code not valid on DOS in DP table
031	Invalid Procedure, HCPC, or Revenue Code for the Date of Service.	Proc/Rev Cd not valid on DOS in DP table
032	Invalid DRG code for date of service	DRG code not valid on DOS in DP table
033	Invalid NDC number	NDC not found in DP table
034	NEW	DMIS ID/Patient/Sponsor not found in DP table
035	NEW	Field has invalid date format
036	NEW	Adm dt cannot be >3 yrs from submit per

*004 - The 004 error is checked in the Medical (MCD) files. The DMIS ID, Patient ID and Service Start Date are checked against the Date of Birth (DOB) and the Enrollment Date.

*005 - The 005 error is checked in the Medical (MCD), Pharmacy (Rx) and Fee files and is only performed if a match is found against the DMIS ID and Patient ID. In the MCD and Rx files, the DMIS ID, Patient ID and Service Date/Dispensed Date are checked. In the Fee files, the DMIS ID, Patient ID and Paid Through Date are checked.

8.1.1 PNT Error Codes and Sequence

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
1	DMIS_ID	DMIS ID	002, 007
2	PN_SEX_CD	Patient's Gender	002, 007
3	PN_BRTH_DT	Patient's Date of Birth	002, 035
4	SVC_CD	Service Branch Code	002, 007
5	STATUS	Active Duty Status	002, 007
6	ENRL_END_DT/ENRL_BEGN_DT	Comparison of 2 fields	008

8.1.2 Medical Error Codes and Sequence

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
1	PTNT_ID	Patient ID	002, 008, 034
2	DMIS_ID	DMIS ID	002, 007, 034
3	SPSR_SSN	Sponsor SSN	002, 008, 034
5	UNIQ_PROV_ID	Unique Provider ID	002, 021
7	DIAG_1	Diagnosis 1	030
8	DIAG_2	Diagnosis 2	030
9	DIAG_3	Diagnosis 3	030
10	DIAG_4	Diagnosis 4	030
11	DIAG_5	Diagnosis 5	030
12	DIAG_6	Diagnosis 6	030
13	DIAG_7	Diagnosis 7	030
14	DIAG_8	Diagnosis 8	030
15	DIAG_9	Diagnosis 9	030
16	DIAG_10	Diagnosis 10	030
17	DIAG_11	Diagnosis 11	030
18	DIAG_12	Diagnosis 12	030
19	SRVC_1_PROC_CD	Service 1 Procedure Code	031
20	SRVC_2_PROC_CD	Service 2 Procedure Code	031
21	SRVC_3_PROC_CD	Service 3 Procedure Code	031
22	SRVC_4_PROC_CD	Service 4 Procedure Code	031
23	SRVC_5_PROC_CD	Service 5 Procedure Code	031
24	SRVC_6_PROC_CD	Service 6 Procedure Code	031
25	SRVC_1_REL_DIAG_CD	Service 1 Related Diagnosis Code	030
26	SRVC_2_REL_DIAG_CD	Service 2 Related Diagnosis	030

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
		Code	
27	SRVC_3_REL_DIAG_CD	Service 3 Related Diagnosis Code	030
28	SRVC_4_REL_DIAG_CD	Service 4 Related Diagnosis Code	030
29	SRVC_5_REL_DIAG_CD	Service 5 Related Diagnosis Code	030
30	SRVC_6_REL_DIAG_CD	Service 6 Related Diagnosis Code	030
31	SRVC_1_PL_OF_SRVC	Service 1 Place of Service	002, 007
32	SRVC_2_PL_OF_SRVC	Service 2 Place of Service	002, 007
33	SRVC_3_PL_OF_SRVC	Service 3 Place of Service	002, 007
34	SRVC_4_PL_OF_SRVC	Service 4 Place of Service	002, 007
35	SRVC_5_PL_OF_SRVC	Service 5 Place of Service	002, 007
36	SRVC_6_PL_OF_SRVC	Service 6 Place of Service	002, 007
37	HOSP_SRV_PROC_1	Hospital Service Procedure 1	031
38	HOSP_SRV_PROC_2	Hospital Service Procedure 2	031
39	HOSP_SRV_PROC_3	Hospital Service Procedure 3	031
40	HOSP_SRV_PROC_4	Hospital Service Procedure 4	031
41	HOSP_SRV_PROC_5	Hospital Service Procedure 5	031
42	HOSP_SRV_PROC_6	Hospital Service Procedure 6	031
43	TRANS_TYP_CD	Transaction Type	002, 007
44	ENCTR_SETTING_CD	Encounter Setting	002, 007
45	HOSP_SRVC_DISP_STS_CD	Hospital Service Disposition Status	002, 007
46	HOSP_SRVC_ADMIS_SRC_CD	Hospital Service Admission Source	002, 007
47	HOSP_SRVC_ADMIS_TYP_CD	Hospital Service Admission Type	002, 007
48	DRG_CD	Diagnosis Related Group	032
49	INST_TYP_CD	Institution Type Code	007
50	SRVC_1_STRT_DT	Service 1 Start Date	002, 035, 004
51	SRVC_2_STRT_DT	Service 2 Start Date	002, 035, 004
52	SRVC_3_STRT_DT	Service 3 Start Date	002, 035, 004
53	SRVC_4_STRT_DT	Service 4 Start Date	002, 035, 004
54	SRVC_5_STRT_DT	Service 5 Start Date	002, 035, 004
55	SRVC_6_STRT_DT	Service 6 Start Date	002, 035, 004
56	SRVC_1_END_DT	Service 1 End Date	002, 035, 005
57	SRVC_2_END_DT	Service 2 End Date	002, 035, 005
58	SRVC_3_END_DT	Service 3 End Date	002, 035, 005

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
59	SRVC_4_END_DT	Service 4 End Date	002, 035, 005
60	SRVC_5_END_DT	Service 5 End Date	002, 035, 005
61	SRVC_6_END_DT	Service 6 End Date	002, 035, 005
62	PTNT_BTH_DT	Patient's Date of Birth	002, 035
63	PTNT_LST_NM	Patient's Last Name	002
64	PTNT_FST_NM	Patient's First Name	002
65	PTNT_GNDR	Patient's Gender	002, 007
66	MBR_CATEGORY_CD	Member Category Code	002, 007
67	SRVC_BRANCH_CLASS_CD	Service Branch Classification Code	002, 007
68	UNIQ_PTNT_REF_NBR	Unique Patient Reference Number	002
69	ORDERING_PHYSICIAN	Ordering Physician	002, 021
70	COPAY	Co-Payment Amount Collected	008
71	EMRG_FLG_IND	Emergency Flag	002, 007
72	NBR_OF_SRVCS	Number of Services	002, 003
73	HOSP_SRV_DISP_DT	Hospital Service Disposition Date	002, 035, 006

8.1.3 Pharmacy Error Codes and Sequence

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
1	DMIS_ID	DMIS ID	002, 007, 034
2	PTNT_ID	Patient ID	002, 008, 034
3	SPSR_SSN	Sponsor SSN	002, 008, 034
4	DSPNSD_DT	Dispensed Date	002, 035, 005
5	UNIQ_PROV_ID	Unique Provider ID	002, 021
6	TRANS_TYP_CD	Transaction Type Code	002, 007
7	DSPNSD_AS_WRT_CD	Dispensed as Written Indicator	002, 007
8	NAT_DRG_CD_NBR	National Drug Code Number	033
9	PTNT_BTH_DT	Patient's Date of Birth	002, 035
10	PTNT_LST_NM	Patient's Last Name	002
11	PTNT_FST_NM	Patient's First Name	002
12	PTNT_GNDR	Patient's Gender	002, 007
13	QTY_DSPNSD	Quantity Dispensed	008
14	UNIQ_PTNT_REF_NBR	Unique Patient Reference Number	002
15	COPAY	Co-Payment Amount Collected	008
16	DAY_PROVD_CNT	Number of Days Provided	002, 008

8.1.4 Provider Error Codes and Sequence

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
1	DMIS_ID	DMIS ID	002, 007
2	UNIQ_PROV_ID	Unique Provider ID	002, 008, 010
3	PROV_FULL_NM	Provider Full Name	002
4	PROV_STR_ADR_TXT	Provider Street Address	002
5	PROV_ZIP_CD	Provider Zip Code	002
6	PROV_CTY_NM	Provider City Name	002
7	PROV_LOC_BEGN_DT	Provider Location Begin Date	002, 035
8	PROV_LOC_END_DT	Provider Location End Date	002, 035
9	INST_TYP_CD	Institution Type Code	002, 007
10	FST_MAJ_SPCL_CD	First Major Specialty Code	002, 007
11	SEC_MAJ_SPCL_CD	Secondary Major Specialty Code	007
12	THRD_MAJ_SPCL_CD	Third Major Specialty Code	007
13	FRTH_MAJ_SPCL_CD	Fourth Major Specialty Code	007

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
14	FTH_MAJ_SPCL_CD	Fifth Major Specialty Code	007
15	PROV_ST_CD	Provider State Name	002, 007
16	PROV_TYP_CD	Provider Type Code	002, 007
17	INST_CD	Institution Code	002, 007
18	GUARD_RSRV_STS_CD	Guard Reserve Status Code	002, 007

8.1.5 OHI Error Codes and Sequence

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
1	Dmis ID	DMIS ID	002, 007, 034
2	Sponsor SSN	Sponsor SSN	002, 008, 034
3	Patient ID	Patient ID	002, 008, 034
4	OHI Begin Date	OHI Begin Date	002, 035
5	OHI Coverage Indicator Type Code	OHI Coverage Indicator Type Code	002, 007
6	OHI Status Code	OHI Status Code	002, 007
7	Policy Priority Code	Policy Priority Code	002, 007
8	OHI Carrier Name	OHI Carrier Name	002
9	OHI Subscriber Name	OHI Subscriber Name	002

8.1.6 Enrollment Fee Error Codes and Sequence

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
1	DMIS_ID	DMIS ID	002, 007, 034
2	SPSR_SSN	Sponsor SSN	002, 008, 034
3	PATIENT ID	Patient ID	002, 008, 034
4	ENRL_FEE_PYMT_PD_THRU_DT	Enrollment Fee Payment Paid Through Date	002, 035, 005, 008
5	PLN_TYP_CD	Payment Plan Type Code	002, 007
6	PYMT_TYP_CD	Payment Type Code	002, 007
7	PLN_TYP_CD/PYMT_TYP_CD	Plan Type Code / Payment Type Code	007
8	HCDP_POL_ENRL_PRD_BEGN_DT	HCDP Policy Enrollment Period Begin Calendar Date	002, 035
9	PRD_BEGN_DT/PYMT_PD_THRU_DT	HCDP Begin Date / Payment Paid Through Date	001
10	ENRL_FEE_CLCTED_AMT	Enrollment Fee Collected	002, 008
11	PYMT_XCPT_RSN_CD	Payment Exception Reason Code	002, 007

SEQUENCE	FIELD NAME	FIELD NAME DESCRIPTION	ERROR CODE
12	EMC_POL_ENRL_PRD_BEGN_DT	EMC Policy Enrollment Period Begin Calendar Date	002, 035
13	ENRL_FEE_PYMT_RECV_DT	Enrollment Fee Payment Received Date	002, 035
14	ENRL_FEE_PYMT_ACT_CD	Enrollment Fee Payment Action Code	002, 007
15	HCDP_FISC_YR_ID	Fiscal Year	002, 008

9.PNT END REASON CODES

End Reason Code	Approved Display to the User	Data Dictionary Definition	Recoupable?
1	Insufficient init pymt - record retained	Insufficient initial payment - record retained	N
2	No init pymt - record retained	No initial payment - record retained	N
3	Bounced check - record retained	Bounced check - record retained	N
4	Cancellation - rec retained	Cancellation - record retained	N
5	Disenrollment because person has OHI	Disenrollment because person has other health insurance	Y
6	Termination due to contract transition	Termination due to contract transition	Y
7	Loss of eligibility - person action	Loss of eligibility for this coverage due to person action	N
8	Loss of eligibility - family assoc	Loss of eligibility for this coverage due to change in family association	N
9	Loss of eligibility - change in coverage	Loss of eligibility for this coverage due to change in personal health care coverage	N
A	Failure to maintain Medicare Part B	Failure to maintain Medicare Part B	Y
B	Failure to comply w/ prog req	Failure to comply with program requirements, or disruptive behavior	Y
C	Termination of mid-month enrollment (obsolete)	Termination of mid-month enrollment	Y
D	Loss of eligibility due to death	Loss of eligibility for this coverage due to death	N
E	Cancellation - record removed	Cancellation - record removed	Y
F	Invalid entry	Invalid entry	N
G	Duty station chg to facility/clinic area	Duty station change to health care facility/clinic area	N
H	Permanent change of station (PCS)	Permanent change of station (PCS)	Y
I	Relocation	Relocation	Y
J	Moved out of serv area (OCONUS dental)	Moved outside of service area (OCONUS for dental)	Y
K	Chg of coverage plan w/i HCDP	Change of coverage plan within health care delivery program	N
L	Enrolled to another HCDP	Enrolled to another health care delivery program	Y
M	Loss of Eligibility - current HCDP	Loss of eligibility for current health care delivery program	N

End Reason Code	Approved Display to the User	Data Dictionary Definition	Recoupable?
N	Voluntary disenrollment by sponsor	Voluntary disenrollment by sponsor	Y
O	Voluntary disenrollment by beneficiary	Voluntary disenrollment by beneficiary	Y
P	Dissatisfied with program	Dissatisfied with program	Y
Q	This date is certain (proj end of elig)	This date is certain (projected end of eligibility)	Depends on why this came in, shouldn't cause a recoup, since it's a projected end date.
R	Re-enrollment date required for transfer	Date re-enrollment is required (this value used only on transfer record)	
S	Loss of eligibility for DoD benefits	Loss of eligibility for DoD benefits	N
T	Transfer of enrollment	Transfer of enrollment	N
U	No date can be predicted	No date can be predicted	Can't recoup if no end date is provided.
V	Not in a valid pay status per contractor	Not in a valid pay status (as determined by the contractor)	Y
X	Disenrollment - unknown reason	Disenrollment for unknown reasons (historical)	N
Y	Failure to pay enrollment fee/premium	Failure to pay enrollment fee/premium	Y
Z	Termination of mid-month enrollment	Termination of mid-month enrollment	Y

10. NAMING CONVENTIONS

a. Inputs from Designated Providers (DP)

Input Name	File Name	Format	Freq	Ultimate Recipient
Medical Encounters	MCD-dmis_id-ccyyymm-seq.DAT	FIXED	M	Ingenix
Pharmacy Encounters	RX-dmis_id-ccyyymm-seq.DAT	FIXED	M	Ingenix
Other Health Insurance and Primary Care Manager	OHI-dmis_id-ccyyymm-seq.DAT	FIXED	M	Ingenix
Provider	PRV-dmis_id-ccyyymm-seq.DAT	FIXED	M	Ingenix
Enrollment Fee Collections	FEE-dmis_id-ccyyymm-seq.DAT	FIXED	M	Ingenix

b. Outputs to Designated Providers (DP)

Output Name	File Name	Format	Freq	Ultimate Recipient
ENROL03 - Monthly Enrollment Activity	ENROL03-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL04 - Disenrollment Summary	ENROL04-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL04 - Disenrollment Summary	ENROL04-dmis_id-ccyymm.PDF	PDF	M	DP
ENROL05 - New Enrollment Summary	ENROL05-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL05 - New Enrollment Summary	ENROL05-dmis_id-ccyymm.PDF	PDF	M	DP
ENROL06 - Beneficiaries with Conditional Enrollment Status	ENROL06-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL06 - Beneficiaries with Conditional Enrollment Status	ENROL06-dmis_id-ccyymm.PDF	PDF	M	DP
ENROL07 - Projected Disenrollment Report	ENROL07-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL08 - Enrollment Data Summary	ENROL08-dmis_id-ccyymm.PDF	PDF	M	DP
ENROL09 - All Enrollees	ENROL09-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL09 - All Enrollees	ENROL09-dmis_id-ccyymm.PDF	PDF	M	DP
ENROL10 - Medicare Enrollees	ENROL10-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL10 - Medicare Enrollees	ENROL10-dmis_id-ccyymm.PDF	PDF	M	DP
ENROL11 - Enrollment File	ENROL11-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
ENROL12 – Medicare B Change Report	ENROL12-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
FINAN01 - Capitated Dollars for All Enrollees	FINAN01-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
FINAN01 - Capitated Dollars for All Enrollees	FINAN01-dmis_id-ccyymm.PDF	PDF	M	DP
FINAN02 - Capitated Dollars for Medicare Enrollees	FINAN02-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
FINAN02 - Capitated Dollars for Medicare Enrollees	FINAN02-dmis_id-ccyymm.PDF	PDF	M	DP
FINAN04 - Capitated Payment File	FINAN04-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
NOTIF01 - Notification Change Summary Report (PNT)	NOTIF01-dmis_id-ccyymmdd.PIP	Delim w/pipe	D	DP
NOTIF02 - Notification Detail (PNT)	NOTIF02-dmis_id-ccyymmdd.PDF	PDF	D	DP

Output Name	File Name	Format	Freq	Ultimate Recipient
NOTIF03 - Patient ID Changes	NOTIF03-dmis_id-ccyymmdd.PIP	Delim w/pipe	W	DP
NOTIF04 - Sponsor SSN Changes	NOTIF04-dmis_id-ccyymmdd.PIP	Delim w/pipe	D	DP
SUMRY01 - Error Summary by Setting and Data Type	SUMRY01-dmis_id-ccyymm.PDF	PDF	M	DP
SUMRY02 - Medical Encounter Error Summary by Error Code	SUMRY02-dmis_id-ccyymm.PDF	PDF	M	DP
SUMRY03 - Medical Encounter Error Detail	SUMRY03-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
SUMRY04 - Providers of Medical Encounters not on the Provider file	SUMRY04-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
SUMRY05 - Rx Encounter Error Summary by Error Code	SUMRY05-dmis_id-ccyymm.PDF	PDF	M	DP
SUMRY06 - Rx Encounter Error Detail	SUMRY06-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
SUMRY07 - Provider File Errors Detail	SUMRY07-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
SUMRY08 - Provider File Errors Summary	SUMRY08-dmis_id-ccyymm.PDF	PDF	M	DP
SUMRY09 - OHI File Errors Detail	SUMRY09-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
SUMRY10 - OHI File Errors Summary	SUMRY10-dmis_id-ccyymm.PDF	PDF	M	DP
SUMRY11 - Enrollment Fee Errors Detail	SUMRY11-dmis_id-ccyymm.PIP	Delim w/pipe	M	DP
SUMRY12 - Enrollment Fee Errors Summary	SUMRY12-dmis_id-ccyymm.PDF	PDF	M	DP
SUMRY13 - MCD Encounter Errors File	SUMRY13-dmis_id-ccyymm.DAT	FIXED	M	DP
SUMRY13A – Cumulative MCD Encounter Errors File	SUMRY13A-dmis_id-ccyymm.DAT	FIXED	Q	DP
SUMRY14 - RX Encounter Errors File	SUMRY14-dmis_id-ccyymm.DAT	FIXED	M	DP
SUMRY14A – Cumulative RX Encounter Errors File	SUMRY14A-dmis_id-ccyymm.DAT	FIXED	Q	DP
SUMRY15 – Enrollment Fee Errors File	SUMRY15-dmis_id-ccyymm.DAT	FIXED	M	DP

11. GLOSSARY OF TERMS

Term	Definition
MCD SUBMISSION TYPES	<p><u>Hospital Services</u> are defined and reported as facility care/services provided in Inpatient Facilities that require the patient to check-in or stay the night in that institution. Examples are inpatient acute admissions, skilled care, and observation bed stays. Services provided are reported by submitting ICD-9 CM diagnosis code(s) and ICD-9 CM procedure code(s). It is not necessary to report each lab, x-ray, or similar type services.</p> <p><u>Inpatient Professional Services</u> are defined as provider (usually physician) professional charges associated with an Inpatient Facility stay. These services include physician services such as radiologist, pathologist, and anesthesiologist. Additionally, the attending physician, specialist, and/or surgeon will also submit professional charges associated with providing care to the patient while in the inpatient setting. Services reported in this category are identified by ICD-9 CM diagnosis code(s) and CPT-4 and/or HCPCS procedure codes to define the services/care provided.</p> <p><u>Outpatient Professional Services</u> cover a broader range of care/services. This category encompasses all charges for care/services and for physician professional charges that are provided in all settings other than inpatient admissions. Some examples of care/services reported in this category are Outpatient surgery (both hospital based and free standing), Outpatient laboratory, Outpatient x-rays, Outpatient therapies, and physician/clinic visits. Services provided are reported in this category by ICD-9 CM diagnosis code(s) and CPT-4 and/or HCPCS procedure codes to define the services/care provided.</p>
NCPDP	National Council Prescription Drug Program
DP	Designated Provider
MCD	Management Clinical Data
DP	Designated Provider
ICD-9 CM	International Classifications of Diseases, 9 th Revision Clinical Modification
CPT	An acronym for Current Procedural Terminology published by the American Medical Association. CPT is required TRICARE procedural coding system for medical procedures for all contracts beginning on or after October 1, 1981.
E&M Code	Evaluation and Management Codes
HCPCS	Healthcare Common Procedure Coding System
SERVICE AREA	The DP defined zip code area where the facility can manage beneficiary care and provides service to these beneficiaries.
CREDENTIALING	The processes by which providers are allowed to participate in a network. This includes a review of the provider's training, degrees, licensure, practice history, etc.

SECTION TWO – Pipe-Delimited & .DAT output files

The attached document provides the pipe-delimited output file layouts for the following files:

- ENROL03 - Monthly Enrollment Activity
- ENROL04 - Disenrollment Summary
- ENROL05 - New Enrollment Summary
- ENROL06 - Beneficiaries with Conditional Enrollment Status
- ENROL07 - Projected Disenrollment Report
- ENROL09 - All Enrollees
- ENROL10 - Medicare Enrollees
- ENROL11 - Enrollment File
- ENROL12 – Medicare B Change Report
- SUMRY03 - Medical Encounter Errors Detail
- SUMRY04 – Providers of Medical Encounters not on the Provider File
- SUMRY06 – Rx Encounter Errors Detail
- SUMRY07 - Provider File Errors Detail
- SUMRY09 - OHI File Errors Detail
- SUMRY11 - Enrollment Fee Errors Detail
- SUMRY13 - MCD Encounter Errors File (.dat)
- SUMRY14 - RX Encounter Errors File (.dat)
- SUMRY13A - Cumulative MCD Encounter Errors File (Quarterly and .dat format also)
- SUMRY14A - Cumulative RX Encounter Errors File (.dat)
- SUMRY15 - Enrollment Fee Errors File (.dat)
- NOTIF01 - Notification Change Summary
- NOTIF03 - Patient ID Changes
- NOTIF04 - Sponsor SSN Changes
- FINAN01 - Capitated Dollars for All Enrollees
- FINAN02 - Capitated Dollars for Medicare Enrollees
- FINAN04 - Capitated Payment File



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SECTION THREE – DP Sample Reports

The attached document provides the sample report layout for the following reports:

Clinical Reports

IFMC Reports	Apptis Reports
MCD05 - Screening Summary	Sumry01 - Error Summary by Setting and Data Type
MCD19 - Listing of Deleted Records for this Submission	Sumry01 - Error Summary by Setting and Data Type
MCD02 - Global Screening Error Summary	Sumry02 - Medical Encounter Error Summary by Error Code
MCD03 - Hospital Screening Error Summary	Sumry02 - Medical Encounter Error Summary by Error Code
MCD04 - Professional Screening Error Summary	Sumry02 - Medical Encounter Error Summary by Error Code
MCD01 - Fatal/Warnings Error Detail	Sumry03 - Medical Encounter Error Detail
MCD06 - Providers not found on the Provider file summary	Sumry04 - Providers of Medical Encounters not on the Provider file

Pharmacy Reports

IFMC Reports	Apptis Reports
Phar03 - Screening Summary	Sumry01 - Error Summary by Setting and Data Type
Phar11 - Listing of Deleted Records for this Submission	Sumry01 - Error Summary by Setting and Data Type
Phar02 - Screening Error Summary	Sumry05 - Rx Encounter Error Summary by Error Code
Phar01 - Fatal/Warnings Error Detail	Sumry06 - Rx Encounter Error Detail

Enrollment Reports

IFMC Reports	Apptis Reports
US1T011-A Enrollees Eligible/Ineligible for Payment	N/A
US1T010-C Enrollment File Fatal Errors Detail	N/A
US1T010-D Enrollment File Warning Errors Detail	N/A
US1T012-C Enrollee's with Changes in Enrollment Start or End Dates	Enrol03 - Monthly Enrollment Activity
US1T012-D Enrollee's with Changes in Sponsor Status or Rank	Enrol03 - Monthly Enrollment Activity
US1T013-A New Disenrollments	Enrol03 - Monthly Enrollment Activity
US1T013-C New Enrollments	Enrol03 - Monthly Enrollment Activity
US1T013-B New Disenrollments - Summary	Enrol04 - Disenrollment Summary
US1T013-D New Enrollments - Summary	Enrol05 - New Enrollments Summary
Report 29 - Beneficiaries with Conditional Enrollee Status	Enrol06 - Beneficiaries with Conditional Enrollment
Report 30 - Projected Disenrollment Report	Enrol07 - Projected Disenrollment Report
Report 31 - Beneficiaries Ineligible, Not yet Disenrolled	Removed

Notifications (PNT) Reports

IFMC Reports	Apptis Reports
NOTESUM - Notification Summary	Notif01 - Notification Change Summary Report
NOTEDTL - Notification Detail	Notif02 - Notification Detail
PTNT962A - Patient ID Changes	Notif03 - Patient ID Changes
SPSN963A - Sponsor SSN Changes	Notif04 - Sponsor SSN Changes

Financial Reports

IFMC Reports	Apptis Reports
Report22-A USFHP Enrollment Calculations by Facility, Age Group, Gender, Sponsor Status and Sponsor Service	Finan01 - Capitated Dollars for non-Medicare Enrollees
Report22-B USFHP Capitation Calculations by Facility, Age Group, Gender, Sponsor Status and Sponsor Service	Finan01 - Capitated Dollars for non-Medicare Enrollees
Report22-C USFHP Enrollment Calculations by Facility, Age Group, Gender, Sponsor Status and Sponsor Service Medicare Eligible Retired or Survivors	N/A
Report22-D USFHP Capitation Calculations by Facility, Age Group, Gender, Sponsor Status and Sponsor Service Medicare Eligible Retired or Survivors	Finan02 - Capitated Dollars for Medicare Enrollees
	Finan04 - Capitated Payment File

Provider Reports

IFMC Reports	Apptis Reports
US1T315-A USFHP Provider File Fatal/Warning Errors Detail	Sumry07 - Provider File Errors Detail
US1T315-B USFHP Provider File Fatal/Warning Errors Summary	Sumry08 - Provider File Errors Summary
US1T315-C USFHP Provider File Summary Report	Sumry01 - Error Summary by Setting and Data Type

Address/OHI Reports

IFMC Reports	Apptis Reports
US1802-B USFHP Address/OHI Update Duplicate Enrollees	Eliminated
US1805-A USFHP Address/OHI Update Fatal/Warning Errors Detail	Sumry09 - OHI File Errors Detail
US1805-B USFHP Address/OHI Update Fatal/Warning Errors Summary	Sumry10 - OHI File Errors Summary
US1805-D USFHP Address/OHI Update Summary Report	Sumry01 - Error Summary by Setting and Data Type
US1822-A USFHP Address/OHI Update Report of Enrollee Counts by PCP Number	Eliminated

Enrollment Fee Reports

IFMC Reports	Apttis Reports
US1T835-A Fatal/Warning Errors Detail	Sumry11 - Enrollment Fee Errors Detail
US1T835-B Fatal/Warning Errors Summary	Sumry12 - Enrollment Fee Errors Summary

Open Enrollment Reports

IFMC Reports	Apttis Reports
US1T059-A Open Enrollment	Enrol08 - Enrollment Data Summary



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SECTION FOUR – DP Website specifications

1. INTRODUCTION

1.1. Purpose

This purpose of this document is to provide a description of the DefenseWeb TRICARE Management Activity (TMA) Designated Provider (DP) website for the end users at the Designated Provider facilities. This website is intended to be used for the following purposes:

- To upload monthly data files
- To view monthly reports to include
 - Enrollment & Capitation (based on your access level assigned)
 - Summary and Error, Reports from Monthly Uploaded Files)
 - Monthly Eligibility Files
- To view Defense Eligibility Enrollment Reporting System (DEERS) updates to include:
 - Daily enrollment changes to a beneficiary's record (inclusive of the former Enrollment Information Transactions (EITs) and Policy Notification Changes (PNTs)
 - Patient ID Changes (DefenseWeb receives and processes these on a weekly basis as the volume is relatively low)
- To perform Conditional Enrollments into the Data Warehouse

DefenseWeb will be operating both a test and production site for the DPs. Both of these sites are not publicly accessible and can only be accessed through the DefenseWeb-managed VPN device at your facility.

The test site will be available at <http://www.testmadp.com> and will be used for testing purposes. This is the site where new requirements such as DEERS changes will be tested before moving the changes to the live production site.

The production site will be available at <http://www.tricareusfhp.com>; this site will contain live data and will be used to gain daily information to support your sites.

Both sites will require that you register prior to using them.

2. END USER SYSTEM REQUIREMENTS

2.1. Web Browser Support

The user and management side of the DP portal shall be developed to support Internet Explorer, Version 6.0 or later.

2.2 Screen Resolution

The module will be designed to operate based on a 1024x768 screen resolution.

3. WEBSITE REGISTRATION

3.1. Website Registration Description

This section describes the process of registering for the TMA DP website. Below are bulleted steps on how users will gain access to this system. Users will be required to register on both the test (<http://www.testmadp.com>) and production (<http://www.tricareusfhp.com>) sites.

- User will type the test or production url into their web browser
- User will choose the “Registration” option from the left-hand navigation
- User will fill out the registration form that will require
 - First Name
 - Last Name
 - Username
 - Password
 - Email Address
 - Work Phone Number
 - Community

Password requirements for registering will conform with TMA’s requirements; they will have to be at least 8 characters and contain the following:

- one special character
- one number
- one uppercase

Passwords will be required to be changed every 90 days and the same password cannot be used twice.

4. WEBSITE FUNCTIONAL AREAS

4.1. Purpose

This section outlines the functions of the system that you will have access to once your registration is approved. From the home page you will be able to do a variety of things. Each area is outlined in detail below in the order that they appear on the home page.

4.2. Upload Monthly Files

On the main page, the first link that appears is “Upload Monthly Files”. By the 15th of each month, you will be required to upload a variety of files for processing and commission to the Data Warehouse. This capability will be provided via the website; the steps are outlined below:

- Click on the “Browse” button
- Locate the file that you wish to upload
- Chose “Open”
- Choose “Save”
- Once saved, you will choose “Process”, this will submit your files for validation from which there are 2 possible outcomes:
 - Your files will be validated with no fatal errors
 - Your files have fatal errors and you will be notified to correct these errors and re-upload

From this page, you will be able to delete files uploaded in error and you will also be able to view past file uploads.

4.3. Monthly Reports

“Monthly Reports” is the second link that appears on the main page. This area of the website will allow you to view your monthly reports. On the 10th of each month, you will be able to view Enrollment and Capitation reports. On the 20th of each month, you will be able to view the results from your Monthly Submissions. Your Government-approved access level will determine which reports are available for your viewing. Each DP will **only** have access to reports for their specific facility.

The monthly reports link will also be where you will access the quarterly reconciliation reports as well as the monthly eligibility files; both of these reports will reside under the “Other Reports” category. To access reports, simply click on the link next to the report name.

Each DP will also be able to access older, archived reports from this location as well.

4.4. Daily DEERS Updates

The “Daily DEERS Updates” appears third on the main page and will give you access to information that has changed within DEERS that may impact your beneficiaries’ records. These changes are referred to by DMDC/ DEERS as Policy Notification Transfers (PNTs). Oftentimes, these changes will be initiated by you making a change in the DEERS Online Enrollment System (DOES) application. Other times, these changes may come from other venues. Examples of these changes include the following:

- New Enrollments
- Disenrollments
- Address Change

On this section of the website, you will have access to the following:

- Daily compiled PNT reports in both .csv format and .pdf formats with Archives
- Search capability to query past PNTs by Patient ID/Sponsor ID and/or date received
- Detailed view on PNTs returned with print capability

4.5. Weekly Patient ID Updates

The “Weekly Patient ID Updates” is the fourth link on the main page and will provide you with access to the Patient ID changes (PIDS) that come in from DEERS. These occur when there is a change in a beneficiary’s ID (ie SSN).

From this page you will have access to the following:

- Ability to access your Weekly Patient ID Change report in .csv format with ability to view older reports through Archive link
- Search capability to query past PIDS by Sponsor ID, Patient ID and/or start and end dates

4.6. Conditional Enrollment

“Conditional Enrollment” is the last link on the main page. Users will use this area to conditionally enroll newborns or adoptees into the Data Warehouse while waiting for the child to be enrolled within DEERS. Newborns or adoptees can only be enrolled if the mother is enrolled to your facility. To insure that this rule prevails, conditional enrollment will be a 2 step process.

First, users will be asked to enter:

- Sponsor SSN and
- Mothers Patient ID

Upon submission, the data warehouse will be checked to insure that the mother is enrolled. If she is enrolled, the user will be prompted to fill out the following fields:

- First Name

- Last Name
- Gender
- Date of Birth/ Date of Adoption

Once these fields are filled out and submitted, this conditional enrollment will be flagged in the data warehouse for 60 days from the respective Date of Birth/Date of Adoption for capitation payment purposes.

SECTION FIVE – PROBLEM RESOLUTION PROCESS

1. INTRODUCTION

Apptis recognizes that each of the DPs is unique within the overall DP Program and acknowledges that there will be challenges in meeting and addressing DP requests and ensuring that an appropriate and accurate response is provided. Apptis expects to receive a number of questions that may concern policy issues that require a certain level of sensitivity and urgency. Policy issues will be identified and immediately escalated to the COR and/or DP Program Manager to ensure that appropriate action is taken.

The purpose of the problem resolution process is to document the specific process for a user to report a problem and obtain resolution to ensure that TMA and the DPs to ensure that all requirements are validated. Apptis is responsible for routing and responding to all problems and issues. The Apptis DP Support Desk is located in close proximity to TMA which will facilitate timely collaboration and coordination.

2. OBJECTIVE

This document presents the overall process for reporting a problem to the DP Support Desk. The document specifically describes the methods of reporting a problem/issue, escalation procedures and routing of issues, and the notification process to close the loop between the data contractor and the user.

3. DP SUPPORT GENERAL CONCEPT

The DP Support procedures have been developed to ensure that any problem or issue that a user may encounter is properly reported, documented, assigned, and resolved. All problems and issues will be thoroughly documented and archived. This will allow the DP Support desk to build a knowledge base of “Frequently Asked Questions” (FAQs) that can be updated and posted on the DP Website and be utilized as a tool for ongoing training. A description of the DP Support process is depicted in Figure 1 and described in further detail below.

4. DP SUPPORT PROBLEM RESOLUTION PROCESS

The user will have three ways to contact the DP Support Desk – telephone (phone number to be provided), e-mail (dpsupport@tma.osd.mil), and via the “Feedback Form” (to be implemented in the future) on the DP Website. All problems/issues will be routed through Apptis. The preferred method of communication is via dpsupport@tma.osd.mil because issues are initially documented by the user along with a specific description of the problem and contact information.

The DP Support Desk will document the problem and acknowledge receipt of the issue. Apptis will provide a response within 24 hours of a user submitting the issue. The response will not necessarily provide an immediate resolution to the problem, but will acknowledge receipt of the problem, verify the problem description and contact information, and/or may request additional information. All issues/problems will be logged with the following information:

Field	Description
ID Number	Assigned by the person logging the problem
Date Reported	The date that the problem was reported
Reported By	The person who reported the problem
Phone Number	Phone number of the user that reported the problem

Field	Description
E-mail Address	E-mail address of the user that reported the problem
Entered By	The DP Support person that logs the problem
Problem Description	detailed description of the problem
Problem Type	Problems can be placed into the following categories: Technical Questions, Policy/Procedures, Training, Website, Reports, Connectivity, Interfaces, Route Printing, Data Submission, Cosmetic, Enhancement
Priority	Denotes the level of importance based upon the assessment of impact the problem has on the system (Immediate, High, Medium, Low, Future Enhancement)
Severity Level	Used in combination with the Priority (Cosmetic, Minor, Major w/Workaround, Major w/o Workaround, Severe)
Status	Denotes the current status of the problem and includes the following: Open, Work in Progress, Closed
Resolution	Items that have a status of Closed will also have a resolution that includes the following: Code Change, Documentation Change, Clarification, On Hold, Enhancement
Additional Detail	Any additional information relevant to the problem/issue

The DP Support Desk will then route the problem/issue to the appropriate responsible party based on the Problem Type as summarized below:

Type of Problem/Issue	Responsible Party
Technical Questions	DefenseWeb or Ingenix
Policy/Procedures	TMA
Training	Apptis
Website	DefenseWeb
Reports	Ingenix
Connectivity	DefenseWeb
Interfaces	DefenseWeb or Ingenix
Route Printing	DefenseWeb
Data Submission	DefenseWeb or Ingenix

After the problem has been assigned, the DP Support Desk will notify the user that submitted the problem that the problem has been assigned and who is now working the issue. If additional questions or detail is required by the organization that is working the issue, they may contact the user directly. Apptis will continually provide updates to the

user on the status of their problem/issue as it is being worked by the responsible party. Status update requirements will be specified by the COR.

Once the responsible party has communicated that the issue has been resolved, the DP Support Desk will document the resolution, the date the problem was resolved, and status of the problem. Items that have a status of Closed will also have a resolution. Potential resolution options include: Code Change, Documentation Change, Clarification, On Hold, and Future Enhancement.

The final step in the process is to notify the user of the final disposition of the problem and to take further action if required to test the issue and/or verify that it was closed.

The DP Support Desk will play a critical role in communicating the status of a problem, sending information e-mails to TMA, and requesting additional information from the user. It provides a centralized location for TMA and the DPs to communicate information. Notifications such as Standard Maintenance schedules for the DP Website and any System Downtime will be sent via the DP Support Desk. Notifications may also be posted on the website. In addition, users will be encouraged to submit feedback and recommendations with regards to any processes, reports, etc. via the DP Support Desk. This will ensure that ideas are captured, logged, and reviewed. Eventually, FAQs will be posted on the website to help minimize the number of questions or problems that may be logged.

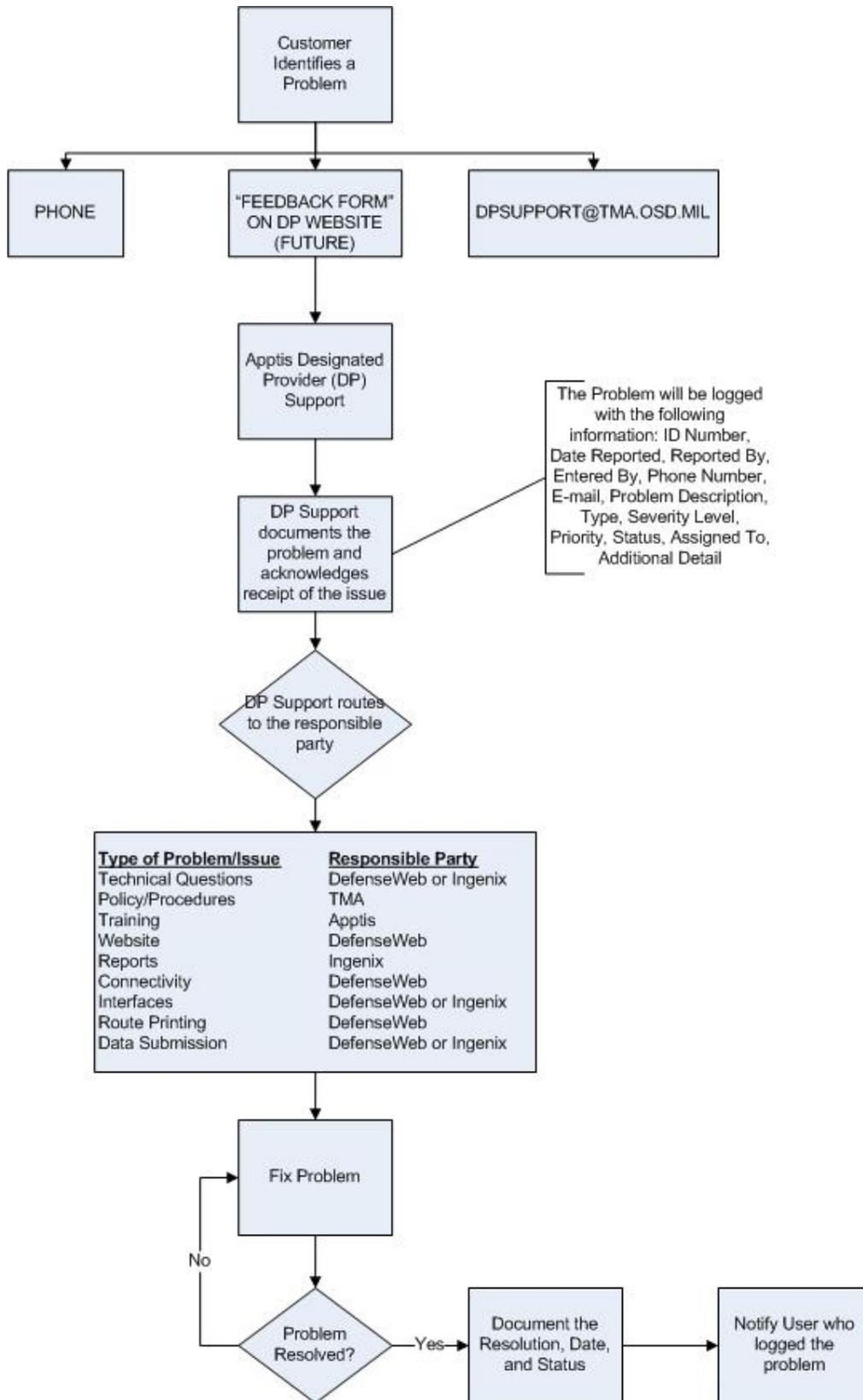


Figure 1. Problem Resolution Process

5. STATUS REPORTING

Apptis attends status meetings with TMA on a weekly basis. DP Support issues will be presented to TMA as part of this weekly status meeting. During the transition period, problems and issues will be captured and reported via processes that align to the testing phase of the project. Once Apptis has completed the transition, a regular conference call will be scheduled with the DPs to discuss DP Support operations. Apptis will furnish a copy of all submitted problems/issues and responses to the COR on a monthly basis. Apptis is focused on Continual Quality Improvement (CQI) and wants to capture and document lessons learned, additional FAQs, and provide a statistical analysis of the number of problems logged, number of problems resolved within a certain period, etc during these calls.



Designated Provider (DP) Data Dictionary

CDRL-74A Version 1.5.2

04.17.2008

Designated Provider Data

W74V8H-04-D-0023 Order B307

Prepared For:

Tricare Management Activity
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INGENIX.



Task Order Information

Task Order No./DO:	W74V8H-04-D-0023-B307
Task Order Title:	Designated Provider Data Contract
Apptis Project Manager:	Jennifer Brown
COR for the Task Order:	Danielle McCammon

Document Identification

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Version No.:	v1.5.2
Date:	4/17/2008
Contact:	Jennifer Brown

Revision History

Ver #	Rev #	Description of Changes	Approved By	Authored By	Date
1	.5.1	<ul style="list-style-type: none"> Final 	TMA	Sharon Neborsky	4/21/2006
1	.5.2 Draft	<ul style="list-style-type: none"> DRG Code: Added a reference for the latest codes - See DP Secure Website (Download Center) for the latest codes. Enrollment Fee Payment Action Code: Added H Credit. Enrollment Fee Payment Exception Reason Code: Removed S Split enrollment situation ("free rider"); Removed T Policy transfer from another contractor; Added W Enrollment fee for this payment period has been affected by individual family member fee waiver(s) Enrollment Management Contractor Enrollment End Reason Code: Removed R Date re-enrollment is required (this value used only on transfer record) Mailing Address Type Code: Removed M Mailing Address if different from the primary address given; W Work Address (this is for civilians primarily who do not have a UIC); X Unconfirmed primary (has not been run through mailing address quality software yet); Y Unconfirmed Work Address (has not been run through mailing address quality software yet); Z Unconfirmed Mailing Address (has not been run through mailing address quality software yet). Enrollment Fee Unique Identifier: Added this data element Prior Enrollment Management Contractor Enrollment End Reason Code: Removed R Date re-enrollment is required (this value used only on transfer record) Procedure Code: Removed the list of Rev Codes and Added a reference for the latest codes - See DP Secure Website (Download Center) for the latest codes. Rank Code: Changed "LTFirst Lieutenant" to "First Lieutenant"; changed "SGFirst Lieutenant" to "First Lieutenant"; changed "LTSecond Lieutenant" to "Second Lieutenant". Quantity Dispensed: Updated the data type from (8,2) to (6,2) to align with the specs. 	TMA	Jennifer Brown	3/25/2008
1	.5.2 Final	<ul style="list-style-type: none"> Updated Cover and Document Description Sections Final 	TMA	Jennifer Brown	4/17/2008

Distribution

This document is distributed to:

- TRICARE Management Activity (TMA), TRICARE Operations Directorate (for dissemination to designated reviewers, and for project control)
- Apptis PM (for dissemination to the Apptis Team)
- Apptis CM Library

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Referenced Documents

To prepare the Designated Provider Data Dictionary, the DP Project Team relied upon information received from a number of sources.

These reference documents, and their associated versions, are shown in the table that follows.

Document or Information Description	Source
N/A	

Key Stakeholders

The stakeholders identified in this section are responsible for reviewing and approving the Final Designated Provider Specifications at inception and after any changes made at a later time.

Ms. Jennifer Brown		
_____	_____	_____
Apptis Program Manager	Signature	Date
Mr. David Osmek		
_____	_____	_____
Ingenix Project Manager	Signature	Date
Ms. Maria Gaboury		
_____	_____	_____
DefenseWeb Program Manager	Signature	Date
Ms. Danielle McCammon		
_____	_____	_____
DP Data Contract COR	Signature	Date

Ingenix Attribute Name: Active Duty Status Indicator

Source Field Name: Ingenix Derived Attribute

Data Type: CHAR(1)

Description: Indicates whether a person is an active duty service member.

Ingenix DW Name: ACTV_DUTY_STS_IND

Entity List:

Capitation Demographic Group

Ingenix Attribute Name: Address Index Number

Source Field Name: Ingenix Derived Attribute

Data Type: NUMBER(2)

Description: DW generated mailing address index identifier.

Ingenix DW Name: ADR_IDX_NBR

Entity List:

Mailing Address

Ingenix Attribute Name: Annual Capitation Rate Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ANNL_CPTATN_RT_AMT

Data Type: NUMBER(9,2)

Description: The contractual amount for providing service to an individual within the specified demographic group (Age, Gender, etc) and service area (defined by DMIS ID) in a particular fiscal year.

Entity List:

Annual Capitation Rate

Ingenix Attribute Name: Basis for Cost Determination Code

Source Field Name: Basis for Cost Determination

Ingenix DW Name: BAS_FOR_CST_DTRM_CD

Data Type: CHAR(3)

Description: Code indicating the method drug costs were calculated.

Entity List:

Basis for Cost Determination

Encounter

Valid Values:

- 00 Not applicable or not available
- 01 Average Wholesale Price (AWP)
- 02 Local wholesale
- 03 Direct
- 04 Estimated Acquisition Cost (EAC)
- 05 Acquisition
- 06 Federal Maximum Allowable Cost (MAC)
- 06x Brand medically necessary
- 07 Usual & customary (submitted total price)
- 08 Unit dose used on tape and diskette only
- 09 Other
- 20 State unit cost
- 30 Baseline price

- 88 Submitted ingredient cost
- 90 Undiscounted ingredient cost

Ingenix Attribute Name: Capitation Demographic Group System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CPTATN_DEMO_GRP_SYS_ID

Data Type: INTEGER

Description: An Ingenix system generated value identifying a group of persons by Age, Gender, and Active Duty Status.

Entity List: Annual Capitation Rate

- Capitation Demographic Group
- Capitation Payment

Ingenix Attribute Name: Capitation Ineligibility Reason Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CPTATN_INELIG_RSN_CD

Data Type: CHAR(1)

Description: A code that represents a reason why an enrollment is not eligible for capitation payment.

Entity List:

- Capitation Ineligibility Reason
- Capitation Payment

Ingenix Attribute Name: Capitation Payment Adjustment Reason Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CPTATN_PYMT_ADJ_RSN_CD

Data Type: CHAR(4)

Description: A code representing an reason for a change in a Capitation Payment for an individual, such as a change in enrollment status or CATCAP recalculation.

Entity List:

- Capitation Payment
- Capitation Payment Adjustment Reason

Valid Values:

- ASTS Update - Active Duty Status
- DISN Disenrollment - Non-Recoupable
- DISR Disenrollment - Recoupable
- DOB Correction - Date of Birth
- ENRL Enrollment - New Enrollee
- GNDR Correction - Gender
- PID Correction - Patient Consolidation

Ingenix Attribute Name: Capitation Payment Transaction System Identifier

Ingenix DW Name: CPTATN_PYMT_TRANS_SYS_ID

Source Field Name: Ingenix Derived Attribute

Data Type: INTEGER

Description: A system generated unique identifier that identifies an Ingenix calculation of capitation for an enrollment for a specified month and year.

Entity List:

- Capitation Payment

Ingenix Attribute Name: Civilian Primary Care Manager Place Of Care Sequence Identifier

Source Field Name: Civilian Primary Care Manager Place Of Care Sequence Identifier

Ingenix DW Name: CIVIAN_PCM_PL_OF_CARE_SEQ_ID

Data Type: CHAR(2)

Description: The identifier that specifies a place of care for a specific PCM.

Entity List:

Enrollment

Ingenix Attribute Name: Code Expiration Date

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CD_EXPIR_DT

Data Type: DATE

Description: The last date for which a code is valid. See also Code Grace Period End Date.

Entity List:

Diagnosis Code

Procedure Code

Ingenix Attribute Name: Code Grace Period End Date

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CD_GRC_PRD_END_DT

Data Type: DATE

Description: The final date that a code will be accepted for processing an encounter. Following the end of the grace period, the code will be rejected as invalid.

Entity List:

Diagnosis Code

Procedure Code

Ingenix Attribute Name: Code Set Code

Source Field Name: Industry Standard Values

Ingenix DW Name: CD_SET_CD

Data Type: CHAR(8)

Description: A code identifying the code set to which a particular diagnosis or procedure code belongs.

Entity List:

Code Set

Valid Values:

CPT4 CPT4 Procedure Codes

HCPC HCPC (Health Care Provider Code) Procedure Codes

ICD9 ICD-9 Diagnosis Codes

REV Revenue Codes

Ingenix Attribute Name: Code Valid Date

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CD_VLD_DT

Data Type: DATE

Description: The first date for which a code is valid for coding on an encounter.

Entity List:

Diagnosis Code

Procedure Code

Ingenix Attribute Name: Conditional Enrollee Adoption Date

Source Field Name: DP Entered via DefenseWeb Web Application

Ingenix DW Name: CONDAL_ENRLEE_ADOPTION_DT

Data Type: DATE

Description: The date that a conditionally enrolled individual was adopted. This will only contain a valid date when the enrollment is conditional and the enrollee is an adoptee.

Entity List:

Enrollment

Ingenix Attribute Name: Conditional Enrollment Expiration Date

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CONDAL_ENRL_EXPIR_DT

Data Type: DATE

Description: The date on which a conditional enrollment will no longer be valid. This field will only be populated for conditionally enrolled persons. This value is 60 days from date of birth for newborns and 60 days from date of adoption for adoptees less than 365 days old at time of adoption.

Entity List:

Person

Ingenix Attribute Name: Conditional Enrollment Indicator

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CONDAL_ENRL_IND

Data Type: CHAR(1)

Description: A flag that is set when an enrollment record is created as a result of a conditional enrollment entry rather than a PNT record.

Entity List:

Enrollment

Ingenix Attribute Name: Cost Data Amount

Source Field Name: Cost Data

Ingenix DW Name: CST_DATA_AMT

Data Type: NUMBER(9,2)

Description: The facility's total charges generated by or billed to the beneficiary for services rendered for one full episode of care when reporting clinical encounters. An episode of care is one issuance of one clinical encounter/prescription (each 'I' and 'F' are separate episodes of care).

Entity List:

Encounter

Notes: For clinical submissions, report the total cost of the episode of care on the initial submission record, ("I" transaction code).

Total costs on all overflow records, ("F" transaction codes) should be blank. On pharmacy submissions, report the total cost of the prescription on each transaction type.

Valid Values:

0000000000 – 9999999999

Ingenix Attribute Name: Creation Date

Source Field Name: DP Source File Header

Ingenix DW Name:

Data Type: DATE

Description: Date a submission file was created. Appears on submission file header.

Entity List:

ADDL_ATTRIB

Ingenix Attribute Name: Current Month Calculated CATCAP Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CURR_MO_CALC_CATCAP_AMT

Data Type: CHAR(18)

Description: The total CATCAP amount reported to the DPs. This amount is equal to the DEERS current total CATCAP amount + the total current month copay and fee amounts.

Entity List:

Family Catastrophic Capitation and Deductible

Individual Catastrophic Capitation and Deductible

Ingenix Attribute Name: Current Month Family Total Fee Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CURR_MO_FAM_TOT_FEE_AMT

Data Type: CHAR(18)

Description: The sum of all fee payments and adjustments submitted to Ingenix during the current month.

Entity List:

Family Catastrophic Capitation and Deductible

Ingenix Attribute Name: Current Month Individual Total Fee Amount

Source Field Name: Ingenix Derived Attribute

Data Type: CHAR(18)

Ingenix DW Name: CURR_MO_INDV_TOT_FEE_AMT

Description: The sum of all fee payments and adjustments submitted to Ingenix during the current month. This value will only be non-zero for a Subscriber.

Entity List:

Individual Catastrophic Capitation and Deductible

Ingenix Attribute Name: Current Month Total Copay Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CURR_MO_TOT_COPAY_AMT

Data Type: CHAR(18)

Description: The sum of all encounter copayments by any family member reported this month to Ingenix. Note: For adjusted encounters, the difference in copays between the original and adjusted amounts will be included in this total.

Entity List:

Family Catastrophic Capitation and Deductible

Individual Catastrophic Capitation and Deductible

Ingenix Attribute Name: Current Total Copayment Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: CURR_TOT_COPAY_AMT

Data Type: NUMBER(9,2)

Description: The current total dollar amount collected from the beneficiary or family unit for an encounter after any adjustments have been applied.

Entity List:

Encounter Standardized Copayment

Ingenix Attribute Name: Data Warehouse Process Status Code

Source Field Name: Ingenix Derived Attribute

Description: A code defining where a record currently stands in the system data process flow, including information about what systems have received the data and whether data has been accepted or rejected by various systems.

Data Type: CHAR(2)

Entity List:

Data Warehouse Process Status

Encounter

Ingenix DW Name: DW_PROC_STS_CD

Valid Values:

- 1 Record received from DP, No errors (Ingenix Accepted), DEERS submission pending.
- 2 Record received from DP, No errors (Ingenix Accepted), DEERS submission accepted.
- 3 Record received from DP, No errors (Ingenix Accepted), DEERS submission rejected.
- 4 Record received from DP, Fatal Errors (Ingenix Rejected), DEERS submission pending.
- 5 Record received from DP, Fatal Errors (Ingenix Rejected), DEERS submission accepted.
- 6 Record received from DP, Fatal Errors (Ingenix Rejected), DEERS submission rejected.

Ingenix Attribute Name: Days Provided Count

Source Field Name: Number of Days Provided

Ingenix DW Name: DAY_PROVD_CNT

Data Type: INTEGER

Description: Number of days the filled prescription will cover.

Entity List:

Encounter

Valid Values:

001 – 999

Ingenix Attribute Name: DEERS Beneficiary Identifier

Source Field Name: DEERS Beneficiary Identifier

Ingenix DW Name: DEERS_BENFY_ID

Data Type: CHAR(2)

Description: The identifier that, along with DEERS Family Identifier, uniquely identifies a family member for the purposes of DoD benefits.

Entity List:

Enrollment

Valid Values:

- 00 Sponsor
- 01-99 Dependents

Ingenix Attribute Name: DEERS Family Identifier

Source Field Name: DEERS Family Identifier

Ingenix DW Name: DEERS_FAM_ID

Data Type: CHAR(9)

Description: The identifier that uniquely identifies a family for the purposes of DoD benefits.

Entity List:

- Enrollment
- Enrollment Fee Collection
- Family
- Family Catastrophic Capitation and Deductible

Ingenix Attribute Name: DEERS Reported Family CATCAT Amount

Source Field Name: DEERS CC&D Response

Ingenix DW Name: DEERS_RPT_FAM_CATCAT_AMT

Data Type: CHAR(18)

Description: The total YTD CATCAP amount as reported on the CCDD Totals Response (FAM_FY_CCAP_AM field).

Entity List:

- Family Catastrophic Capitation and Deductible

Ingenix Attribute Name: DEERS Reported Individual CATCAT Amount

Source Field Name: DEERS CC&D Response

Ingenix DW Name: DEERS_RPT_INDV_CATCAT_AMT

Data Type: CHAR(18)

Description: The total individual YTD CATCAP amount as reported on the CCDD Totals Response (INV_FY_CCAP_PMT_AM field).

Entity List:

- Individual Catastrophic Capitation and Deductible

Ingenix Attribute Name: DEERS Reporting Effective Timestamp

Source Field Name: DEERS CC&D Response

Ingenix DW Name: DEERS_RPT_EFF_TMSTMP

Data Type: CHAR(18)

Description: The Transaction Online Date and Time of the DEERS CCDD inquiry.

Entity List:

- Family Catastrophic Capitation and Deductible
- Individual Catastrophic Capitation and Deductible

Ingenix Attribute Name: Diagnosis Code

Source Field Name: Patient Principal/Primary Diagnosis

- Patient Diagnosis 2
- Patient Diagnosis 3
- Patient Diagnosis 4
- Patient Diagnosis 5
- Patient Diagnosis 6
- Patient Diagnosis 7
- Patient Diagnosis 8

Patient Diagnosis 9
Patient Diagnosis 10
Patient Diagnosis 11
Patient Diagnosis 12

Ingenix DW Name: DIAG_CD

Data Type: CHAR(7)

Description: ICD-9-CM code identifying a diagnosis that affects the care, management, or treatment provided during an inpatient or outpatient encounter.

Entity List:

Diagnosis Code
Encounter Diagnosis

Ingenix Attribute Name: Diagnosis Code Set Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: DIAG_CD_SET_CD

Data Type: CHAR(8)

Description: A code identifying the code set to which a particular diagnosis or procedure code belongs.

Entity List:

Diagnosis Code
Encounter Diagnosis

Valid Values:

See Code Set Code.

Ingenix Attribute Name: Diagnosis Line Number

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: DIAG_LN_NBR

Data Type: NUMBER(2)

Description: Diagnosis line number on the encounter where this diagnosis code appeared, between 1 and 12 for non-split encounters or up to 99 for split encounters.

Entity List:

Encounter Diagnosis

Ingenix Attribute Name: Dispense Date

Source Field Name: Date Dispensed

Ingenix DW Name: DSPNS_DT

Data Type: DATE

Description: Date prescription was dispensed.

Entity List:

Encounter

Ingenix Attribute Name: Dispensed as Written Code

Source Field Name: Dispensed as Written Indicator

Ingenix DW Name: DSPNSD_AS_WRT_CD

Data Type: CHAR(1)

Description: Code indicating if the drug was dispensed as written on the prescription.

Notes: Blank is not a valid value

Entity List:

Dispensed as Written Code

Encounter

Valid Values:

Industry Standard DAW Coding

0 Not Product Selection Indicated

1 Substitution NOT Allowed. Brand Drug Mandated by Prescriber.

2 Substitution Allowed. Patient Requested Brand Drug.

3 Substitution Allowed. Pharmacist Selected Brand Drug.

4 Substitution Allowed. Generic Not in Stock.

5 Substitution Allowed. Brand Drug Dispensed as Generic.

6 Override

7 Substitution NOT Allowed. Brand Drug Mandated by Law.

8 Substitution Allowed. Generic Not Available in Marketplace.

9 Other

Ingenix Attribute Name: DMIS Identifier

Source Field Name: DMIS ID

Ingenix DW Name: DMIS_ID

Data Type: CHAR(4)

Description: Defense Medical Information System (DMIS) Identification Code.

Entity List:

Annual Capitation Rate

Designated Provider Valid Region

DMIS

Encounter

Enrollment Fee Collection

ETL Record Count

Provider

Valid Values:

0190 Johns Hopkins Medical Services Corporation

0191 Brighton Marine Health Care

0192 CHRISTUS Health – St. John's

0193 Saint Vincent Catholic Medical Centers of NY

0194 Pacific Medical Clinics

0196 CHRISTUS Health – St. Joseph's

0197 CHRISTUS Health – St. Marys

0198 Martin's Point Health Care

Ingenix Attribute Name: DRG Code

Source Field Name: Diagnosis Related Group (DRG)

Ingenix DW Name: DRG_CD

Data Type: CHAR(3)

Description: Patient classification scheme, which provides a means of relating the types of patients a hospital treats to the costs incurred by the hospital.

Notes: Required field when reporting acute hospital, skilled and observation encounters.

Entity List:

Diagnosis Related Group

Encounter

Valid Values:

Valid TRICARE Diagnosis Related Group (DRG)

Acute hospital DRG assignment

777 Acute hospital (Johns Hopkins only)

See DP Secure Website (Download Center) for the latest codes.

Ingenix Attribute Name: Earliest Service Date

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ERLY_SRVC_DT

Data Type: DATE

Description: The earliest Service Start Date on any service listed on the encounter. Used to determine eligibility based on enrollment.

Entity List:

Encounter

Ingenix Attribute Name: Email Address Text

Source Field Name: Email Address Text

Ingenix DW Name: EMAIL_ADR_TXT

Data Type: VARCHAR2(80)

Description: Text of the person's or organization's email address in the format xxx@xxxxxx.

Notes: Information only

Entity List:

Person

Ingenix Attribute Name: Email Address Use Priority Code

Source Field Name: Email Address Use Priority Code

Ingenix DW Name: EMAIL_ADR_USE_PRR_CD

Data Type: CHAR(1)

Description: Code that represents the priority of the usage of the e-mail mailing addresses.

Notes: Required if email text field contains a value

Entity List:

Email Address Use Priority

Person

Valid Values:

1 Primary

2 Secondary

3 Tertiary

Ingenix Attribute Name: Emergency Flag Indicator

Source Field Name: Emergency Flag

Ingenix DW Name: EMRG_FLG_IND

Data Type: CHAR(1)

Description: Flag indicating emergency ambulatory care.

Notes: Required on Inpatient (I) and Outpatient (O) encounter records

Entity List:

Encounter

Ingenix Attribute Name: Encounter Setting Code

Source Field Name: Encounter Setting

Ingenix DW Name: ENCTR_SETTING_CD

Data Type: CHAR(1)

Description: Setting of patient encounter/episode of care, such as hospital, inpatient or outpatient. This value will only be populated during the processing of medical encounters.

Entity List:

Encounter

Encounter Setting

Valid Values:

H Hospital Services

I Inpatient Professional Services

O Outpatient Professional Services

Ingenix Attribute Name: Encounter System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENCTR_SYS_ID

Data Type: INTEGER

Description: System key generated by Ingenix to uniquely identify an encounter.

Entity List:

Encounter

Encounter Diagnosis

Encounter Procedure

Encounter Standardized Copayment

Ingenix Attribute Name: Encounter Type Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENCTR_TYP_CD

Data Type: CHAR(3)

Description: A code representing a type of encounter, Pharmacy (RX) or Medical.

Entity List:

Encounter

Encounter Type

Valid Values:

MED Medical (Clinical) Encounter (MCD)

RX Pharmacy (RX) Encounter

Ingenix Attribute Name: Enrollee Person System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENRLEE_PERS_SYS_ID

Data Type: INTEGER

Description: An Ingenix system generated value uniquely identifying an enrollee (an individual).

Entity List:

Enrollment

Ingenix Attribute Name: Enrollment Fee Collected

Source Field Name: Enrollment Fee Collected

Data Type: NUM (6)

Ingenix DW Name: ENRL_FEE_CLCTED_AMT

Description: Amount of money collected, from the family unit, of the annual enrollment fee. Data Type: NUMBER(9,2)

Notes: Dollars and cents, assumed decimal point

Entity List:

Enrollment Fee Collection

Valid Values:

-999.99 – 999.99

Ingenix Attribute Name: Enrollment Fee Collection System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENRL_FEE_CLCT_SYS_ID

Data Type: INTEGER

Description:

Entity List:

Enrollment Fee Collection

Ingenix Attribute Name: Enrollment Fee Payment Action Code

Source Field Name: Enrollment Fee Payment Action Code

Ingenix DW Name: ENRL_FEE_PYMT_ACT_CD

Data Type: CHAR(1)

Description: Code that represents the type of enrollment fee being made for the Health Care Delivery Program.

Entity List:

Enrollment Fee Collection

Enrollment Fee Payment Action

Valid Values:

A Payment

B Adjustment

C Other

H Credit

Ingenix Attribute Name: Enrollment Fee Payment Exception Reason Code

Source Field Name: Health Care Delivery Program Enrollment Fee Payment Exception Reason Code

Ingenix DW Name: ENRL_FEE_PYMT_XCPT_RSN_CD

Data Type: CHAR(1)

Description: The code representing the reason that the Health Care Delivery Program enrollment fee payment was either partial or no payment at all.

Entity List:

Enrollment Fee Collection

Enrollment Fee Payment Exception Reason

Valid Values:

C Catastrophic Cap and Deductible have been met for this payment period

F Fees waived due to EY to FY realignment

L Fee waiver exists for an individual

M Multiple fee waivers in family

N No fee waiver exception

W Enrollment fee for this payment period has been affected by individual family member fee waiver(s)

Ingenix Attribute Name: Enrollment Fee Payment Paid Through Date

Source Field Name: Health Care Delivery Program Enrollment Fee Payment Paid-Through Calendar Date

Ingenix DW Name: ENRL_FEE_PYMT_PD_THRU_DT

Data Type: DATE

Description: Date that the Health Care Delivery Program fee payment has been paid through.

Entity List:

Enrollment Fee Collection

Ingenix Attribute Name: Enrollment Fee Payment Plan Type Code

Source Field Name: Health Care Delivery Program Enrollment Fee Payment Plan Type Code

Ingenix DW Name: ENRL_FEE_PYMT_PLN_TYP_CD

Data Type: CHAR(1)

Description: Code representing the type of fee payment plan that was chosen for this Health Care Delivery Program.

Entity List:

Enrollment Fee Collection

Enrollment Fee Payment Plan Type

Valid Values:

A Annually

M Monthly (payroll deduction) (EFT or allotment)

Q Quarterly

R Request to begin EFT or allotment (3 month payment)

Ingenix Attribute Name: Enrollment Fee Payment Received Date

Source Field Name: Enrollment Fee Payment Received Date

Ingenix DW Name: ENRL_FEE_PYMT_RECV_DT

Data Type: DATE

Description: The date the enrollment fee payment was received.

Entity List:

Enrollment Fee Collection

Ingenix Attribute Name: Enrollment Fee Payment Type Code

Source Field Name: Health Care Delivery Program Enrollment Fee Payment Type Code

Ingenix DW Name: ENRL_FEE_PYMT_TYP_CD

Data Type: CHAR(1)

Description: The code that indicates the form of payment used to pay an enrollment fee.

Notes: DP values submitted on the Enrollment Fee Collection file will be translated as shown to DEERS values for reporting.

Entity List:

Enrollment Fee Collection

Enrollment Fee Payment Type

Valid Values:

DEERS DP Description

O 0 No payment

O 1 Cash

D 2 Credit Card

C 3 Check

M 4 Money order
 A 5 Allotment
 E 6 Electronic Funds Transfer (EFT)

Ingenix Attribute Name: Enrollment Fee Transaction Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENRL_FEE_TRANS_ID

Data Type: NUMBER(10)

Description: A proposed unique transaction identifier provided by the DPs to uniquely identify a Fee Payment or Adjustment transaction.

Entity List:

Enrollment Fee Collection

Ingenix name: Enrollment Fee Unique Identifier

Source Field name: Enrollment Fee Unique Identifier

Ingenix DW Name: ENRL_FEE_UNIQ_ID

Data type: CHAR (12)

Description: Unique record identifier for Enrollment Fee records

Note: For use in tracking Enrollment Fee records, not validated and is allowed to be null

Entity List: ENROLLMENT_FEE_COLLECTION

Ingenix Attribute Name: Enrollment Management Contractor Code

Source Field Name: Health Care Delivery Program Enrollment Management Contractor Code

Ingenix DW Name: EMC_CD

Data Type: CHAR(2)

Description: The code that indicates the contractor currently managing enrollment for a Health Care Delivery Program.

Entity List:

DMIS
 Enrollment
 Enrollment Management Contractor

Valid Values:

08 Ingenix
 12 Martin's Point Health Care
 13 Johns Hopkins Medical Services Corporation
 14 Brighton Marine Health Care
 15 St. Vincents Catholic Medical Centers of NY
 17 CHRISTUS Health
 18 Pacific Medical Clinics
 31 Martin's Point Health Care (TNEX)
 32 Johns Hopkins Medical Services Corporation (TNEX)
 33 Brighton Marine Health Care (TNEX)
 34 St. Vincent's Catholic Medical Centers of New York (TNEX)
 36 Christus Health (TNEX)
 37 Pacific Medical Clinics (TNEX)

Ingenix Attribute Name: Enrollment Management Contractor Enrollment Application Received Date

Source Field Name: Enrollment Management Contractor Health Care Delivery Program Enrollment Application Received Calendar Date

Data Type: DATE

Ingenix DW Name: EMC_ENRL_APPL_RECV_DT

Description: Date that a contractor received an Health Care Delivery Program enrollment application.

Entity List:

Enrollment

Ingenix Attribute Name: Enrollment Management Contractor Enrollment Begin Date

Source Field Name: Enrollment Management Contractor Enrollment Begin Calendar Date

Data Type: DATE

Ingenix DW Name: EMC_ENRL_BEGN_DT

Description: The date that the contractor began managing a person's enrollment with a Health Care Delivery Program.

Entity List:

Enrollment

Ingenix Attribute Name: Enrollment Management Contractor Enrollment End Date

Source Field Name: Enrollment Management Contractor Enrollment End Date

Ingenix DW Name: EMC_ENRL_END_DT

Data Type: DATE

Description: The date that a person's Health Care Delivery Program ends or will end with a particular enrollment management contractor.

Notes: Past, present or future date.

Entity List:

Enrollment

Ingenix Attribute Name: Enrollment Management Contractor Enrollment End Reason Code

Source Field Name: Enrollment Management Contractor Enrollment End Reason Code

Ingenix DW Name: EMC_ENRL_END_RSN_CD

Data Type: CHAR(1)

Description: The code that represents the reason an enrollment with an enrollment management contractor ended or will end.

Entity List:

Enrollment

Enrollment Management Contractor Enrollment End Reason

Valid Values:

- 1 Insufficient initial payment - record retained
- 2 No initial payment - record retained
- 3 Bounced check - record retained
- 4 Cancellation - record retained
- 5 Disenrollment because person has other health insurance
- 6 Termination due to contract transition
- 7 Loss of eligibility for this coverage due to personnel action
- 8 Loss of eligibility for this coverage due to change in family association
- 9 Loss of eligibility for this coverage due to change in personal health care coverage
- A Failure to maintain Medicare Part B
- B Failure to comply with program requirements, or disruptive behavior

C Termination of mid-month enrollment
 D Loss of eligibility for this coverage due to death
 E Cancellation - record removed
 F Invalid entry
 G Duty station change to health care facility/clinic area
 H Permanent change of station (PCS)
 I Relocation
 J Moved outside of service area (OCONUS for dental)
 K Change of coverage plan within health care delivery program
 L Enrolled to another health care delivery program
 M Loss of eligibility for current health care delivery program
 N Voluntary disenrollment by sponsor
 O Voluntary disenrollment by beneficiary
 P Dissatisfied with program
 Q This date is certain (projected end of eligibility)
 S Loss of eligibility for DoD benefits
 T Transfer of enrollment
 U No date can be predicted
 V Not in a valid pay status (as determined by the contractor)
 X Disenrollment for unknown reasons (historical)
 Y Failure to pay enrollment fee/premium
 Z Termination of mid-month enrollment

Ingenix Attribute Name: Enrollment Management Contractor Enrollment Extended Reason Code

Source Field Name: Enrollment Management Contractor Enrollment Extended Reason Code

Ingenix DW Name: EMC_ENRL_EXT_RSN_CD

Data Type: CHAR(2)

Description: This field will be populated if the Enrollment Management Contractor Enrollment End Reason Code = 'X'.

Entity List:

Enrollment
 Enrollment Management Contractor Enrollment Extended Reason

Ingenix Attribute Name: Enrollment Management Contractor Enrollment Residence Mailing Address Zip Code

Source Field Name: Enrollment Management Contractor Enrollment Residence Mailing Address US Postal Region ZIP Code

Ingenix DW Name: EMC_ENRL_RES_MAIL_ADR_ZIP_CD

Data Type: CHAR(5)

Description: ZIP code of the residence mailing address of the enrollee with the contractor.

Entity List:

Enrollment

Ingenix Attribute Name: Enrollment Management Contractor Enrollment Work Mailing Address Zip Code

Source Field Name: Enrollment Management Contractor Enrollment Work Mailing Address US Postal Region ZIP Code

Ingenix DW Name: EMC_ENRL_WRK_MAIL_ADR_ZIP_CD

Data Type: CHAR(5)

Description: The ZIP code of the work mailing address of the sponsor.

Entity List:

Enrollment

Ingenix Attribute Name: Enrollment Management Contractor Policy Enrollment Period Begin Date

Source Field Name: Enrollment Management Contractor Policy Enrollment Period Begin Calendar Date

Ingenix DW Name: EMC_POL_ENRL_PRD_BEGN_DT

Data Type: DATE

Description: Policy begin date for the enrollment management contractor reported on Fee Collection records.

Entity List:

Enrollment Fee Collection

Ingenix Attribute Name: Enrollment System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENRL_SYS_ID

Data Type: INTEGER

Description: An Ingenix system generated value uniquely identifying an enrollment.

Entity List:

Capitation Payment

Enrollment

Ingenix Attribute Name: Enrollment Year Age

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: ENRL_YR_AGE

Data Type: NUMBER(3)

Description: The age of the enrollee at the beginning of the enrollment year (June 1). This age is used to determine Capitation Demographic Group for the purpose of Capitation Payments.

Entity List:

Capitation Payment

Ingenix Attribute Name: Family Identifier Effective Timestamp

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: FAM_ID_EFF_TMSTMP

Data Type: DATE

Description: The date and time of the PNT where this DEERS Family Identifier first appeared.

Entity List:

Family

Ingenix Attribute Name: Family Identifier End Timestamp

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: FAM_ID_END_TMSTMP

Data Type: DATE

Description: The date and time that the DEERS Family Identifier is no longer valid.

Entity List:

Family

Ingenix Attribute Name: Fax Telephone Number

Source Field Name: Fax Telephone Number Code

Ingenix DW Name: FAXRAY_TEL_NBR

Data Type: CHAR(20)

Description: Fax telephone number.

Notes: Informational only

Entity List:

Person

Ingenix Attribute Name: Fifth Major Specialty Code

Source Field Name: 5th Major Specialty

Ingenix DW Name: FTH_MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code or type of institution where care was provided reported on the encounter.

Notes: Required for non-institutional providers who have more than four major specialties

Entity List:

Provider

Valid Values:

For valid values, see Major Specialty

Ingenix Attribute Name: File Type

Source Field Name: DP Source File Header

Ingenix DW Name:

Data Type: CHAR(3)

Description: Type of data file submitted. Appears on submission file header.

Entity List:

ADDL_ATTRIB

Valid Values:

EFC Enrollment Fee Collections

ENR Enrollment Data

MCD Management Clinical Data

OHI OHI/PCM Update Data

NDC Pharmacy Data

PRV Provider Data

Ingenix Attribute Name: First Major Specialty Code

Source Field Name: Major Spec/Institution Type

Ingenix DW Name: FST_MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code or type of institution where care was provided reported on the encounter.

Entity List:

Provider

Ingenix Attribute Name: Fiscal Year Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: FISC_YR_ID

Data Type: NUMBER(4)

Description: The fiscal year to which the capitation rate applies.

Entity List:

Annual Capitation Rate

Capitation Demographic Group

Ingenix Attribute Name: Fourth Major Specialty Code

Source Field Name: 4th Major Specialty

Ingenix DW Name: FRTH_MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code or type of institution where care was provided reported on the encounter.

Notes: Required for non-institutional providers who have more than three major specialties

Entity List:

Provider

Valid Values:

For valid values, see Major Specialty

Ingenix Attribute Name: Gender Code

Source Field Name: Provider Gender Code

Ingenix DW Name: GDR_CD

Data Type: CHAR(1)

Description: Code to indicate the gender of provider.

Entity List:

Gender

Valid Values:

F Female

M Male

Z Unknown

Ingenix Attribute Name: Group Gender Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: GRP_GDR_CD

Data Type: CHAR(1)

Description: The gender of the demographic group, Male or Female.

Entity List:

Capitation Demographic Group

Valid Values:

See Gender Code.

Ingenix Attribute Name: Group Maximum Age

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: GRP_MAX_AGE

Data Type: NUMBER(3)

Description: The upper bound (inclusive) value, in years, of a demographic group age range.

Entity List:

Capitation Demographic Group

Ingenix Attribute Name: Group Minimum Age

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: GRP_MIN_AGE

Data Type: NUMBER(3)

Description: The lower bound (inclusive) value, in years, of a demographic group age range. 0 is valid (under 1 year old).

Entity List:

Capitation Demographic Group

Ingenix Attribute Name: Guard Reserve Status Code

Source Field Name: Guard/Reserve Status

Ingenix DW Name: GUARD_RSRV_STS_CD

Data Type: CHAR(1)

Description: If non-institution, code that represents provider's Guard/Reserve status.

Notes: Required for all non-institutional providers

Entity List:

Guard Reserve Status

Provider

Valid Values:

G Guard

R Reserve

N Not Applicable

Ingenix Attribute Name: HCDP Enrollment Card Request Date

Source Field Name: Health Care Delivery Program Enrollment Card Request Calendar Date

Ingenix DW Name: HCDP_ENRL_CRD_REQ_DT

Data Type: DATE

Description: The date on which an enrollment card was last requested for an individual.

Notes: Does not apply to the Designated Provider Program

Entity List:

Enrollment

Ingenix Attribute Name: HCDP Enrollment Card Request Status Code

Source Field Name: Health Care Delivery Program Enrollment Card Request Status Code

Ingenix DW Name: HCDP_ENRL_CRD_REQ_STS_CD

Data Type: CHAR(1)

Description: The code that represents the process status of a request for an enrollment card to be produced for an individual.

Notes: Does not apply to the Designated Provider Program. A value of "Z" will be found in this field.

Entity List:

Enrollment

HCDP Enrollment Card Request Status

Valid Values:

C Requested enrollment card for enrollee who has changed Primary Care Manager or region

N Produce new enrollment card for this individual

R Produce a replacement enrollment card for individual

Z Do not produce an enrollment card for this individual

Ingenix Attribute Name: HCDP Enrollment Fee Payment Update Code

Source Field Name: Health Care Delivery Program Enrollment Fee Payment Update Code

Ingenix DW Name: HCDP_ENRL_FEE_PYMT_UPDT_CD

Data Type: CHAR(1)

Description: Code that indicates the type of change that occurred in the Health Care Delivery Program enrollment fee payment section of the transfer reconciliation record.

Entity List:

Enrollment
HCDP Enrollment Fee Payment Update

Valid Values:

A Add new data
N No action
T Fee information from policy with previous contractor
U Update existing information

Ingenix Attribute Name: HCDP Enrollment Management Contractor Plan Status Code

Source Field Name: Health Care Delivery Program Enrollment Management Contractor Plan Status Code

Ingenix DW Name: HCDP_EMG_PLN_STS_CD

Data Type: CHAR(1)

Description: The code that indicates the status of the enrollment, such as enrolled or pending.

Entity List:

Enrollment
HCDP Enrollment Management Contractor Plan Status

Valid Values:

E Enrolled, active
N Enrolled, active - no action taken by MCSC/USFHP
P Pending, not active

Ingenix Attribute Name: HCDP Enrollment Management Contractor Plan Status Date

Source Field Name: Health Care Delivery Program Enrollment Management Contractor Plan Status Date

Ingenix DW Name: HCDP_EMG_PLN_STS_DT

Data Type: DATE

Description: The date associated to the Health Care Delivery Program Enrollment Management Contractor Plan Status Code.

Entity List:

Enrollment

Ingenix Attribute Name: HCDP Enrollment Notification Type Code

Source Field Name: Health Care Delivery Program Enrollment Notification Type Code

Ingenix DW Name: HCDP_ENRL_NTFY_TYP_CD

Description: The code that represents the type of HCDP Enrollment Notification.

Data Type: CHAR(1)

Entity List:

Enrollment
HCDP Enrollment Notification Type

Valid Values:

D Disenrollment Letter
P PCM Letter

Ingenix Attribute Name: HCDP Fiscal Year Identifier

Source Field Name: Health Care Delivery Program Fiscal Year Identifier

Ingenix DW Name: HCDP_FISC_YR_ID

Data Type: CHAR(4)

Description: The four digit year that identifies a TRICARE fiscal year.

Entity List:

Enrollment Fee Collection
 Family Catastrophic Capitation and Deductible
 Individual Catastrophic Capitation and Deductible

Ingenix Attribute Name: HCDP Individual Enrollment Fee Waiver Reason Code

Source Field Name: Health Care Delivery Program Individual Enrollment Fee Waiver Reason Code

Ingenix DW Name: HCDP_INDV_ENRL_FEE_WAIV_RSN_CD

Data Type: CHAR(1)

Description: The code representing the reason that Health Care Delivery Program enrollment fees are waived for this individual.

Entity List:

Enrollment
 HCDP Individual Enrollment Fee Waiver Reason

Valid Values:

A Mental Health Wraparound Program
 B Bosnia Special Operation
 C Below 65 years of age and Medicare A and B eligible
 D Dependent of parents who both have enrollment fees waived
 U USFHP beneficiary with Medicare Part B

Ingenix Attribute Name: HCDP Plan Coverage Active Duty Restriction Indicator

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: HCDP_PLN_COV_ACT_DTY_RSTRC_IND

Data Type: CHAR(1)

Description: Indicates whether a HCDP Plan Coverage is restricted to beneficiaries of active duty sponsors.

Entity List:

HCDP Plan Coverage

Ingenix Attribute Name: HCDP Plan Coverage Code

Source Field Name: Health Care Delivery Program Plan Coverage Code

Ingenix DW Name: HCDP_PLN_COV_CD

Data Type: CHAR(3)

Description: A code that represents the plan coverage a family member or sponsor has within a Health Care Delivery Program (HCDP) type.

Entity List:

Enrollment
 HCDP Plan Coverage

Valid Values:

107 TRICARE Prime Individual Coverage for ADFMs
 108 TRICARE Prime Family Coverage for ADFMs
 109 TRICARE USFHP Direct Care Coverage for ADFMS
 110 TRICARE Prime for Individual Coverage for Survivors of Active Duty Deceased Sponsors
 111 TRICARE Prime Family Coverage for Survivors of Active Duty Deceased Sponsors
 112 TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
 113 TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
 114 TRICARE USFHP Direct Care Individual Coverage for Survivors of Active Duty Deceased Sponsors
 115 TRICARE USFHP Direct Care Family Coverage for Survivors of Active Duty Deceased Sponsors

- 116 TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- 117 TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- 118 TRICARE USFHP Direct Care Individual Coverage for Retired Sponsors and Family Members
- 119 TRICARE USFHP Direct Care Family Coverage for Retired Sponsors and Family Members
- 131 TRICARE Prime Individual Coverage for Transitional Survivors of Active Duty Deceased Sponsors
- 132 TRICARE Prime Family Coverage for Transitional Survivors of Active Duty Deceased Sponsors
- 133 TRICARE USFHP Direct Care Coverage for Transitional Survivors of Active Duty Deceased Sponsors
- 134 TRICARE Prime Individual Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
- 135 TRICARE Prime Family Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
- 138 TRICARE USFHP Direct Care Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors
- 139 TRICARE USFHP Direct Care Family Coverage for Survivors of Guard/Reserve Deceased Sponsors

Ingenix Attribute Name: HCDP Plan Fee Structure Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: HCDP_PLN_FEE_STRCT_CD

Data Type: CHAR(1)

Description: A code identifying a HCDP Plan Coverage as either a Family or Individual plan for the purpose of enrollment fee calculation.

Entity List:

- HCDP Plan Coverage
- HCDP Plan Fee Structure

Ingenix Attribute Name: HCDP Policy Enrollment Period Begin Date

Source Field Name: Health Care Delivery Program Policy Enrollment Period Begin Calendar Date

Ingenix DW Name: HCDP_POL_ENRL_PRD_BEGN_DT

Data Type: DATE

Description: Calendar date that a person's Health Care Delivery Program policy period became effective for an enrollment period for dental and medical programs. This represents date enrollment began in the current coverage plan for the individual or family (anniversary date).

Entity List:

- Enrollment

Ingenix Attribute Name: HCDP Policy Enrollment Period End Date

Source Field Name: Health Care Delivery Program Policy Enrollment Period End Calendar Date

Ingenix DW Name: HCDP_POL_ENRL_PRD_END_DT

Data Type: DATE

Description: The date that the policy enrollment period was terminated or was projected to end (derived value).

Entity List:

- Enrollment

Ingenix Attribute Name: Home Telephone Number

Source Field Name: Home Telephone Number Code

Ingenix DW Name: HOM_TEL_NBR

Data Type: CHAR(20)

Description: Home telephone number.

Notes: Informational only

Entity List:

Person

Ingenix Attribute Name: Hospital Service Admission Date

Source Field Name: Hospital Service Admission Date

Ingenix DW Name: HOSP_SRVC_ADMIS_DT

Data Type: DATE

Description: Date of hospital admission.

Notes: Required for hospital services. If interim bill, use admission date of interim bill. An interim bill will have a disposition status code of 30 (still a patient).

Entity List:

Encounter

Ingenix Attribute Name: Hospital Service Admission Source Code

Source Field Name: Hospital Service Admission Source

Description: The code to indicate source of admission for this hospital stay.

Data Type: CHAR(1)

Ingenix DW Name: HOSP_SRVC_ADMIS_SRC_CD

Entity List:

Encounter

Hospital Service Admission Source

Valid Values:

- 1 Physician Referral
- 2 Clinic Referral
- 3 HMO Referral
- 4 Transfer from a Hospital
- 5 Transfer from a Skilled Nursing Facility
- 6 Transfer from Another Health Care Facility
- 7 Emergency
- 8 Court/ Law Enforcement
- 9 Information Not Available

Ingenix Attribute Name: Hospital Service Admission Type Code

Source Field Name: Hospital Service Admission Type

Ingenix DW Name: HOSP_SRVC_ADMIS_TYP_CD

Data Type: CHAR(1)

Description: The code to indicate admission type for hospital services stay.

Entity List:

Encounter

Hospital Service Admission Type

Valid Values:

- 1 Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
- 2 Urgent: The patient requires immediate medical intervention for the care of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodations. Use for mothers who are delivering.
- 3 Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
- 4 Newborn: Use of this code necessitates the use of special source of admission codes (A-D). Do not use for mother.
- 5 Trauma Center

6 Inpatient Mental Health

9 Info Not Available

Ingenix Attribute Name: Hospital Service Disposition Date

Source Field Name: Hospital Service Disposition Date

Ingenix DW Name: HOSP_SRVC_DISP_DT

Description: Date of discharge from hospital.

Notes: Required for hospital services. If interim bill, disposition date of interim bill or blanks are acceptable. An interim bill will have a disposition status code of 30 (still a patient).

Data Type: DATE

Entity List:

Encounter

Ingenix Attribute Name: Hospital Service Disposition Status Code

Source Field Name: Hospital Service Disposition Status

Data Type: CHAR(2)

Ingenix DW Name: HOSP_SRVC_DISP_STS_CD

Description: The code to indicate status of patient upon discharge from the hospital.

Entity List:

Encounter

Hospital Service Disposition Status

Valid Values:

01 Discharge to home or self-care

02 Discharged/Transferred to another short-term general hospital

03 Discharged/Transferred skilled nursing facility (SNF)

04 Discharged/Transferred to an intermediate care facility (ICF)

05 Discharged/Transferred to another type of institution

06 Discharged/Transferred to home under care of organized home health service organization

07 Left against medical advice

08 - 09 Reserved for national assignment

10 - 19 Discharged to be defined at state level, if necessary

20 Deceased

21 - 29 Deceased to be defined at state level, if necessary

30 Still a patient

31 - 39 Still a patient to be defined at state level, if necessary

40 Expired at home*

41 Expired in a medical facility; e.g., hospital, SNF, ICF, free standing hospice*

42 Expired - Place Unknown*

43 - 99 Reserved for National Assignment

*For use only on Medicare claims for hospital care

Ingenix Attribute Name: Institution Code

Source Field Name: Institution/Non-Institution

Ingenix DW Name: INST_CD

Data Type: CHAR(1)

Description: The code indicating whether provider/pharmacy is institution or non-institution.

Notes: Required

Entity List:

Institution Code

Provider

Valid Values:

I Institutional

N Non-institutional

Ingenix Attribute Name: Institution Type Code

Source Field Name: Major Spec/Institution Type

Ingenix DW Name: INST_TYP_CD

Data Type: CHAR(2)

Description: Code identifying the type of institution providing care on an institutional encounter.

Entity List:

Institution Type

Provider

Valid Values:

10 General Medical and Surgical

11 Hospital Unit of an Institution (Prison Hospital, College Infirmary, etc.)

12 Hospital Unit within an Institution for the Mentally Retarded

22 Psychiatric Hospital or Unit

33 Tuberculosis and Other Respiratory Disease

44 Obstetrics and Gynecology

45 Eyes, Ear, Nose, and Throat

46 Rehabilitation

47 Orthopedic

48 Chronic Disease

49 Miscellaneous

50 Children's General

51 Children's Hospital Unit of an Institution

52 Children's Psychiatric Hospital or Unit

53 Children's Tuberculosis and Other Respiratory Diseases

55 Children's Eye, Ear, Nose, and Throat

56 Children's Rehabilitation

57 Children's Orthopedic

58 Children's Chronic

59 Children, Other Specialty

62 Institution for Mental Retardation

70 Home Health Care Agency

71 Specialized Treatment Facility

72 Residential Treatment Facility

73 Extended Care Facility

74 Christian Science Facility

75 Hospital-Based Ambulatory Surgery Center

76 Skilled Nursing Facility

78 Non-Hospital-Based Hospice

79 Hospital-Based Hospice

82 Alcoholism and Other Chemical Dependency

90 Cancer

91 Sole Community
 92 Freestanding Ambulatory Surgery Center

Ingenix Attribute Name: Mailing Address City Name

Source Field Name: Mailing Address City Name

Ingenix DW Name: MAIL_ADR_CTY_NM

Data Type: CHAR(20)

Description: The name of the city of the person's mailing address.

Entity List:

Mailing Address

Ingenix Attribute Name: Mailing Address Country Code

Source Field Name: Mailing Address Country Code

Ingenix DW Name: MAIL_ADR_CNTRY_CD

Data Type: CHAR(2)

Description: The code that represents the country of the person's mailing address. The valid values also include dependencies and areas of special sovereignty.

Notes: DP enrollees must reside in the United States (US)

Entity List:

Mailing Address

Mailing Address Country

Valid Values:

AA Aruba - Added April 1986; formerly part of Netherlands Antilles (NA).
 AC Antigua and Barbuda - Formerly Antigua (AC).
 AE United Arab Emirates
 AF Afghanistan
 AG Algeria
 AJ Azerbaijan - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).
 AL Albania
 AM Armenia - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).
 AN Andorra
 AO Angola
 AQ American Samoa
 AR Argentina
 AS Australia - Included Coral Sea Islands (CR) prior to June 1974. Included Ashmore and Cartier Islands (AT) and Coral Sea Islands (CR) between March 1977 and May 1983.
 AT Ashmore and Cartier Islands - Deleted March 1977; readded May 1983; see Australia (AS).
 AU Austria
 AV Anguilla - Added June 1974; formerly part of St. Christopher-Nevis-Anguilla (SC).
 AY Antarctica
 BA Bahrain
 BB Barbados
 BC Botswana
 BD Bermuda
 BE Belgium
 BF Bahamas, The
 BG Bangladesh - Added June 1974; formerly part of Pakistan (PK).
 BH Belize - Formerly British Honduras (BH).

BK Bosnia and Herzegovina - Formerly Bosnia and Hercegovina (BK). Added August 1992; formerly part of Yugoslavia (YO).

BL Bolivia

BM Burma

BN Benin - Added May 1983; formerly Benin (DM).

BO Belarus - Formerly Byelarus (BO). Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

BP Solomon Islands - Formerly British Solomon Islands (BP).

BQ Navassa Island - Prior to June 1974 part of US Miscellaneous Caribbean Islands (BQ).

BR Brazil

BS Bassas da India - Added May 1983; formerly part of Reunion (RE).

BT Bhutan

BU Bulgaria

BV Bouvet Island - Formerly Bouvetoya (BV).

BX Brunei

BY Burundi

CA Canada

CB Cambodia - Formerly Kampuchea (CB) and Khmer Republic (CB).

CD Chad

CE Sri Lanka - Formerly Ceylon (CE).

CF Congo - Formerly Congo (Brazzaville) (CF).

CG Congo (Democratic Republic of the)- Formerly Zaire.

CH China - Formerly China, Peoples Republic of (CH) and China, Communist (CH).

CI Chile

CJ Cayman Islands

CK Cocos (Keeling) Islands

CM Cameroon

CN Comoros

CO Colombia - As of June 1974 includes part of US Miscellaneous Caribbean Islands (BQ).

CQ Northern Mariana Islands - Added April 1989; formerly part of Trust Territory of the Pacific Islands (TQ).

CR Coral Sea Islands - Added June 1974; deleted March 1977; readded May 1983; see Australia (AS).

CS Costa Rica

CT Central African Republic - Formerly Central African Empire (CT).

CU Cuba

CV Cape Verde - Formerly Cape Verde, Republic of (CV).

CW Cook Islands

CY Cyprus

CZ Czechoslovakia (obsolete value)

DA Denmark

DJ Djibouti - Added July 1977; formerly French Territory of the Afars and Issas (FT).

DO Dominica

DQ Jarvis Island - Added May 1983; formerly part of US Miscellaneous Pacific Islands (IQ).

DR Dominican Republic

EC Ecuador

EG Egypt - Formerly United Arab Republic (EG).

EI Ireland

EK Equatorial Guinea

EN Estonia - Added September 1991; formerly part of Union of Soviet Socialist Republics (UR).

ER Eritrea - Added May 1993; formerly part of Ethiopia (ET).
ES El Salvador
ET Ethiopia - Included Eritrea (ER) prior to May 1993.
EU Europa Island - Added May 1983; formerly part of Reunion (RE).
EZ Czech Republic - Added February 1993; formerly part of Czechoslovakia (CZ).
FG French Guiana
FI Finland
FJ Fiji
FK Falkland Islands (Islas Malvinas) - Added January 1991; formerly part of
Falkland Islands (Islas Malvinas) (FA).
FM Federated States of Micronesia - Added February 1987; formerly part of Trust Territory of the Pacific Islands (NQ).
FO Faroe Islands - Formerly Faeroe Islands (FO).
FP French Polynesia - Included Clipperton Island (IP) prior to May 1983.
FQ Baker Island - Added May 1983; formerly part of US Miscellaneous Pacific Islands (IQ).
FR France - Included Mayotte (MF) prior to May 1983.
FS French Southern and Antarctic Lands
GA Gambia, The - Formerly Gambia (GA).
GB Gabon
GG Georgia - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).
GH Ghana
GI Gibraltar
GJ Grenada
GK Guernsey - Added May 1983; formerly part of United Kingdom (UK).
GL Greenland
GM Germany - Added October 1990; formerly Germany, Berlin (BZ), German Democratic Republic (GC), and Germany,
Federal Republic of (GE).
GO Glorioso Islands - Added May 1983; formerly part of Reunion (RE).
GP Guadeloupe
GQ Guam
GR Greece
GT Guatemala
GV Guinea
GY Guyana
GZ Gaza Strip
HA Haiti
HK Hong Kong
HM Heard Island and McDonald Islands
HO Honduras - As of June 1974 includes former Swan Islands (SQ).
HQ Howland Island - Added May 1983; formerly part of US Miscellaneous Pacific Islands (IQ).
HR Croatia - Added August 1992; formerly part of Yugoslavia (YO).
HU Hungary
IC Iceland
ID Indonesia - As of September 1976 includes former Portuguese Timor (PT).
IM Man, Isle of - Added May 1983; formerly part of United Kingdom (UK).
IN India - As of April 1975 includes former Sikkim (SK).
IO British Indian Ocean Territory
IP Clipperton Island - Added May 1983; formerly part of French Polynesia (FP).

IR Iran

IS Israel - As of March 1977 includes former Israel-Syria Demilitarized Zone (IU) and Israel-Jordan Demilitarized Zone (IW).

IT Italy

IV Cote D'Ivoire - Formerly Ivory Coast (IV).

IZ Iraq

JA Japan - As of June 1974 includes former Ryukyu Islands (YQ).

JE Jersey - Added May 1983; formerly part of United Kingdom (UK).

JM Jamaica

JN Jan Mayen - Deleted March 1977; readded May 1983; see Svalbard and Jan Mayer (JS).

JO Jordan

JQ Johnston Atoll

JU Juan de Nova Island - Added May 1983; formerly part of Reunion (RE).

KE Kenya

KG Kyrgyzstan - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

KN Korea, Democratic People's Republic of - Formerly Korea, North (KN).

KQ Kingman Reef - Added May 1983; formerly part of US Miscellaneous Pacific Islands (IQ).

KR Kiribati - Added November 1979; formerly Canton and Enderbury Islands (EQ) and Gilbert Islands (GS).

KS Korea, Republic of

KT Christmas Island

KU Kuwait

KZ Kazakhstan - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

LA Laos

LE Lebanon

LG Latvia - Added September 1991; formerly part of Union of Soviet Socialist Republics (UR).

LH Lithuania - Added September 1991; formerly part of Union of Soviet Socialist Republics (UR).

LI Liberia

LO Slovakia - Added February 1993; formerly part of Czechoslovakia (CZ).

LQ Palmyra Atoll - Added May 1983; formerly part of US Miscellaneous Pacific Islands (IQ).

LS Liechtenstein

LT Lesotho

LU Luxembourg

LY Libya

MA Madagascar

MB Martinique

MC Macau - Formerly Macao (MC).

MD Moldova - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

MF Mayotte - Added May 1983; formerly part of France (FR).

MG Mongolia

MH Montserrat

MI Malawi

MK Macedonia - Added August 1992; formerly part of Yugoslavia (YO).

ML Mali

MN Monaco

MO Morocco

MP Mauritius

MQ Midway Islands

MR Mauritania
MT Malta
MU Oman - Formerly Muscat and Oman (MU).
MV Maldives
MW Montenegro - Added August 1992; formerly part of Yugoslavia (YO).
MX Mexico
MY Malaysia
MZ Mozambique
NC New Caledonia
NE Niue
NF Norfolk Island
NG Niger
NH Vanuatu - Formerly New Hebrides (NH).
NI Nigeria
NL Netherlands
NO Norway
NP Nepal
NR Nauru
NS Suriname - Formerly Surinam (NS).
NT Netherlands Antilles - Added January 1991; formerly Netherlands Antilles (NA).
NU Nicaragua
NZ New Zealand
PA Paraguay
PC Pitcairn Islands - Formerly Pitcairn (PC).
PE Peru
PF Paracel Islands
PG Spratly Islands
PK Pakistan - Included Bangladesh (BG) prior to June 1974.
PL Poland
PM Panama - Added June 1980; formerly Panama (PN) and Canal Zone (PQ).
PO Portugal
PP Papua New Guinea - Formerly Papua and New Guinea (PP).
PS Palau
PU Guinea-Bissau - Formerly Portuguese Guinea (PU).
QA Qatar
RE Reunion - Included Bassas da India (BS), Europa Island (EU), Glorioso Islands (GO), Juan de Nova Island (JU), and Tromelin Island (TE) prior to May 1983.
RM Marshall Islands - Added February 1987; formerly part of Trust Territory of the Pacific Islands (NQ).
RO Romania
RP Philippines
RQ Puerto Rico
RS Russia - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).
RW Rwanda
SA Saudi Arabia
SB St. Pierre and Miquelon

SC St. Kitts and Nevis - Included Anguilla (AV) prior to June 1974. Formerly St. Christopher and Nevis (SC) and St. Christopher-Nevis-Anguilla (SC).

SE Seychelles

SF South Africa

SG Senegal

SH St. Helena

SI Slovenia - Added August 1992; formerly part of Yugoslavia (YO).

SL Sierra Leone

SM San Marino

SN Singapore

SO Somalia

SP Spain - As of March 1977 includes former Spanish North Africa (ME).

SR Serbia - Added August 1992; formerly part of Yugoslavia (YO).

ST St. Lucia

SU Sudan

SV Svalbard - Deleted March 1977; readded May 1983; see Svalbard and Jan Mayer (JS).

SW Sweden

SX South Georgia and the South Sandwich Islands - Added January 1991; formerly part of Falkland Islands (Islas Malvinas) (FA).

SY Syria

SZ Switzerland

TD Trinidad and Tobago

TE Tromelin Island - Added May 1983; formerly part of Reunion (RE).

TH Thailand

TI Tajikistan - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

TK Turks and Caicos Islands

TL Tokelau

TN Tonga

TO Togo

TP Sao Tome and Principe

TS Tunisia

TT East Timor

TU Turkey

TV Tuvalu - Added April 1976; formerly part of Gilbert and Ellice Islands (GN).

TW Taiwan - Formerly China (Taiwan) (TW) and China, Republic of (TW).

TX Turkmenistan - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

TZ Tanzania, United Republic of - Formerly Tanzania (TZ).

UG Uganda

UK United Kingdom - Included Guernsey (GK), Isle of Man (IM), and Jersey (JE) prior to May 1983.

UP Ukraine - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

UR Union of Soviet Socialist Republics (obsolete value)

US United States

UV Burkina Faso- Formerly Upper Volta (UV).

UY Uruguay

UZ Uzbekistan - Added January 1992; formerly part of Union of Soviet Socialist Republics (UR).

VC St. Vincent and the Grenadines - Formerly St. Vincent (VC).

VE Venezuela
 VI British Virgin Islands
 VM Vietnam - Added August 1976; formerly Viet-nam, North (VN) and Vietnam, Republic of (VS).
 VQ Virgin Islands
 VT Vatican City
 WA Namibia - Formerly South-West Africa (WA).
 WE West Bank
 WF Wallis and Futuna
 WI Western Sahara - Added March 1977; formerly Spanish Sahara (SS).
 WQ Wake Island
 WS Samoa - formerly Western Samoa
 WZ Swaziland
 YM Yemen - Added October 1990; formerly Yemem (Sanaa) (YE) and Yemen (Aden) (YS).
 YO Yugoslavia (obsolete value)
 ZA Zambia
 ZI Zimbabwe - Added May 1980; formerly Southern Rhodesia (RH).

Ingenix Attribute Name: Mailing Address Effective Date

Source Field Name: Mailing Address Effective Calendar Date

Ingenix DW Name: MAIL_ADR_EFF_DT

Data Type: DATE

Description: The date when the person's mailing address became effective.

Entity List:

Mailing Address

Ingenix Attribute Name: Mailing Address Line 1 Text

Source Field Name: Mailing Address Line 1 Text

Ingenix DW Name: MAIL_ADR_LN_1_TXT

Data Type: VARCHAR2(40)

Description: The number and street of the person's mailing address.

Entity List:

Mailing Address

Ingenix Attribute Name: Mailing Address Line 2 Text

Source Field Name: Mailing Address Line 2 Text

Ingenix DW Name: MAIL_ADR_LN_2_TXT

Data Type: VARCHAR2(40)

Description: The text that is supplemental to the number and street of the person's mailing address-for example, the apartment number.

Entity List:

Mailing Address

Ingenix Attribute Name: Mailing Address Maintenance Source Code

Source Field Name: Mailing Address Maintenance Source Code

Ingenix DW Name: MAIL_ADR_MNT_SRC_CD

Data Type: CHAR(3)

Description: The code that represents the source of the last update processed for this mailing address record.

Entity List:

Mailing Address

Mailing Address Maintenance Source

Valid Values:

- 000 All batch sources (used only in processing; not stored)
- 010 All MILPERCENs (used only in processing; not stored)
- 011 Army MILPERCEN
- 012 Air Force MILPERCEN
- 013 Navy MILPERCEN
- 014 Marine Corps MILPERCEN
- 015 Coast Guard MILPERCEN
- 016 Public Health PERCEN
- 017 NOAA PERCEN
- 020 All Finance Centers (used only in processing; not stored)
- 021 Army Retired Finance Center
- 022 Air Force Retired Finance Center
- 023 Navy Retired Finance Center
- 024 Marine Corps Finance Center (Retired)
- 025 Coast Guard Retired Finance Center
- 026 Public Health Finance Center
- 027 NOAA Finance Center
- 030 All Academies (used only in processing; not stored)
- 031 Army Academy
- 032 Air Force Academy
- 033 Navy Academy
- 035 Coast Guard Academy
- 040 All Reserves (used only in processing; not stored)
- 041 Army Reserve
- 042 Air Force Reserve
- 043 Navy Reserve
- 044 Marine Corps Reserve
- 045 Coast Guard Reserve
- 046 Public Health Reserve
- 050 All Guards (used only in processing; not stored)
- 051 Army Guard
- 052 Air Force Guard
- 060 Non-Service maintained populations (used only in processing; not stored)
- 061 Veterans Administration (future)
- 062 Civil Service (future)
- 080 All online sources (used only in processing; not stored)
- 081 Online/RAPIDS
- 082 Project officers
- 083 DEERS Support Office
- 084 Managed Care Support Contractors (MCSCs)
- 085 Composite Health Care System (CHCS)
- 086 Dental Contractor
- 087 USFHP
- 090 All secondary indirect sources (used only in processing; not stored)

- 091 MEPCOM
- 092 Mobilization by UIC or SSN
- 100 Internally generated transactions (used only in processing; not stored)
- 101 Error fix transactions from DEERS Support Office (edit error)
- 102 Error fix transactions from DEERS Support Office (update error)
- 103 Sweep processing
- 104 Repaired or changed by DBSD or DEERS Support Office
- 255 Sponsor-update record (used only in processing; not stored)

Ingenix Attribute Name: Mailing Address Quality Code

Source Field Name: Mailing Address Quality Code

Data Type: CHAR(1)

Ingenix DW Name: MAIL_ADR_QLTY_CD

Description: The code that indicates whether the address standardization software was able to assign a ZIP identifier, ZIP identifier extension, and carrier route during processing.

Notes: This attribute has two purposes: to determine whether an address is reliable enough to be stored in DEERS, and to determine whether to send a certain type of letter to this address. Used in DEERS 3.0 and later only. Formerly Finalist Quality Code.

Entity List:

- Mailing Address
- Mailing Address Quality

Valid Values:

- 0 ZIP Code, ZIP Code extension, and carrier route assigned
- 1 ZIP Code (five-digit only) and carrier route assigned
- 2 ZIP Code (five-digit only) assigned
- 9 The address was not verified or standardized by the address software and may not be a valid mailing address.

Ingenix Attribute Name: Mailing Address State Code

Source Field Name: Mailing Address US Postal Region State Code

Ingenix DW Name: MAIL_ADR_ST_CD

Data Type: CHAR(2)

Description: The code that represents the state of the person's mailing address. Note: The valid values also include the District of Columbia and outlying areas of the United States.

Notes: Valid values also include the District of Columbia and outlying areas of the United States

Entity List:

- Mailing Address

Valid Values:

- See State code

Ingenix Attribute Name: Mailing Address Type Code

Source Field Name: Mailing Address Type Code

Ingenix DW Name: MAIL_ADR_TYP_CD

Data Type: CHAR(1)

Description: The code that represents the type of mailing address such as primary, secondary, work, etc.

Entity List:

- Mailing Address
- Mailing Address Type

Valid Values:

P Primary
 S Secondary
 T Temporary

Ingenix Attribute Name: Mailing Address Zip Code

Source Field Name: Mailing Address US Postal Region Zip Code

Ingenix DW Name: MAIL_ADR_ZIP_CD

Data Type: CHAR(5)

Description: The first five digits of the Zone Improvement Plan (ZIP) Code of a person's mailing address.

Entity List:

Mailing Address

Ingenix Attribute Name: Mailing Address Zip Extension Code

Source Field Name: Mailing Address US Postal Region Zip Extension Code

Ingenix DW Name: MAIL_ADR_ZIP_EXT_CD

Data Type: CHAR(4)

Description: The four digit extension of the Zone Improvement Plan (ZIP) Code of a person's mailing address.

Entity List:

Mailing Address

Ingenix Attribute Name: Major Specialty Code

Source Field Name: Major Spec/Institution Type

Ingenix DW Name: MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code or type of institution where care was provided reported on the encounter.

Entity List:

Provider Specialty

Valid Values:

01 General Practice
 02 General Surgery
 03 Allergy
 04 Otology, Laryngologist, Rhinology
 05 Anesthesiology
 06 Cardiovascular Disease
 07 Dermatology
 08 Family Practice
 10 Gastroenterology
 11 Internal Medicine
 12 Neurology
 14 Neurological Surgery
 16 Obstetrics/Gynecology
 18 Ophthalmology
 19 Oral Surgery (Dentists only)
 20 Orthopedic Surgery
 22 Pathology
 24 Plastic Surgery
 25 Physical Medicine and Rehabilitation
 26 Psychiatry

28 Proctology
29 Pulmonary Diseases
30 Radiology
33 Thoracic Surgery
34 Urology
35 Chiropractor, licensed
36 Nuclear Medicine
37 Pediatrics
38 Geriatrics
39 Nephrology
40 Neonatology
42 Nurses (RN)
43 Nurses (LPN)
44 Occupational Therapy (OTR)
45 Speech Pathologist/Speech Therapist
47 Endocrinology
48 Podiatry - Surgical Chiropody
50 Proctology and Rectal Surgery
51 Medical Supply Co.
57 Certified Prosthetist - Orthoist
59 Ambulance Service Supplier
60 Public Health or Welfare Agencies
61 Voluntary Health or Charitable Agencies
62 Psychologist (Billing Independently)
63 Audiologists (Billing Independently)
65 Physical Therapist (Independent Practice)
69 Independent Laboratory (Billing Independently)
70 Clinic or Other Group Practice
80 Anesthetist
81 Dietitian
82 Education Specialist
83 Nurse, Private Duty
84 Physician's Assistant
85 Social Worker
86 Christian Science
90 Nurse Practitioner
91 Clinical Psychiatric Nurse Specialist
92 Midwife
93 Mental Health Counselor
94 Marriage and Family Counselor
95 Pastoral Counselors
96 Marriage and Family Therapist (valid only for Connecticut, Massachusetts, New Jersey)
97 M.S.W., A.S.W.
98 Optometrist
99 Facility charges - use for facility charges for outpatient services, (e.g., ambulatory surgery, hospital services)
BC Birthing Centers/Rooms
BL Blood Center

DT Dental
EM Emergency Medicine
HA Home Health Care Agency
HH Home Health Aide/Homemaker
HI Home Infusion
HM Hematology
ID Infectious Disease
NT Nutrition
OC Oncology
PH Pharmacist
RN Rheumatology
TS Transportation Services (Private-Owned Vehicle)
*1 Pediatric Ophthalmology
*2 Pediatric Medical Genetics
*3 Medical Genetics
*4 Home Health Infusion RN
*5 Cardiothoracic Surgery
*6 Electroencephalography
*7 Electromyography
*8 Immunology
*9 Surgery Critical Care
*A Reproductive Endocrinology
*B Sports Medicine
*C Clinical Cardiac Electrophysiologist
*D Critical Care Medicine
*F Interventional Cardiologist
*G Occupational Health
*H Clinical Neurophysiologist
*I Osteopathic Manipulative Medicine
*J Gynecologic Oncologist
*K Hand Surgeon
*L Pediatric Cardiologist
*M Pediatric Endocrinologist
*N Pediatric Gastroenterologist
*O Pediatric Hematologist - Oncologist
*P Pediatric Nephrologist
*Q Pediatric Pulmonologist
*R Pediatric Developmental Specialist
*S Electro Diagnostic Medicine
*T Vascular Surgeon

Ingenix Attribute Name: Member Category Code

Source Field Name: Member Category Code

Ingenix DW Name: MBR_CATGY_CD

Data Type: CHAR(1)

Description: Code that represents how DEERS views the sponsor based on his or her entitlements.

Entity List:

Member Category

Person

Valid Values:

- I Transitional Compensation Beneficiaries (formerly abused dependents)
- A Active duty
- B Presidential Appointee
- C DoD civil service employee, except Presidential employee
- D Disabled American veteran
- E DoD contract employee
- F Former member (Reserve service, discharged from the Ready Reserve or Standby Reserve following notification of retirement eligibility)
- G National Guard member (mobilized or on active duty for 31 days or more)
- H Medal of Honor recipient
- I Other Government Agency employee, except Presidential appointee
- J Academy student (does not include Officer Candidate School or Merchant Marine Academy)
- K Non-Appropriated Fund DoD employee
- L Lighthouse service
- M Non-government Agency Personnel
- N National Guard member (not on active duty or on active duty for 30 days or less)
- O Other Government contract employee
- P Transitional Assistance Management Program member
- Q Reserve retiree not yet eligible for retired pay ('gray-area retiree')
- R Retired military member eligible for retired pay
- S Reserve member (mobilized or on active duty for 31 days or more)
- T Foreign military member
- U Foreign national employee (DoD or non-DoD employee)
- V Reserve member (not on active duty or on active duty for 30 days or less)
- W Former Spouse (not to be used for Transitional Compensation Beneficiaries)
- Y Service affiliates (including ROTC and Merchant Marines)
- Z Unknown

Ingenix Attribute Name: National Drug Code Number

Source Field Name: National Drug Code Number

Ingenix DW Name: NAT_DRG_CD_NBR

Data Type: CHAR(11)

Description: Specific national drug code number assigned for the drug, or the default values for the durable medical equipment and compound drugs.

Notes: Do not include dashes

Entity List:

Encounter

National Drug Code Number

Valid Values:

Valid National Drug Code or for Durable Medical Equipment use 5555555551, for
Compounds use 8888888881

Ingenix Attribute Name: National Provider Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: NAT_PROV_ID

Data Type: CHAR(10)

Description: A unique identifier assigned to a provider by the National Provider System (NPS).

Entity List:

Provider

Ingenix Attribute Name: Ordering Physician Unique Provider Identifier

Source Field Name: Ordering Physician

Ingenix DW Name: ORDR_PHYSN_UNIQ_PROV_ID

Data Type: CHAR(18)

Description: Provider who ordered ancillary services, or who referred patient for specialty or inpatient care.

Notes: When reporting Inpatient Professional and Outpatient Professional records, this field should be populated with the unique provider ID number of the provider who ordered the services. When reporting Hospital services, leave blank.

Entity List:

Encounter

Ingenix Attribute Name: Other Government Program Begin Reason Code

Source Field Name: Other Government Program Begin Reason Code

Ingenix DW Name: OGP_BEGN_RSN_CD

Data Type: CHAR(1)

Description: The code that indicates the reason that the person's period of eligibility for a non-DoD Other Government Program began. The begin reason code applies to OGP Type Codes of A or B only.

Entity List:

Other Government Program

Other Government Program Begin Reason

Valid Values:

A Eligible for Medicare. Eligibility began after age 65 (the person did not have enough quarters of Social Security contributions to qualify at age 65). This value applies to Medicare Part A

B Enrollment in Medicare Part B; over or under age 65. Medicare Part B can only be obtained by payment of monthly premiums. This value applies to Medicare Part B.

D Eligible for Medicare under age 65 because of disability. This value applies to Medicare Part A.

E Eligible for Medicare at age 65. This value applies to Medicare Part A.

F Eligibility for Medicare defaulted at age 65; verification not received from Centers for Medicare and Medicaid Services (CMS). Applies to Part A only.

N Not eligible for Medicare. Under age 65 this is the default value. At age 65 this indicates eligibility could not begin because the person did not have enough quarters of Social Security contributions to qualify. This value applies to Medicare Part A.

P Eligible for Medicare at or after age 65 because of purchase. This value applies to Medicare Part A.

R Eligible for Medicare under age 65 because of end-stage renal disease. This value applies to Medicare Part A.

V Eligible for the Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA).

W Not applicable

Ingenix Attribute Name: Other Government Program Effective Date

Source Field Name: Other Government Program Effective Calendar Date

Ingenix DW Name: OGP_EFF_DT

Data Type: DATE

Description: The date on which a person's non-DoD government program coverage became effective.

Entity List:

Other Government Program

Ingenix Attribute Name: Other Government Program Expiration Date

Source Field Name: Other Government Program Expiration Calendar Date

Ingenix DW Name: OGP_EXPIR_DT

Description: The date on which a person's non-DoD government program coverage expires.

Data Type: DATE

Entity List:

Other Government Program

Ingenix Attribute Name: Other Government Program Type Code

Source Field Name: Other Government Program Type Code

Ingenix DW Name: OGP_TYP_CD

Data Type: CHAR(1)

Description: The code representing a non-DoD government program that provides health insurance coverage.

Entity List:

Other Government Program

Other Government Program Type

Valid Values:

A Medicare Part A

B Medicare Part B

H Medicare HMO

V CHAMPVA

Ingenix Attribute Name: Other Health Insurance Begin Date

Source Field Name: OTHER HEALTH INSURANCE (OHI) BEGIN DATE

Ingenix DW Name: OHI_BEGN_DT

Data Type: DATE

Description: Date the OHI policy became effective.

Entity List:

Other Health Insurance

Ingenix Attribute Name: Other Health Insurance Carrier Name

Source Field Name: OTHER HEALTH INSURANCE (OHI) CARRIER NAME

Ingenix DW Name: OHI_CARR_NM

Data Type: VARCHAR2(40)

Description: Company name of the OHI carrier.

Notes: Required, none, unknown, N.A. and NA are not acceptable.

Entity List:

Other Health Insurance

Ingenix Attribute Name: Other Health Insurance Coverage Indicator Type Code

Source Field Name: OTHER HEALTH INSURANCE (OHI) COVERAGE INDICATOR TYPE CODE

Ingenix DW Name: OHI_COV_IND_TYP_CD

Data Type: CHAR(2)

Description: Code that indicates whether the beneficiary has Other Health Insurance (OHI) coverage.

Entity List:

- Other Health Insurance
- Other Health Insurance Coverage Indicator Type

Valid Values:

- C TRICARE Supplement
- GR Group/Employee
- M Medicare/Medicaid Supplement
- NG Non-group (Private)
- SD Student

Ingenix Attribute Name: Other Health Insurance Coverage Type Code

Source Field Name: Other Health Insurance Coverage Type Code

Ingenix DW Name: OHI_COV_TYP_CD

Data Type: CHAR(2)

Description: Code that indicates whether the beneficiary has Other Health Insurance (OHI) coverage (derived).

Entity List:

- Other Health Insurance
- Other Health Insurance Coverage Type

Valid Values:

- A OHI inpatient health coverage
- B OHI outpatient health coverage
- D OHI dental health coverage
- E OHI partial hospitalization coverage
- H OHI mental health coverage
- L OHI long-term care coverage
- M OHI medical coverage
- N OHI skilled nursing care coverage
- P OHI pharmacy coverage (includes mail-order prescription drug coverage)
- V OHI vision coverage

Ingenix Attribute Name: Other Health Insurance Date Received

Source Field Name: OTHER HEALTH INSURANCE (OHI) DATE RECEIVED

Ingenix DW Name: OHI_DT_RECV

Data Type: DATE

Description: Date the DP received the OHI information.

Entity List:

- Other Health Insurance

Ingenix Attribute Name: Other Health Insurance End Date

Source Field Name: OTHER HEALTH INSURANCE (OHI) END DATE

Ingenix DW Name: OHI_END_DT

Data Type: DATE

Description: Date the OHI policy ended or will end.

Entity List:

Other Health Insurance

Ingenix Attribute Name: Other Health Insurance Policy Identifier

Source Field Name: OTHER HEALTH INSURANCE (OHI) POLICY IDENTIFIER

Ingenix DW Name: OHI_POL_ID

Data Type: CHAR(17)

Description: OHI policy number.

Entity List:

Other Health Insurance

Ingenix Attribute Name: Other Health Insurance Status Code

Source Field Name: OTHER HEALTH INSURANCE (OHI) STATUS CODE

Ingenix DW Name: OHI_STS_CD

Data Type: CHAR(1)

Description: Code to indicate status of OHI policy.

Entity List:

Other Health Insurance

Other Health Insurance Status

Valid Values:

A Active

B Inactive

Ingenix Attribute Name: Other Health Insurance Subscriber Name

Source Field Name: OTHER HEALTH INSURANCE (OHI) SUBSCRIBER NAME

Ingenix DW Name: OHI_SBSCR_NM

Data Type: VARCHAR2(40)

Description: Full name of the OHI subscriber.

Notes: Left justify, blank fill. Must begin with last name followed by first name and middle initial each separated with a space.

Entity List:

Other Health Insurance

Ingenix Attribute Name: Other Health Insurance Subscribers Birth Date

Source Field Name: OTHER HEALTH INSURANCE (OHI) SUBSCRIBERÆS DATE OF BIRTH

Ingenix DW Name: OHI_SBSCR_BTH_DT

Data Type: DATE

Description: Date of birth of the OHI subscriber.

Entity List:

Other Health Insurance

Ingenix Attribute Name: Patient Identifier

Source Field Name: Patient Identifier

Ingenix DW Name: PTNT_ID

Data Type: CHAR(10)

Description: Unique identifier associated with a specific individual. This identifier is generated by DEERS and used by all DP systems to uniquely identify an individual.

Notes: Required

Entity List:

Person

Ingenix Attribute Name: Patient PCM Number

Source Field Name: PATIENT'S PCM NUMBER

Ingenix DW Name: PTNT_PCM_NBR

Data Type: CHAR(18)

Description: Identifier that uniquely represents a Primary Care Manager.

Entity List:

Enrollment

Ingenix Attribute Name: Payment Adjustment Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PYMT_ADJ_AMT

Data Type: NUMBER(9,2)

Description: The amount of change from the previous calculation of capitation, regardless of ability to recoup. This amount will be zero unless an adjustment is made to the calculated capitation amount. See also Payment Recoup Amount.

Entity List:

Capitation Payment

Ingenix Attribute Name: Payment Enrollment Month Number

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PYMT_ENRL_MO_NBR

Data Type: NUMBER(2)

Description: The enrollment month number for which the payment was calculated.

Entity List:

Capitation Payment

Valid Values:

1 - 12 (Jan = 1)

Ingenix Attribute Name: Payment Enrollment Year Number

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PYMT_ENRL_YR_NBR

Data Type: NUMBER(4)

Description: The enrollment four digit year for which the payment was calculated.

Entity List:

Capitation Payment

Ingenix Attribute Name: Payment Recipient DMIS Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PYMT_RCIP_DMIS_ID

Data Type: CHAR(4)

Description: The DMIS Identifier of the Designated Provider in which an enrollee is enrolled.

Entity List:

Capitation Payment

Valid Values:

See DMIS Identifier.

Ingenix Attribute Name: Payment Recoup Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PYMT_RCUP_AMT

Data Type: NUMBER(9,2)

Description: The portion of the Payment Adjustment Amount that is recoupable according to the rule defined for Capitation Payment Adjustment Reasons.

Entity List:

Capitation Payment

Ingenix Attribute Name: Person Association Reason Code

Source Field Name: Person Association Reason Code

Ingenix DW Name: PERS_ASSOC_RSN_CD

Data Type: CHAR(2)

Description: The code that represents the underlying basis of an association of one person to another person. For example, a person is a child of another person. This code is used in enrollment to identify the relationship between a beneficiary and sponsor.

Entity List:

Enrollment

Person Association Reason

Valid Values:

AA Spouse

AB Child

AD Parent

AE Parent-in-law

AF Stepchild

AH Step-parent

AI In loco parentis

AX Emergency contact

BB Ward

BC Former spouse (not assignable after RAPIDS 6.3)

BD Self (i.e., the person and other person are the same person). Transaction only – not stored

BE Joint marriage spouse

BF Other health insurance subscriber

BG Pre-adoptive child

CA Member of household headed by sponsor's former spouse (child, stepchild, or ward only)

ZZ Unknown

Ingenix Attribute Name: Person Birth Date

Source Field Name: Person Birth Calendar Date

Ingenix DW Name: PERS_BTH_DT

Data Type: DATE

Description: Date when a person was born.

Entity List:

Person

Ingenix Attribute Name: Person Cadency Name

Source Field Name: Person Cadency Name

Ingenix DW Name: PERS_CDNCY_NM

Data Type: CHAR(4)

Description: Cadency name (e.g., Sr, Jr, III) of the person.

Entity List:

Person

Ingenix Attribute Name: Person Death Date

Source Field Name: Person Death Calendar Date

Ingenix DW Name: PERS_DTH_DT

Data Type: DATE

Description: The date when the person died (if applicable).

Entity List:

Person

Ingenix Attribute Name: Person First Name

Source Field Name: Person First Name

Ingenix DW Name: PERS_FST_NM

Data Type: CHAR(20)

Description: First name of the person.

Entity List:

Person

Ingenix Attribute Name: Person Gender Code

Source Field Name: Person Sex Code

Ingenix DW Name: PERS_GDR_CD

Data Type: CHAR(1)

Description: The code that represents a classification of a person according to the reproductive functions. F, M, or Z for Unknown. For the purpose of cap unknown gender will be paid as male.

Entity List:

Person

Valid Values:

F Female

M Male

Z Unknown

Ingenix Attribute Name: Person Identifier

Source Field Name: Person Identifier

Ingenix DW Name: PERS_ID

Data Type: CHAR(9)

Description: The identifier that represents a human being. This attribute will usually contain the person's Social Security number but may contain an alternate ID as determined by the Person Identifier Type Code.

Entity List:

Person

Ingenix Attribute Name: Person Identifier Type Code

Source Field Name: Person Identifier Type Code

Ingenix DW Name: PERS_ID_TYP_CD

Data Type: CHAR(1)

Description: The code that represents a specific kind of person identifier.

Entity List:

Person

Person Identifier Type

Valid Values:

D Special 9-digit code created for individuals (i.e. babies) who do not have or have not provided an SSN when the

F Special 9-digit code created for foreign military and nationals

I Tax identification number

P Special 9-digit code created for U.S. military personnel from Service Numbers before the switch to Social Security

R Special 9-digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS. The associated

S Social Security Number

T Test (858 series)

Ingenix Attribute Name: Person Last Name

Source Field Name: Person Last Name

Ingenix DW Name: PERS_LST_NM

Description: Last (family) name of the person.

Data Type: CHAR(26)

Entity List:

Person

Ingenix Attribute Name: Person Middle Name

Source Field Name: Person Middle Name

Ingenix DW Name: PERS_MIDL_NM

Data Type: CHAR(20)

Description: Middle name of the person.

Entity List:

Person

Ingenix Attribute Name: Person System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PERS_SYS_ID

Data Type: INTEGER

Description: An Ingenix system generated value uniquely identifying an individual.

Entity List:

- Encounter
- Encounter Standardized Copayment
- Individual Catastrophic Capitation and Deductible
- Mailing Address
- Other Government Program
- Other Health Insurance
- Person

Ingenix Attribute Name: Pharmacy NCPDP Number

Source Field Name: Unique Provider ID Number/Pharmacy NABP Number

Ingenix DW Name: PHRM_NCPDP_NBR

Data Type: CHAR(18)

Description: A pharmacy's National Association of Pharmaceutical Doctors (NAPD) number reported on the encounter.

Entity List:

- Encounter
- Provider

Ingenix Attribute Name: Place of Service Code

Source Field Name: Service 1 Place Of Service

Service 2 Place Of Service

Service 3 Place Of Service

Service 4 Place Of Service

Service 5 Place Of Service

Service 6 Place Of Service

Ingenix DW Name: PL_OF_SRVC_CD

Data Type: CHAR(2)

Description: Code that represents the type of setting in which provider performed the service/procedure.

Notes: Required for both inpatient and outpatient professional services

Entity List:

- Encounter Procedure
- Place of Service

Valid Values:

- 00 Unassigned
- 03 School
- 04 Homeless Shelter
- 05 Indian Health Services FS
- 06 Indian Health Services PB
- 07 Tribal – Free Standing
- 08 Tribal Provider Based
- 11 Office
- 12 Home

15 Mobile Unit
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance - Land
42 Ambulance - Air or Water
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility Partial Hospitalization
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Center
72 Rural Health Clinic
81 Independent Laboratory
90 Pharmacy
99 Other Unlisted Facility

Ingenix Attribute Name: PNT Transaction Type Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PNT_TRANS_TYP_CD

Data Type: CHAR(1)

Description: An Ingenix generated code identifying the type of change in enrollment that an incoming PNT represents.

Entity List:

Enrollment
PNT Transaction Type

Valid Values:

D Disenrollment
E Enrollment
T Transfer
U Update

Ingenix Attribute Name: Policy Priority Code

Source Field Name: POLICY PRIORITY CODE

Ingenix DW Name: POL_PRR_CD

Data Type: CHAR(1)

Description: Code indicating the priority of the policy in payment of claims or services.

Notes: Required, cannot be blank, if beneficiary has OHI

Entity List:

- Other Health Insurance
- Policy Priority

Valid Values:

- 1 Primary
- 2 Secondary
- 3 Tertiary

Ingenix Attribute Name: Primary Care Manager Enrolling Division DMIS Identifier

Source Field Name: Primary Care Manager Enrolling Division DMIS Identifier

Ingenix DW Name: PCM_ENRL_DIV_DMIS_ID

Data Type: CHAR(4)

Description: DMIS identifier, of the enrolling division, with whom the Primary Care Manager is affiliated.

Entity List:

- Enrollment

Valid Values:

- See DMIS Identifier.

Ingenix Attribute Name: Primary Care Manager Identifier

Source Field Name: Primary Care Manager Identifier

Ingenix DW Name: PCM_ID

Data Type: CHAR(32)

Description: The identifier that uniquely represents a Primary Care Manager.

Notes: A corresponding entry must be submitted on the monthly provider data submission.

Entity List:

- Enrollment

Ingenix Attribute Name: Primary Care Manager Identifier Type Code

Source Field Name: Primary Care Manager Identifier Type Code

Ingenix DW Name: PCM_ID_TYP_CD

Data Type: CHAR(1)

Description: The code that specifies what type of identifier is being used to uniquely identify a Primary Care Manager.

Entity List:

- Enrollment

Valid Values:

- C Managed Care Support Care Contractor (MCSC) internal provider identifier
- D Drug Enforcement Agency (DEA) Number (used by pharmacists)
- E DoD Electronic Data Interchange Person Identifier
- H Health Insurance Portability and Accountability Act (HIPPA) provider identifier
- L Legacy Value
- P CHCS created Pseudo PCM Identifier

S Social Security Number

T Tax Identifier

Ingenix Attribute Name: Primary Care Manager Network Provider Type Code

Source Field Name: Primary Care Manager Network Provider Type Code

Ingenix DW Name: PCM_NTWK_PROV_TYP_CD

Data Type: CHAR(1)

Description: The code identifying the type of network provider.

Entity List:

Enrollment

Valid Values:

C Civilian Network

D Direct Care Network

N None

U Uniformed Services Family Health Plan (USFHP)

Z Not Applicable

Ingenix Attribute Name: Primary Care Manager Plan Status Code

Source Field Name: Primary Care Manager Plan Status Code

Ingenix DW Name: PCM_PLN_STS_CD

Data Type: CHAR(1)

Description: The code that indicates the status of the plan for the Primary Care Manager selected.

Entity List:

Enrollment

Valid Values:

E Enrolled, active

P Pending, not active

N Enrolled, active – no action taken by USFHP

Ingenix Attribute Name: Primary Care Manager Plan Status Date

Source Field Name: Primary Care Manager Plan Status Date

Ingenix DW Name: PCM_PLN_STS_DT

Data Type: DATE

Description: The date that corresponds to the Primary Care Manger Plan Status Code.

Entity List:

Enrollment

Ingenix Attribute Name: Primary Care Manager Region Code

Source Field Name: Primary Care Manager Region Code

Ingenix DW Name: PCM_RGN_CD

Data Type: CHAR(2)

Description: Code that represents the geographic region of a medical care provider in the Military Health System.

Entity List:

Enrollment

Valid Values:

00 No Region

01 TRICARE Northeast

- 02 TRICARE Mid-Atlantic
- 03 TRICARE Southeast
- 04 TRICARE Gulf South
- 05 TRICARE Heartland
- 06 TRICARE Southwest
- 07 TRICARE Central
- 08 TRICARE Central
- 09 TRICARE Southern California
- 10 TRICARE Golden Gate
- 11 TRICARE Northwest
- 12 TRICARE Hawaii
- 13 TRICARE Europe
- 14 TRICARE Pacific
- 15 Prime Latin America/Canada
- 17 TRICARE North
- 18 TRICARE South
- 19 TRICARE West

Ingenix Attribute Name: Primary Care Manager Selection Begin Date

Source Field Name: Primary Care Manager Selection Begin Calendar Date

Ingenix DW Name: PCM_SEL_BEGN_DT

Data Type: DATE

Description: Date when a beneficiary begins with a Primary Care Manager.

Entity List:

- Enrollment

Ingenix Attribute Name: Primary Care Manager Selection End Date

Source Field Name: Primary Care Manager Selection End Calendar Date

Ingenix DW Name: PCM_SEL_END_DT

Data Type: DATE

Description: Ending date [projected or actual] for the insured with a particular Primary Care Manager.

Entity List:

- Enrollment

Ingenix Attribute Name: Primary Care Manager Selection End Reason Code

Source Field Name: Primary Care Manager Selection End Reason Code

Ingenix DW Name: PCM_SEL_END_RSN_CD

Data Type: CHAR(1)

Description: The code that represents the reason the selection of a Primary Care Manager ended or will end.

Entity List:

- Enrollment

Valid Values:

- 4 Cancellation – record retained
- 6 PCM change due to contract transition
- B Panel Reassignment of PCM
- C Disenrollment
- E Cancellation – record removed

F Invalid entry
 H Permanent Change of Station (PCS)
 I Relocation
 M Loss of eligibility for Health Care Delivery Program (HCDP)
 P Dissatisfied with Primary Care Manager
 Q The date is certain (projected end of eligibility)
 S Loss of eligibility
 T Transfer of enrollment
 U No date can be predicted

Ingenix Attribute Name: Primary Care Manager Selection Preference Text

Source Field Name: PRIMARY CARE MANAGER SELECTION PREFERENCE TEXT

Ingenix DW Name: PCM_SEL_PREF_TXT

Data Type: VARCHAR2(80)

Description: The text information that indicates a beneficiary's preference for a Primary Care Manager selection.

Notes: Informational only

Entity List:

Enrollment

Ingenix Attribute Name: Prior Enrollment Management Contractor Enrollment End Reason Code

Source Field Name: Prior Enrollment Management Contractor Enrollment End Reason Code

Ingenix DW Name: PRR_EM_C_ENRL_END_RSN_CD

Data Type: CHAR(1)

Description: The code that represents the reason an enrollment with an enrollment management contractor ended or will end.

Entity List:

Enrollment

Valid Values:

1 Insufficient initial payment-record retained
 2 No initial payment-record retained
 3 Bounced check-record retained
 4 Cancellation-record retained
 5 Disenrollment because person has other health insurance
 6 Termination due to contract transition
 7 Loss of eligibility for this coverage due to personnel action
 8 Loss of eligibility for this coverage due to change in family association
 9 Loss of eligibility for this coverage due to change in personal health care coverage
 A Failure to maintain Medicare Part B
 B Failure to comply with program requirements, or disruptive behavior
 C Termination of mid-month enrollment
 D Loss of eligibility for this coverage due to death
 E Cancellation-record removed
 F Invalid entry
 G Duty station change to health care facility/clinic area
 H Permanent Change of Station (PCS)
 I Relocation
 J Moved outside of service area (OCONUS for dental)
 K Change of coverage plan within health care delivery program

L Enrolled in another health care delivery program
 M Loss of eligibility for current health care delivery program
 N Voluntary disenrollment by sponsor
 O Voluntary disenrollment by beneficiary
 P Dissatisfied with program
 Q The date is certain (Projected end of eligibility)
 S Loss of eligibility
 T Transfer of enrollment
 U No end date can be predicted
 V Not in a valid pay status (as determined by contractor)
 X Disenrollment for unknown reasons (historical)
 Y Failure to pay enrollment fees/premium
 Z Termination of mid-month enrollment

Ingenix Attribute Name: Prior Enrollment Management Contractor Enrollment Extended Reason Code

Source Field Name: Enrollment Management Contractor Enrollment Extended Reason Code

Ingenix DW Name: PRR EMC ENRL EXT RSN CD

Data Type: CHAR(2)

Description: This field will be populated if the Enrollment Management Contractor Enrollment End Reason Code = 'X'.

Entity List:

Enrollment

Ingenix Attribute Name: Prior Primary Care Manager Selection End Reason Code

Source Field Name: Prior Primary Care Manager Selection End Reason Code

Ingenix DW Name: PRR_PCM_SEL_END_RSN_CD

Data Type: CHAR(1)

Description: The code that represents the reason the selection of a Primary Care Manager in a prior segment ended or will end.

Entity List:

Enrollment

Valid Values:

4 Cancellation – record retained
 9 End of inquiry period (transactions only)
 B Panel Reassignment of PCM
 C Disenrollment
 E Cancellation – record removed
 F Invalid entry
 H Permanent change of station (PCS) of Primary Care Manager (PCM)
 I Relocation
 K Change of coverage plan within Health Care Delivery Program
 L Enrollment in another health care delivery program
 M Loss of eligibility for current Health Care Delivery Program (HCDP)
 P Dissatisfied with Primary Care Manager
 Q This date is estimated (projected end of eligibility)
 S Loss of eligibility
 T Transfer of enrollment
 U No end date can be predicted
 V Not in a valid pay status (as determined by contractor)

- X Disenrollment for unknown reasons (historical)
- Y Failure to pay enrollment fees/premium
- Z Termination of mid-month enrollment

Ingenix Attribute Name: Procedure Code

Source Field Name: Service 1 Procedure Code
 Service 2 Procedure Code
 Service 3 Procedure Code
 Service 4 Procedure Code
 Service 5 Procedure Code
 Service 6 Procedure Code
 Hospital Service Patient Principal Procedure
 Hospital Service Patient Procedure 2
 Hospital Service Patient Procedure 3
 Hospital Service Patient Procedure 4
 Hospital Service Patient Procedure 5
 Hospital Service Patient Procedure 6

Ingenix DW Name: PROC_CD

Data Type: CHAR(13)

Description: CPT or HCPCS code describing the service and/or procedure performed.

Notes: Left justify, blank fill. Use ZZZZZs when no procedures have been performed for this encounter. Required for both inpatient and outpatient professional services.

Entity List:

- Encounter Procedure
- Procedure Code

Valid Values:

- See official CPT4, HCPC, or ICD-9 codes.
- See DP Secure Website (Download Center) for the latest codes.

Ingenix Attribute Name: Procedure Code Set Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PROC_CD_SET_CD

Data Type: CHAR(8)

Description: A code identifying the code set to which a particular diagnosis or procedure code belongs.

Entity List:

- Encounter Procedure
- Procedure Code

Valid Values:

See Code Set Code.

Ingenix Attribute Name: Procedure Line Number

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: PROC_LN_NBR

Data Type: NUMBER(2)

Description: Procedure (service) line number on the encounter where this procedure code appeared.

- Entity List:
- Encounter Procedure

Ingenix Attribute Name: Provider Accreditation Indicator

Source Field Name: Provider Accreditation Indicator

Ingenix DW Name: PROV_ACCRDT_IND

Data Type: CHAR(1)

Description: Code that indicates if the provider is accredited.

Entity List:

Provider

Ingenix Attribute Name: Provider Affiliation Code

Source Field Name: Provider Affiliation Code

Ingenix DW Name: PROV_AFFIL_CD

Data Type: CHAR(1)

Description: Code to indicate the affiliation of provider/pharmacy to DP entity.

Entity List:

Provider

Provider Affiliation

Valid Values:

Required on all provider submissions from the Designated Provider

C Contracted

S Staff

O Other

Ingenix Attribute Name: Provider Assignment Remarks Text

Source Field Name: Provider Assignment Remarks Text

Ingenix DW Name: PROV_ASGN_RMRK_TXT

Data Type: VARCHAR2(80)

Description: Remarks about the assignment of a provider.

Entity List:

Provider

Ingenix Attribute Name: Provider City Name

Source Field Name: Provider City

Data Type: CHAR(20)

Ingenix DW Name: PROV_CTY_NM

Description: City where provider/pharmacy is located.

Entity List:

Provider

Ingenix Attribute Name: Provider Entity Tax Identifier

Source Field Name: Tax ID of Provider Entity

Ingenix DW Name: PROV_ENTY_TAX_ID

Data Type: CHAR(9)

Description: Provider's Tax ID number for the individual/group responsible for the service provided. Use clinic's Tax ID when care is provided in a clinic setting, physician's Tax ID if care is provided in a non-clinic setting, or pharmacy's Tax ID for pharmacies.

Entity List:

Provider

Ingenix Attribute Name: Provider Full Name

Source Field Name: Provider Full Name

Data Type: VARCHAR2(40)

Ingenix DW Name: PROV_FULL_NM

Description: Full name of provider/pharmacy.

Notes: Do not include professional titles as part of the provider's name

Entity List:

Provider

Ingenix Attribute Name: Provider Gender Code

Source Field Name: Provider Gender Code

Ingenix DW Name: PROV_GDR_CD

Data Type: CHAR(1)

Description: Code to indicate the gender of provider.

Entity List:

Provider

Valid Values:

F Female

M Male

Z Unknown

Ingenix Attribute Name: Provider Group Name

Source Field Name: Provider Group Name

Ingenix DW Name: PROV_GRP_NM

Data Type: VARCHAR2(40)

Description: Group name of the provider.

Entity List:

Provider

Ingenix Attribute Name: Provider License Identifier

Source Field Name: Provider License Identifier

Ingenix DW Name: PROV_LIC_ID

Data Type: CHAR(24)

Description: Provider's license number.

Notes: If not available, use five (5) 9's. Left justify, blank fill.

Entity List:

Provider

Ingenix Attribute Name: Provider Location Begin Date

Source Field Name: Provider Location Begin Date

Ingenix DW Name: PROV_LOC_BEGN_DT

Data Type: DATE

Description: Date the provider began providing services for the DP.

Notes: Required for network provider only If not known, use first day of contract

Entity List:

Provider

Ingenix Attribute Name: Provider Location End Date

Source Field Name: Provider Location End Date

Ingenix DW Name: PROV_LOC_END_DT

Data Type: DATE

Description: Date the provider terminated providing services for the DP or the end of the DP contract.

Notes: Default date is end of DP contract, e.g., May 31, 2008

Entity List:

Provider

Ingenix Attribute Name: Provider State Code

Source Field Name: Provider State

Ingenix DW Name: PROV_ST_CD

Data Type: CHAR(2)

Description: The two character postal abbreviation for a provider's state. Note: The valid values also include the District of Columbia and outlying areas of the United States.

Entity List:

Provider

Valid Values:

See State Code.

Ingenix Attribute Name: Provider Street Address Text

Source Field Name: Provider Street Address

Ingenix DW Name: PROV_STR_ADR_TXT

Data Type: VARCHAR2(40)

Description: Street address where provider/pharmacy is located.

Entity List:

Provider

Ingenix Attribute Name: Provider Telephone Number

Source Field Name: Provider Telephone Number

Ingenix DW Name: PROV_TEL_NBR

Data Type: CHAR(14)

Description: Telephone number of the provider.

Entity List:

Provider

Ingenix Attribute Name: Provider Type Code

Source Field Name: Provider Type Code

Ingenix DW Name: PROV_TYP_CD

Data Type: CHAR(1)

Description: Code to indicate whether the provider is a network or non-network provider.

Entity List:

Provider

Provider Type

Valid Values:

C Civilian network

D Direct Care network
 N None
 U Uniformed Services Family Health Plan (USFHP)

Ingenix Attribute Name: Provider Zip Code

Source Field Name: Provider Zip Code

Ingenix DW Name: PROV_ZIP_CD

Data Type: CHAR(9)

Description: Zip code of provider/pharmacy providing service.

Notes: Electronic Funds Transfer justify. Include the zip code extension if known. If OC (Out of Country) file will be validated to ensure a zip code is entered

Valid Values:

United States: 006010000-999509999; Outside United States or Unknown: 123456789

Entity List:

Provider

Ingenix Attribute Name: Quantity Dispensed Number

Source Field Name: Quantity Dispensed

Ingenix DW Name: QTY_DSPNSD_NBR

Data Type: DECIMAL(6,2)

Description: Drug quantity the patient physically received, not the amount prescribed by the physician.

Notes: A decimal point is an acceptable character

Entity List:

Encounter

Ingenix Attribute Name: Rank Code

Source Field Name: Sponsor Rank Code

Ingenix DW Name: RNK_CD

Data Type: CHAR(6)

Description: The code that represents the sponsor's rank

Entity List:

Person

Rank

Valid Values:

1LT First Lieutenant

1SG First Sergeant

1ST First Lieutenant

1ST First Sergeant

1ST First Lieutenant

2LT Second Lieutenant

2ND LT Second Lieutenant

2NDLT Second Lieutenant

A1C Airman First Class

AB Airman Basic

AC Aircraftsman

ACMSHL Air Chief Marshal

ACOMDR Air Commodore

ADM Admiral
AMN Airman
AMSHL Air Marshal
AOC Aviation Officer Candidate
AVM Air Vice Marshal
BG Brigadier General
BGEN Brigadier General
BRIG Brigadier
CADET Cadet
CAPT Captain
CDR Commander
CMDR Commodore
CMSAF Chief Master Sergeant of the Air Force
CMSGT Chief Master Sergeant
COL Colonel
CPL Corporal
CPO Chief Petty Officer
CPT Captain
CSGT Colour Sergeant
CSM Command Sergeant Major
CW02 Chief Warrant Officer
CW0-2 Chief Warrant Officer
CW03 Chief Warrant Officer
CW0-3 Chief Warrant Officer
CW04 Chief Warrant Officer
CW0-4 Chief Warrant Officer
CW05 Chief Warrant Officer
CW0-5 Chief Warrant Officer
CW2 Chief Warrant Officer
CW3 Chief Warrant Officer
CW4 Chief Warrant Officer
CW5 Chief Warrant Officer
CWO-2 Chief Warrant Officer
CWO-3 Chief Warrant Officer
CWO-4 Chief Warrant Officer
CWO-5 Chief Warrant Officer
ENS Ensign
FLGOFF Flying Officer
FLTLT Flight Lieutenant
FLTSGT Flight Sergeant
GEN General
GPCAPT Group Captain
GYSGT Gunnery Sergeant
LAC Leading Aircraftsman
LCDR Lieutenant Commander
LCPL Lance Corporal
LH Leading Hand

LT Lieutenant
LTC Lieutenant Colonel
LTCDR Lieutenant Commander
LTCOL Lieutenant Colonel
LTG Lieutenant General
LTGEN Lieutenant General
LTJG Lieutenant Junior Grade
MAJ Major
MAJGEN Major General
MCPO Master Chief Petty Officer
MCPOCG Master Chief Petty Officer of the Coast Guard
MCPON Master Chief Petty Officer of the Navy
MG Major General
MGYSGT Master Gunnery Sergeant
MIDSHP Midshipman
MSG Master Sergeant
MSGT Master Sergeant
OC Officer Candidate
ORD Ordinary
PFC Private First Class
PLC Platoon Leaders Class
PLTOFF Pilot Officer
PO Petty Officer
PO1 Petty Officer First Class
PO2 Petty Officer Second Class
PO3 Petty Officer Third Class
PSG Platoon Sergeant
PTE Private
PV1 Private (no insignia)
PV2 Private
PVT Private (no insignia)
RADM Rear Admiral
ROTC Reserve Officer Training Corps
SA Seaman Apprentice
SAC Senior Aircraftsman
SCPO Senior Chief Petty Officer
SFC Sergeant First Class
SGM Sergeant Major
SGNLDR Squadron Leader
SGT Sergeant
SGTMAJ Sergeant Major
SLT Sub Lieutenant
SMA Sergeant Major of the Army
SMOFMC Sergeant Major of the Marine Corps
SMSGT Senior Master Sergeant
SN Seaman
SP4 Specialist 4

SP5 Specialist 5
 SP6 Specialist 6
 SPC Specialist
 SR Seaman Recruit
 SRA Senior Airman
 SSG Staff Sergeant (obsolete)
 SSGT Staff Sergeant
 TSGT Technical Sergeant
 VADM Vice Admiral
 W01 Warrant Officer
 W02 Warrant Officer Class 2
 WGCDR Wing Commander
 WO Warrant Officer
 WO1 Warrant Officer Class 1
 WO-1 Warrant Officer
 WO2 Warrant Officer Class 2

Ingenix Attribute Name: Recoupable Reason Indicator

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: RCUPABL_RSN_IND

Data Type: CHAR(1)

Description: An indicator that is set when a recuperation of capitation payments is allowed for this reason code.

Entity List:

Capitation Payment Adjustment Reason

Ingenix Attribute Name: Related Admission Date

Source Field Name: Date of Related Admission

Ingenix DW Name: REL_ADMIS_DT

Data Type: DATE

Description: Date of admission for inpatient hospital care related to professional services.

Notes: Required for Inpatient and Professional services only

Entity List:

Encounter

Ingenix Attribute Name: Related Diagnosis Code

Source Field Name: Service 1 Related Diagnosis Code

Service 2 Related Diagnosis Code

Service 3 Related Diagnosis Code

Service 4 Related Diagnosis Code

Service 5 Related Diagnosis Code

Service 6 Related Diagnosis Code

Ingenix DW Name: REL_DIAG_CD

Data Type: CHAR(7)

Description: ICD-9-CM code identifying a diagnosis that affects the care, management, or treatment provided during an inpatient or outpatient encounter.

Notes: Required for both inpatient and outpatient professional services. The decimal point is not coded.

Entity List:

Encounter Procedure

Valid Values:

ICD-9-CM diagnosis code that is valid for date of service. Left justify, blank fill.

Do not code the decimal point.

See Data Reporting Specifications Section II (1) c for details on code "grace period."

Ingenix Attribute Name: Related Diagnosis Code Set Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: REL_DIAG_CD_SET_CD

Data Type: CHAR(8)

Description: A code identifying the code set to which a particular diagnosis or procedure code belongs.

Entity List:

Encounter Procedure

Valid Values:

See Code Set Code.

Ingenix Attribute Name: Related Disposition Date

Source Field Name: Date of Related Disposition

Ingenix DW Name: REL_DISP_DT

Data Type: DATE

Description: Date of disposition for inpatient hospital care related to professional services.

Notes: Required for Inpatient and Professional services only.

Entity List:

Encounter

Ingenix Attribute Name: Remote Enrollee Assignment Indicator

Source Field Name: Remote Enrollee Assignment Indicator Code

Ingenix DW Name: RMOT_ENRLEE_ASGN_IND

Data Type: CHAR(1)

Description: Code that represents whether a Primary Care Manager can be assigned to a beneficiary enrolled in a TRICARE remote coverage plan.

Entity List:

Provider

Ingenix Attribute Name: Reported Copayment Amount

Source Field Name: Co-Payment Amount Collected

Ingenix DW Name: RPT_COPAY_AMT

Data Type: NUMBER(9,2)

Description: Money collected from the beneficiary or family unit for an episode of care. This value is "Reported" due to the differences in the source processing system.

Notes: This field is interpreted differently by each DP and should not be used for calculations. Use Total Copayment Amount in the Encounter Standardized Payment table instead.

Entity List:

Encounter

Ingenix Attribute Name: Reported DEERS Beneficiary Identifier

Source Field Name: DEERS Beneficiary Identifier

Ingenix DW Name: RPT_DEERS_BENFY_ID

Data Type: CHAR(2)

Description: The identifier that, along with DEERS Family Identifier, uniquely identifies a family member for the purposes of DoD benefits. This field is "Reported" because the Patient ID/Sponsor SSN combination is used on Designated Provider feeds to identify persons.

Entity List:

Encounter

Valid Values:

00 Sponsor

01-99 Dependents

Ingenix Attribute Name: Reported DEERS Family Identifier

Source Field Name: DEERS Family Identifier

Ingenix DW Name: RPT_DEERS_FAM_ID

Data Type: CHAR(9)

Description: The identifier that uniquely identifies a family for the purposes of DoD benefits. This field is "Reported" because the Patient ID/Sponsor SSN combination is used on Designated Provider feeds to identify persons.

Notes: Assigned by DEERS

Entity List:

Encounter

Ingenix Attribute Name: Reported Institution Type Code

Source Field Name: Major Spec/Institution Type

Ingenix DW Name: RPT_INST_TYP_CD

Data Type: CHAR(2)

Description: Code identifying the type of institution providing care on an institutional encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Legacy DEERS Dependent Suffix Number

Source Field Name: Legacy DEERS Dependent Suffix

Ingenix DW Name: RPT_LGCY_DEERS_DEPN_SUFN_NBR

Data Type: CHAR(2)

Description: Suffix assigned and maintained by Legacy DEERS. Field is no longer used.

Entity List:

Encounter

Valid Values:

Legacy Values

00 Conditionally enrolled (applies only to the Designated Providers)

01-19 Dependent children of sponsor

20 Sponsor

30-39 Spouse of sponsor

40-44 Mother of sponsor

45-49 Father of sponsor

50-54 Mother-in-law of sponsor

55-59 Father-in-law of sponsor

60-69 Other dependents

99 Other or unknown relationship

Ingenix Attribute Name: Reported Major Specialty Code

Source Field Name: Major Spec/Institution Type

Ingenix DW Name: RPT_MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient Birth Date

Source Field Name: Patient's Date of Birth

Ingenix DW Name: RPT_PTNT_BTH_DT

Data Type: DATE

Description: Beneficiary's date of birth reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient Cadency Name

Source Field Name: Patient's Cadency Name

Ingenix DW Name: RPT_PTNT_CDNCY_NM

Data Type: CHAR(4)

Description: Cadency name (e.g., Sr, Jr, III) of the beneficiary reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient First Name

Source Field Name: Patient's First Name

Ingenix DW Name: RPT_PTNT_FST_NM

Data Type: CHAR(20)

Description: First name of patient reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient Gender Code

Source Field Name: Patient's Gender

Ingenix DW Name: RPT_PTNT_GDR_CD

Data Type: CHAR(1)

Description: Code to indicate the gender of the patient reported on the encounter.

Entity List:

Encounter

Valid Values:

Gender Code

Ingenix Attribute Name: Reported Patient Identifier

Source Field Name: Patient Identifier

Ingenix DW Name: RPT_PTNT_ID

Data Type: CHAR(10)

Description: The identifier associated with a particular patient. This value is "Reported" since Patient ID Changes (PIDs) could have been processed for the patient since processing this encounter. For reporting purposes Patient Identifier on the Person table will be used.

Notes: Required

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient Last Name

Source Field Name: Patient's Last Name

Ingenix DW Name: RPT_PTNT_LST_NM

Data Type: CHAR(26)

Description: Last name of patient reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient Middle Name

Source Field Name: Patient's Middle Name

Ingenix DW Name: RPT_PTNT_MIDL_NM

Data Type: CHAR(20)

Description: Middle name of patient reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Patient Zip Code

Source Field Name: Patient's Zip Code

Ingenix DW Name: RPT_PTNT_ZIP_CD

Data Type: CHAR(5)

Description: US resident zip code reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Reported Provider Entity Tax Identifier

Source Field Name: Tax ID of Provider Entity

Ingenix DW Name: RPT_PROV_ENTY_TAX_ID

Data Type: CHAR(9)

Description: Provider's Tax ID number reported on the encounter for the individual/group responsible for the service provided. Use clinic's Tax ID when care is provided in a clinic setting, physician's Tax ID if care is provided in a non-clinic setting, or pharmacy's Tax ID for pharmacies.

Entity List:

Encounter

Ingenix Attribute Name: Reported Provider Zip Code

Source Field Name: Provider Zip Code

Ingenix DW Name: RPT_PROV_ZIP_CD

Data Type: CHAR(9)

Description: Zip code of provider/pharmacy providing service reported on the encounter.

Notes: Electronic Funds Transfer justify. Include the zip code extension if known. If OC (Out of Country) file will be validated to ensure a zip code is entered

Entity List:

Encounter

Valid Values:

United States: 006010000-999509999; Outside United States or Unknown: 123456789

Ingenix Attribute Name: Reported Sponsor SSN

Source Field Name: Sponsor Social Security Number (SSN)

Ingenix DW Name: RPT_SPSR_SSN

Data Type: CHAR(9)

Description: Social Security number of beneficiary's sponsor reported on the encounter.

Entity List:

Encounter

Ingenix Attribute Name: Second Major Specialty Code

Source Field Name: 2nd Major Specialty

Ingenix DW Name: SEC_MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code or type of institution where care was provided reported on the encounter.

Notes: Required for non-institutional providers who have more than one major specialty

Entity List:

Provider

Valid Values:

For valid values, see Major Specialty

Ingenix Attribute Name: Service Branch Classification Code

Source Field Name: Service Branch Classification Code

Ingenix DW Name: SRVC_BR_CLSS_CD

Data Type: CHAR(1)

Description: Code that represents the branch of service classification with which the sponsor is affiliated.

Entity List:

Person

Rank

Valid Values:

NED Values

A Army

C Coast Guard

D Office of the Secretary of Defense

F Air Force

H The Commissioned Corps of the Public Health Service

M Marine Corps

N Navy

O The Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA)

X Not Applicable

1 Foreign Army

2 Foreign Navy

3 Foreign Marine Corps

4 Foreign Air Force

Ingenix Attribute Name: Service End Date

Source Field Name: Service 1 End Date
Service 2 End Date
Service 3 End Date
Service 4 End Date
Service 5 End Date
Service 6 End Date

Ingenix DW Name: SRVC_END_DT

Data Type: DATE

Description: Last date the provider provided service for this encounter.

Notes: Required for both inpatient and outpatient professional services.

Entity List:

Encounter Procedure

Ingenix Attribute Name: Service Quantity

Source Field Name: Service 1 Quantity
Service 2 Quantity
Service 3 Quantity
Service 4 Quantity
Service 5 Quantity
Service 6 Quantity

Data Type: NUMBER(3)

Ingenix DW Name: SRVC_QTY

Description: Number of days or units, most commonly used for multiple visits, units of supplies, anesthesia units, or oxygen volume.

Entity List:

Encounter Procedure

Ingenix Attribute Name: Service Start Date

Source Field Name: Service 1 Start Date
Service 2 Start Date
Service 3 Start Date
Service 4 Start Date
Service 5 Start Date
Service 6 Start Date

Ingenix DW Name: SRVC_STRT_DT

Data Type: DATE

Description: Start date the provider provided service for this encounter.

Notes: CCYYMMDD format. Required for both inpatient and outpatient professional services.

Entity List:

Encounter Procedure

Ingenix Attribute Name: Sponsor Enrollment Management Contractor Enrollment Residence Zip Code

Source Field Name: Sponsor Enrollment Management Contractor Enrollment Residence Mailing Address US Postal Region ZIP Code

Ingenix DW Name: SPSR_EM_C_ENRL_RES_ZIP_CD

Data Type: CHAR(5)

Description: The ZIP code of the residence mailing address of the enrollee's sponsor with the contractor.

Entity List:

Enrollment

Ingenix Attribute Name: Sponsor Person System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: SPSR_PERS_SYS_ID

Data Type: INTEGER

Description: The Ingenix system generated value uniquely identifying the family sponsor.

Entity List:

Family

Ingenix Attribute Name: Sponsor SSN

Source Field Name: Sponsor Social Security Number (SSN)

Ingenix DW Name: SPSR_SSN

Data Type: CHAR(9)

Description: Social Security number of beneficiary's sponsor.

Entity List:

Enrollment Fee Collection

Ingenix Attribute Name: State Code

Source Field Name: Industry Standard Values

Ingenix DW Name: ST_CD

Data Type: CHAR(2)

Description: The two character postal abbreviation for a state. Note: The valid values also include the District of Columbia and outlying areas of the United States.

Entity List:

State

Valid Values:

AA APO/FPO

AE APO/FPO (New York)

AK Alaska

AL Alabama

AP APO/FPO (San Francisco)

AR Arkansas

AS American Samoa

AZ Arizona

CA California

CO Colorado

CT Connecticut

DC District of Columbia

DE Delaware

FL Florida

FM Federated State of Micronesia
GA Georgia
GU Guam
HI Hawaii
IA Iowa
ID Idaho
IL Illinois
IN Indiana
KS Kansas
KY Kentucky
LA Louisiana
MA Massachusetts
MD Maryland
ME Maine
MH Marshall Islands
MI Michigan
MN Minnesota
MO Missouri
MP North Mariana Islands
MS Mississippi
MT Montana
NC North Carolina
ND North Dakota
NE Nebraska
NH New Hampshire
NJ New Jersey
NM New Mexico
NV Nevada
NY New York
OC Out of the Country (Out of Continental USA)
OH Ohio
OK Oklahoma
OR Oregon
PA Pennsylvania
PR Puerto Rico
PW Palau
RI Rhode Island
SC South Carolina
SD South Dakota
TN Tennessee
TX Texas
UM US minor outlying islands, (Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingdom Reef, Midway Island)
UT Utah
VA Virginia
VI Virgin Islands
VT Vermont

WA Washington
WI Wisconsin
WV West Virginia
WY Wyoming

Ingenix Attribute Name: Submission Period

Source Field Name: DP Source File Header

Ingenix DW Name: ADDL_ATTRIB

Data Type: CHAR(6)

Description: Month and year the data is submitted. Appears on submission file header.

Entity List:

Ingenix Attribute Name: Subscriber Legacy DEERS Dependent Suffix Number

Source Field Name: Subscriber Legacy DEERS Dependent Suffix

Ingenix DW Name: SBSCR_LGCY_DEERS_DEPN_SUFEX_NBR

Data Type: CHAR(2)

Description: Suffix assigned and maintained by Legacy DEERS for the sponsor.

Entity List:

Enrollment Fee Collection

Valid Values:

See Legacy DEERS Dependent Suffix

Ingenix Attribute Name: Subscriber Patient ID

Source Field Name: Patient Identifier

Ingenix DW Name: SBSCR_PTNT_ID

Data Type: CHAR(10)

Description: The Patient ID of the subscriber. The subscriber is the highest ranking (according to the provided hierarchy) enrolled family member.

Notes: Required

Entity List:

Enrollment Fee Collection

Ingenix Attribute Name: Subscriber Person System Identifier

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: SBSCR_PERS_SYS_ID

Data Type: INTEGER

Description: The Ingenix system generated value uniquely identifying the beneficiary who, according to the provided hierarchy, is the highest ranking enrolled family member.

Entity List:

Family

Ingenix Attribute Name: Third Major Specialty Code

Source Field Name: 3rd Major Specialty

Ingenix DW Name: THRD_MAJ_SPCL_CD

Data Type: CHAR(2)

Description: Provider Major Specialty code or type of institution where care was provided reported on the encounter.

Notes: Required for non-institutional providers who have more than two major specialties

Entity List:

Provider

Valid Values:

For valid values, see Major Specialty

Ingenix Attribute Name: Total Payment Amount

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: TOT_PYMT_AMT

Data Type: NUMBER(9,2)

Description: The monthly capitation amount owed a DP for an enrollee for the specified month. This amount reflects our current understanding of all attributes that affect capitation rates.

Entity List:

Capitation Payment

Ingenix Attribute Name: Total Records

Source Field Name: DP Source File Header

Ingenix DW Name:

Data Type: INTEGER

Description: The count of the number of records included in a submission file. Appears on submission file header.

Entity List:

ADDL_ATTRIB

Ingenix Attribute Name: Transaction Type Code

Source Field Name: Transaction Type

Ingenix DW Name: TRANS_TYP_CD

Data Type: CHAR(1)

Description: Code to indicate the transaction type of the record on Clinical and Pharmacy submissions.

Entity List:

Encounter

Transaction Type

Valid Values:

I Initial submission

F Further episode submission

C Correction submission

D Delete submission

Ingenix Attribute Name: TRICARE Service Center HCDP Enrollment Application Received Date

Source Field Name: TRICARE Service Center Health Care Delivery Program Enrollment Application Received Calendar Date

Ingenix DW Name: TRICARE_SRVC_CTR_HCDP_ENRL_APP

Data Type: DATE

Description: The calendar date that a Health Care Delivery Program enrollment application was received at a TRICARE Service Center.

Entity List:

Enrollment

Ingenix Attribute Name: Unique Patient Reference Number

Source Field Name: Unique Patient Reference Number

Ingenix DW Name: UNIQ_PTNT_REF_NBR

Data Type: CHAR(12)

Description: Unique claim or episode of care number.

Notes: Valid claim, invoice encounter, or reference number that uniquely identifies the encounter Every transaction type "I" record will have a separate unique number. On transactions "D" and "C", the record will have the originally submitted unique patient reference number.

Entity List:

Encounter

Ingenix Attribute Name: Unique Provider Identifier

Source Field Name: Unique Provider ID Number/Pharmacy NABP Number

Ingenix DW Name: UNIQ_PROV_ID

Data Type: CHAR(18)

Description: Facility created unique provider ID number or each pharmacy's National Association of Pharmaceutical Doctors (NAPD) number.

Entity List:

Encounter

Provider

Ingenix Attribute Name: Valid Zip Code

Source Field Name: Ingenix Derived Attribute

Ingenix DW Name: VLD_ZIP_CD

Data Type: CHAR(5)

Description: A Postal ZIP Code in which the specified DMIS is allowed to provide services.

Entity List:

Designated Provider Valid Region

Ingenix Attribute Name: Work Telephone Number

Ingenix DW Name: WRK_TEL_NBR

Data Type: CHAR(20)

Source Field Name: Work Telephone Number Code

Description: Work telephone number.

Entity List:

Person

	MILITARY HEALTH SYSTEM (MHS) INFORMATION ASSURANCE (IA) IMPLEMENTATION GUIDE		IMPLEMENTATION GUIDE No. 12	
			EFFECTIVE DATE 07/19/05	REVISED DATE 03/27/2007
Subject: <p style="text-align: center;">INFORMATION ASSURANCE VULNERABILITY MANAGEMENT (IAVM) PROGRAM</p>				

PURPOSE AND SCOPE

The provisions of this guide are policy for all TRICARE Management Activity (TMA) Components (TMA Directorates; TRICARE Regional Offices (TRO), and the Program Executive Office (PEO), Joint Medical Information Systems Office (JMISO)) (hereafter referred to as the TMA Component(s)). For TMA Contractors, this document is policy if required by contract; otherwise it serves as information assurance guidance. The Chief Information Officers of the Service Medical Departments are encouraged to incorporate this document into their information assurance policies and procedures.

The Information Assurance Vulnerability Management (IAVM) process provides positive control of vulnerability notification and corresponding corrective action for TMA system/ network assets. Vulnerabilities in computing systems and networks are weaknesses that could compromise sensitive or patient health information and deny service to beneficiaries of TMA.

This implementation guide establishes responsibilities and procedures for the TMA IAVM program, to include organizational and individual responsibilities, registration, compliance criteria, Plans of Actions and Milestones (POA&Ms), enforcement, and verification.

POLICY

It is TMA policy that TMA Components shall monitor and report mitigation of known Information Assurance Vulnerability Alerts (IAVAs) to the TMA IAVM Coordinator through the DoD Vulnerability Management System (VMS). The TMA IAVM guidance establishes an IAVM program that provides responsive and effective vulnerability management as required by Chairman of the Joint Chief of Staff Manual (CJCSM) 6510.01, "Defense in Depth: Information Assurance (IA) and Computer Network Defense (CND)."

PROCEDURES

TMA Component Asset Owners shall:

- a. Designate a primary and secondary representative responsible for managing its internal IAVM program and register primary and secondary POCs in the VMS.
- b. Acknowledge receipt of the IAVA or Information Assurance Vulnerability Bulletin (IAVB) messages within the mandated timeframe in the IAVM notice.

- c. Report IAVA and IAVB compliance status via VMS as specified in the individual IAVA and IAVB message (typically 21 days from the date on the message) and update the VMS weekly, at a minimum.
- d. Establish a process to ensure that all DoD contracts for DoD ISs and services contain language requiring participation in the IAVM program.

Roles & Responsibilities

THE DAA SHALL:

- a. Ensure IAVM notices are available to all Information Assurance Managers (IAMs), Information Assurance Officers (IAOs), and System Administrators (SAs) as required.
- b. Review POA&Ms and, if appropriate, disconnect compromised systems from the network immediately if unable to comply with the IAVM notice.
- c. Monitor IAVM compliance and overall status for those assets under their control and ensure compliance is reported as required.

THE IAM AND IAO SHALL:

- a. Ensure IAVA notices are disseminated to the lowest level IAOs, SAs, and other individuals identified as participants in the IAVM process.
- b. Ensure all subordinate organizations comply with all IAVAs within designated compliance window or in accordance with the POA&M process.
- c. Monitor IAVB and Information Assurance Vulnerability Technical Advisory (IAVT) notices.
- d. Review and develop POA&Ms; monitor POA&Ms with their associated mitigation plans and implementation timelines as required.
- e. Ensure that all required risk mitigation actions are implemented in accordance with associated timeline, once POA&M is approved.
- f. Ensure compliance checks of their subordinate organizations to make certain mitigating and/or corrective actions are completed.
- g. Maintain positive configuration control of all ISs and/or assets under their purview. Maintain configuration documentation that identifies specific system and/or asset owners and SAs including applicable network addresses.
- h. Ensure networked assets are managed and administered in a manner allowing both chain of command and authorized independent verification of corrective actions.

PROGRAM OF RECORD (POR) PROGRAM MANAGERS (PM) OF CENTRALLY MANAGED PROGRAMS SHALL:

- a. Register with the VMS for a User Identification (ID) and password for VMS.

- b. Designate a primary and secondary IAVM POC.
- c. Respond to each IAVM message as the system configuration manager.
- d. Acknowledge receipt of the IAVM messages through VMS.
- e. Publish a program action plan for every IAVM notice issued by JTF-GNO; the program plan should provide an initial status to DAA.
- f. Provide a patch and implementation guidance in time to meet the date identified in the IAVM notice.
- g. Provide periodic status updates, as required, throughout the life cycle of the vulnerability until the corrective action has been completed.
- h. Ensure dissemination of the action plan, if necessary, to affected SAs.
- i. Process program level POA&Ms through the DAA.

TMA IAVM COORDINATOR SHALL:

- a. Serve as primary POC for JTF-GNO.
- b. Acknowledge receipt of IAVA and IAVB notices within VMS by specified acknowledgement date.
- c. Disseminate IAVM notices to appropriate TMA Component Asset Owners and TMA Contractors.
- d. Generate compliance report for TMA Components using VMS.
- e. Generate monthly TMA compliance report to TMA CIO.
- f. Send TMA compliance report to TMA IA Staff
- g. Send TRICARE Contractor status report to TMA IA Staff.
- h. Monitor TMA Components and TMA Contractors compliance.
- i. Develop and present IAVM Status Report briefing at quarterly Information Assurance Working Group (IAWG) meeting and other meetings.
- j. Respond to requests for VMS user account creation, technical support, password resets, etc.

DESIGNATED IAVM REPRESENTATIVES SHALL:

- a. Register with the TMA IAVM Coordinator for assignment of User ID and password in the VMS system.
- b. Disseminate IAVM notices to lowest level SAs.
- c. Enter their organization's acknowledgment and compliance and/or POA&M data into VMS.

- d. Monitor compliance status of IAVM notices, and update VMS as statistics change throughout the life cycle of the IAVM notice.

THE SA SHALL:

- a. Ensure all devices are IAVA compliant prior to connecting the devices to DoD networks.
- b. Respond to all active IAVAs – any asset found with an active vulnerability, where the IAVA completion date has closed, must be brought into compliance immediately, must have a POA&M submitted and approved or the asset must be disconnected.
- c. Test and evaluate all patches intended to resolve an IAVM notice unless POR process applies. Monitor appropriate web sites for new vulnerability notices.
- d. Report compliance and/or POA&M information through the command channels for aggregation and reporting.
- e. Prepare and submit a POA&M (including implementation timelines) prior to the time specified in the IAVM notice (usually 15 days), if unable to comply with the notice. Submitted POA&Ms must be reviewed/approved by the DAA prior to the IAVM notice mitigation date.

IAVA POA&M Process and Timelines

ASSET OWNERS WILL OPERATE NONCOMPLIANT ASSETS ONLY WITH AN APPROVED POA&M WITH MITIGATION ACTIONS AND TIMELINES.

NONCOMPLIANT ASSETS MUST LIST THE VULNERABILITY IN THE SYSTEM POA&M. THE POA&M PROVIDES A PLAN OF ACTION TO MITIGATE AND/OR CORRECT THE VULNERABILITY.

- a. If a system already has a POA&M due to other vulnerabilities, then that POA&M needs to be updated to include any new vulnerability.
- b. If a system does not have a POA&M, then a POA&M must be created.

ASSET OWNERS MUST MAINTAIN AN APPROVED POA&M WITH IMPLEMENTED MITIGATION ACTIONS UNTIL ASSETS ARE BROUGHT INTO COMPLIANCE OR ASSETS ARE REMOVED FROM THE NETWORK.

DAA APPROVES POA&MS. APPROVAL MUST BE BASED ON A SOUND POA&M WITH MITIGATION ACTIONS THAT MINIMIZE THE RISK OF COMPROMISE TO LOCAL SYSTEMS. LOCAL DAAS MUST CONSIDER THE ASSOCIATED RISK SHARED BY OTHER DOD NETWORKS WHEN APPROVING A POA&M.

- 3.3.5 Failure to have a DAA approved POA&M will result in TMA being placed on the JTF-GNO Watch List. The Watch List reports CC/S/A IAVM compliance to USSTRATCOM and ASD(NII).

VMS User Enrollment and Training

- All users assigned responsibility to update or monitor IAVM compliance in VMS shall apply for and obtain a VMS account. The TMA IAVM Coordinator shall create VMS accounts and assign appropriate permissions, or afford heads of Program Offices to assign permissions to their subordinate users.
- Individuals applying for a VMS account shall complete a DD Form 2875, “System Authorization Access Request (SAAR),” available from DISA at <https://vms.disa.mil/help/DD2875Apr2005.pdf> and return the completed form to the TMA IAVM Coordinator for review and approval by TMA IA or JMIS, as appropriate.
- Applicants should meet the minimum qualifications prior to applying for a VMS account:
 - For United States (U.S.) citizens: Possess a NAC or better investigation for Non-secure Internet Protocol Router Net (NIPR), and a minimum of a secret clearance for Secret Internet Protocol Router Network (SIPR) access.
 - For non-U.S. citizens: DoD policies state that the required investigation must be completed and favorably adjudicated prior to authorizing ADP/IT access to DoD systems/networks. Interim approvals are not authorized to non U. S. citizen contractor employees for access to DoD systems/networks.
 - Training is available through DISA and within the VMS application. New VMS users should review the training module available within the VMS application, or contact TMA IAVM Coordinator for live DISA training.

Non-Compliance Notification and Enforcement Procedures

- a. Commander, USSTRATCOM, shall notify TMA IAVM Coordinator POC to verify IS or network is non-compliant and to coordinate a resolution.
- b. TMA shall be considered non-compliant under any of the following conditions:
 - Failure to report IAVA compliance.
 - Incidents resulting from exploitation of IAVA vulnerability.
 - Non-compliant assets identified by outside scans, audits, or inspections.
 - Missing or incomplete Plans of Actions and Milestones (POA&Ms).
 - A pattern of organization IAVM non-compliance and/or failure to identify causes and take corrective action.
- c. If TMA is not responsive or fails to follow through with resolving the non-compliance, USSTRATCOM shall release an IAVA noncompliance message addressed to TMA Director.
 - TMA will respond within 4 working days that assets have been brought into compliance or report reasons for noncompliance, planned corrective actions, mitigation plan, and operational impact. TMA shall respond to USSTRATCOM (info: ASD (NII)/IA, Joint Staff/J-3 and /J-6, and JTF-GNO).
- d. USSTRATCOM shall review TMA corrective actions and coordinate any additional actions required to mitigate vulnerability created by non-compliance in accordance with Paragraph 5.12.5, DoD Directive O-8530.1, “Computer Network Defense,” 8 January 2001.

- USSTRATCOM, in coordination with the Joint Staff (J-3 and J-6), shall determine global operational impact of continued IAVA noncompliance as required.
- If USSTRATCOM or TMA has an issue that cannot be resolved concerning compliance actions, Assistant Secretary of Defense (Networks & Information Integration) (ASD (NII)) and the Chairman of the Joint Chiefs of Staff shall be informed.

TMA Contractors shall:

- a. Be manually managed by the TMA IAVM Coordinator; VMS is not currently used to track contractor assets.
- b. Designate two POCs for their organizations.

3.6.1 TMA Contractor POCs shall:

- a. Acknowledge receipt of IAVA and IAVB notice.
- b. Inform TMA IAVM Coordinator of applicability or non-applicability of IAVA notice.
- c. Ensure IAVA notices are disseminated to the lowest level individuals identified as participants in the IAVM process.
- d. Implement patch or mitigation strategy and report compliance as specified in notice to TMA IAVM Coordinator if IAVA applies.
- e. Develop/submit POA&M if IAVA applies, but cannot mitigate within the compliance time frame.
- f. POA&M must be reviewed/approved by the DAA prior to the mitigation date.
- g. Ensure that all required risk mitigation actions are implemented in accordance with associated timeline, once POA&M is approved.
- h. Ensure compliance checks of their subordinate contractors to make certain mitigating and/or corrective actions are completed.
- i. Respond to TMA IAVM Coordinator query as to compliance status, if necessary, two weeks prior to suspense date.
- j. Respond to TMA IAVM Coordinator query as to compliance status, if necessary, one week prior to suspense date.
- k. Monitor IAVB and IAVT notices.

references

- a. DoDD 8500.1, “Information Assurance (IA),” 24 October 2002
- b. DoDI 8500.2, “Information Assurance (IA) Implementation,” 6 February 2003
- c. CJCSM 6510.01, Change 1, “Defense in Depth: Information Assurance and Computer Network Defense,” 10 August 2004

- d. CJCSM 6510.01, Change 2, “Defense in Depth: Information Assurance and Computer Network Defense,” 26 January 2006
- e. DoD Amplifying Guidance to CJCSM 6510.01 Change 2 for the NETOPS and IAVM Community, April 20, 2006
- f. Interim Department of Defense (DoD) Information Assurance (IA) Certification and Accreditation (C&A) Guidance, 6 July 2006
- g. DoDI O-8530.1, “Computer Network Defense,” 8 January 2001
- h. DoDI O-8530.2, “Support to Computer Network Defense (CND),” 9 March 2001
- i. DoD 5200.1-R, “Information Security Program,” January 1997
- j. DoD 5200.2-R, Change 3, “Personnel Security Program,” 23 February 1996
- k. Federal Information Security Management Act of 2002
- l. Health Insurance Portability and Accountability Act (HIPAA) Security Final Rule, 20 February 2003.

Acronyms

ADP	Automated Data Processing
ASD(NII)	Assistant Secretary of Defense (Networks & Information Integration)
CC/S/A	Combatant Commands, Services, and Agencies
CIO	Chief Information Officer
CJCSI	Chairman of the Joint Chiefs of Staff Instruction
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CND	Computer Network Defense
DAA	Designated Authorizing Authority
DISA	Defense Information Systems Agency
DISN	Defense Information Systems Network
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DSAWG	Defense Information Systems Network (DISN) Security Accreditation Working Group
IA	Information Assurance

IAM Information Assurance Manager
 IAO Information Assurance Officer
 IAVA Information Assurance Vulnerability Alert
 IAVB Information Assurance Vulnerability Bulletin
 IAVM Information Assurance Vulnerability Management
 IAVT Information Assurance Vulnerability Technical Advisory
 ID Identification
 IDS Intrusion Detection System
 IS Information System
 IT Information Technology
 JMISO Joint Medical Information Systems Office
 JTF-GNO Joint Task Force, Global Network Operations
 MHS Military Health System
 NSA National Security Agency
 PEO Program Executive Office
 POA&M Plan of Action and Milestones
 POC Point of Contact
 POR Program of Record
 SA System Administrator
 TA Technical Advisory
 TMA TRICARE Management Activity
 TRO TRICARE Regional Offices
 USSTRATCOM United States Strategic Command
 VMS Vulnerability Management System

GENERAL ADP REQUIREMENTS

1.0. GENERAL

1.1. The TRICARE Systems Manual defines the contractor's responsibilities related to automated processing of health care information and transmission of relevant data between the contractor and **TRICARE Management Activity (TMA)**. It covers three major categories of information flowing among the contractor and **TMA/Defense Enrollment Eligibility Reporting System (DEERS)**: health care coverage information; provider information; and pricing information. For each of these categories it presents specifics of submission, record and data element specifications, editing requirements, and TMA reporting of detected errors to the contractor.

1.2. This chapter addresses major **administrative**, functional and technical requirements related to the flow of health care related **Automated Data Processing (ADP/IT)** information between the contractor and TMA. TRICARE Encounter Data (TED) records as well as provider and pricing information **shall** be submitted to TMA in electronic media. This information is essential to both the accounting and statistical needs of TMA in management of the TRICARE program and in required reports to Department of Defense, Congress, other governmental entities, and to the public. Technical requirements for the transmission of data between the contractor and TMA are presented in this section. The requirements for submission of TRICARE Encounter Data records and resubmission of records are outlined in [Chapter 2, Section 1.1](#), the TMA requirements related to submission and updating of provider information **are** outlined in [Chapter 2, Section 1.2](#) and the TMA requirements related to submission and updating of pricing information **are** outlined in [Chapter 2, Section 1.3](#).

1.3 For the purposes of this contract, DoD/TMA data includes any information provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, capitation, fees, patient health information, protected as defined by DoD 6025.18-R, or any other information for which the source is the Government. Any information received by a contractor or other functionary or system(s), whether Government owned or contractor owned, in the course of performing government business is also DoD/TMA data. DoD/TMA data means any information, regardless of form or the media on which it may be recorded.

1.4. The ADP requirements **shall** incorporate the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** mandated standards where required.

1.5 Management and quality controls specific to the accuracy and timeliness of transactions associated with automatic data processing (ADP) and financial functions are addressed in the TRICARE Operations Manual, Chapter 1, Section 4. In addition to those

requirements, TMA also conducts reviews of ADP and financial functions for data integrity purposes and may identify issues specific to data quality (e.g., catastrophic cap coverage issue). Upon notification of data quality issues by TMA, contractors are required to participate in the development of a resolution to the issue(s) identified, as appropriate. If TMA determines corrective actions are required as a result of Government actions, the Contracting Officer will identify the actions to be taken by the contractor to resolve the data issues. Corrective actions that must be taken by the contractor to correct data integrity issues, resulting from contractor actions, are the responsibility of the contractor.

2.0. SYSTEM INTEGRATION, IMPLEMENTATION AND TESTING MEETINGS

The TMA Purchased Care Systems Branch hosts regularly scheduled meetings, via teleconference, with contractor and government representatives. Government attendees may include, but are not limited to DMDC, TIMPO and DISA. The purpose of these meetings is to:

- Review the status of system connectivity and communications
- Identification of new DEERS applications or modifications to existing applications, e.g., DEERS On-line Enrollment System (DOES)
- Issuance of software enhancements
- Implementation of system changes required for the implementation of new Programs and/or benefits
- Review data correction issues and corrective actions to be taken (e.g., catastrophic cap effort--review, research and adjustments)
- To monitor the results of contractor testing efforts and;
- Other activities as appropriate.

NOTE: Meetings scheduled for the development of requirements for implementation of new Programs, and/or benefits shall be separately funded from the System Integration, Implementation and testing meetings.

TMA provides a standing agenda for the teleconference with the meeting announcement. Unique subjects for the meetings are identified as appropriate. Contractors are required to ensure representatives participating in the calls are subject matter experts for meeting agenda items and are able to provide the current status of activities for their organization. It is also the responsibility of the contractor to ensure testing activities are completed within the scheduled timeframes and any problems experienced during testing are reported via "TestTrack Pro" for review and corrective action by TMA or their designee. Upon the provision of a corrective action strategy or implementation of a modification to a software application by TMA (to correct the problem reported by the contractor), the

CONTRACTOR IS RESPONSIBLE FOR RETESTING THE SCENARIO TO DETERMINE IF THE RESOLUTION IS SUCCESSFUL. RETESTING SHALL BE ACCOMPLISHED WITHIN THE AGREED UPON TIMEFRAME. CONTRACTORS ARE REQUIRED TO UPDATE "TESTTRACK PRO" UPON COMPLETION OF RETESTING ACTIVITIES.

3.0. ADP REQUIREMENTS

It is the responsibility of the contractor to employ adequate hardware, software, personnel, procedures, controls, contingency plans, and documentation to satisfy TMA data processing and reporting requirements. Items requiring special attention are listed below.

3.1. Continuity of Operations Plan (COOP)

3.1.1. The contractor shall develop a plan to ensure the **continuous operation** of their **information technologies (IT)** systems and **data** support of TRICARE. The COOP shall ensure the availability of the system and associated data in the event of hardware, software and/or communications failures. The contractor shall develop a COOP that will enable compliance with all processing standards as defined in the TRICARE Operations Manual, [Chapter 1, Section 3](#).

3.1.2. The contractor shall conduct a test of the backup system within the first quarter of the initial health care delivery period and shall continue to assure backup capabilities by testing or reviewing the availability and capability of the backup ADP/IT system to process the TRICARE data and produce the expected results. The contractor's testing of the backup system shall be done at least once a year.

3.1.3. **Annual disaster recovery tests shall involve a total of 400 claims and be performed in two parts. Contractors shall perform claims and catastrophic inquiries for 200 claims against production DEERS and the production Catastrophic Cap and Deductible Database (CCDD) on DEERS. This test will demonstrate the ability to connect to production DEERS and the CCDD from the recovery site and the ability to successfully submit claims inquiries and receive DEERS claims responses and Catastrophic Cap Inquiries and responses. Contractors shall not perform catastrophic cap updates in the CCDD and DEERS production regions for these 200 test claims.**

3.1.4. **To successfully demonstrate the ability to perform catastrophic cap updates and to create newborn placeholder records on DEERS the contractor shall process an additional 200 claims using the DEERS and CCDD contractor test region. Contractors shall coordinate connectivity to the DEERS and the CCDD production and contractor test regions with DMDC at least 30 days prior to the test. In all cases, the results of the review and/or test results shall be reported to the TMA, Contract Management Division within 15 days of conclusion of the review or test.**

3.2. Information Assurance (IA) Requirements

The Contractor shall comply with the documents listed below.

- DoD Directive 8500.1, "Information Assurance (IA)," October 24, 2002
- DoD Instruction 8500.2, "Information Assurance (IA) Implementation," February 6, 2003
- DoD 5200.2-R, "DoD Personnel Security Program," January 1987
- DoD Memo, Interim Department of Defense Information Assurance Certification and Accreditation Process (DIACAP) Guidance, July 6, 2006
- DoD Interim Guidance, "DoD Information Assurance Certification and Accreditation Process (DIACAP)," July 6, 2006
- DoD Instruction 8551.1, "Ports, Protocols, and Services Management (PPSM)," August 13, 2004
- DoD Instruction 8520.2, "Public Key Infrastructure (PKI) and Public Key (PK) Enabling," April 1, 2004
- Defense Information Systems Agency (DISA), "Security Technical Implementation Guides"
- DoD 5200.8-R, "Physical Security Program," May 1991
- DoD Assistant Secretary of Defense (ASD) Health Affairs (HA) Memorandum, "Interim Policy Memorandum on Electronic Records and Electronic Signatures for Clinical Documentation," August 4, 2005
- "DISA Computing Services Security Handbook" Version 3, Change 1, December 1, 2000
- Chairman Joint Chiefs of Staff Manual (CJCSM) 6510.01, "Defense-in-Depth: Information Assurance (IA) and Computer Network Defense (CND)," March 18, 2005
- "Health Insurance Portability and Accountability Act (HIPAA), Security Standards, Final Rule," February 20, 2003
- Military Health System (MHS) Physical Security Assessment Matrix, August 15, 2004
- Military Health System (MHS) DIACAP Checklist, July 2006
- Military Health System (MHS) Security Incident Checklist, September 2005
- Military Health System (MHS) Information Assurance Policy Guidance, March 5, 2004
- MHS IA Implementation Guide No.2, "Sanitization and Disposal of Electronic Storage Media and IT Equipment Procedures," July 19, 2005

- MHS IA Implementation Guide No.3, "Incident Reporting and Response Program," July 19, 2005
- MHS IA Implementation Guide No.5, "Physical Security," July 19, 2005
- MHS IA Implementation Guide No.6, "Wireless Local Area Networks (WLANs)," July 19, 2005
- MHS IA Implementation Guide No.7, "Data Integrity" July 19, 2005
- MHS IA Implementation Guide No.8, "Certification and Accreditation (C&A)," July 19, 2005
- MHS IA Implementation Guide No.9, "Configuration Management – Security," July 19, 2005
- MHS IA Implementation Guide No.10, "System Lifecycle Management," July 19, 2005
- MHS IA Implementation Guide No.11, "DoD Public Key Infrastructure (PKI) and Public Key Enabling (PKE)," July 19, 2005
- MHS IA Implementation Guide No.12, "Information Assurance Vulnerability Management (IAVM) Program," July 19, 2005
- MHS IA Implementation Guide No. 15, "Identity Protection (IdP)," September 14, 2006
- MHS Standard Operating Procedures (SOP) for Management of Unauthorized Disclosure of DoD Sensitive Information Incidents, July 15, 2005
- Federal Information Process Standard 140-2, "Security Requirements for Cryptographic Modules," May 2001
- National Institute of Standards and Technology (NIST) Special Publication (SP) 800-26 "Security Self-Assessment Guide for Information Technology Systems," November 2001

3.2.1. **Certification and Accreditation Process (C&A)**

Contractors shall achieve certification and accreditation (C&A) of all information systems (IS) that access, process, display, store or transmit Department of Defense (DoD) sensitive information (SI). C&A must be achieved as specified on contract. Failure to achieve C&A will result in return visits by assessment teams. Return visits will prompt the government to exercise its rights in reducing the contract price. The contract price will be reduced by an amount to reflect costs incurred by the government for each re-assessment of the contractor's information systems, as allowed under contract clause 52.246-4, Inspection of Services-Fixed Price.

Contractor information systems in support of the DoD Military Health System shall obtain, maintain, and use sensitive and personal information strictly in accordance with controlling laws, regulations, and DoD policy.

The contractor shall safeguard sensitive information through the use of a mixture of

administrative, procedural, physical, communications, emanations, computer and personnel security measures that together achieve the same requisite level of security established for DoD IS/networks for the protection of information referred to as "Sensitive Information" (SI) and/or "Controlled Unclassified Information." The contractor shall provide a level of trust which encompasses trustworthiness of systems/networks, people and buildings that ensure the effective safeguarding of SI against unauthorized modifications, disclosure, destruction and denial of service.

The contractor shall provide a phased approach to completing the Department of Defense (DoD) Certification and Accreditation (C&A) process in accordance with Interim DoD Instruction, "DoD Information Assurance Certification and Accreditation Process (DIACAP)," July 6, 2006, within ten months, following contract award date.

After contract award date and approval to operate is granted, reaccreditation is required every three years or when significant changes occur that impact the security posture of the information system. An annual IA review shall be conducted that comprehensively evaluates existing contractor system security posture in accordance with FISMA.

C&A requirements apply to all DoD and contractor's Information Systems (ISs) that access, process, display, store or transmit DoD information. The contractor shall comply with the C&A process for safeguarding Sensitive Information (SI). Certification is the determination of the appropriate level of protection required for ISs. Certification also includes a comprehensive evaluation of the technical and non-technical security features and countermeasures required for each system.

Accreditation is the formal approval by the government for the contractor's ISs to operate in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows ISs to operate within the given operational environment with stated interconnections; and with appropriate levels of information assurance security controls.

The contractor shall comply with C&A requirements, as specified by the government that meet appropriate DoD Information Assurance requirements. The C&A requirements shall be met before the contractor's system is authorized to access DoD data or interconnect with any DoD IS. The contractor shall initiate the C&A process by providing the Contracting Officer, within 60 days following contract award, the required documentation necessary to receive an Approval to Operate (ATO). The contractor shall make their ISs available for testing, and initiate the C&A testing four months (120 days) in advance of accessing DoD data or interconnecting with DoD ISs. The contractor shall ensure the proper contractor support staff is available to participate in all phases of the C&A process. They include, but are not limited to: (a) Attending and supporting C&A meetings with the government; (b) Supporting/conducting the vulnerability mitigation process; and (c) Supporting the C&A Team during system security testing.

Contractors must confirm that their system baseline configuration remains static during the initial testing.

Confirmation of system baseline configuration shall be agreed upon during the definition of the C&A boundary and be signed by the government and the contractor and documented as part of the System Identification Profile (SIP) and artifacts.

During the actual baseline and mitigation assessment scans, the information system must remain frozen. The freeze is only in place during the actual testing periods. Changes can be made between baseline testing and mitigation testing, as long as the changes are coordinated and approved by the MHS IA Program Office in advance.

Any re-configuration or change in the system during the C&A testing process may require a re-baselining of the system and documentation of system changes. This action could negatively impact the C&A timeline.

Vulnerabilities that have been identified by the government as "must-fix" issues during C&A process must be mitigated according to the timeline identified by the Government Representative. The contractor shall comply with the Military Health System (MHS) DIACAP Checklist. Reference material may be obtained at: http://www.tricare.osd.mil/tmis_new/ia.htm.

The C&A process will review the trustworthiness determination (Background Checks) of personnel accessing DoD sensitive information (SI).

3.2.2. Information Assurance Vulnerability Management (IAVM)

The DoD IAVM program provides electronic security notification against known threats and vulnerabilities. The contractor shall comply with the IAVM program requirements to ensure an effective security posture is maintained.

Guidance regarding the requirement for IAVM is contained in the Chairman of the Joint Chiefs of Staff Manual (CJCSM) 6510.01 provides additional reference information.

3.2.3. Disposing of Electronic Media

Vendors shall follow the DoD standards, procedures, and use approved products to dispose of unclassified hard drives and other electronic media, as appropriate, in accordance with DoD Memorandum, "Disposition of Unclassified Computer Hard Drives," June 4, 2001. DoD guidance on sanitization of other internal and external media components are found in DODI 8500.2, "Information Assurance (IA) Implementation," 6 Feb 2003 (see PECS-1 in enclosure 4 Attachment 5) and DoD 5220.22-M, "Industrial Security Program Operating Manual (NISPOM)," (Chapter 8)

4.0. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The contractor shall be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented by the Department of Health and Human Services (HHS) Privacy Rule of April 14, 2003 and the Final Rule on Health Insurance Reform: Security Standards (45 Code of Federal Regulations, Parts 160, 162, and 164) of April 21, 2005 and the Standards for Privacy of Individually Identifiable Health Information (45 Code of Federal Regulations, Parts 160 and 164, Subpart E as modified on August 14, 2002. DoD 6025.18-R, DoD Health Information Privacy Regulation, DoD 5400.11-R, DoD Privacy Regulations, Privacy Act 1974, and HA Policy 06-010, Health Insurance Portability and Accountability Act Security Compliance implement these final rules and apply to all DoD IS/networks and contractor's IS/networks that access, manage, store, or manipulate protected health information.. **The contractor shall comply with the requirements of the Final Rule at the start-work date of this contract.**

As part of this measure, the contractor shall have knowledge of the DoD Health Information Privacy Regulation (DoD 6025.18-R) of January 24, 2003. Contractors shall follow contractor established procedures as required by the TRICARE Systems Manual (TSM), Chapter 1 and the TRICARE Operations Manual (TOM), Chapter 21, Sections 3 and 4, to assure the confidentiality, integrity and availability of all beneficiary and provider information.

4.1 Data Use Agreement (DUA)

The contractor shall provide a Data Use Agreement (DUA) in order to be compliant with DoD and HIPAA regulations by submitting a DUA annually or until their contract is no longer valid as required in the TSM and the TOM Chapter 21, Section 3. Subcontractors or agents working on behalf of the primary contractor who require the use of or access to individually identifiable data or protected health information under the provisions of the TSM shall be in compliance with DoD regulation and HIPAA as outlined in the TOM, Chapter 21, Section 3.

4.2 Protected Health Information Management Tool (PHIMT)

The contractor shall be compliant with the HHS Privacy Rule requiring covered entities to maintain a history of disclosures of Protected Health Information (PHI). The contractor shall also follow the specific guidance of the Privacy Act of 1974 and DoD 6025.18-R, Health Information Privacy Regulation. The contractor shall follow C7 and C14.4 of the DoD 6025.18-R which specifically defines the requirements for accounting of disclosures and complaint management. The contractor shall implement the provisions of the HHS Privacy Rule and Privacy Act of 1974 by employing the TMA disclosure tracking tool, known as the Protected Health Information Management Tool (PHIMT).

The PHIMT is an electronic disclosure-tracking tool hosted within a DIACAP certified Protected Enclave at TMA. The PHIMT stores information regarding disclosures, complaints, authorizations, restrictions, and confidential communications that are made about or requested by a patient.

The contractor shall use the PHIMT for disclosure management, complaint management and generating administrative summary reports. The disclosure management function will track the following: disclosure requests; disclosure restrictions; accounting for disclosures; authorizations; PHI amendments; Notice of Privacy Practices distribution management; and confidential communications. The complaint management function will store privacy complaint data. The administrative summary report function will generate reports and track information found in the disclosure management and complaint management sections of the PHIMT. The contractor and its subcontractor will follow the procedures as outlined in the PHIMT User Guide (Version 3.0) located on the TMA web site:
<http://www.tricare.osd.mil/tmaprivacy/hipaa> .

5.0. PHYSICAL SECURITY REQUIREMENTS

The contractor shall employ physical security safeguards for IS/networks involved in the operation of its systems of records to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of SI and to otherwise protect the confidentiality and ensure the authorized use of SI. In addition, the contractor shall support a Physical Security Audit performed by the government of its internal information management infrastructure using the criteria from the Physical Security Audit Matrix. The contractor shall correct any deficiencies identified by the government of its physical security posture. The Physical Security Audit Matrix can be accessed via the Policy and Guidance/Security Matrices section at http://www.tricare.osd.mil/tmis_new/ia.htm.

6.0. PERSONNEL SECURITY ADP/IT REQUIREMENTS

6.1. Policy References

Personnel to be assigned to an ADP/IT position must undergo a successful security screening before being granted access to DoD information technology (IT) resources. The references and specific guidance below provided to TMA by the Under Secretary of Defense for Intelligence (USDI) and the Office of Personnel Management (OPM) safeguard against inappropriate use and disclosure.

- Privacy Act of 1974
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
- DoD 5200.2-R, "Personnel Security Program," January 1987
- DoD 5220.22-M, "National Industrial Security Program Operating Manual (NISPOM)," January 1995 (Change 2, May 1, 2000)
- DoDI 8500.1, "Information Assurance (IA)," October 24, 2002
- DoD 5400.11-R "DoD Privacy Program," August 1983
- DoDD 5400.11 "DoD Privacy Program," November 16, 2004

The requirement above must be met by contractors, subcontractors and others who have access to DoD information systems containing information protected by the Privacy Act of 1974 and protected health information under HIPAA. Background checks are required for all **ADP/IT contractor** personnel who receive, process, store, display, or transmit sensitive information (SI) on a DoD IT system prior to being granted access.

6.2. Formal Designations Required

All contractor personnel in positions requiring access to DoD IS/networks or COCO IS/networks interconnected with DoD IS/networks must be designated as ADP/IT-I, ADP/IT-II, or ADP/IT-III. ADP's/ ITs are Suitability/Public Trust Positions. They are not security clearances. Only TRICARE contractors are permitted to submit ADP/IT background checks in

accordance with this policy. Military Service and Military Treatment Facility contractors are not to use this guidance.

6.3. Access Requirements

New employees hired by contractors are granted interim access upon receipt of the Investigation Schedule Notice (ISN) from the TMA Privacy Office, after submitting the SF85P and FD 258 (Fingerprint cards) to OPM. Contractors must notify the TMA Privacy Office of the submission of SF85Ps for new hires and the date submitted. The notification should include the Name, SSN, ADP designation, Date submitted to OPM, and company name. In addition, contractors are required to respond timely to Defense Industrial Security Clearance Office (DISCO) or Defense Office of Hearings and Appeals (DOHA) requests for additional information required during the investigation process. Failure to respond timely to DISCO/DOHA will result in the revocation of interim access by the TMA Privacy Office, discontinuation/ termination of the investigation by OPM, and Denial of Access by DOHA.

6.3.1 Special Access Requirements

All contractor personnel accessing the Defense Enrollment Eligibility Reporting System (DEERS) database or the Business to Business (B2B) Gateway must have an ADP/ IT-II Trustworthiness Determination. The most current edition of the DD2875 System Authorization Access Request (SAAR) is required for each individual accessing the B2B Gateway, as outlined in paragraph 9.3.

Contractors are required to ensure personnel viewing data obtained from DEERS or the B2B Gateway or viewing Privacy Act protected data follow contractor established procedures as required by the TRICARE Operations Manual, Chapter 1, Section 4, paragraph 3.0., to assure confidentiality of all beneficiary and provider information. The contractor is required to assure the rights of the individual are protected in accordance with the provisions of the Privacy Act, HIPAA and Health and Human Services (HHS) Privacy regulation and to prevent the unauthorized use of TMA files.

6.3.2 Unauthorized Disclosure Requirements

The contractor shall report any unauthorized disclosures of personal information from a system of records or the maintenance of any system of records that are not authorized by DoDD 5400.11, November 16, 2004 to the Applicable Privacy POC for his or her DoD Component.

6.4. ADP/IT Category Guidance

In establishing the categories of positions, a combination of factors may affect the determination. Unique characteristics of the system or the safeguards protecting the system permit position category placement based on the agency's judgement. Guidance on ADP/IT categories is:

ADP/IT-I - Critical Sensitive Position. A position where the individual is responsible for the development and administration of MHS IS/network security programs and the direction and control of risk analysis and/or threat assessment. The required investigation is equivalent to a Single-Scope Background Investigation (SSBI). Responsibilities include:

- Significant involvement in life-critical or mission-critical systems.
- Responsibility for the preparation or approval of data for input into a system, which does not necessarily involve personal access to the system, but with relatively high risk for effecting severe damage to persons, properties or systems, or realizing significant personal gain.
- Relatively high risk assignments associated with or directly involving the accounting, disbursement, or authorization for disbursement from systems of (1) dollar amounts of \$10 million per year or greater; (2) lesser amounts if the activities of the individuals are not subject to technical review by higher authority in the ADP/IT-I category to insure the integrity of the system.
- Positions involving major responsibility for the direction, planning, design, testing, maintenance, operation, monitoring and or management of systems hardware and software.
- Other positions as designated by the Designated Accrediting Authority (DAA) that involve a relatively high risk for causing severe damage to persons, property or systems, or potential for realizing a significant personal gain.

ADP/IT-II - Non-critical-Sensitive Position. A position where an individual is responsible for systems design, operation, testing, maintenance and/or monitoring that is carried out under technical review of higher authority in the ADP/IT-I category, includes but is not limited to: (1) access to and/or processing of proprietary data, information requiring protection under the Privacy Act of 1974, or Government-developed privileged information involving the award of contracts; (2) accounting, disbursement, or authorization for disbursement from systems of dollar amounts less than \$10 million per year.

Other positions are designated by the DAA that involve a degree of access to a system that creates a significant potential for damage or personal gain less than that in ADP/IT-I positions. The required investigation is equivalent to a National Agency Check with Law and Credit Checks (NACLC).

ADP/ITs submitted as a NAC to DSS prior to 2000 were approved as ADP/IT-II/III. Effective 2000, OPM took over the investigation process for TMA. The submission requirements for ADP/IT levels were upgraded as follows: ADP/IT-III is a NAC; ADP/IT-II is a NACLC and; an ADP/IT-I is a SSBI. Investigations submitted before 2000 for a NAC (ADP/IT-II/III) will need to submit a new SF85P User Form and fingerprint card for a NACLC to be upgraded to an ADP/IT-II.

ADP/IT-III - Non-sensitive Position. All other positions involved in Federal computer activities. The required investigation is equivalent to a National Agency Check (NAC).

6.5. **Additional ADP/IT Level I Designation Guidance**

All TMA contractor companies requiring ADP/IT-I Trustworthiness Determinations for their personnel are required to submit a written request for approval to the TMA Privacy Office prior to submitting applications to OPM. The justification will be submitted to the TMA Privacy Officer, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 22041, on the letterhead of the applicant's contracting company. The request letter must be signed by, at a

minimum, the company security officer or other appropriate executive, include contact information for the security officer or other appropriate executive, and a thorough job description which justifies the need for the ADP/IT-I Trustworthiness Determination. Contractor employees shall not apply for an ADP/IT-I Trustworthiness Determination unless specifically authorized by the TMA Privacy Officer.

6.6. **Required Forms**

Each contractor employee shall be required to complete and submit the Standard Form 85P (Questionnaire for Public Trust Positions), FD 258 (Fingerprint Form), and other documentation as may be required by OPM to open and complete investigations. Additional information may be requested while the investigation is in progress. This information must be provided in the designated timeframe or the investigation will be closed/ discontinued. All contractor employees that are prior military should include Copy 4 of the DD214 (Certificate of Release or Discharge from Active Duty) with their original submission. Forms and guidance can be found at <http://www.opm.gov/extra/investigate>.

NOTE: The appropriate billing code will be provided following contract award. Contractors should contact the TMA Privacy Office to obtain the PIPS Form 12 when applying for a Submitting Office Number (SON). The application and billing information must be requested from the TMA Privacy Office. Each Prime contracting company is responsible for the submission of the SF85P for the subcontracting company's employee personnel.

6.7 **Notification Of Submittal And Termination**

Contracting companies shall notify the TMA Privacy Office when the Security Officer has submitted the SF85P to OPM for new employees. Upon termination of a contractor employee from the TRICARE Contract, contracting companies shall notify the TMA Privacy Office and OPM of the action, including the termination date. Additionally, contracting companies shall notify the TMA Privacy Office when an employee has been rehired. The TMA Privacy Office must be notified when Unacceptable Case Notices and/or FD 258 are resubmitted to OPM.

6.8. **Transfers Between TRICARE Contractor Organizations**

6.8.1. When contractor employees transfer employment from one TRICARE contract to another, while their investigation for ADP/IT Trustworthiness Determination is in process, the investigation being conducted for the previous employer may be applied to the new employing contractor. The new contracting company shall send an Excel spreadsheet to the TMA Privacy Office to provide notification of the addition of the new contractor employee from another TRICARE contracting company. The spreadsheet must contain the following:

- Name
- Social Security Number
- Name of the former contracting company
- ADP/IT level applied for
- Effective date of the transfer/employment

TMA Privacy Office will verify the status of the Trustworthiness Determination/scheduled investigation for the employee(s) being transferred. If the

investigation has not been completed, the TMA Privacy Office will notify OPM to transfer the investigation from the old SON (submitting office number) to the new SON. If the investigation has been completed, OPM cannot affect the transfer. If the Trustworthiness Determination has been approved, TMA Privacy Office will verify the approval of the Trustworthiness Determination and send a copy to the new contracting company office.

6.9 Interim Access: (U.S. Citizens Working In The U.S. Only)

All contractor personnel who are U.S. Citizens will receive an OPM Investigation Schedule Notice (ISN) from the TMA Privacy Office once the Office of Personnel Management (OPM) has scheduled the investigation. TMA Privacy Office sends the ISN to the contracting security officer as validation for interim access. The contractor security officer may use receipt of the ISN as their authority to grant interim access to DoD IS/networks until a Trustworthiness Determination is made.

6.10 Temporary Access (U.S. Citizens Only)

Temporary employees include intermittent, volunteers, and seasonal workers. Efforts shall be taken to obtain an approved ADP/IT-II or ADP/IT-III Trustworthiness Determination for those positions requiring access to DoD systems containing sensitive information. Interim access is allowed as outlined in [paragraph 5.5.2.](#) above.

6.11 Preferred/Partnership Providers At OCONUS MHS Facilities (U.S. Citizens Only)

To obtain an ADP Trustworthiness Determination for a preferred/partnership provider the Security Officer of the MTF will contact the TMA Privacy Officer for instructions and guidance on completing and submitting the SF85P User Form, fingerprint cards and system access. The TMA Privacy Officer will provide guidance on system access upon contact by the Security Officer of the MTF.

6.12 ADP/IT Level Trustworthiness Determination Upgrades

Contact the TMA Privacy Office if a higher ADP/IT level is required than what was submitted for an employee. In addition, the contractor's security officer must contact the OPM Federal Investigations Processing Center, Status Line to determine the status of the investigation. OPM can upgrade the level of investigation only if the investigation has not been closed/completed. If the NAC is pending, you may fax a written request to OPM, Attention: Corrections Technician, to upgrade the NAC to a NACL. You must provide the name, SSN, and Case Number on your request (Case Number can be found on the ISN). If the SF85P User Form is missing information, the Correction Technician will call the requester for missing information. Addresses for each organization are shown below.

- TMA Privacy Office, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 22041
- OPM Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618
- OPM Corrections Department, Federal Investigations Processing Center, P.O. Box

618, Boyers, Pennsylvania, 16018-0618

If the investigation has been closed/completed, the original SF85P Agency User Form (coversheet) must be submitted for the higher ADP/IT level. The SF85P may be re-used within 120 days of the case closed date, with corrected ADP level code O8B. The letter "I" must be inserted in the Codes box located above C and D on the SF85P Agency User Form and no fingerprint card is needed. The contractor's Security Officer must update the SF85P Agency User Form, re-sign and re-date the form in Block P. The individual must line through any obsolete information, replacing it with corrected information and initial all changes made to the SF85P. The individual must then re-sign and re-date the certification section of the form.

If it is beyond the 120 day period, the old SF85P may be used if all the information is updated and the certification part of the form is re-dated, and re-signed by the individual. A new SF85P Agency User Form (coversheet) showing the correct ADP/IT level code O8B is required at this time. Each correction/change made to the form must be initialed and dated by the individual. Fingerprint cards must be submitted if the case has been closed for more than 120 days.

6.13 Access for Non-U.S. Citizens

6.13.1 Policy

Interim Access at CONUS locations for Non-U.S. Citizens is Not Authorized. Non-U.S. citizen contractor employees' investigations are not being adjudicated for any Trustworthiness positions, therefore interim access is not authorized for DoD/IT systems.

6.13.2 Grandfathering of Non-U.S. Citizens

Earlier guidance authorized the grandfathering (continuation) of certain CONUS non-U.S. Citizens who previously were working on a TRICARE contract. Grandfathered contractor personnel are authorized to continue working under the existing contract until contract expiration date. This provision is not applicable to contractor employees who opt to transition employment from a contractor holding a legacy TRICARE contract to a contractor awarded a contract under the TRICARE Next Generation series of contracts.

6.13.3 End Date of CONUS Non-U.S. Citizen Access

Access to DoD IS/Networks or data will end on December 31, 2004 for all CONUS non-U.S. Citizen contractor personnel, or in accordance with the guidance provided in paragraph 5.6.2.

6.13.4 Non-U.S. Citizens/Local Nationals Working At OCONUS MHS Facilities

Non-U.S. Citizens/Local Nationals employed by DoD organizations overseas, whose duties do not require access to classified information, shall be the subject of record checks that include host-government law enforcement and security agency checks at the city, state

(province), and national level, whenever permissible by the laws of the host government, initiated by the appropriate Military Department investigative organization prior to employment.

6.14 New Contractor Personnel With Recent Secret Clearance

New contractor personnel who have had an active secret clearance within the last two years should not submit a SF85P to OPM. The contracting company must contact the TMA Privacy Office for verification of previous investigation results..

7.0. DOD/MHS INFRASTRUCTURE SECURITY, PORTS, PROTOCOLS AND RISK MITIGATION STRATEGIES

Contractors will comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies. The Joint Task Force for Global Network Operations (JTGGNO) is the responsible proponent for the security of the DoD/MHS Infrastructure. Upon identification of security risks, the JTF-GNO issues JTF-GNO Warning Orders notifying users of scheduled changes for access to the DoD/MHS Infrastructure. TMA will provide contractors with JTF-GNO Warning Orders for review and identification of impacts to their connections with the DoD/MHS. Contractors are required to review the Warning Order upon receipt and provide a response to TMA indicating whether the change will or will not impact their connection. An example of this requirement is implementation of Public Key Infrastructure (PKI) requirements. DoD is developing requirements for the authentication of users and systems within DoD. At a date to be determined, contractors will be provided guidance for implementing the PKI requirements of DoD.

Upon identification of an impact by the contractor, the contractor shall develop a mitigation strategy to mitigate the potential risk. The mitigation strategy should identify the required actions, schedule for implementation and anticipated costs for implementation. The mitigation strategy must be submitted to TMA for review and approval by the JTF-GNO.

Mitigation strategies required for connectivity requirements, designated by the Government for the fulfillment of contract requirements, impacted by DoD guidance and/or JTF-GNO Warning Orders will be developed by the governing agencies.

8.0. PUBLIC KEY INFRASTRUCTURE (PKI)

The DoD has initiated a Public Key Infrastructure policy to enhance the identification and authentication of users and systems within DoD. The PKI program is in its initial stage and is evolving. Additional guidance as it applies to this contract will be provided as the policy and implementation guidance is finalized within DoD.

9.0. TELECOMMUNICATIONS

9.1. MHS Demilitarized Zone (DMZ) Managed Partner Care Business To Business (B2B) Gateway

9.1.1. All contractor systems that will communicate with DoD systems will interconnect

through the established MHS B2B gateway. For all Web applications, contractors will connect to a DISA-established Web DMZ.

9.1.2. In accordance with contract requirements, MCS contractors will connect to the B2B gateway via a contractor procured Internet Service Provider (ISP) connection. Contractors will assume all responsibilities for establishing and maintaining their connectivity to the B2B Gateway. This will include acquiring and maintaining the circuit to the B2B Gateway and acquiring a Virtual Private Network (VPN) device compatible with the MHS VPN device.

9.1.3. It is anticipated that modifications will also allow provisioning of dedicated point-to-point commercial circuits to the B2B gateway. The DISA B2B Gateway is a redundant service that is provisioned at two locations. If contractors require high availability, they may acquire redundant circuits to both locations.

9.1.4. Contractors will comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies.

9.2. Contractor Provided IT Infrastructure

9.2.1. Platforms shall support HTTP, HTTPS, Web derived Java Applets, client/server, FTP, secure FTP, and all software that the contractor proposes to use to interconnect with DoD facilities.

NOTE: The DoD is phasing out the use of FTP. Upon notification from the government, the contractor shall cease using FTP and begin utilizing the FTP alternative stipulated by the government.

9.2.2. Contractors shall configure their networks to support access to government systems (e.g., configure ports and protocols for access).

9.2.3. Contractors shall provide full time connections to a TIER 1 or TIER 2 ISP. Dial-up ISP connections are not acceptable.

9.3. System Authorization Access Request (SAAR) DD Form 2875

All contractors who use the Department of Defense (DoD) gateways to access government Information Technology (IT) systems must submit the most current version of DD Form 2875 found on the Defense Information Systems Agency (DISA) website: <http://www.dlis.dla.mil/PDFs/DD2875.pdf> in accordance with Contracting Officer guidance. DD Form 2875's are required for each contractor employee who will access any system on a DoD network. The DD Form 2875 must clearly specify the system name and justification for access to that system.

Contractors shall complete and submit to the TMA Privacy Office the DD Form 2875 for verification of ADP Designation. The TMA Privacy Office will verify that the contractor employee has the appropriate background investigation completed/or a request for background investigation has been submitted to the Office of Personnel Management (OPM). Acknowledgement from OPM that the request for a background investigation has been received and that an investigation has been scheduled will be verified by the TMA Privacy Office prior to approving access.

The TMA Privacy Office will forward the DD Form 2875 to the Tri-Service Infrastructure Management Program Office (TIMPO) for processing to DISA. TIMPO will forward DD Form 2875s to DISA. Once a user

account and password have been established, a representative from DISA will notify the user of his/her ID and password via email. User IDs and passwords are not to be shared.

The contracting organization shall review a list of individuals, no less than monthly, who have been granted access to DoD networks to verify that access is still required. The TMA Privacy Office shall be notified on a monthly or more frequent basis of any de-activations that are required. Negative responses are also required to ensure a review has been done.

9.4. **MHS Systems Telecommunications**

9.4.1. The primary communication links shall be via Secure Internet Protocol (IPSEC) virtual private network (VPN) tunnels between the contractor's primary site and the MHS B2B Gateway.

9.4.2. The contractor shall place the VPN appliance device outside the contractor's firewalls and shall allow full management access to this device (e.g., in router access control lists) to allow Central VPN Management services provided by the Defense Information Systems Agency (DISA) or other source of service as designated by the MHS to remotely manage, configure, and support this VPN device as part of the MHS VPN domain.

9.4.3. For backup purposes, an auxiliary VPN device for contractor locations shall also be procured and configured for operation to minimize any downtime associated with problems of the primary VPN.

9.4.4. The MHS VPN management authority (e.g., DISA) will remotely configure the VPN once installed by the contractor.

9.4.5. Maintenance and repair of contractor procured VPN equipment shall be the responsibility of the contractor. Troubleshooting of VPN equipment shall be the responsibility of the government.

9.5. **Contractors Located On Military Treatment Facilities (MTFs)**

9.5.1. If the contractor plans to locate personnel on a military facility, the contractor must coordinate with the Base/Post/Camp communications office and the MTF.

9.5.2. Contractors located on military facilities who require direct access to government systems shall coordinate/obtain these connections with the local MTF and Base/Post/Camp communication personnel. These connections will be furnished by the government.

9.5.3. Contractors located on military facilities that require direct connections to their networks shall either:

- Coordinate their network connections to the respective military infrastructure and through the MHS B2B Gateway.
- If the contractor requires a direct connection back to the contractor's network, they shall provide an isolated IT infrastructure, coordinate with the Base/Post/Camp communications personnel and the MTF in order to get

approval for a contractor procured circuit to be installed and to ensure the contractor is within compliance with the respective organizational security policies, guidance and protocols. Note: In some cases, the contractor may not be allowed to establish these connections due to local administrative/security requirements.

9.5.4. The contractor shall be responsible for all security certification documentation as required to support DoD Information Assurance requirements for network interconnections. Further, the contractor shall provide, on request, detailed network configuration diagrams to support DIACAP accreditation requirements. The contractor shall comply with DIACAP accreditation requirements. All network traffic shall be via TCP/IP using ports and protocols in accordance with current Service security policy. All traffic that traverses MHS, DMDC, and/or military Service Base/Post/Camp security infrastructure is subject to monitoring by security staff using Intrusion Detection Systems.

9.6. DEERS

9.6.1. Primary Site

9.6.1.1. The DEERS primary site is located in Auburn Hills, Michigan and the backup site is located in Seaside, California.

9.6.1.2. The contractor shall communicate with DEERS through the MHS B2B Gateway.

9.6.2. PCs/Hardware

The contractor is responsible for all systems and operating system software needed internally to support the DOES.

9.7. TMA/TRICARE Encounter Data

9.7.1. Primary Site

The TRICARE Encounter Data (TED) primary site is currently located in Denver, Colorado, and operated by the Defense Enterprise Computing Center (DECC), Denver Detachment for the DISA. Note: The location of the primary site may be changed. The contractor shall be advised should this occur.

9.7.2. General

The common means of administrative communication between Government representatives and the contractor is via telephone and e-mail. An alternate method may be approved by TMA, as validated and authorized by TMA. Each contractor on the telecommunication network is responsible for furnishing to TMA at the start-up planning meeting (and update when a change occurs), the name, address, and telephone number of the person who will serve as the technical point of contact. Contractors shall also furnish a separate computer center (Help Desk) number to TMA which the TMA computer operator can use for resolution of problems related to data transmissions.

9.7.3. TED-Specific Data Communications Technical Requirements

9.7.3.1. Systems Interface Requirements

The contractor shall communicate with the government's Data Center through the MHS B2B Gateway.

9.7.3.2. Communication Protocol Requirements

9.7.3.2.1. File transfer software shall be used to support communications with the TED Data Processing Center. CONNECT:Direct is the current communications software standard for TED transmissions. The contractor is expected to upgrade/comply with any changes to this software. The contractor shall provide this product and a platform capable of supporting this product with the TCP/IP option included. Details on this product can be obtained from:

Sterling Commerce
4600 Lakehurst Court
P.O. Box 8000
Dublin, OH 43016-2000 USA
<http://www.sterlingcommerce.com/solutions/products/ebi/connect/direct.html>
Phone: 614-793-7000
Fax: 614-793-4040

9.7.3.2.2. For Ports and Protocol support, TCP/IP communications software incorporating the TN3270 emulation shall be provided by the contractor.

9.7.3.2.3. Transmission size is limited to any combination of 250,000 records at one time.

9.7.3.2.4. "As Required" Transfers

Ad hoc movement of data files shall be coordinated through and executed by the network administrator or designated representative at the source file site. Generally speaking, the requestor needs only to provide the point of contact at the remote site, and the source file name. Destination file names shall be obtained from the network administrator at the site receiving the data. Compliance with naming conventions used for recurring automated transfers is not required. Other site specific requirements, such as security constraints and pool names are generally known to the network administrators.

9.7.3.2.5. File Naming Convention

9.7.3.2.5.1. All files received by and sent from the TMA data processing site shall comply with the following standard when using CONNECT:Direct:

POSITION(S)	CONTENT
1 - 2	'TD'
3 - 8	YYMMDD Date of transmission
9 - 10	Contractor number
11 - 12	Sequence number of the file sent on a particular day. Ranges from 01 to 99. Reset with the first file transmission the next day.

9.7.3.2.5.2. All files sent from the TMA data processing site shall be named after coordination with receiving entities in order to accommodate specific communication requirements for the receivers.

9.7.3.2.5.3. **Timing**

Telecommunication transfers during normal business hours may be adversely affected by normal processing. Therefore, every attempt shall be made to maximize utilization of telecommunications lines by deferring transfers to night-time operation. Ideally, a single file will be transmitted at night. However, there are no restrictions on the number of files that may be transmitted. Under most circumstances, the source file site shall initiate automated processes to cause transmission to occur. With considerations for timing and frequency, activation of transfers for each application shall be addressed on a case by case basis.

9.7.3.2.5.4. **Alternate Transmission**

Should the contractor not be able to transmit their files through the normal operating means, the contractor should notify TMA (EL/DS Operations) that they will be sending their files by tape via overnight delivery.

9.8. **TMA/MHS Referral And Authorization System**

9.8.1. **Primary Site**

The MHS Referral and Authorization System primary site is to be determined.

9.8.2. **PCs/Hardware**

The contractor is responsible for all systems and operating system software needed internally to support the MHS Referral and Authorization System.

9.9. **TMA/TRICARE Duplicate Claims System**

9.9.1. **Primary Site**

The TRICARE Duplicate Claims System (DCS) primary site is located in Aurora, Colorado. Note: The location of the primary site may be changed. The contractor shall be advised should this occur.

9.9.2. Contractor Connection With TMA For The Duplicate Claims System (DCS)

The DCS is planned to operate as a web application. The contractor is responsible for providing internal connectivity to the public Internet. The contractor is responsible for all systems and operating system software needed internally to support the DCS. (See the TRICARE Operations Manual, [Chapters 9](#) and [10](#) for DCS Specifications.)

10.0. PRIVACY IMPACT ASSESSMENT (PIA) ONLINE

It is the responsibility of the contractor to employ practices that satisfy the requirements and regulations of the Privacy Act of 1974, as Amended (5 USC 552a); the E-Government Act 2002 (Public Law 107-347, 44 USC CH36 <http://uscode.house.gov/download/pls/44C36.txt>) - Section 208; the Office of Management and Budget (OMB) Guidance for Implementing the Privacy Provisions of the E-Government Memorandum 03-22 (September 26, 2003) and OMB Circular A-130 Management of Federal Information Resources; and Department of Defense (DoD) Privacy Impact Assessment (PIA) Guidance, October 28, 2005 and TMA reference: TMA Memorandum Tricare Management Activity Privacy Impact Assessments (PIAs) , February 10, 2006. In implementing the privacy provisions of the above, the contractor shall complete a Privacy Impact Assessment (PIA) when developing, sustaining or procuring information technology systems or projects that collect, maintain, or disseminate information in identifiable form from or about members of the public (which shall include all TRICARE beneficiaries) totaling at least 10 individuals. Contractors and their subcontractors shall follow the guidelines outlined within the TRICARE Management Activity Privacy Impact Assessment Online User and Program Manager Guide 2006 Version 3.0.

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
1.1 Procedural Review	An annual IA review is conducted that comprehensively evaluates existing policies and processes to ensure procedural consistency and to ensure that they fully support the goal of uninterrupted operations. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
1.2 Best Security Practices	The DoD information system security design incorporates best security practices such as single sign-on, PKE, smart card, and biometrics. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.3 Control Board	All DoD information systems are under the control of a chartered configuration control board that meets regularly. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.4 Configuration Specifications	A DoD reference document, such as a security technical implementation guide or security recommendation guide constitutes the primary source for security configuration or implementation guidance for the deployment of newly acquired IA- and IA-enabled IT products that require use of the product's IA capabilities. If a DoD reference document is not available, the following are acceptable in descending order as available: (1) Commercially accepted practices (e.g., SANS); (2) Independent testing results (e.g., ICSSA); or (3) Vendor literature. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.5 Compliance Testing	A comprehensive set of procedures is implemented that tests all patches, upgrades, and new AIS applications prior to deployment. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
1.6 Dedicated IA Services	Acquisition or outsourcing of dedicated IA services, such as incident monitoring, analysis and response;	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	operation of IA devices, such as firewalls; or key management services are supported by a formal risk analysis and approved by the DoD Component CIO. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
1.7 Functional Architecture for AIS Applications	For AIS applications, a functional architecture that identifies the following has been developed and is maintained: - all external interfaces, the information being exchanged, and the protection mechanisms associated with each interface; - user roles required for access control and the access privileges assigned to each role; - unique security requirements (e.g., encryption of key data elements at rest); - categories of sensitive information processed or stored by the AIS application, and their specific protection plans (e.g., Privacy Act, HIPAA); - restoration priority of subsystems, processes, or information. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.8 Hardware (HW) Baseline	A current and comprehensive baseline inventory of all hardware (HW) (to include manufacturer, type, model, physical location and network topology or architecture) required to support enclave operations is maintained by the Configuration Control Board (CCB) and as part of the SSAA. A backup copy of the inventory is stored in a fire-rated container or otherwise not collocated with the original. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
1.9 Interconnection Documentation	For AIS applications, a list of all [potential] hosting enclaves is developed and maintained along with evidence of deployment planning and coordination and the exchange of connection rules and requirements. For enclaves, a list of all hosted AIS applications, interconnected outsourced IT-based processes, and interconnected IT platforms is developed and maintained along with evidence of deployment planning and coordination and the exchange of connection rules and requirements. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.10 IA Impact Assessment	Changes to the DoD information system are assessed for IA and accreditation impact prior to implementation. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.11 IA for IT Services	Acquisition or outsourcing of IT services explicitly addresses Government, service provider, and end user IA roles and responsibilities. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.12 Mobile Code	The acquisition, development, and/or use of mobile code to be deployed in DoD systems meets the following requirements {1 - 7 below}: (Ref: DODI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
	(1) Emerging mobile code technologies that have not undergone a risk assessment by NSA and been assigned to a Risk Category by the DoD CIO is not used. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	<p>(2) Category 1 mobile code is signed with a DoD-approved PKI code signing certificate; use of unsigned Category 1 mobile code is prohibited; use of Category 1 mobile code technologies that cannot block or disable unsigned mobile code (e.g., Windows Scripting Host) is prohibited. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p> <p>(3) Category 2 mobile code which executes in a constrained environment without access to system resources (e.g., Windows registry, file system, system parameters, network connections to other than the originating host) may be used. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p> <p>(4) Category 2 mobile code that does not execute in a constrained environment may be used when obtained from a trusted source over an assured channel (e.g., SIPRNET, SSL connection, S/MIME, code is signed with a DoD-approved code signing certificate). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p> <p>(5) Category 3 mobile code may be used. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p> <p>(6) All DoD workstation and host software are configured, to the extent possible, to prevent the download and execution of mobile code that is prohibited. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p> <p>(7) The automatic execution of all mobile code in email is prohibited; email software is configured to prompt the user prior to executing mobile code in attachments. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p>	<p>Integrity</p> <p>Integrity</p> <p>Integrity</p> <p>Integrity</p> <p>Integrity</p> <p>Integrity</p>	<p>R</p> <p>R</p> <p>R</p> <p>R</p> <p>R</p> <p>R</p>
1.13 Non-repudiation	NIST FIPS 140-2 validated cryptography (e.g., DoD PKI class 3 or 4 token) is used to implement	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	encryption (e.g., AES, 3DES, DES, Skipjack), key exchange (e.g., FIPS 171), digital signature (e.g., DSA, RSA, ECDSA), and hash (e.g., SHA-1, SHA-256, SHA-384, SHA-512). Newer standards should be applied as they become available. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
1.14 Public Domain Software Controls	Binary or machine executable public domain software products and other software products with limited or no warranty such as those commonly known as freeware or shareware are not used in DoD information systems unless they are necessary for mission accomplishment and there are no alternative IT solutions available. Such products are assessed for information assurance impacts, and approved for use by the DAA. The assessment addresses the fact that such software products are difficult or impossible to review, repair, or extend, given that the Government does not have access to the original source code and there is no owner who could make such repairs on behalf of the Government. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
1.15 Ports, Protocols, and Services	DoD information systems comply with DoD ports, protocols, and services guidance. AIS applications, outsourced IT-based processes and platform IT identify the network ports, protocols, and services they plan to use as early in the life cycle as possible and notify hosting enclaves. Enclaves register all active ports, protocols, and services in accordance with DoD and DoD Component guidance. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
1.16 Configuration Management Process	A configuration management (CM) process is implemented that includes requirements for: (1) Formally documented CM roles, responsibilities, and procedures to include the management of IA	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	<p>information and documentation; (2) A configuration control board that implements procedures to ensure a security review and approval of all proposed DoD information system changes, to include interconnections to other DoD information systems; (3) a testing process to verify proposed configuration changes prior to implementation in the operational environment; and (4) A verification process to provide additional assurance that the CM process is working effectively and that changes outside the CM process are technically or procedurally not permitted. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p>		
1.17 Information Assurance Documentation	<p>All appointments to required IA roles (e.g., DAA and Information Assurance Manager/Information Assurance Officer) are established in writing, to include assigned duties and appointment criteria such as training, security clearance, and IT-designation. A System Security Plan is established that describes the technical, administrative, and procedural IA program and policies that govern the DoD information system, and identifies all IA personnel and specific IA requirements and objectives (e.g., requirements for data handling or dissemination, system redundancy and backup, or emergency response). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p>	Availability	R
1.18 System Library Management Controls	<p>System libraries are managed and maintained to protect privileged programs and to prevent or minimize the introduction of unauthorized code. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.</p>	Integrity	R
1.19 Software Quality	<p>Software quality requirements and validation methods that are focused on the minimization of flawed or malformed software that can negatively impact integrity or availability (e.g., buffer overruns) are specified for all software development initiatives.</p>	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	(Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
1.20 System State Changes	System initialization, shutdown, and aborts are configured to ensure that the system remains in a secure state. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
1.21 Software (SW) Baseline	A current and comprehensive baseline inventory of all software (SW) (to include manufacturer, type, and version and installation manuals and procedures) required to support DoD information system operations is maintained by the CCB and as part of the C&A documentation. A backup copy of the inventory is stored in a fire-rated container or otherwise not collocated with the original. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
1.22 Acquisition Standards	The acquisition of all IA- and IA-enabled GOTS IT products is limited to products that have been evaluated by the NSA or in accordance with NSA-approved processes. The acquisition of all IA- and IA-enabled COTS IT products is limited to products that have been evaluated or validated through one of the following sources - the International Common Criteria (CC) for Information Security Technology Evaluation Mutual Recognition Arrangement, the NIAP Evaluation and Validation Program, or the FIPS validation program. Robustness requirements, the mission, and customer needs will enable an experienced information systems security engineer to recommend a Protection Profile, a particular evaluated product or a security target with the appropriate assurance requirements for a product to be submitted for evaluation (See also DCSR-1). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
1.23 Specified Robustness - Medium	At a minimum, medium-robustness COTS IA and IA-enabled products are used to protect sensitive	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	<p>information when the information transits public networks or the system handling the information is accessible by individuals who are not authorized to access the information on the system. The medium-robustness requirements for products are defined in the Protection Profile Consistency Guidance for Medium Robustness published under the IATF.</p> <p>Applies to MAC II and MAC III.</p> <p>COTS IA and IA-enabled IT products used for access control, data separation, or privacy on sensitive systems already protected by approved medium-robustness products, at a minimum, satisfy the requirements for basic robustness. If these COTS IA and IA-enabled IT products are used to protect National Security Information by cryptographic means, NSA-approved key management may be required. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>		R
2.0 Identification and Authentication			
2.1 Key Management	<p>Symmetric Keys are produced, controlled, and distributed using NIST-approved key management technology and processes. Asymmetric Keys are produced, controlled, and distributed using DoD PKI Class 3 certificates or pre-placed keying material. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Integrity	R
2.2 Token and Certificate Standards	<p>Identification and authentication is accomplished using the DoD PKI Class 3 or Class 4 certificate and hardware security token (when available). (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Integrity	R
2.3 Group Identification and Authentication	<p>Group authenticators for application or network access may be used only in conjunction with an individual authenticator. Any use of group authenticators not based on the DoD PKI has been explicitly approved by the Designated Approving Authority (DAA). (Ref: DoDI 8500.2, February 6,</p>	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	2003) Applies to MAC II and MAC III.		
2.4 Individual Identification and Authentication	DoD information system access is gained through the presentation of an individual identifier (e.g., a unique token or user login ID) and password. For systems utilizing a logon ID as the individual identifier, passwords are, at a minimum, a case sensitive 8-character mix of upper case letters, lower case letters, numbers, and special characters, including at least one of each (e.g., emPagd2!). At least four characters must be changed when a new password is created. Deployed/tactical systems with limited data input capabilities implement the password to the extent possible. Registration to receive a user ID and password includes authorization by a supervisor, and is done in person before a designated registration authority. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
	Additionally, to the extent system capabilities permit, system mechanisms are implemented to enforce automatic expiration of passwords and to prevent password reuse. All factory set, default or standard-user IDs and passwords are removed or changed. Authenticators are protected commensurate with the classification or sensitivity of the information accessed; they are not shared; and they are not embedded in access scripts or stored on function keys. Passwords are encrypted both for storage and for transmission. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
3.0 Enclave and Computing Environment			
3.1 Audit Trail, Monitoring, Analysis and Reporting	Audit trail records from all available sources are regularly reviewed for indications of inappropriate or unusual activity. Suspected violations of IA policies are analyzed and reported in accordance with DoD information system IA procedures. (Ref: DoDI	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	8500.2, February 6, 2003) Applies to MAC II and MAC III.		
3.2 Changes to Data	Access control mechanisms exist to ensure that data is accessed and changed only by authorized personnel. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.3 Instant Messaging	Instant messaging traffic to and from instant messaging clients that are independently configured by end users and that interact with a public service provider is prohibited within DoD information systems. Both inbound and outbound public service instant messaging traffic is blocked at the enclave boundary. Note: This does not include IM services that are configured by a DoD AIS application or enclave to perform an authorized and official function. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.4 Network Device Controls	An effective network device (e.g., routers, switches, firewalls) control program is implemented and includes: instructions for restart and recovery procedures; restrictions on source code access, system utility access, and system documentation; protection from deletion of system and application files, and a structured process for implementation of directed solutions (e.g., IAVA). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC III.	Integrity	R
3.5 Privileged Account Control	All privileged user accounts are established and administered in accordance with a role-based access scheme that organizes all system and network privileges into roles (e.g., key management, network, system administration, database administration, web administration). The IAM tracks privileged role assignments. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.6 Production Code Change Controls	Application programmer privileges to change production code and data are limited and are	Integrity	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	periodically reviewed. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
3.7 Audit Reduction and Report Generation	Tools are available for the review of audit records and for report generation from audit records. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.8 Security Configuration Compliance	For Enclaves and AIS applications, all DoD security configuration or implementation guides have been applied. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
3.9 Software Development Change Controls	Change controls for software development are in place to prevent unauthorized programs or modifications to programs from being implemented. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.10 Transmission Integrity Controls	Good engineering practices with regards to the integrity mechanisms of COTS, GOTS and custom developed solutions are implemented for incoming and outgoing files, such as parity checks and cyclic redundancy checks (CRCs). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.11 Audit Trail Protection	The contents of audit trails are protected against unauthorized access, modification, or deletion. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.12 Voice over Internet Protocol	Voice over Internet Protocol (VoIP) traffic to and from workstation IP telephony clients that are independently configured by end users for personal use is prohibited within DoD information systems. Both inbound and outbound individually configured voice over IP traffic is blocked at the enclave boundary. Note: This does not include VoIP services that are configured by a DoD AIS application or enclave to perform an authorized and official function. (Ref: DoDI 8500.2, February 6, 2003)	Availability	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	Applies to MAC II and MAC III.		
3.13 Virus Protection	All servers, workstations, and mobile computing devices implement virus protection that includes a capability for automatic updates. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
3.14 Wireless Computing and Networking	Wireless computing and networking capabilities from workstations, laptops, personal digital assistants (PDAs), handheld computers, cellular phones, or other portable electronic devices are implemented in accordance with DoD wireless policy, as issued. Unused wireless computing capabilities internally embedded in interconnected DoD IT assets are normally disabled by changing factory defaults, settings or configurations prior to issue to end users. Wireless computing and networking capabilities are not independently configured by end users. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
3.15 Affiliation Display	To help prevent inadvertent disclosure of controlled information, all contractors are identified by the inclusion of the abbreviation "ctr" and all foreign nationals are identified by the inclusion of their two-character country code in: - DoD user e-mail addresses (e.g., john.smith.ctr@army.mil or john.smith.uk@army.mil); - DoD user e-mail display names (e.g., John Smith, Contractor<john.smith.ctr@army.mil> or John Smith, United Kingdom <john.smith.uk@army.mil>); and - automated signature blocks (e.g., John Smith, Contractor, J-6K, Joint Staff or John Doe, Australia, LNO, Combatant Command). Contractors who are also foreign nationals are identified as both (e.g., john.smith.ctr.uk@army.mil). Country codes and guidance regarding their use are in FIPS 10-4. (Ref: DoDI 8500.2, February 6, 2003)	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
Applies to MAC II and MAC III.			
3.16 Access for Need-to-Know	<p>Access to all DoD information is determined by both its classification and user need-to-know. Need-to-know is established by the Information Owner and enforced by discretionary or role-based access controls. Access controls are established and enforced for all shared or networked file systems and internal websites, whether classified, sensitive, or unclassified. All internal classified, sensitive, and unclassified websites are organized to provide at least three distinct levels of access:</p> <p>(1) Open access to general information that is made available to all DoD authorized users with network access. Access does not require an audit transaction.</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
	<p>(2) Controlled access to information that is made available to all DoD authorized users upon the presentation of an individual authenticator. Access is recorded in an audit transaction.</p> <p>(3) Restricted access to need-to-know information that is made available only to an authorized community of interest. Authorized users must present an individual authenticator and have either a demonstrated or validated need-to-know. All access to need-to-know information and all failed access attempts are recorded in audit transactions. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.17 Audit Record Content	<p>Audit records include:</p> <ul style="list-style-type: none"> - User ID. - Successful and unsuccessful attempts to access security files. - Date and time of the event. - Type of event. - Success or failure of event. 	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	<ul style="list-style-type: none"> - Successful and unsuccessful logons. - Denial of access resulting from excessive number of logon attempts. - Blocking or blacklisting a user ID, terminal or access port and the reason for the action. - Activities that might modify, bypass, or negate safeguards controlled by the system. (Ref: DoDI 8500.2, February 6, 2003) <p>Applies to MAC II and MAC III.</p>		
3.18 Encryption for Confidentiality (Data at Rest)	<p>If required by the information owner, NIST-certified cryptography is used to encrypt stored sensitive information. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.19 Encryption for Confidentiality (Data in Transit)	<p>Unclassified, sensitive data transmitted through a commercial or wireless network are encrypted using NIST-certified cryptography (See also DCSR-2). (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.20 Interconnections among DoD Systems and Enclaves	<p>Discretionary access controls are a sufficient IA mechanism for connecting DoD information systems operating at the same classification, but with different need-to-know access rules. A controlled interface is required for interconnections among DoD information systems operating at different classifications levels or between DoD and non-DoD systems or networks. Controlled interfaces are addressed in separate guidance. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.21 Logon	<p>Successive logon attempts are controlled using one or more of the following:</p> <ul style="list-style-type: none"> - access is denied after multiple unsuccessful logon attempts. - the number of access attempts in a given period is limited. - a time-delay control system is employed. 	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	<p>If the system allows for multiple-logon sessions for each user ID, the system provides a capability to control the number of logon sessions. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>		
3.22 Least Privilege	<p>Access procedures enforce the principles of separation of duties and "least privilege." Access to privileged accounts is limited to privileged users. Use of privileged accounts is limited to privileged functions; that is, privileged users use non-privileged accounts for all non-privileged functions. This control is in addition to an appropriate security clearance and need-to-know authorization. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.23 Marking and Labeling	<p>Information and DoD information systems that store, process, transit, or display data in any form or format that is not approved for public release comply with all requirements for marking and labeling contained in policy and guidance documents, such as DOD 5200.1R. Markings and labels clearly reflect the classification or sensitivity level, if applicable, and any special dissemination, handling, or distribution instructions. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.24 Conformance Monitoring and Testing	<p>Conformance testing that includes periodic, unannounced, in-depth monitoring and provides for specific penetration testing to ensure compliance with all vulnerability mitigation procedures such as the DoD IAVA or other DoD IA practices is planned, scheduled, and conducted. Testing is intended to ensure that the system's IA capabilities continue to provide adequate assurance against constantly evolving threats and vulnerabilities. (Ref: DoDI 8500.2, February 6, 2003)</p> <p>Applies to MAC II and MAC III.</p>	Confidentiality	R
3.25 Encryption for Need-To-Know	Information in transit through a network at the same	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	classification level, but which must be separated for need-to-know reasons, is encrypted, at a minimum, with NIST-certified cryptography. This is in addition to ECCT (encryption for confidentiality). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
3.26 Resource Control	All authorizations to the information contained within an object are revoked prior to initial assignment, allocation, or reallocation to a subject from the system's pool of unused objects. No information, including encrypted representations of information, produced by a prior subject's actions is available to any subject that obtains access to an object that has been released back to the system. There is absolutely no residual data from the former object. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
3.27 Audit Record Retention	If the DoD information system contains sources and methods intelligence (SAMI), then audit records are retained for 5 years. Otherwise, audit records are retained for at least 1 year. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Integrity	R
3.28 Tempest Controls	Measures to protect against compromising emanations have been implemented according to DoD Directive S-5200.19. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	A
3.29 Warning Message	All users are warned that they are entering a Government information system, and are provided with appropriate privacy and security notices to include statements informing them that they are subject to monitoring, recording and auditing. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
3.30 Account Control	A comprehensive account management process is implemented to ensure that only authorized users can	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	gain access to workstations, applications, and networks and that individual accounts designated as inactive, suspended, or terminated are promptly deactivated. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
4.0 Enclave Boundary Defense			
4.1 Boundary Defense	Boundary defense mechanisms to include firewalls and network intrusion detection systems (IDS) are deployed at the enclave boundary to the wide area network, at layered or internal enclave boundaries and at key points in the network, as required. All Internet access is proxied through Internet access points that are under the management and control of the enclave and are isolated from other DoD information systems by physical or technical means. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
4.2 Connection Rules	The DoD information system is compliant with established DoD connection rules and approval processes. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
4.3 Virtual Private Network Controls (VPN)	All VPN traffic is visible to network intrusion detection systems (IDS). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
4.4 Intrusion Detection	Certify and evaluate the availability and effectiveness of tools and procedures to ensure real-time monitoring and alerts, intrusion detection, network analysis, audit analysis, user management, risk analysis, and network configuration management tools. Applies to MAC II and MAC III.	Availability	R
4.5 Public WAN Connection	Connections between DoD enclaves and the Internet or other public or commercial wide area networks require a demilitarized zone (DMZ). (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
4.6 Remote Access for Privileged Functions	Remote access for privileged functions is discouraged, is permitted only for compelling operational needs, and is strictly controlled. In addition to EBRU-1, sessions employ security measures, such as a VPN with blocking mode enabled. A complete audit trail of each remote session is recorded, and the IAM/O reviews the log for every remote session. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
4.7 Remote Access for User Functions	All remote access to DoD information systems, to include telework access, is mediated through a managed access control point, such as a remote access server in a DMZ. Remote access always uses encryption to protect the confidentiality of the session. The session level encryption equals or exceeds the robustness established in ECCT. Authenticators are restricted to those that offer strong protection against spoofing. Information regarding remote access mechanisms (e.g., Internet address, dial-up connection telephone number) is protected. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Confidentiality	R
5.0 Continuity			
5.1 Alternate Site Designation	An alternate site is identified that permits the partial restoration of mission or business essential functions. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.2 Protection of Backup and Restoration Assets	Procedures are in place assure the appropriate physical and technical protection of the backup and restoration hardware, firmware, and software, such as router tables, compilers, and other security-related system software. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.3 Data Backup Procedures	Data backup is performed at least weekly. (Ref:	Availability	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
5.3.1 Data Continuity	Certify that each file or data collection in the system has an identifiable source throughout its life cycle. (Ref: OMB A-130, Appx III, Transmittal No. 4) Applies to MAC II and MAC III.	Availability	R
5.4 Disaster and Recovery Planning	A disaster plan exists that provides for the partial resumption of mission or business essential functions within 5 days of activation. (Disaster recovery procedures include business recovery plans, system contingency plans, facility disaster recovery plans, and plan acceptance.) (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.5 Enclave Boundary Defense	Enclave boundary defense at the alternate site provides security measures equivalent to the primary site. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.6 Scheduled Exercises and Drills	The continuity of operations or disaster recovery plans are exercised annually. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.7 Identification of Essential Functions	Mission and business essential functions are identified for priority restoration planning. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.8 Maintenance Support	Maintenance support for key IT assets is available to respond within 24 hours of failure. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.9 Power Supply	Electrical power is restored to key IT assets by manually activated power generators upon loss of electrical power from the primary source. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.10 Spares and Parts	Maintenance spares and spare parts for key IT assets can be obtained within 24 hours of failure. (Ref:	Availability	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
5.11 Backup Copies of Critical SW	Back-up copies of the operating system and other critical software are stored in a fire rated container or otherwise not collocated with the operational software. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
5.12 Trusted Recovery	Recovery procedures and technical system features exist to ensure that recovery is done in a secure and verifiable manner. Circumstances that can inhibit a trusted recovery are documented and appropriate mitigating procedures have been put in place. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
6.0 Vulnerability and Incident Management			
6.1 Incident Response Planning	An incident response plan exists that identifies the responsible Computer Network Defense Service Provider in accordance with DoD Instruction O-8530.2, defines reportable incidents, outlines a standard operating procedure for incident response to include INFOCON, provides for user training, and establishes an incident response team. The plan is exercised at least annually. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.	Availability	R
6.2 Vulnerability Management	A comprehensive vulnerability management process that includes the systematic identification and mitigation of software and hardware vulnerabilities is in place. Wherever system capabilities permit, mitigation is independently validated through inspection and automated vulnerability assessment or state management tools. Vulnerability assessment tools have been acquired, personnel have been appropriately trained, procedures have been developed, and regular internal and external assessments are conducted. For improved interoperability, preference is given to tools that	Availability	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	express vulnerabilities in the Common Vulnerabilities and Exposures (CVE) naming convention and use the Open Vulnerability Assessment Language (OVAL) to test for the presence of vulnerabilities. (Ref: DoDI 8500.2, February 6, 2003) Applies to MAC II and MAC III.		
7.0 Certification and Accreditation			
7.1 Assurance	Each information system shall be accredited to operated in accordance with a DAA-approved set of security safeguards. Accreditation will provide the DAA with a measure of confidence that the security features and architecture of an information system accurately mediates and enforces the security policy. Applies to MAC II and MAC III.	Availability	R
7.2 Interim Approval To Operate (IATO)	Information system may be granted and Interim Approval To Operate (IATO) in accordance with a DAA-approved set of security safeguards. The IATO will allow the information system to deploy while enhancement to the security posture of the information system are being implemented.	Availability	R
7.3 Approval to Operate (ATO)	Each information system shall be accredited to operated in accordance with a DAA-approved set of security safeguards. Accreditation will provide the DAA with a measure of confidence that the security features and architecture of an information system accurately mediates and enforces the security policy. Applies to MAC II and MAC III.	Availability	R
7.4 System Security Periodic Reviews	Information system shall be subject to system security periodic reviews to ensure no new security risk to the information system has been introduced since the receipt of an ATO for the information system. The periodic reviews will also validate that any changes to the information system since the receipt of an ATO are properly documented. Applies to MAC II and MAC III.	Availability	R
7.5 Re-Accreditation	Each information system shall be accredited to operated in accordance with a DAA-approved set of	Availability	R

DIACAP CHECKLIST

Requirement	Description	Information Assurance Service	Required (R)/ Addressable (A)
1.0 Security Design and Configuration			
	security safeguards. Accreditation will provide the DAA with a measure of confidence that the security features and architecture of an information system accurately mediates and enforces the security policy. Applies to MAC II and MAC III.		
Definitions			
Availability	Timely, reliable access to data and information services for authorized users.		
Confidentiality	Assurance that information is not disclosed to unauthorized entities or processes.		
Integrity	Quality of an information system reflecting the logical correctness and reliability of the operating system; the logical completeness of the hardware and software implementing the protection mechanisms; and the consistency of the data structures and occurrence of the stored data. Note that, in a formal security mode, integrity is interpreted more narrowly to mean protection against unauthorized modification or destruction of information.		

[Add appropriate classification markings]



SITE NAME

PSA SITE NAME

PSA SITE TYPE

REPORT OF FINDINGS

PHYSICAL SECURITY ASSESSMENT

D MONTH YYYY

Prepared for:

Military Health System (MHS)/TRICARE Management Activity (TMA)
Office of the Chief Information Officer (OCIO)
Information Assurance (IA) Program Office

[Add appropriate classification markings]
H94002-09-C-0003 – Attachment 7

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6	ADDENDUM – PHYSICAL SECURITY ASSESSMENT MATRIX	Error! Bookmark not defined

[Add appropriate classification markings]

H94002-09-C-0003 – Attachment 7

**REPORT OF FINDINGS, PHYSICAL SECURITY ASSESSMENT OF [SITE
NAME, PSA SITE NAME, PSA SITE TYPE, CITY, STATE]**

Purpose and Scope

The purpose of conducting the Physical Security Assessment (PSA) was to determine the extent to which facilities comply with Department of Defense (DoD) and Military Health Systems (MHS)/TRICARE Management Activity (TMA) physical security control requirements.

The scope of the assessment included all facilities in which MHS/TMA beneficiary and related DoD information are housed. This PSA was conducted under the direction and authority of the Director of Information Assurance, TMA. The assessment addressed all of the items on the PSA Matrix, contained in the Addendum to this Report. The PSA is an integral element of the MHS/TMA DoD Information Assurance Certification and Accreditation Process (DIACAP).

The personnel conducting the assessment used the PSA Matrix. The PSA Matrix is based on requirements set forth in:

- DoD Instruction 8510.01. "DoD Information Assurance Certification and Accreditation Process." 28 November 2007.
- DoD Directive 8500.01E. "Information Assurance (IA)." 24 October 2002. Certified current 23 April 2007.
- DoD Instruction 8500.2. "Information Assurance (IA) Implementation." 6 February 2003.
- DoD 5200.8-R. "Physical Security Program." 9 April 2007.
- Defense Information Systems Agency Computing Services. "Security Handbook." Version 3, Change 1. 1 December 2000.
- "Military Health System Information Assurance Policy Guidance." 27 March 2007.

[Add appropriate classification markings]

H94002-09-C-0003 – Attachment 7

FACILITY DESCRIPTION

Facility Description

Insert facility description text here.

Physical Security

Insert physical security text here.

[Add appropriate classification markings]

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PERSONNEL CONTACTED

The following *[Site Name]* personnel listed in Table 3-1 were contacted in support of this Physical Security Assessment (PSA).

Personnel Contacted in Support of the Physical Security Assessment		
Name	Role	Contact Information
<i>First Name X. Last Name</i>	<i>Title, Site Name</i>	<i>000-000-0000, ext. contact email</i>

Table 3-1: Personnel Contacted in Support of the Physical Security Assessment

[Add appropriate classification markings]

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PERSONNEL CONDUCTING THE ASSESSMENT

The Military Health System (MHS)/TRICARE Management Activity (TMA) Information Assurance (IA) personnel listed in Table 4-1 conducted this Physical Security Assessment (PSA) on *D Month YYYY*.

Personnel Conducting the Physical Security Assessment		
Name	Role	Contact Information
<i>First Name X. Last Name</i>	Security Consultant <i>XYZ Corporation</i>	<i>000-000-0000</i> <i>first.last@XYZ.com</i>

Table 4-1: Personnel Conducting the Physical Security Assessment

[Add appropriate classification markings]

SUMMARY OF FINDINGS

The results of the *PSA Site Name PSA Site Type* Physical Security Assessment (PSA) are summarized in Table 5-1.

Physical Security Assessment Findings (Summary)			
Item No. and Finding Requirement	Finding/Vulnerability	Recommendation(s)	Recommendations Validated as of DATE
	<i>No findings</i>		

Table 5-1: Physical Security Assessment Findings (Summary)

[Add appropriate classification markings]

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[Add appropriate classification markings]

ADDENDUM TO ARTIFACT 9

PHYSICAL SECURITY ASSESSMENT MATRIX

[Add appropriate classification markings]

6

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ADDENDUM – PHYSICAL SECURITY ASSESSMENT MATRIX

Major focus areas are broken into numbered sub-items and are further designated as either required or addressable.

A required sub-item is defined as an area where risk must be mitigated utilizing one of the strategies listed.

An addressable sub-item is defined as an area where risk may be mitigated by alternative measures.

“Implement Requirement” in the Mitigation Strategy Column depicts a firm requirement. No alternative mitigations are authorized.

Where “Implement Requirement” is not specified, mitigation options are suggestions only. Other possible solutions that may eliminate the risk associated with the finding may exist.

“R” designates an item as “Required.”

“A” designates an item as “Addressable.”

“D” designates that the requirement applies to the “Data Center.” **NOTE: Perform NR 4.13 on both Data Center and Data Closet**

“F” designates that the requirement applies to the “Facility.”

All requirements are baseline requirements for MAC III systems; **MAC II requirements, if different, are identified in blue text.**

Purple colored text indicates additions to the PSA Matrix.

An “X” listed in the box marked “IATO” indicates that the item is required to be mitigated for an Interim Authorization to Operate (IATO).

An “X” listed in the box marked “ATO” indicates that the item is required to be mitigated for an Authorization to Operate (ATO).

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
1.0 Documentation										
1.1	Security Policy	The policy outlines the requirements and guidelines for the proper physical security of information assets. Procedures are implemented to ensure the proper handling and storage of information, such as end-of-day security checks, unannounced security checks and, where appropriate, the imposition of a two-person rule within the computing facility.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
1.2	Incident Response Plan	The Incident Response Plan establishes procedures to address cyber attacks against an organization's information technology (IT) system(s). These procedures are designed to enable security personnel to identify, mitigate, and recover from malicious computer incidents, such as unauthorized access to a system or data, denial of service, or unauthorized changes to system hardware, software, or data (e.g., malicious logic, such as a virus, worm, or Trojan horse).	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
1.3	Disaster Recovery Plan (DRP) including natural disasters (flood, hurricane, earthquake, fire, etc.)	The DRP is maintained for emergency response, backup operations, and post-disaster recovery for an information system (IS), to ensure the availability of critical resources and facilitate the continuity of operations in an emergency situation. A disaster plan exists that provides for the partial resumption of mission essential functions within 5 days of activation. Disaster recovery procedures include business recovery plans, system contingency plans, and facility disaster recovery plans. For MAC II systems, the disaster plan provides for the resumption of mission or business essential functions within 24 hours.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
1.4	Access Control Documentation	A documented means of restricting access based on the identity and need-to-know of users and/or groups should exist. Only authorized personnel with a need-to-know are granted physical access to computing facilities that process sensitive information (SI) or unclassified information that has not been cleared for release.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
1.5	Backup Plan	A backup plan establishes plans, procedures and technical measures that can enable a system to be recovered quickly and effectively following a service disruption. A backup plan provides a means of recovery without loss of data, in the event of a malicious act, natural disaster, or human error.	R	D	Implement Requirement	N/A			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
1.6	Key Control is logged, maintained, and reviewed	Administrative procedures for the control and accounting of keys shall be established. The level of protection provided such keys should be equivalent to that afforded the classification of the information being protected. A procedure must be established for initiation, modification, and/or removal of an individual's authorization to enter the area.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.0 Physical Access										
2.1	Picture Identification (ID) is present and visible	A means of physically establishing positive identification of personnel authorized to enter and exit the controlled area, should be present. Facilities that do not use picture ID systems must control access through the use of receptionists/clerks with authorization lists, log-in/out systems, and limited entry and exit points. For small data centers that have a limited number of authorized users (fewer than 30) with access to the computer room, there may not be a requirement for a badge system; however, their access must be controlled via receptionist/clerk, log-in/out system, plus an access authorization list. The decision concerning whether data center personnel require a badge system shall be determined by the facility manager/commander, after a risk assessment has been completed.	R	D/F	To control access to facilities and data centers, managers may use: Option 1: Receptionists with authorization lists, and sign-in/out logs Option 2: ID Cards, or Facility badges Option 3: Biometrics	REQUIREMENT MET			X	X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.2	Badge is present and visible	Authentication of individuals entering a controlled area shall be accomplished by ID badge/card or by personal identity verification.	R	D/F	Option 1: Facilities that do not use picture ID systems must control access through the use of receptionists/ clerks with authorization lists, log-in/out systems, and limited entry and exit points. Option 2: For data centers that have a limited number of authorized users with access to the computer room, there may not be a requirement for a badge system (determination for the requirement will be made by the data center's Information Assurance Officer (IAO) in coordination with the DAA; however, during duty hours, access must be controlled via receptionist/clerk with an access authorization list, or log.	REQUIREMENT MET			X	X
2.3	Visitors Sign-In/Out Log	Each facility shall have procedures for identification and control of visitors. A log of all visitors shall be maintained. Current signing procedures exist for controlling visitor access and maintaining a detailed log of all visitors to the computing facility. For both facilities and data centers, a record must be maintained that identifies visitors who enter the facility and data center. At a minimum, the record shall identify the visitor by name, and the date and time of their arrival and departure.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.4	Badge Control policies in place	Procedures regarding the distribution and maintenance of ID badges, PINs, level of access, personnel clearance, and similar system-related records shall be maintained. For facilities and data centers, policies and procedures must be in place that control access to the facilities (e.g., key control, swipe card, cipher lock). The underlying theme is to insure that access mechanisms are maintained.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
2.5	Badge Logs are assessed	Records shall be maintained reflecting active assignment of access to controlled facilities. Records concerning personnel removed from the system shall be retained for 90 days. Badge logs should be assessed semi-annually by the IAO or his/her representative. At a minimum, logs shall include the first and last name of the individual, time and date of authorization to access the facility/data center, time and date of loss of authorization, and name of authorizing official.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
2.6	Access Card or Swipe Token are presented at automated reader for building/secure area entry, or presentation of access card to security personnel required for building/secure area entry	Data center controls include: key control, swipe card, or cipher lock access systems. Secure computing areas should be protected by appropriate entry controls to ensure only authorized personnel are allowed access. At facilities where there are a number of access points, and personnel do not pass through a sentry point (receptionist), there must be a process for controlling access to the data center.	R	D	Implement Requirement	N/A			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.7	Authorized Personnel Access List is available inside the Data Center (DC)	An access roster listing all authorized personnel shall be maintained.	R	D	Implement Requirement	N/A			X	X
2.8	Data backup tapes are securely stored onsite until moved to an offsite facility	The backup tapes and documents should be stored in a locked, fireproof container until they are removed from the facility to an offsite storage location.	R	D	Implement Requirement	N/A			X	X
2.9	Data backup tapes are securely stored offsite	The backup tapes shall be removed from the facility to an authorized, offsite storage.	R	D	Implement Requirement	N/A			X	X
2.10	Deposits and withdrawals of tapes and other storage media from the data backup library are authorized and logged	All access to the tape library should be logged for proper accountability. The log must record logistical transactions in the library (additions and withdrawals). Logs shall be reviewed by the IAO annually.	R	D	Implement Requirement	N/A			X	X
2.11	Password protected screen saver is set to turn on automatically after 15 minutes of inactivity	Implement electronic procedures that lock the computer keyboard after a predetermined time (15 minutes). Once the workstation screen-lock is activated, access to the workstation requires the knowledge of a unique authenticator, for example, a UserID and password.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
3.0	Facilities									

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.1	Windows and glass walls are protected by an Intrusion Detection System (IDS) if fewer than 18 feet from ground or roof level	Windows should be constructed from or covered with materials that will provide protection from forced entry. Windows not consisting of these materials should be protected by an Intrusion Detection System. The IDS alerts a service that responds within 15 minutes.	A	D/F	Option 1: Data centers and facilities may use roving guards, or duty personnel Option 2: Remove windows, enclose space Option 3: Install Closed Circuit Television (CCTV)	REQUIREMENT MET				X
3.2	Openings that are more than 96 square inches are covered by material the same as the wall, or by iron bars or 18-gauge wire mesh.	Expanded metal, wire mesh or rigid metal bars are not required if an IDS is used as supplemental protection.	A	D/F	Openings that allow undetected access to the facility are blocked by: Option 1: Grills or bars Option 2: Alarmed with a system that alerts a response service. This requirement covers vents, ducts, and similar openings in excess of 96 square inches.	REQUIREMENT MET				X
3.3	Individual personnel who have access to restricted areas, must not allow piggybacking or entry to unauthorized individuals	Unauthorized personnel shall not be allowed access to a restricted area based on another person's authorization. People who access the area must use their own authentication to gain access.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
3.4	Entrance doors must be constructed of solid wood, metal, metal clad, or bullet-proof glass	Acceptable types of doors include: Solid wood core door that is a minimum of 1.75 inches thick; sixteen gauge metal cladding over wood or composition materials that is a minimum of 1.75 inches thick; or metal fire or acoustical protection door that is a minimum of 1.75 inches thick.	R	D	Implement Requirement	N/A				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.5	Emergency doors will be void of all devices on the outside, thereby allowing exit but no entry (Subject to life safety codes)	There should be no door handles or devices on the outside of the door that allow entry. If there are door handles, they must not be operational from the outside of the door. For facilities where the data center is very small, there may be only one entry and exit point. If that is the case, the door must have emergency exit capability (breaker bar), and the door must be locked (from the outside) at all times.	R	D/F	Implement Requirement	REQUIREMENT MET				X
3.6	Emergency doors will be equipped with emergency bar openers on the inside, with a deadbolt throw of at least ½ inch (Subject to life safety codes)	Doors will be secured with deadlocking panic hardware on the inside and have no exterior hardware. Door equipment will have the capability to allow expeditious exit.	R	D/F	Implement Requirement	REQUIREMENT MET				X
3.7	Doors have hinges on the inside. If door hinges are on the outside, the hinges must be panned, welded or equipped with setscrew fastener	If doors are equipped with hinge pins located on the exterior side of the door where it opens into an uncontrolled area outside the controlled area, the hinges will be treated to prevent removal of the door (e.g., welded, set screws).	R	D/F	Implement Requirement	REQUIREMENT MET				X
3.8	Intrusion Detection System should be placed on the protected side of doors, windows, or other moveable openings greater than 96 square inches, to protect against movement	Data Centers must use simple magnetic alarm that can detect unauthorized penetration. Facilities may use: Option 1: Roving guards to guard against/identify unauthorized penetration Option 2: Duty personnel to guard against/identify unauthorized penetration	R	D/F	Facilities may use: Option 1: Roving guards to guard against/identify unauthorized penetration Option 2: Duty personnel to guard against/identify unauthorized penetration	REQUIREMENT MET			X	X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.9	Walls solid and contained from true floor to next floor or roof	Walls shall be constructed of materials such as plaster, gypsum wallboard, metal panels, hardboard, wood, plywood, or other materials offering resistance to, and evidence of, unauthorized entry into the area. False ceilings should be avoided.	A	D	<p>Develop cost-effective security controls over all physical access points and address significant threats to sensitive areas. Mitigations include:</p> <p>Option 1: Install an IDS (motion detectors, etc.) above or below the false ceiling. Alarms should sound at a point where a force can respond within 15 minutes.</p> <p>Option 2: Reinforce false ceilings with wire mesh, and roving guards check inside the facility on a routine basis during non-working hours.</p>	N/A				X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.10	True Floor to ceiling walls constructed of a material that would provide detection of surreptitious entry	The ceiling and walls shall be constructed of plaster, gypsum, wallboard material, hardware, or other acceptable material.	R	D	<p>For small facilities or facilities that have been housed in rooms that do not have a true ceiling:</p> <p>Option 1: An IDS may be installed to detect entry through the ceiling, and may be installed above or below the false ceiling.</p> <p>Option 2: Motion detectors installed in a way that allows maximum coverage of the room, and install wire mesh to reinforce the ceiling.</p> <p>Option 3: Roving guards check inside the facility on a routine basis during non-working hours.</p>	N/A				X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.11	Secure areas are protected with true ceilings and true floors	The data center must be constructed of solid permanent construction materials (plaster, gypsum wallboard, metal panels, hardboard, wood, plywood), or materials that will deter and detect unauthorized penetration.	A	D	<p>For small data centers or data centers that are housed in rooms that do not have a true ceiling:</p> <p>Option 1: An IDS may be installed below the false ceiling to detect entry through the ceiling.</p> <p>Option 2: Motion detectors installed in a way that allows maximum coverage of the room; and install wire mesh to reinforce the ceiling.</p> <p>Option 3: Roving guards check inside the facility on a routine basis during non-working hours.</p>	N/A				X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.12	Closed Circuit TV (CCTV) in use	The perimeter entrance should be under visual control at all times during non-working hours to prevent entry by unauthorized personnel.	A	D	<p>Protective measures should appear formidable enough to prevent or deter criminal attempts.</p> <p>Option 1: Warning notices/signs on doors</p> <p>Option 2: Security checkpoint sign-off sheets for roving guards</p> <p>Mutually supporting protective measures include:</p> <p>Option 1: Guard posted within visual range of the data center.</p> <p>Option 2: Simple magnetic alarm on data center doors/windows that sound in response force area; response forces are capable of reacting within 15 minutes, and install an IDS.</p>	N/A				X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.13	Roving Guard	Roving guards' coverage will consist of, but not be limited to,: physical checks of the window or door access points, classified containers, and improperly secured documents or spaces. Every physical access point to facilities housing workstations that process or display SI or unclassified information (which has not been cleared for release), is controlled during working hours and guarded or locked during non-work hours. Roving guards check the data center.	A	D/F	<p>After normal working hours:</p> <p>On non-military installations: A contracted response service may respond within 15 minutes; an IDS must be in place to alert the response service.</p> <p>On military installations: Alarm sounds in duty officer area, and in the military police area, and response is available within 15 minutes.</p>	REQUIREMENT MET			X	X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.14	Main access managed by security personnel	Visual monitoring shall be maintained at all times during working hours.	A	D/F	Access must be managed. 1. Military Treatment Facilities (MTFs)/ clinics/leased facilities: A central point of access is most desirable; however, this may not be reasonable due to the number of entry points. Receptionist, clinic clerks, and other receiving personnel may act as the visual monitor to sensitive area access. Personnel must receive security training. 2. Business facilities. A central point of access is required unless: Option 1: Swipe cards are used Option 2: Cipher locks are used	REQUIREMENT MET			X	X
3.15	Security lighting for all exterior doors	The lighting shall be of sufficient intensity to allow detection of unauthorized activity. For MAC II systems, an automatic emergency lighting system is installed that covers all areas necessary to maintain mission or business essential functions, to include emergency exits and evacuation routes.	R	D/F	Implement Requirement	REQUIREMENT MET				X
4.0 ENVIRONMENTAL										

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.1	Appropriate fire extinguishers (levels A, B, C) are present with current inspection information (Subject to life safety codes)	Facilities must undergo periodic fire marshal inspections. Deficiencies discovered should be promptly resolved. Handheld fire extinguishers or fixed fire hoses are available.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
4.2	Data center should not contain wet pipe	Building plumbing lines should not endanger the computer facility or, at a minimum, shutoff valves and procedures exist and are known.	A	D	Appropriate and adequate controls will vary depending on individual system requirements. This is not intended to imply that all ADP facilities must have a dry pipe system, but a mitigation plan must be in place to reduce damage. The following three items must be in place. 1. Plastic sheeting must be available to cover hardware 2. Personnel must know the location of shutoff valves and their operation 3. Procedures for alerting facility engineers/fire department must be prominently displayed	N/A			X	X
4.3	Identify wet and dry pipes in the data center	Wet and dry pipes should be identified in the facility so that actions may be taken in case of rupture of extinguisher discharge. Shutoff valves and shutoff procedures should be known.	R	D	Implement Requirement	N/A				X
4.4	Heating, Ventilation, & Air Conditioning (HVAC) is present and working	Resources supporting business essential functions have been implemented.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.5	Backup air conditioning is present and in working condition	Redundancy exists in the air-cooling system.	A	D	<p>Temperature monitors should be in place to alert employees when the room temperature is too high. Systems should be shut down to mitigate system damage.</p> <p>Option 1: Cut off the comfort air conditioning to the remaining office space in the building and redirect to the data center; and lighting and unnecessary equipment should be turned off</p> <p>Option 2: Floor fans may be used to expel computer exhaust outside the data center.</p>	N/A				X
4.6	Heat and smoke sensors are present and in working condition	Fire suppression devices have been installed and are in working order (e.g., smoke detectors, fire extinguishers, sprinkler systems). Battery-operated or electric stand-alone smoke detectors are installed in the facility. For MAC II systems, a servicing fire department receives an automatic notification of any activation of the smoke detection or fire suppression system.	R	D	Implement Requirement	N/A			X	X

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.7	Uninterruptible Power Supply (UPS) is present and in working condition	Critical devices are attached to a UPS to ensure against network and system disruption during power outages. For MAC II systems, a master power switch or emergency cutoff switch to IT equipment is present. It is located near the main entrance of the IT area, and it is labeled and protected by a cover to prevent accidental shutoff.	R	D	Implement Requirement	N/A			X	X
4.8	24-hour temperature monitor/alarm is present and working	Temperature controls should be installed that provide an alarm when temperature fluctuation is potentially harmful to equipment; adjustments to heating or cooling systems may be made manually.	R	D	Implement Requirement	N/A				X
4.9	Moisture control devices are present and working	Humidity controls should be installed to provide an alarm if fluctuations occur that are potentially harmful to equipment; adjustments to humidifier/de-humidifier systems may be made manually. For MAC II systems, automatic humidity controls are installed to prevent humidity fluctuations.	A	D	Install portable de-humidifiers and check equipment operation daily.	N/A				X
4.10	Emergency Lighting	An automatic emergency lighting system is installed that covers emergency exits and evacuation routes. For MAC II systems, emergency lighting covers all areas necessary to maintain mission or business essential functions.	R	D/F	Implement Requirement	REQUIREMENT MET				X
4.11	Voltage Regulators	Automatic voltage control is implemented for key IT assets.	R	D	Implement Requirement	N/A				X
4.12	Clearing and Sanitizing	All documents, equipment, and machine-readable media containing sensitive data are cleared and sanitized before being released outside the Department of Defense.	R	D	Implement Requirement	N/A			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.13	Environmental Control Training	For MAC II systems, employees receive initial and periodic training in the operation of environmental controls.	A	D	Implement Requirement	REQUIREMENT MET				
4.14	Fire Suppression System (Subject to life safety codes)	Handheld fire extinguishers or fixed hoses are available, should an alarm be sounded or fire detected. For MAC II systems, a fully automatic fire suppression system automatically activates when it detects heat, smoke, or particles.	R	D	Implement Requirement	N/A			X	X
5.0 Human Threat										
5.1	Intentional and unintentional <i>internal</i> threat policies/procedures in place	As part of the contingency of operations plan, an internal threat policy shall be designed to ensure that procedures are in place. A set of rules that clearly delineate IA responsibilities and expected behavior of all employees are in place. Rules include the consequences of inconsistent behavior or non-compliance. Signed acknowledgement of the rules is a condition of access.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
5.2	Intentional and unintentional <i>external</i> threat policies/procedures in place	As part of the contingency of operations plan, an external threat policy shall be designed to ensure that procedures are in place. Drills should be executed annually or when significant changes occur.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
5.3	Power Outage policies/procedures in place	Staff are aware of the locations of regular and auxiliary electrical power switches.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
6.0 Mobile Computing Devices										

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
6.1	Unattended portable and wireless devices are secured and locked	Wireless devices containing SI shall be physically safeguarded to prevent unauthorized access. Laptops, PDAs and other wireless devices, when left unattended, should be protected in such a way as to discourage theft. 1. Laptops that are used during the day as a workstation should be positioned on desks not convenient to casual traffic. If not used as a workstation - they should be stored in a locked container (locker, locking file cabinet). 2. As with laptops, PDAs and other handheld devices should also be mounted in areas that are not convenient to casual traffic and easy theft.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
6.2	Unattended removable media containing sensitive information (SI) are secured and locked	Unattended removable media containing SI shall be physically safeguarded to prevent unauthorized access. Hard drives, disks, magnetic tapes, CD ROMs, etc., must be stored in an area that is not convenient to casual traffic. 1. Locked inside desks, cabinets, or file cabinets 2. Removed from the tops of desks, work areas, team and conference rooms, or other accessible work areas	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.0	HARD COPY OUTPUT ACCESS									
7.1	Hard copy sensitive information (SI) that is no longer required is shredded or destroyed	All documents containing SI shall be shredded.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
7.2	All sensitive hard copy output is immediately removed from output devices	Policies and practices shall be put in place to require the immediate pickup of SI from printers or other sources of hard copy output. SI in hard copy form shall be protected at all times.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.3	All sensitive hard copy output is secured and locked	All documents containing sensitive data should be secured and locked when not in use. SI, when left unattended, should be stored in a container (drawer, etc.). When an office is left unattended, either the container is locked or the office is locked.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.4	Data Interception	Devices that display or output classified or SI in human-readable form are positioned to deter unauthorized individuals from reading the information. Computer screens should be positioned so that casual passersby cannot read the data on the screen. Printers, faxes, and copiers should be positioned in areas that are not available to casual traffic.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
8.0	Marking									
8.1	Sensitive data is marked with the appropriate security label	Appropriate labels and markings must appear on media (tapes, hard copy output) to inform personnel that the information is sensitive.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
9.0	Incident Response									

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
9.1	Incident Response Plan/Procedures	All Assessable administrative functions relating to information security should be reviewed. This should include specific security "post-mortems" on contingency plan testing, program assessments, and risk analyses. Review and documentation gives upper management the opportunity to impose reasonable countermeasures to detected vulnerabilities. Part of the program should require formal review of incidents as well as mock exercises for system-wide failures.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
9.2	Computer Emergency Response Team	All attacks by viruses, Trojan horses, etc. within the data center and user workstations shall be reported to the Computer Emergency Response Team.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

ADDENDUM TO ARTIFACT 9

PHYSICAL SECURITY ASSESSMENT MATRIX

[Add appropriate classification markings]

1

ADDENDUM – PHYSICAL SECURITY ASSESSMENT MATRIX

Major focus areas are broken into numbered sub-items and are further designated as either required or addressable.

A required sub-item is defined as an area where risk must be mitigated utilizing one of the strategies listed.

An addressable sub-item is defined as an area where risk may be mitigated by alternative measures.

“Implement Requirement” in the Mitigation Strategy Column depicts a firm requirement. No alternative mitigations are authorized.

Where “Implement Requirement” is not specified, mitigation options are suggestions only. Other possible solutions that may eliminate the risk associated with the finding may exist.

“R” designates an item as “Required.”

“A” designates an item as “Addressable.”

“D” designates that the requirement applies to the “Data Center.” **NOTE: Perform NR 4.13 on both Data Center and Data Closet**

“F” designates that the requirement applies to the “Facility.”

All requirements are baseline requirements for MAC III systems; **MAC II requirements, if different, are identified in blue text.**

Purple colored text indicates additions to the PSA Matrix.

An “X” listed in the box marked “IATO” indicates that the item is required to be mitigated for an Interim Authorization to Operate (IATO).

An “X” listed in the box marked “ATO” indicates that the item is required to be mitigated for an Authorization to Operate (ATO).

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
1.0 Documentation										
1.1	Security Policy	The policy outlines the requirements and guidelines for the proper physical security of information assets. Procedures are implemented to ensure the proper handling and storage of information, such as end-of-day security checks, unannounced security checks and, where appropriate, the imposition of a two-person rule within the computing facility.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
1.2	Incident Response Plan	The Incident Response Plan establishes procedures to address cyber attacks against an organization's information technology (IT) system(s). These procedures are designed to enable security personnel to identify, mitigate, and recover from malicious computer incidents, such as unauthorized access to a system or data, denial of service, or unauthorized changes to system hardware, software, or data (e.g., malicious logic, such as a virus, worm, or Trojan horse).	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
1.3	Disaster Recovery Plan (DRP) including natural disasters (flood, hurricane, earthquake, fire, etc.)	The DRP is maintained for emergency response, backup operations, and post-disaster recovery for an information system (IS), to ensure the availability of critical resources and facilitate the continuity of operations in an emergency situation. A disaster plan exists that provides for the partial resumption of mission essential functions within 5 days of activation. Disaster recovery procedures include business recovery plans, system contingency plans, and facility disaster recovery plans. For MAC II systems, the disaster plan provides for the resumption of mission or business essential functions within 24 hours.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
1.4	Access Control Documentation	A documented means of restricting access based on the identity and need-to-know of users and/or groups should exist. Only authorized personnel with a need-to-know are granted physical access to computing facilities that process sensitive information (SI) or unclassified information that has not been cleared for release.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
1.5	Backup Plan	A backup plan establishes plans, procedures and technical measures that can enable a system to be recovered quickly and effectively following a service disruption. A backup plan provides a means of recovery without loss of data, in the event of a malicious act, natural disaster, or human error.	R	D	Implement Requirement	N/A			X	X

[Add appropriate classification markings]

Site Name
 PSA Site Name PSA Site Type

Addendum to Artifact 9 Physical Security Assessment Matrix
 D Month YYYY

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
1.6	Key Control is logged, maintained, and reviewed	Administrative procedures for the control and accounting of keys shall be established. The level of protection provided such keys should be equivalent to that afforded the classification of the information being protected. A procedure must be established for initiation, modification, and/or removal of an individual's authorization to enter the area.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.0 Physical Access										
2.1	Picture Identification (ID) is present and visible	A means of physically establishing positive identification of personnel authorized to enter and exit the controlled area, should be present. Facilities that do not use picture ID systems must control access through the use of receptionists/clerks with authorization lists, log-in/out systems, and limited entry and exit points. For small data centers that have a limited number of authorized users (fewer than 30) with access to the computer room, there may not be a requirement for a badge system; however, their access must be controlled via receptionist/clerk, log-in/out system, plus an access authorization list. The decision concerning whether data center personnel require a badge system shall be determined by the facility manager/commander, after a risk assessment has been completed.	R	D/F	To control access to facilities and data centers, managers may use: Option 1: Receptionists with authorization lists, and sign-in/out logs Option 2: ID Cards, or Facility badges Option 3: Biometrics	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.2	Badge is present and visible	Authentication of individuals entering a controlled area shall be accomplished by ID badge/card or by personal identity verification.	R	D/F	<p>Option 1: Facilities that do not use picture ID systems must control access through the use of receptionists/ clerks with authorization lists, log-in/out systems, and limited entry and exit points.</p> <p>Option 2: For data centers that have a limited number of authorized users with access to the computer room, there may not be a requirement for a badge system (determination for the requirement will be made by the data center's Information Assurance Officer (IAO) in coordination with the DAA; however, during duty hours, access must be controlled via receptionist/clerk with an access authorization list, or log.</p>	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.3	Visitors Sign-In/Out Log	Each facility shall have procedures for identification and control of visitors. A log of all visitors shall be maintained. Current signing procedures exist for controlling visitor access and maintaining a detailed log of all visitors to the computing facility. For both facilities and data centers, a record must be maintained that identifies visitors who enter the facility and data center. At a minimum, the record shall identify the visitor by name, and the date and time of their arrival and departure.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
2.4	Badge Control policies in place	Procedures regarding the distribution and maintenance of ID badges, PINs, level of access, personnel clearance, and similar system-related records shall be maintained. For facilities and data centers, policies and procedures must be in place that control access to the facilities (e.g., key control, swipe card, cipher lock). The underlying theme is to insure that access mechanisms are maintained.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
2.5	Badge Logs are assessed	Records shall be maintained reflecting active assignment of access to controlled facilities. Records concerning personnel removed from the system shall be retained for 90 days. Badge logs should be assessed semi-annually by the IAO or his/her representative. At a minimum, logs shall include the first and last name of the individual, time and date of authorization to access the facility/data center, time and date of loss of authorization, and name of authorizing official.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.6	Access Card or Swipe Token are presented at automated reader for building/secure area entry, or presentation of access card to security personnel required for building/secure area entry	Data center controls include: key control, swipe card, or cipher lock access systems. Secure computing areas should be protected by appropriate entry controls to ensure only authorized personnel are allowed access. At facilities where there are a number of access points, and personnel do not pass through a sentry point (receptionist), there must be a process for controlling access to the data center.	R	D	Implement Requirement	N/A			X	X
2.7	Authorized Personnel Access List is available inside the Data Center (DC)	An access roster listing all authorized personnel shall be maintained.	R	D	Implement Requirement	N/A			X	X
2.8	Data backup tapes are securely stored onsite until moved to an offsite facility	The backup tapes and documents should be stored in a locked, fireproof container until they are removed from the facility to an offsite storage location.	R	D	Implement Requirement	N/A			X	X
2.9	Data backup tapes are securely stored offsite	The backup tapes shall be removed from the facility to an authorized, offsite storage.	R	D	Implement Requirement	N/A			X	X
2.10	Deposits and withdrawals of tapes and other storage media from the data backup library are authorized and logged	All access to the tape library should be logged for proper accountability. The log must record logistical transactions in the library (additions and withdrawals). Logs shall be reviewed by the IAO annually.	R	D	Implement Requirement	N/A			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
2.11	Password protected screen saver is set to turn on automatically after 15 minutes of inactivity	Implement electronic procedures that lock the computer keyboard after a predetermined time (15 minutes). Once the workstation screen-lock is activated, access to the workstation requires the knowledge of a unique authenticator, for example, a UserID and password.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
3.0 Facilities										
3.1	Windows and glass walls are protected by an Intrusion Detection System (IDS) if fewer than 18 feet from ground or roof level	Windows should be constructed from or covered with materials that will provide protection from forced entry. Windows not consisting of these materials should be protected by an Intrusion Detection System. The IDS alerts a service that responds within 15 minutes.	A	D/F	Option 1: Data centers and facilities may use roving guards, or duty personnel Option 2: Remove windows, enclose space Option 3: Install Closed Circuit Television (CCTV)	REQUIREMENT MET				X
3.2	Openings that are more than 96 square inches are covered by material the same as the wall, or by iron bars or 18-gauge wire mesh.	Expanded metal, wire mesh or rigid metal bars are not required if an IDS is used as supplemental protection.	A	D/F	Openings that allow undetected access to the facility are blocked by: Option 1: Grills or bars Option 2: Alarmed with a system that alerts a response service. This requirement covers vents, ducts, and similar openings in excess of 96 square inches.	REQUIREMENT MET				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.3	Individual personnel who have access to restricted areas, must not allow piggybacking or entry to unauthorized individuals	Unauthorized personnel shall not be allowed access to a restricted area based on another person's authorization. People who access the area must use their own authentication to gain access.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
3.4	Entrance doors must be constructed of solid wood, metal, metal clad, or bullet-proof glass	Acceptable types of doors include: Solid wood core door that is a minimum of 1.75 inches thick; sixteen gauge metal cladding over wood or composition materials that is a minimum of 1.75 inches thick; or metal fire or acoustical protection door that is a minimum of 1.75 inches thick.	R	D	Implement Requirement	N/A				X
3.5	Emergency doors will be void of all devices on the outside, thereby allowing exit but no entry (Subject to life safety codes)	There should be no door handles or devices on the outside of the door that allow entry. If there are door handles, they must not be operational from the outside of the door. For facilities where the data center is very small, there may be only one entry and exit point. If that is the case, the door must have emergency exit capability (breaker bar), and the door must be locked (from the outside) at all times.	R	D/F	Implement Requirement	REQUIREMENT MET				X
3.6	Emergency doors will be equipped with emergency bar openers on the inside, with a deadbolt throw of at least ½ inch (Subject to life safety codes)	Doors will be secured with deadlocking panic hardware on the inside and have no exterior hardware. Door equipment will have the capability to allow expeditious exit.	R	D/F	Implement Requirement	REQUIREMENT MET				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.7	Doors have hinges on the inside. If door hinges are on the outside, the hinges must be panned, welded or equipped with setscrew fastener	If doors are equipped with hinge pins located on the exterior side of the door where it opens into an uncontrolled area outside the controlled area, the hinges will be treated to prevent removal of the door (e.g., welded, set screws).	R	D/F	Implement Requirement	REQUIREMENT MET				X
3.8	Intrusion Detection System should be placed on the protected side of doors, windows, or other moveable openings greater than 96 square inches, to protect against movement	Data Centers must use simple magnetic alarm that can detect unauthorized penetration. Facilities may use: Option 1: Roving guards to guard against/identify unauthorized penetration Option 2: Duty personnel to guard against/identify unauthorized penetration	R	D/F	Facilities may use: Option 1: Roving guards to guard against/identify unauthorized penetration Option 2: Duty personnel to guard against/identify unauthorized penetration	REQUIREMENT MET			X	X
3.9	Walls solid and contained from true floor to next floor or roof	Walls shall be constructed of materials such as plaster, gypsum wallboard, metal panels, hardboard, wood, plywood, or other materials offering resistance to, and evidence of, unauthorized entry into the area. False ceilings should be avoided.	A	D	Develop cost-effective security controls over all physical access points and address significant threats to sensitive areas. Mitigations include: Option 1: Install an IDS (motion detectors, etc.) above or below the false ceiling. Alarms should sound at a point where a force can respond within 15 minutes. Option 2: Reinforce false ceilings with wire mesh, and roving guards check inside the facility on a routine basis during non-working hours.	N/A				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.10	True Floor to ceiling walls constructed of a material that would provide detection of surreptitious entry	The ceiling and walls shall be constructed of plaster, gypsum, wallboard material, hardware, or other acceptable material.	R	D	<p>For small facilities or facilities that have been housed in rooms that do not have a true ceiling:</p> <p>Option 1: An IDS may be installed to detect entry through the ceiling, and may be installed above or below the false ceiling.</p> <p>Option 2: Motion detectors installed in a way that allows maximum coverage of the room, and install wire mesh to reinforce the ceiling.</p> <p>Option 3: Roving guards check inside the facility on a routine basis during non-working hours.</p>	N/A				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.11	Secure areas are protected with true ceilings and true floors	The data center must be constructed of solid permanent construction materials (plaster, gypsum wallboard, metal panels, hardboard, wood, plywood), or materials that will deter and detect unauthorized penetration.	A	D	<p>For small data centers or data centers that are housed in rooms that do not have a true ceiling:</p> <p>Option 1: An IDS may be installed below the false ceiling to detect entry through the ceiling.</p> <p>Option 2: Motion detectors installed in a way that allows maximum coverage of the room; and install wire mesh to reinforce the ceiling.</p> <p>Option 3: Roving guards check inside the facility on a routine basis during non-working hours.</p>	N/A				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.12	Closed Circuit TV (CCTV) in use	The perimeter entrance should be under visual control at all times during non-working hours to prevent entry by unauthorized personnel.	A	D	<p>Protective measures should appear formidable enough to prevent or deter criminal attempts.</p> <p>Option 1: Warning notices/signs on doors</p> <p>Option 2: Security checkpoint sign-off sheets for roving guards</p> <p>Mutually supporting protective measures include:</p> <p>Option 1: Guard posted within visual range of the data center.</p> <p>Option 2: Simple magnetic alarm on data center doors/windows that sound in response force area; response forces are capable of reacting within 15 minutes, and install an IDS.</p>	N/A				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.13	Roving Guard	Roving guards' coverage will consist of, but not be limited to,: physical checks of the window or door access points, classified containers, and improperly secured documents or spaces. Every physical access point to facilities housing workstations that process or display SI or unclassified information (which has not been cleared for release), is controlled during working hours and guarded or locked during non-work hours. Roving guards check the data center.	A	D/F	<p>After normal working hours:</p> <p>On non-military installations: A contracted response service may respond within 15 minutes; an IDS must be in place to alert the response service.</p> <p>On military installations: Alarm sounds in duty officer area, and in the military police area, and response is available within 15 minutes.</p>	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
3.14	Main access managed by security personnel	Visual monitoring shall be maintained at all times during working hours.	A	D/F	Access must be managed. 1. Military Treatment Facilities (MTFs)/ clinics/leased facilities: A central point of access is most desirable; however, this may not be reasonable due to the number of entry points. Receptionist, clinic clerks, and other receiving personnel may act as the visual monitor to sensitive area access. Personnel must receive security training. 2. Business facilities. A central point of access is required unless: Option 1: Swipe cards are used Option 2: Cipher locks are used	REQUIREMENT MET			X	X
3.15	Security lighting for all exterior doors	The lighting shall be of sufficient intensity to allow detection of unauthorized activity. For MAC II systems, an automatic emergency lighting system is installed that covers all areas necessary to maintain mission or business essential functions, to include emergency exits and evacuation routes.	R	D/F	Implement Requirement	REQUIREMENT MET				X
4.0	ENVIRONMENTAL									

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.1	Appropriate fire extinguishers (levels A, B, C) are present with current inspection information (Subject to life safety codes)	Facilities must undergo periodic fire marshal inspections. Deficiencies discovered should be promptly resolved. Handheld fire extinguishers or fixed fire hoses are available.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
4.2	Data center should not contain wet pipe	Building plumbing lines should not endanger the computer facility or, at a minimum, shutoff valves and procedures exist and are known.	A	D	Appropriate and adequate controls will vary depending on individual system requirements. This is not intended to imply that all ADP facilities must have a dry pipe system, but a mitigation plan must be in place to reduce damage. The following three items must be in place. 1. Plastic sheeting must be available to cover hardware 2. Personnel must know the location of shutoff valves and their operation 3. Procedures for alerting facility engineers/fire department must be prominently displayed	N/A			X	X
4.3	Identify wet and dry pipes in the data center	Wet and dry pipes should be identified in the facility so that actions may be taken in case of rupture of extinguisher discharge. Shutoff valves and shutoff procedures should be known.	R	D	Implement Requirement	N/A				X
4.4	Heating, Ventilation, & Air Conditioning (HVAC) is present and working	Resources supporting business essential functions have been implemented.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.5	Backup air conditioning is present and in working condition	Redundancy exists in the air-cooling system.	A	D	<p>Temperature monitors should be in place to alert employees when the room temperature is too high. Systems should be shut down to mitigate system damage.</p> <p>Option 1: Cut off the comfort air conditioning to the remaining office space in the building and redirect to the data center; and lighting and unnecessary equipment should be turned off</p> <p>Option 2: Floor fans may be used to expel computer exhaust outside the data center.</p>	N/A				X
4.6	Heat and smoke sensors are present and in working condition	Fire suppression devices have been installed and are in working order (e.g., smoke detectors, fire extinguishers, sprinkler systems). Battery-operated or electric stand-alone smoke detectors are installed in the facility. For MAC II systems, a servicing fire department receives an automatic notification of any activation of the smoke detection or fire suppression system.	R	D	Implement Requirement	N/A			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.7	Uninterruptible Power Supply (UPS) is present and in working condition	Critical devices are attached to a UPS to ensure against network and system disruption during power outages. For MAC II systems, a master power switch or emergency cutoff switch to IT equipment is present. It is located near the main entrance of the IT area, and it is labeled and protected by a cover to prevent accidental shutoff.	R	D	Implement Requirement	N/A			X	X
4.8	24-hour temperature monitor/alarm is present and working	Temperature controls should be installed that provide an alarm when temperature fluctuation is potentially harmful to equipment; adjustments to heating or cooling systems may be made manually.	R	D	Implement Requirement	N/A				X
4.9	Moisture control devices are present and working	Humidity controls should be installed to provide an alarm if fluctuations occur that are potentially harmful to equipment; adjustments to humidifier/de-humidifier systems may be made manually. For MAC II systems, automatic humidity controls are installed to prevent humidity fluctuations.	A	D	Install portable de-humidifiers and check equipment operation daily.	N/A				X
4.10	Emergency Lighting	An automatic emergency lighting system is installed that covers emergency exits and evacuation routes. For MAC II systems, emergency lighting covers all areas necessary to maintain mission or business essential functions.	R	D/F	Implement Requirement	REQUIREMENT MET				X
4.11	Voltage Regulators	Automatic voltage control is implemented for key IT assets.	R	D	Implement Requirement	N/A				X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
4.12	Clearing and Sanitizing	All documents, equipment, and machine-readable media containing sensitive data are cleared and sanitized before being released outside the Department of Defense.	R	D	Implement Requirement	N/A			X	X
4.13	Environmental Control Training	For MAC II systems, employees receive initial and periodic training in the operation of environmental controls.	A	D	Implement Requirement	REQUIREMENT MET				
4.14	Fire Suppression System (Subject to life safety codes)	Handheld fire extinguishers or fixed hoses are available, should an alarm be sounded or fire detected. For MAC II systems, a fully automatic fire suppression system automatically activates when it detects heat, smoke, or particles.	R	D	Implement Requirement	N/A			X	X
5.0 Human Threat										
5.1	Intentional and unintentional internal threat policies/procedures in place	As part of the contingency of operations plan, an internal threat policy shall be designed to ensure that procedures are in place. A set of rules that clearly delineate IA responsibilities and expected behavior of all employees are in place. Rules include the consequences of inconsistent behavior or non-compliance. Signed acknowledgement of the rules is a condition of access.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
5.2	Intentional and unintentional external threat policies/procedures in place	As part of the contingency of operations plan, an external threat policy shall be designed to ensure that procedures are in place. Drills should be executed annually or when significant changes occur.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
5.3	Power Outage policies/procedures in place	Staff are aware of the locations of regular and auxiliary electrical power switches.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
6.0 Mobile Computing Devices										
6.1	Unattended portable and wireless devices are secured and locked	Wireless devices containing SI shall be physically safeguarded to prevent unauthorized access. Laptops, PDAs and other wireless devices, when left unattended, should be protected in such a way as to discourage theft. 1. Laptops that are used during the day as a workstation should be positioned on desks not convenient to casual traffic. If not used as a workstation - they should be stored in a locked container (locker, locking file cabinet). 2. As with laptops, PDAs and other handheld devices should also be mounted in areas that are not convenient to casual traffic and easy theft.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
6.2	Unattended removable media containing sensitive information (SI) are secured and locked	Unattended removable media containing SI shall be physically safeguarded to prevent unauthorized access. Hard drives, disks, magnetic tapes, CD ROMs, etc., must be stored in an area that is not convenient to casual traffic. 1. Locked inside desks, cabinets, or file cabinets 2. Removed from the tops of desks, work areas, team and conference rooms, or other accessible work areas	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.0 HARD COPY OUTPUT ACCESS										

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
7.1	Hard copy sensitive information (SI) that is no longer required is shredded or destroyed	All documents containing SI shall be shredded.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.2	All sensitive hard copy output is immediately removed from output devices	Policies and practices shall be put in place to require the immediate pickup of SI from printers or other sources of hard copy output. SI in hard copy form shall be protected at all times.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.3	All sensitive hard copy output is secured and locked	All documents containing sensitive data should be secured and locked when not in use. SI, when left unattended, should be stored in a container (drawer, etc.). When an office is left unattended, either the container is locked or the office is locked.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
7.4	Data Interception	Devices that display or output classified or SI in human-readable form are positioned to deter unauthorized individuals from reading the information. Computer screens should be positioned so that casual passersby cannot read the data on the screen. Printers, faxes, and copiers should be positioned in areas that are not available to casual traffic.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
8.0 Marking										
8.1	Sensitive data is marked with the appropriate security label	Appropriate labels and markings must appear on media (tapes, hard copy output) to inform personnel that the information is sensitive.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
9.0 Incident Response										

[Add appropriate classification markings]

MHS Physical Security Assessment Matrix										
NR	Requirement	Description	R/A	D/F	Mitigation Strategies	Findings	Site Mitigation Plan of Action	Mitigation Validation Date	IATO	ATO
9.1	Incident Response Plan/Procedures	All Assessable administrative functions relating to information security should be reviewed. This should include specific security "post-mortems" on contingency plan testing, program assessments, and risk analyses. Review and documentation gives upper management the opportunity to impose reasonable countermeasures to detected vulnerabilities. Part of the program should require formal review of incidents as well as mock exercises for system-wide failures.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X
9.2	Computer Emergency Response Team	All attacks by viruses, Trojan horses, etc. within the data center and user workstations shall be reported to the Computer Emergency Response Team.	R	D/F	Implement Requirement	REQUIREMENT MET			X	X

[Add appropriate classification markings]

ABBREVIATIONS, ACRONYMS AND REFERENCES

A-Z Browse TRICARE - <http://www.tricare.mil/atoz-text-only.cfm#M>

AAPCC = Average Adjusted Per Capita Costs

ACO = Administrative Contracting Officer

ACOR = Alternate Contracting Officer's Representative

ADD(s) = Active Duty Dependant(s)

ADP = Automated Data Processing - <http://www.tricare.mil/TMAPrivacy/personnel-security.cfm>

ASSIST = Acquisition Streamlining and Standardization Information System <http://assist.daps.dla.mil/online/start/>

ATO = Approval to Operate

C&A = Certification and Accreditation

Catchment area(s) = Military Treatment Facility Catchment areas - <http://www.tricare.mil/catchmentarea/>

CD = Compact Disk

CFR = Code of Federal Regulations - <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html#page1>

CHAMPUS = Civilian Health and Medical Program of the Uniformed Services – See A-Z Browse TRICARE

CLIN(s) = Contract Line Item Number(s)

CMS = Centers for Medicare & Medicaid Services - <http://www.cms.hhs.gov/>

CO = Contracting Officer

COR = Contracting Officer's Representative

DAPA = Distribution and Pricing Agreements, Federal Supply Schedule

ABBREVIATIONS, ACRONYMS AND REFERENCES

DCAA = Defense Contract Audit Agency - <http://www.dcaa.mil/>

DUA = Data Use Agreement - <http://www.tricare.mil/tmaprivacy/Data-Use.cfm>

DEERS = Defense Enrollment Eligibility Reporting System - <http://www.tricare.mil/mybenefit/home/overview/Eligibility/DEERS>

DD Form 250 = Material Inspection and Receiving Report – <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd0250.pdf>

DD Form 2005 = Privacy Act Statement – Health Care Records - <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2005.pdf>

DD Form 2876 = Enrollment Form – <http://www.tricare.mil/mybenefit/Forms.do>

DD Form 2877 = Disenrollment Form - <http://www.tricare.mil/mybenefit/Forms.do>

DIACAP = DoD Information Assurance Certification and Accreditation Process - <http://iase.disa.mil/ditscap/index.html>

DIACAP Tools – http://www.tricare.mil/tmis_new/IA.htm#diacap

DoD 5200.2 = “DoD Personnel Security Program,” April 9, 1999 - <http://www.dtic.mil/whs/directives/corres/html/520002.htm>

DoD 5200.2-R = “DoD Personnel Security Program,” February 23, 1996 - <http://www.dtic.mil/whs/directives/corres/pdf/520002r.pdf>

DoD 5400.11 “DoD Privacy Program” May 8, 2007 – <http://www.dtic.mil/whs/directives/corres/html/540011.htm>

DoD 5400.11-R “DoD Privacy Program” May 14, 2007- <http://www.dtic.mil/whs/directives/corres/html/540011r.htm>

DoD 6010.8-R “Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)” - see CFR 199 for current revision

<http://www.dtic.mil/whs/directives/corres/html/60108r.htm> -

DoD 6025.18-R, “DoD Health Information Privacy Regulation” January 24, 2003 -

<http://www.dtic.mil/whs/directives/corres/html/602518r.htm>

DoD 8500.1 = “Information Assurance (IA)” October 24, 2002 – http://www.tricare.mil/tmis_new/Policy/DoD/d85001p.pdf

ABBREVIATIONS, ACRONYMS AND REFERENCES

DoD 8500.2 = “Information Assurance (IA) Implementation” February 6, 2003 - http://www.tricare.mil/tmis_new/ia/i85002p.pdf

DoD 8510.01-M = DoD information Assurance Certification and Accreditation Process (DIACAP) – November 28, 2007 -

<http://www.dtic.mil/whs/directives/corres/pdf/851001p.pdf>

DoD 8580.2-R “DoD Health Information Security Regulation” July 12, 2007 - <http://www.dtic.mil/whs/directives/corres/pdf/858002rp.pdf>

DoD Privacy Policy - <http://www.tricare.mil/tmaprivacy/hipaa/hipaacompliance/library/Policy-Memos.htm>

DoD Memorandum, “Disposition of Unclassified Computer Hard Drives,” June 4, 2001. -

http://www.tricare.mil/tmis_new/ia/DoD_Memo_Disposition_of_Harddrives_20016004.pdf

DOES = Defense Online Enrollment System

DOT = Department of Transportation - <http://www.dot.gov/>

DP(s) = USFHP Designated Provider(s) - <http://www.usfhp.com/newsite/portal/default.asp>

DRG(s) = Diagnostic Related Groups - <http://www.tricare.mil/drgrates/>

EFT = Electronic Funds Transfer

EOB = Explanation of Benefit - <http://www.tricare.mil/mybenefit/Forms.do>

ESRD = End Stage Renal Disease - <http://www.cms.hhs.gov/center/esrd.asp>

FAR = Federal Acquisition Regulation - <http://www.acqnet.gov/far/index.html>

FDA = Food and Drug Administration - <http://www.fda.gov/>

FEHBP = Federal Employee Health Benefits Plan - <http://www.opm.gov/insure/health/>

FFS = Fee for Service - http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/05_FFS_Data.asp

ABBREVIATIONS, ACRONYMS AND REFERENCES

FIPS PUB 201 = Federal Information Processing Standards Publication 201 -

http://www.nist.org/nist_plugins/content/content.php?content.49

FR = Federal Register - <http://www.gpoaccess.gov/fr/search.html>

GAF = Medicare Capital Geographic Adjustment Factor

HA Policy 06-010 – HIPAA - <http://www.ha.osd.mil/policies/2006/06-010.pdf>

Healthy People 2010 - <http://www.healthypeople.gov/>

HIPAA = Health Insurance Portability and Accountability Act of 1996 – <http://www.tricare.mil/hipaa/>

HHS = Department of Health and Human Services - <http://www.hhs.gov/>

HHS Secretary - <http://www.hhs.gov/secretary/>

HMOs = Health Maintenance Organization

HSA = Health Status Adjustment

IA = Information Assurance

IAVA = Information Assurance Vulnerability Management - http://www.tricare.mil/tmis_new/Policy/iavamemo.pdf

IBNR = Incurred But Not Reported

IPT = Integrated Process Teams

IS = Information System

IT = Information Technology

MAC III = Mission Assurance Category III Sensitive level

ABBREVIATIONS, ACRONYMS AND REFERENCES

Medicare - <http://www.medicare.gov/>

Medline Plus - <http://medlineplus.gov>

MEPRS = Medical Expense & Performance Reporting System - http://www.tricare.mil//ebc/rm_home/meprs/

MHS = TRICARE Military Health Services - <http://www.ha.osd.mil/>

MHS IA Policy/Guidance Manual - http://www.tricare.mil/tmis_new/ia/SIGNED_MHS_IA_Policy_Guidance_Manual_03_27_2007.pdf

MHS Enterprise Architecture guidance - http://www.ha.osd.mil/mhscio/ea_reference_docs.htm.

Military Construction Authorization Act of 1982 = P.L. 97-99

MOA = Memorandum of Agreement

MTF = Military Treatment Facility

NADD(s) = Non-Active Duty Dependand(s)

NDAA 2001 = National Defense Authorization Act of 2001 – PL 106-398 - <http://www.dod.mil/dodgc/olc/docs/2001NDAA.pdf>

NDMS = National Disaster Medical System - <http://www.oep-ndms.dhhs.gov>

NHE = National Health Expenditures -

http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=PubMed&list_uids=10124432&dopt=Abstract

NIH = National Institutes of Health - <http://www.nih.gov/>

NLM = U.S. National Library of Medicine - <http://www.nlm.nih.gov/>

NQMC = National Quality Monitoring Contract - <http://www.maximus.com/nqmc/pages/index.asp>

OBRA = The Omnibus Reconciliation Act

ABBREVIATIONS, ACRONYMS AND REFERENCES

OCONUS = Outside the Continental United States

OHI = Other Health Insurance

OMB = Office of Management and Budget - <http://www.whitehouse.gov/omb/>

OMB M-05-24 = Implementation of Homeland Security Presidential Directive (HSPD) 12 – Policy for a Common Identification Standard for Federal Employees and Contractors - <http://www.whitehouse.gov/omb/memoranda/fy2005/m05-24.pdf>

OMB M-06-16 = Protection of Sensitive Agency Information - <http://www.whitehouse.gov/omb/memoranda/fy2006/m06-16.pdf>

OPM = Office of Personnel Management - <http://www.opm.gov/>

OPPS = Medicare Outpatient Prospective Payment System

OSD = Office of the Secretary of Defense - <http://www.defenselink.mil/osd/>

OSD Memorandum 12282-05 = Notifying Individuals When Personal information is Lost, Stolen, or Compromised = <http://www.army.mil/ciog6/references/policy/docs/OSDPrivateInfo.pdf>

PCO = Procuring Contracting Officer

PDST = Pharmacy Data Transaction Service

PHI = Protected Health Information – see HIPAA

PLCA = Patient Level Cost Accounting

PL = Public Law

P.L. 93-579, December 31, 1974 = Privacy Act, as amended – <http://www.dtic.mil/whs/directives/corres/html/540011r.htm>

P.L. 97-99, December 23, 1981 = Military Construction Authorization Act of 1982

ABBREVIATIONS, ACRONYMS AND REFERENCES

P.L. 104-201, September 23, 1996 = National Defense Authorization Act of 1997 – <http://www.dod.mil/dodgc/olc/docs/1997NDAA.pdf>

PHS = Public Health Services – see HHS <http://commcorps.shs.net/default.aspx>

PMPM = Per Member Per Month

PPI = Protected Personal Information

PPS = Medicare Prospective Payment System

Privacy Act, as amended = P.L. 93-579, December 31, 1974 - <http://www.dtic.mil/whs/directives/corres/html/540011r.htm>

RBRVS = Resource-Based Relative Value Scale

RVU(s) = Resource Value Unit

Security Standards for the Protection of Electronic Protected Health Information.

SI = sensitive information

SIP = System Identification Profile

SNF = Skilled Nursing Facilities - <http://www.cms.hhs.gov/center/snf.asp>

Standards for Electronic Transactions - <http://www.tricare.mil/hipaa/transactions.html>

Standards for Privacy of Individually Identifiable Health Information – TRICARE Operations Manual Chapter 24, Section 3

TAMP = Transitional Assistance Management Program - <http://www.tricare.mil/factsheets/viewfactsheet.cfm?id=317>

TeamSTEPPS™ = Team Strategies & Tools to Enhance Performance & Patient Safety -

<http://dodpatientsafety.usuhs.mil/index.php?name=News&file=article&sid=31>

TFL = TRICARE for Life

ABBREVIATIONS, ACRONYMS AND REFERENCES

TITLE 10, United States Code, Chapter 55 (Laws in effect as of January 3, 2005) -

http://www.access.gpo.gov/uscode/title10/subtitlea_partii_chapter55.html

TPL = Third Party Liability

TRICARE - Chief of Health Plan Operations = <http://www.tricare.mil/tma/orgs/index.cfm>

TRICARE – Forms = . <http://www.tricare.mil/mybenefit/Forms.do>

TRICARE - Deputy Director - <http://www.tricare.mil/tma/orgs/Deputy-Director-2.cfm>

TRICARE - Formulary & Non-Formulary Search - <http://www.tricareformularysearch.org/dod/medicationcenter/default.aspx>

TRICARE - Marketing Division = <http://www.health.mil/InternalPartners.aspx>

TRICARE - Privacy Office - <http://www.tricare.osd.mil/tmaprivacy>

TRICARE Manuals - <http://manuals.tricare.osd.mil/>

TOM = TRICARE Operations Manual 6010.51-M, August 1, 2002 - <http://manuals.tricare.osd.mil/>

TPM = TRICARE Policy Manual 6010.54-M, August 1, 2002 - <http://manuals.tricare.osd.mil/>

TSM = TRICARE Systems Manual 7950.1, August 1, 2002 - <http://manuals.tricare.osd.mil/>

TRM = TRICARE Reimbursement Manual 6010.55-M, August 1, 2002 - <http://manuals.tricare.osd.mil/>

TMOP = TRICARE Mail Order Pharmacy –

<http://www.tricare.mil/mybenefit/ProfileFilter.do;jsessionid=HhcGdnyRLsYGm5wCzmCTRG6mlMLmp8VM2J8QLWyKhWLJy2h3ft5y!1495076454?puri=%2Fhome%2Fprescriptions%2Ffillingprescriptions%2FTMOP>

UF = Uniform Formulary - <http://www.tricareformularysearch.org/dod/medicationcenter/default.aspx>

ABBREVIATIONS, ACRONYMS AND REFERENCES

USC = United States Code - <http://www.access.gpo.gov/uscode/index.html>

USDI = Under Secretary of Defense for Intelligence - <http://www.defenselink.mil/osd/topleaders.aspx>

USFHP = Uniformed Service Family Health Plan = <http://www.usfhp.com/newsite/portal/default.asp>

USPCC = United States Per Capita Cost

USTF = Uniformed Services Treatment Facilities

VA = Veterans Affairs - <http://www.va.gov/>

VPN = Virtual Private Network



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

TABLE 1 – TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002; THROUGH CHANGE 63 1
 TABLE 2 – TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002; THROUGH CHANGE 74 DATED APRIL 7, 2008 3
 TABLE 3 – TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002 THROUGH CHANGE 77 DATED MAY 1, 2008 3
 TABLE 4 – TRICARE SYSTEMS MANUAL 7950.1, AUGUST 1, 2002; THROUGH CHANGE 57 DATED MARCH 6, 2008 3

Table 1 – TRICARE Operations Manual 6010.51-M, August 1, 2002; through change 63

Chapter/Section	Exceptions and Rationale
<i>Chapter 1 – Administration</i>	
Section 1 – Organization of the TRICARE Management Activity (TMA)	None
Section 2 - Contract Administration and Instructions to Contractors	None*
Section 3 – TRICARE Processing Standards	1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9 Not applicable. Pertains to claims and TRICARE Encounter Data (TEDs) submissions 6.0-6.4 Not applicable. Pertains to the automated TRICARE Duplicate Claims System and reports.
Section 4 – Management	1.0 Not applicable. Pertains to TRICARE Encounter Data (TEDs) submissions by MCSC 2.3 Pertains to zip code directory of catchment areas for NAS purposes. 2.4 Not applicable. Pertains to reimbursement systems for MCSC provider categories. 3.0 Applies with exception of TRICARE Service Centers and claims processing 3.2 Submission of claims Monthly Cycle Time/Aging Reports 3.4 System to control and report claims adjustments. 4.3-4.3.1 Not applicable. Pertains to claims adjudication review submission to CO. 4.4 Not applicable. 6.2 Not applicable. 6.3 Not applicable.
Section 5 - Compliance with Federal Statutes	None*

*Although no exception may be noted, it is the DP's understanding that portions of the TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 6 – Legal Matters	None*
Section 7 – Fiscal Controls and Access to Records	None*
Section 8 – Transitions	Note. Pertains to phase-in and transition activities. Applicable to US Family Health Plan for new requirements only, which were not previously covered under the prior contract.
Addendum A – Figures	None*
<i>Chapter 2 – Records Management</i>	
Section 1 – General	5.1 Audit activity must comply with regulation regarding commercial contracts and in accordance with FAR 52.212-5 d.
Section 2 – Subject, Description, Indexing, Series Number, Disposition Authority, and Storage Location of Government Records	Indexing of all categories of records shall be at the contractor’s discretion. Storage Media of all categories of records shall be at the contractor’s discretion.
Section 3 – Microfilming	Not Applicable.
Section 4 – Digital – Imaging and Optical Digital Data Disk Storage	Not applicable.
Section 5 - Transferring Records (Federal Records Centers and Transitions)	None*
Section 6 – Destruction of Records	None*
Addendum A – Figures	None*
<i>Chapter 3 – Financial Administration</i>	
Section 1 – General	Not Applicable.
Section 2 - Financing Mechanisms	Not Applicable The DP does not draw cash directly from the Federal Reserve or any government department. DP program does not have government sponsored Bank accounts. 3.0- 9.0 Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.
Section 3 – TED – Voucher Preparation, Check Release Authorization and Payment Integrity	Not Applicable Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.

*Although no exception may be noted, it is the DP's understanding that portions of the 2 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 4 – Non-TED Vouchers	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds through Non-TED vouchers.</p>
Section 5 – Non-Routine Checks and Vouchers	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.</p>
Section 6 – Payments to Beneficiaries/Providers	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.</p>
Section 7 – Refund and Collection Procedures	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.</p>
Section 8 – Staledated, Voided, or Returned Checks/EFTs	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.</p>
Section 9 – Financing Administrative Expenses (Claim Rate)	<p>Not Applicable</p> <p>DPs are paid a fully at risk capitation payment.</p>
Section 10 – Reports	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.</p>
Addendum A - Figures	<p>Not Applicable</p> <p>Under the current contractual arrangement, Fedwire capability is not required and there is no direct drawdown of government funds by the DP.</p>

*Although no exception may be noted, it is the DPs understanding that portions of the 3 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Chapter 4 – Provider Certification and Credentialing	
Section 1 – General	<p>3.0-4.2The DP’s contract does not require the DP to select resource sharing personnel for local military treatment facilities.</p> <p>6.0 NQMC certification constrains the DP from establishing local contract with mental health inpatient facilities that meet state licensing/certification standards for other federal insurance programs. DPs must use Medicare certified mental health facilities.</p> <p>7.0-7.4The DPs are required to submit Clinical and Pharmacy data to the DP Data Contractor.</p> <p>9.0-9.4The DP does not provide Resource Sharing personnel to Military Treatment Facilities.</p>
Addendum A – Figures	None*
Addendum B – Criminal History Background Checks on Individuals in Child Care Services	None*
CHAPTER 5 – PROVIDER NETWORKS	
Section 1 – Network Development	References to the TRICARE Network and reimbursement mechanisms are not applicable to our Plan.

*Although no exception may be noted, it is the DPs understanding that portions of the 4 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
<i>Chapter 6 – Enrollment</i>	
Section 1 – Enrollment Plan	<p>Intro No MTF in or near our service area. USFHP members not issued Universal TRICARE ID cards.</p> <p>2.0 DP’s do not have Point of Service</p> <p>3.0-3.1.1 This paragraph addresses the assignment of PCMs in the direct care system and does not apply to the DP.</p> <p>4.0 The issue of the effective date of newborns and their relationship to other family members enrolled in TRICARE Prime contradicts the requirement that newborns only be enrolled effective the date of birth when the mother is a member of the plan.</p> <p>5.0-5.1 The DP does not coordinate enrollment in the US Family Health Plan with local MTF commanders. Collecting TRICARE Prime applications at the TRICARE Service Centers only applies to MCSC.</p> <p>5.4 The DP does not have access to PIDs enrollment data and therefore cannot be responsible for PIDs data discrepancies.</p> <p>7.1 The DPs are not exempted from the enrollment effective date but TMA will consider application exceptions on a case by case basis.</p> <p>8.1 This paragraph refers to reporting enrollment fee payment to DEERS in accordance with the TRICARE Systems Manual. The DP reports enrollment fee data to DEERS through the DPDC.</p> <p>9.4 Enrollee of the DP program are not issued the Universal TRICARE identification card by DMDC.</p>
Section 2 – Enrollment Portability	1.2 References to the Point of Service Option does not apply to the DP program.
Section 3 – Split Enrollment	None*
Section 4 – TRICARE Plus	TRICARE Plus not part of DP Program
Chapter 7 – Utilization and Quality Management	
Section 1 – Management	None.
Section 2 – Preauthorizations	DP preauthorization requirements may differ due to at risk contract and payment type. If different, the DP will provide detail in technical submission of proposal.

*Although no exception may be noted, it is the DPs understanding that portions of the 5 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 3 – Contractor Relationship with the Military Health System (MHS) National Quality Monitoring Contractor (NQMC)	None*
Section 4 – Clinical Quality Management Program (CQMP)	None
Addendum A – An Important Message from TRICARE	None*
Addendum B – Hospital Issued Notices of Noncoverage	None*
Addendum C – Hospital Adjustments	None*
<i>Chapter 8 – Claims Processing Procedures</i>	
Section 1 – General	None*
Section 2 – Jurisdiction	Not applicable.
Section 3 – Claims Filing Deadline	DP reserves the right to impose a more stringent time limitation on filing US Family Health Plan claims.
Section 4 – Signature Requirements	None*
Section 5 – Referrals/Preauthorizations/Authorizations	None*
Section 6 – Claim Development	3.0-8.0 (e.g., TEDs, claims splitting) are not applicable to the USFHP.
Section 7 – Application of Deductible and Cost-Sharing	None*
Section 8 – Explanation of Benefits (EOBs)	None*
Section 9 – Duplicate Payment Prevention	None*
Addendum A – Figures	None*
Chapter 11 – Claims Adjustments and Recoupments	
Section 1 – General	None
Section 2 – Underpayments	2.0 This paragraph deals with procedures for disposing of underpayment cases relative to TEDs and requires vouchering in accordance with Operations Manual Chapter 3, Sections 3 through 5. As noted on page 2 of this chart, these procedures require direct access to the Federal Reserve Bank. Not applicable.
Section 3 – Overpayments Recovery – Financially Underwritten Funds	None*
Section 4 – Overpayments Recovery – Non-Financially Underwritten Funds	None*

*Although no exception may be noted, it is the DP's understanding that portions of the 6 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 5 – Third Party Recovery Claims	None
Addendum A – Figures	None*
Addendum B – Listing of Government Claims Offices	None*
<i>Chapter 12 – Beneficiary and Provider Services</i>	
Section 1 – Marketing and Education Requirements	<p>1.0-1.4 Marketing and education efforts are not accomplished through collaborative efforts by the DPs.</p> <p>2.0 The DPs develop their own marketing and education materials and submit them to the Director, TRICARE Marketing Department for review and approval. No MOU is required.</p> <p>4.1-4.4 The DP shall not be responsible for disseminating the information specified in these paragraphs that deal with TRICARE Standard beneficiaries. Though the DP agrees to provide US Family Health Care members and providers with newsletters and other bulletins, to TRICARE Prime enrollees in the USFHP.</p>
Section 2 – Beneficiary Education	<p>INTRO The DP shall not be responsible for providing beneficiaries with educational materials concerning TRICARE Standard and TRICARE Extra. That will be the responsibility of the MCSC responsible for educating non-US Family Health Plan members. Additionally, the DP shall not be required to provide educational materials to the TRICARE Service Centers. All other requirements in this paragraph should apply.</p> <p>2.0 Not applicable.</p>
Section 3 – TRICARE Service Centers	None*
Section 4 – Beneficiary, Congressional, and Health Benefit Advisor Relations	None*
Section 5 – Inquiry Services Department – General	None
Section 6 – Correspondence Control, Processing and Appraisal	None*

*Although no exception may be noted, it is the DPs understanding that portions of the TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 7 – Telephone Inquiries	<p>3.7 The DPs will establish telephone systems to provide 24/7 access to its USFHP members. Each DP has an enrollment department that can provide services to potential members during normal working hours.</p> <p>3.1.1.5 The DP shall not be responsible for offering a menu option on an ARU that connects with the Beneficiary Counseling Assistance Coordinator (BCAC) at the Regional Director as the BCAC does not have the responsibility of assisting US Family Health Plan beneficiaries.</p>
Section 8 – Allowable Charge Reviews (Includes DRGs)	None*
Section 9 – Grievances and Grievance Processing	None*
Section 10 – Collection Actions Against Beneficiaries	None*
Section 11 – Behavioral Health Care Provider Locator & Appointment Assistance	<p>1.0 Offer assistance only to Active Duty Family Members (ADFM)s</p> <p>2.0 Assistance provided to ADFMs only.</p>
71B Addendum A – TRICARE Logo	None*
<i>Chapter 13 – Appeals and Hearings</i>	
Section 1 – General	None*
Section 2 - Governing Principles	None*
Section 3 – Reconsideration Procedures	None*
Section 4 – Appeals of Medical Necessity Determinations	None*
Section 5 – Appeal of Factual (Non-Medical Necessity) Determinations	None*
Section 6 – TMA Appeals	None*
Addendum A – Figures	None*
<i>Chapter 14 – Program Integrity</i>	
Section 1 – General	None*
Section 2 – Case Development and Action	None*
Section 3 – Prevention and Detection	None*
Section 4 – Evaluation	None*
Section 5 – Reporting	Not applicable.
Section 6 – Provider Exclusions, Suspensions and Terminations	None*
Section 7 – Provider Reinstatements	None*

*Although no exception may be noted, it is the DPs understanding that portions of the 8 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 8 – Threats Against Contractors	None*
Addendum A – Figures	None*
<i>Chapter 15 – Audits, Inspections and Reports</i>	
Section 1 – Audits and Inspections	In accordance with commercial item contract regulation and policy, consist with FAR52.212-5 d..
Section 2 – Weekly Reports to TMA	The technical requirements set forth the US Family Health Plan reporting requirements.
Section 3 – Monthly Reports	The technical requirements set forth the US Family Health Plan reporting requirements.
Section 4 – Monthly Workload and Cycle time Reports	The technical requirements set forth the US Family Health Plan reporting requirements.
Section 5 – Quarterly Reports	The technical requirements set forth the US Family Health Plan reporting requirements. 3.0 Utilization management of Prime, Extra, and Standard not applicable to the DP program. 4.0 Provider and beneficiary prepayment review not applicable. 5.0 Health Care Finder reports not applicable
Section 6 – Annual Reports	Not applicable.
Section 7 – Special Reports	The technical requirements for any special reports are set forth the US Family Health Plan reporting requirements. MTF Commanders report not applicable.
Addendum A – Figures	The technical requirements set forth the US Family Health Plan reporting requirements. Monthly workload reports are not applicable to the DPs.
Chapter 16 – Regional Director/MTF and Contractor Interfaces	

*Although no exception may be noted, it is the DPs understanding that portions of the TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 1 – Regional Directors/MTF Commanders Interface	If healthcare services can not be provided within the network, the MTF has 1st right of refusal. An MOU will be executed in those cases. 1.0 Balanced workload not applicable 2.0 DP enrollees locked out of MTF for services. 3.0 Specialty referrals not applicable. 4.0 Privacy assessment not applicable 5.0 Coordination of MTF and civilian networks not applicable. 6.0 TRICARE service centers not applicable.
Section 2 – Resource Sharing	The technical requirements set forth the US Family Health Plan MOU requirements
Addendum A – Model Memorandum of Understanding	The technical requirements set forth the US Family Health Plan MOU requirements
<i>Chapter 17 – TRICARE Prime Remote Program</i>	
Section 1 – General	None
Section 2 – Health Care Providers and Review Requirements	None
Section 3 – Marketing, Enrollment, and Support Services	None
Section 4 – Contractor Responsibilities and Reimbursement	None
Section 5 - Reports and Contractor Reimbursement	None
Section 6 - TRICARE Prime Remote for Active Duty Family Members Program	None
Addendum A – Point of Contacts	None
Addendum B – Active Duty Care Guidelines	None
Addendum C – Dental Coverage for Active Duty Service Members (ADSMS) Enrolled in the TRICARE Prime Remote Program	None
Addendum D – Service Point of Contact (SPOC) Review for Fitness for Duty: Protocols and Procedures	None
Chapter 18 – Civilian Care Referred by MHS Facilities	
Section 1 – General	Supplemental healthcare program Not Applicable
Section 2 – Providers of Care	Not Applicable. Supplemental healthcare program.

*Although no exception may be noted, it is the DPs understanding that portions of the 10 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 3 – Contractor Responsibilities	Not Applicable. Supplemental healthcare program.
Section 4 – Payment for Contractor Services Rendered	Not Applicable. Supplemental healthcare program.
Section 5 – Points of Contact	Not Applicable.
Addendum A – Points of Contact	Not Applicable.
Addendum B – Dental Coverage for Active Duty Service Members (ADSMS)	Not Applicable.
Chapter 19 – Civilian Health Care of Uniformed Service Members	
Section 1 – General	Not Applicable DP does not provide care to uniformed service members.
Section 2 – Providers of Care	Not Applicable DP does not provide care to uniformed service members.
Section 3 – Contractor Responsibilities	Not Applicable DP does not provide care to uniformed service members.
Section 4 – Payment for Contractor Services Rendered	Not Applicable DP does not provide care to uniformed service members.
Addendum A – Points of Contact	Not Applicable DP does not provide care to uniformed service members.
Addendum B – Service Point of Contact (SPOC) Review for Authorization: Protocols and Procedures	Not Applicable DP does not provide care to uniformed service members.
Addendum C – Example Notification Letter	Not Applicable DP does not provide care to uniformed service members.
<i>Chapter 20 – Demonstrations</i>	
Section 1 – General	None*
Section 2 – Department of Defense Cancer Prevention and Treatment Clinical Trials Demonstration	None*
Section 3 – DoD In-UTERO Fetal Surgical Repair Of Myelameningocels Clinical Trial Demonstration	None
Section 4 – Operation Noble Eagle/Operation Enduring Freedom Reservist and National Guard benefits demonstration	None

*Although no exception may be noted, it is the DP's understanding that portions of the 11 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 5 – Expanded eligibility under the National Defense Authorization Act for Fiscal Year 2004 and 2005	None
Section 6 – DoD weight management demonstration	None
Section 7 – DoD tobacco cessation demonstration	None
Section 8 – DoD alcohol abuse prevention and education demonstration	None
Section 9 -- TRICARE demonstration project for the state of Alaska – Critical Access Hospital (CAH) Payment Rates.	Not Applicable
Section 10 – DoD Enhanced Access to Autism Services Demonstration	Not applicable .
Addendum A – Participation Agreement for Corporate Services Provider (CSP)	Not applicable.
Chapter 21 – Health Insurance Portability and Accountability Act of 1996 (HIPAA)	
Section 1 – General	None* DP is a covered entity, and as such, is required to comply with the HIPAA mandates set forth by DHH. To the extent these requirements are consistent with HIPAA mandates, DP will comply.
Section 2 – Standards for Electronic Transactions Final Rule	None* DP is a covered entity, and as such, is required to comply with the HIPAA mandates set forth by DHH.
Section 3 – Privacy of Individually Identifiable Health Information	None* DP is a covered entity, and as such, is required to comply with the HIPAA mandates set forth by DHH.
Addendum A – HIPAA Definitions	None* DP is a covered entity, and as such, is required to comply with the HIPAA mandates set forth by DHH.

*Although no exception may be noted, it is the DP's understanding that portions of the 12 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum B – Additional Supporting Information Pertaining to the Transaction and Code Sets Final Rule	None* DP is a covered entity, and as such, is required to comply with the HIPAA mandates set forth by DHH.
Addendum C - Reports	None* DP is a covered entity, and as such, is required to comply with the HIPAA mandates set forth by DHH.
Chapter 22 – TRICARE Dual Eligible Fiscal Intermediary Contract	
Section 1.0 -- General	None
Section 2.0 -- Jurisdiction	None
Section 3.0 – Claims Processing for Dual Eligibles	DPs cover all costs except ESRD
Section 4.0 – Other Contract Requirements	Not applicable to the DP Program
Section 5.0 -- Transition	Not applicable to the DP Program
Chapter 23 – TRICARE Alaska	Not applicable to the DP Program
Chapter 24 – TRICARE Reserve Select	Not applicable to the DP Program

*Although no exception may be noted, it is the DP's understanding that portions of the 13 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Table 2 – TRICARE Policy Manual 6010.54-M, August 1, 2002; through Change 74 dated April 7, 2008

Chapter/Section	Exceptions and Rationale
Chapter 1 – Administration	
Section 1.1 – Exclusions	None*
Section 1.2 – Court-Ordered Care	None*
Section 2.1 – Unproven Drugs, Devices, Medical Treatments, and Procedures	None*
Section 3.1 – Rare Diseases	None*
Section 4.1 – Waiver of Liability	None*
Section 5.1 – Requirements for Documentation for Treatment in Medical Records	None*
Section 5.2 – Medical Photography	None*
Section 6.1 – Nonavailability Statement (DD Form 1251) for Inpatient Admissions	Not applicable
Section 7.1 – Special Authorization Requirements	None*
Section 9.1 – Primary Care Managers	None*
Section 10.1 – Regional Director Requirements	None*
Section 11.1 – Resource Sharing	Not applicable
Section 12.1 – Dept. of Veterans Affairs and Dept. of Defense Health Care Resources Sharing	Not applicable
Section 13.1 – Dept. of Defense Cancer Prevention and Treatment Clinical Trials Demonstration	None*
Section 14.1 – Individual Case Management Program for Persons with Extraordinary Conditions	None*
Section 15.1 – Category II Codes–Performance Measurement	None*
Section 16.1 –Category III Codes	None*
Section 17.1 –Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes	None*
<i>Chapter 2 – Evaluation and Management</i>	
Section 1.1 – Office Visits	None*

*Although no exception may be noted, it is the DPs understanding that portions of the 14 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 1.2 – Office Visits with Surgery	None*
Section 2.1 – Home Services	None*
Section 3.1 – Hospital Care	None*
Section 3.2 – Inpatient Concurrent Care	None*
Section 3.3 – Outpatient Observation Stays	None*
Section 4.1 - Nursing Facility (SNF) Visits	None*
Section 5.1 – Nursing Home Visits	None*
Section 6.1 – Emergency Dept. (ED) Services	None*
Section 6.2 - Neonatal and Pediatric Clinical Care Services	None
Section 7.1 – Urgent Care	None*
Section 8.1 – Consultations	None*
Section 9.1 – Patient Transport	None*
Section 10.1 – Physician Standby Charges	None*
	None*
Chapter 3 - Anesthesia	
Section 1.1- Anesthesia	None*
Section 1.2 – Moderate (Conscious) sedation	None*
Chapter 4 - Surgery	
Section 1.1 – Complications (Unfortunate Sequelae) Resulting From Noncovered Surgery or Treatment	None*
Section 1.1A-Category III Codes	None*
Section 2.1 – Cosmetic, Reconstructive and Plastic Surgery – General Guidelines	None*
Section 3.1- Laser Surgery	None*
Section 4.1 – Assistant Surgeons	None*
Section 5.1 – Integumentary System	None*
Section 5.2 – Post mastectomy Reconstructive Breast Surgery	None*
Section 5.3 – Prophylactic Mastectomy and Prophylactic Oophorectomy	None*
Section 5.4 – Reduction Mammoplasty for Macromastia	None*

*Although no exception may be noted, it is the DP's understanding that portions of the 15 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 5.5 – Silicone or Saline Breast Implant Removal	None*
Section 5.6 – Breast Reconstruction as a result of a congenital anomaly	None*
Section 5.7 – Gynecomastia	None*
Section 6.1 – Musculoskeletal System	None*
Section 7.1 – Oral Surgery	None*
Section 8.1 – Respiratory System	None*
Section 8.2 – Lung Volume Reduction Surgery (LVRS)	None*
Section 9.1 – Cardiovascular System	None*
Section 9.2 – Photopheresis	None*
Section 9.3 – Intracoronary Stents	None*
Section 9.4 – Therapeutic Apheresis	None*
Section 10.1 – Transjugular Intrahepatic Portosystemic shunt (TIPS)	None*
Section 11.1 – Hemic and Lymphatic Systems	None*
Section 12.1 – Mediastinum and Diaphragm	None*
Section 13.1 – Digestive System	None*
Section 13.2 – Surgery for Morbid Obesity	None*
Section 14.1 – Urinary System	None*
Section 15.1 – Male Genital System	None*
Section 16.1 – Intersex Surgery	None*
Section 17.1 – Female Genital System	None*
Section 18.1 – Maternity Care	None*
Section 18.2 – Antepartum Services	None*
Section 18.3 – Abortions	None*
Section 18.4 – Cesarean Sections	None*
Section 18.5 - Fetal Surgery	None*
Section 19.1 – Endocrine System	None*
Section 20.1 – Nervous System	None*
Section 20.2 – Stereotactic Radiofrequency Pallidotomy with Microelectrode Mapping for Treatment of Parkinson’s Disease	None*
Section 20.3 – Stereotactic Radiofrequency Thalamotomy	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 21.1 – Eye and Ocular Adnexa	None*
Section 22.1 – Auditory System	None*
Section 22.2 – Cochlear Implantation	None*
Section 23.1 – High Dose Chemotherapy and Stem Cell Transplantation	None*
Section 24.1 – Heart-Lung and Lung Transplantation	None*
Section 24.2 – Heart Transplantation	None*
Section 24.3 – Combined Heart-Kidney Transplantation	None*
Section 24.4 – Small Intestine, Combined Small Intestine-Liver, and Multivisceral Transplantation	None*
Section 24.5 – Liver Transplantation	None*
Section 24.6 – Combined Liver-Kidney Transplantation	None*
Section 24.7 – Simultaneous Pancreas-Kidney, Pancreas-after-Kidney, and Pancreas-Transplant-Alone	None*
Section 24.8 – Kidney Transplantation	None*
Section 24.9 – Donor Costs	None*
Chapter 5 - Radiology	
Section 1.1 – Diagnostic Radiology (Diagnostic Imaging)	None*
Section 2.1 – Diagnostic Ultrasound	None*
Section 3.1 – Radiation Oncology	None*
Section 4.1 – Nuclear Medicine	None*
Section 5.1 – Thermography	None*
<i>Chapter 6 – Pathology and Laboratory</i>	
Section 1.1 – General	None*
Section 2.1 – Transfusion Services for Whole Blood, Blood Components and Blood Derivatives	None*
Section 3.1 – Diagnostic Genetic Testing and Counseling	None*
Chapter 7 - Medicine	

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 1.1 – Sexual dysfunction, Paraphillias and Gender Identity Disorders	None*
Section 2.1 – Clinical Preventive Services – TRICARE Standard	Not applicable
Section 2.2 – Clinical Preventive Services – TRICARE Prime	None*
Section 2.3 – Family Planning	None*
Section 2.4 – Papanicolaou (PAP) Tests	None*
Section 2.5 – Well-Child Care	None*
Section 2.6 – Routine Physical Examinations	None*
Section 2.7 – Chelation Therapy	None*
Section 2.8 – Hydration, Therapeutic, Prophylactic Injections and Infusions (Excludes Chemotherapy)	None*
Section 3.1 – Limit on Acute Inpatient Mental Health Care	None*
Section 3.2 – Limit on Residential Treatment Center (RTC) Care	None*
Section 3.3 – Preauthorization Requirements for Acute Hospital Psychiatric	None*
Section 3.4 - - Preauthorization Requirements for Residential Treatment Center Care	None*
Section 3.5 – Preauthorization Requirements for Substance Use Disorder Detoxification and Rehabilitation	None*
Section 3.6 – Psychiatric Partial Hospitalization Programs – Preauthorization and Day Limits	None*
Section 3.7 – Substance Use Disorders	None*
Section 3.8 – Learning Disorders	None*
Section 3.9 – Attention-Deficit/Hyperactivity Disorder	None*
Section 3.10 – Treatment of Mental Disorders	None*
Section 3.11 - Ancillary Inpatient Mental Health Services	None*
Section 3.12 – Psychological Testing	None*
Section 3.13 – Psychotherapy	None*
Section 3.14 – Family Therapy	None*
Section 3.15 – Psychotropic Pharmacologic Management	None*
Section 3.16 – Collateral Visits	None*

*Although no exception may be noted, it is the DP's understanding that portions of the 18 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 3.17 – Eating Disorders	None*
Section 4.1 – Biofeedback	None*
Section 4.2 – Dialysis	None*
Section 5.1 – Gastroenterology	None*
Section 6.1 – Ophthalmological Services	None*
Section 6.2 – Lenses (Intraocular or Contact) and Eye Glasses	None*
Section 6.3 – Cardiovascular Therapeutic Services	None*
Section 7.1 – Speech Services	None*
Section 8.1 – Audiology Services	None*
Section 8.2 – Hearing Aid Services	None*
Section 9.1 – Electronystagmography	None*
Section 10.1 – Echocardiogram for Dental and Invasive Procedures	None*
Section 11.1 – Cardiac Rehabilitation	None*
Section 12.1 – Non-invasive Vascular Diagnostic Studies	None*
Section 13.1 – Pulmonary Services	None*
Section 14.1 – Allergy Testing and Treatment	None*
Section 15.1 – Neurology and Neuromuscular Services	None*
Section 15.2 – Sensory Evoked Potentials (SEP)	None*
Section 16.1- Central Nervous System Assessments/Tests	None*
Section 16.2 – Health and Behavior Assessment/Intervention	None*
Section 16.3 - Chemotherapy Administration	None*
Section 16.4 - Education and Training for Patient Self Management	None*
Section 17.1 – Dermatological Procedures – General	None*
Section 18.1 – Rehabilitation - General	None*
Section 18.2 – Physical Medicine/Therapy	None*
Section 18.3 – Occupational Therapy	None*
Section 18.4 – Osteopathic Manipulative Therapy	None*
Section 18.5 – Chiropractic Manipulative Treatment	None*
Section 19.1 – Diagnostic Sleep Studies	None*
Section 20.1 – Hyperbaric Oxygen Therapy	None*
Section 21.1 – Chronic Fatigue Syndrome	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 22.1 – Telemedicine/Telehealth	None*
Section 23.1 - Augmentive Communication Devices (ACD)	None*
Chapter 8 – Other Services	
Section – 1.1 – Ambulance Service	None*
Section 2.1 – Durable Medical Equipment : Basic Program	None*
Section 2.2 – Infantile Apnea Cardiorespiratory Monitor	None*
Section 2.3 – External and Implantable Infusion Pump	None*
Section 2.4 - Cold Therapy Devices for Home Use	None*
Section 2.5 - Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor	None*
Section 2.6 - Breast Pumps	None*
Section 2.7 – Pulsed Irrigation Evacuation (PIE)	None*
Section 3.1 – Orthotics	None*
Section 4.1 – Prosthetic Devices	None*
Section 5.1 – Medical Devices	None*
Section 5.2 – Neuromuscular Electrical Stimulation (NMES) Devices	None*
Section 6.1 – Medical Supplies and Dressings (Consumables)	None*
Section 7.1 – Nutritional Therapy	None*
Section 7.2 – Liquid Protein Diets	None*
Section 8.1 – Diabetes Outpatient Self-Management Training Services	None*
Section 8.2 – Therapeutic Shoes for Diabetes	None*
Section 9.1 – Pharmacy Benefits Program	None*
Section 10.1 – Oxygen and Oxygen Supplies	None*
Section 11.1 – Podiatry	None*
Section 12.1 – Wigs or Hairpiece	None*
Section 13.1 – Adjunctive Dental Care	None*
Section 13.2 - Dental Anesthesia and Institutional Benefit	None*
Section 14.1- Physician-Assisted Suicide	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 15.1 - Custodial Care Transitional Policy (CCTP)	None*
Section 16.1 – Mucus Clearance Devices	None*
Section 17.1 – Lymphedema	None*
Chapter 9 – Program for Persons with Disabilities	
Section 1.1 – General	None*
Section 2.1 – Eligibility General	None*
Section 2.2 - Eligibility – Qualifying Condition: Mental Retardation	None*
Section 2.3 - Eligibility – Qualifying Condition: Serious Physical Disability	None*
Section 2.4 - Eligibility – Qualifying Condition: Other	None*
Section 3.1 – Registration	None*
Section 4.1 – Benefit Authorization	None*
Section 5.1 – Public Facility use Certification	None*
Section 6.1 – Diagnostic Services	None*
Section 7.1 – Treatment Benefit	None*
Section 8.1 – Training Benefit	None*
Section 9.1 – Special Education Benefit	None*
Section 10.1 – Institutional Care Benefit	None*
Section 11.1 – Transportation	None*
Section 12.1 – ECHO Respite Care	None*
Section 13.1 - Other ECHO Benefits	None*
Section 14.1 – Durable Equipment	None*
Section 15.1 - ECHO Home Health Care (EHHC)	None*
Section 16.1 – Cost-Share Liability	None*
Section 17.1 – Providers	None*
Section 18.1 – Claims	None*
Addendum A - ECHO Home Health Care (EHHC) Benefit	None*
<i>Chapter 10 – Eligibility and Enrollment</i>	
Section 1.1 – Eligibility Requirements for TRICARE Beneficiaries	None*
Section 2.1 – Prime - Enrollment	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 3.1 – Prime and Status Changes	None*
Section 4.1 – Continued Health Care Benefit Program (CHCBP) Figure 10-4.1-1 CHCBP Implementing Instructions	None*
Section 5.1 – Transitional Assistance Management Program (TAMP)	None*
Section 6.1 – TRICARE for Life	None*
Section 7.1 Transnional Survivor Status and Survivor Status	None*
<i>Chapter 11 - Providers</i>	
Section 1.1 – Providers - General	None*
Section 1.2 – Institutional Provider, Individual Provider, and Other Non-Institutional Provider Participation	None*
Section 2.1 – Veterans Affairs Health Care Facilities	Not applicable
Section 2.2 – Employer – Operated Medical Facilities	None*
Section 2.3 – Birthing Centers	None*
Section 2.4 – Eating Disorder Programs	None*
Section 2.5 – Psychiatric Partial Hospitalization Program Certification Standards	Not applicable
Section 2.6 – Psychiatric Partial Hospitalization Program Certification Process	None*
Section 2.7 – Psychiatric Hospitals Accreditation	None*
Section 3.1 – Physician Referral and Supervision	None*
Section 3.2 – State Licensure and Certification	None*
Section 3.3 – Accreditation	None*
Section 3.4 – Nurse Anesthetist	None*
Section 3.4A Anesthesiologist Assistant (AA)	None*
Section 3.5 – Certified Clinical Social Worker	None*
Section 3.6 – Certified Psychiatric Nurse Specialist	None*
Section 3.7 – Clinical Psychologist	None*
Section 3.8 – Certified Marriage and Family Therapist	None*
Section 3.9 – Pastoral Counselor	None*
Section 3.10- Mental Health Counselor	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 3.11 – Certified Nurse Midwife	None*
Section 3.12 – Certified Physician Assistant	None*
Section 4.1 - Unauthorized Institution: Related Professional Services	None*
Section 4.2 – Unauthorized Provider: Emergency Services	None*
Section 5.1 – Provider Standards fro Potentially HIV Infectious Blood and Blood Products	None*
Section 6.1 – Ambulatory Surgery	None*
Section 6.2 – Freestanding Ambulatory Surgery Center	None*
Section 7.1 - Certification of Organ Transplant Centers	None*
Section 8.1 – Substance Use Disorder Rehabilitation Facilities Certification Process	Not applicable
Section 9.1 – Other Provider Certification	None*
Section 10.1 - Services Rendered By Employees of Authorized Independent Professional Providers	None*
Section 11.1 – Birthing Center Accreditation	None*
Section 11.2 – Birthing Center Certification Process	None*
Section 11.3 – Certified Marriage and Family Therapist Certification Process	None*
Section 12.1 – Corporate Services Provider Class	None*
Section 12.2 - Qualified Accreditation Organization	None*
Section 12.3 – Participation Agreement Requirements	None*
Addendum A – Standards for Psychiatric Partial Hospitalization Programs (PHPs)	None*
Addendum B – Participation Agreement for Certified Marriage and Family Therapist	Not applicable
Addendum C – Participation Agreement for Freestanding or Institution-Affiliated Birthing Center Maternity Care Services	Not applicable
Addendum D – Application Form For Corporate Services Providers	Not applicable
Chapter 12 – TRICARE Overseas Program (TOP)	
Section 1.1 – Introduction	Not applicable

*Although no exception may be noted, it is the DP's understanding that portions of the 23 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 2.1 – Benefits and Beneficiary Payments	Not applicable
Section 2.2 – Clinical preventive Services (Prime/Standard)	Not applicable
Section 2.3 – Catastrophic Loss Protection (Prime)	Not applicable
Section 3.1 – Eligibility Requirements	Not applicable
Section 3.2 – Enrollment (Prime/TRICARE Plus)	Not applicable
Section 3.3 – Prime and Status Changes	Not applicable
Section 3.4 – Continued Health Care Benefit Program (CHCBP) Overseas	Not applicable
Section 3.5 – Transitional Assistance Management Program (TAMP) Overseas	Not applicable
Section 4.1 – Host Nation Provider	Not applicable
Section 4.2 – TOP Partnership Program	Not applicable
Section 5.1 – Health Care Finders (HCF)	Not applicable
Section 6.1 – Primary Care Managers (PCM) (Prime)	Not applicable
Section 7.1 – TRICARE Area Office (TAO) Director Requirements	Not applicable
Section 8.1 – Authorization Requirements	Not applicable
Section 9.1 – Extended Care Health Option (ECHO) – General	Not applicable
Section 10.1 – Payment Policy	Not applicable
Section 10.2 – Point of Service (POS) Option (Prime)	Not applicable
Section 10.3 – Outside the 50 United States and the District of Columbia Locality-Based Reimbursement Rate Waiver	Not applicable
Section 11.1 – Managed Care Support Contractor Responsibilities for Claims Processing	Not applicable
Section 12.1 – Point of Contract (POC) Program	Not applicable
Section 12.2 – Figures	Not applicable

*Although no exception may be noted, it is the DP's understanding that portions of the 24 TRICARE Manuals that are not part of the DP Program, or are in contradiction to the solicitation Requirements in H94002-07-R-0006, are excluded even if not expressly cited in this exception document.



EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

TRICARE Reimbursement Manual Note: It is the DPs position that the USFHP contract is a full risk capitated arrangement and therefore DoD should not require the use of the payment methodologies set forth in the TRM as it relates to US Family Health Plan network providers. The DPs commit, however, to use the manual as a guide when negotiating/setting provider reimbursement, and in adjudicating claims for non-network providers.

Table 3 – TRICARE Reimbursement Manual 6010.55-M, August 1, 2002 through Change 77 dated May 1, 2008

Chapter/Section	Exceptions and Rationale
<i>Chapter 1 – General</i>	
Section 1 – Network Provider Reimbursement	Exception: Excluding capitation payments from the approved alternative reimbursement systems for network (i.e., contracted) providers would deprive the DP of an important commercially standard tool for managing a full risk commercial contract.
Section 2 – Accommodation of Discounts Under Provider Reimbursement Methods	None*
Section 3 – Claims Auditing Software	None*
Section 4 – Reimbursement in Teaching Setting	None*
Section 5 – National Health Service Corp Physicians of the Public Health Service	None*
Section 6 – Reimbursement of Physician Assistants, Nurse Practitioners, and Certified Psychiatric Nurse Specialists	None*
Section 7 – Reimbursement of Covered Services Provided by Individual Health Care Professional and Other Non-Institutional Health Care Providers	None*
Section 8 – Economic Interest in Connection with Mental Health Admissions	None*
Section 9 – Anesthesia	None*
Section 10 – Postoperative Pain Management	None*
Section 11 – Durable Medical Equipment Claims: Basic Program	None*
Section 12 – Oxygen and Related Supplies	None*
Section 13 – Laboratory Services	None*
Section 14 – Ambulance Services	None*
Section 15 – Legend Drugs and Insulin	Exception: Policies A-D are not applicable. Cost of drugs is based upon access to DAPA.
Section 16 – Surgery	None*
Section 17 – Assistant Surgeons	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 18 – Professional Services: Obstetrical Care	None*
Section 19 – Charges for Provider Administrative Expenses	None*
Section 20 – State Agency Billing	Exception: References to TED reporting requirements Exception: References to Nonavailability Statements (NAS are N/A to TRICRAE Prime enrollees)
Section 21 – Hospital Reimbursement – Billed Charges Set Rates	None*
Section 22 – Hospital Reimbursement – Other than Billed Charges	None*
Section 23 – Hospital Reimbursement – Payment When Only SNF Level of Care is required	None*
Section 24 – Hospital Reimbursement – Outpatient Services	Note. Includes reference to MD HSCRC rates
Section 25 – Preferred Provider Organization (PPO) Reimbursement	Note. Because system set-up would be on a par/non-par basis, if the PPO sent the claim to us first, we would have no way to deny it. We can only implement policy accurately (i.e., deny payment for PPO claims) when a payment has been made.
Section 26 – Supplemental Insurance	None*
Section 27 – Legal Obligation to Pay	None*
Section 28 – Reduction of Payment for Noncompliance with Utilization Review Requirements	None*
Section 29 – Reimbursement of Emergency Inpatient Admissions To Unauthorized Facilities	None*
Section 30 – Reimbursement of Certain Prime Travel Expenses	None*
Section 31 – Newborn Charges	None*
Section 32 – Hospital-Based Birthing Room	None*
Section 33 – Bonus Payments in Health Professional Shortage Areas (HPSA)	None*
Section 34 – Hospital Inpatient Reimbursement in Locations Outside the 50 United States and the District of Columbia	None*
Section 35 – Professional Provider Reimbursement in Specified Locations Outside the 50 United States and the District of Columbia	None*
Addendum A – Sample State Agency Billing Agreement	Note. TMA is responsible for facilitating execution of said agreement.
Addendum B - Figures	None*
Chapter 2 – Beneficiary Liability	

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 1 – Cost-Shares and Deductibles	None*
Section 2 – Catastrophic Loss Protection	<p>Note. Chapter states: 32 CFR 199.18(f), authorizes catastrophic loss protection for TRICARE Prime beneficiary families on a one year enrollment period basis in addition to the protection on a fiscal year basis. The enrollment period shall coincide with the fiscal year (i.e., the beneficiary’s initial enrollment date is May 1 with the enrollment expiration being October 1, all future enrollment periods will be October 1 to October 1.</p> <p>Chapter also states: Under TRICARE Prime, in addition to the catastrophic cap loss protection based on the fiscal year, Prime enrollees also have an enrollment year catastrophic cap...For TRICARE Prime enrollees who are <u>other than active duty</u> personnel or active duty family members...out-of-pocket expenses accrue toward a \$3000 per enrollment year catastrophic cap. Out-of-pocket expenses also accrue toward the \$3000 fiscal year catastrophic cap.</p> <p>Ensure that, as stated in response to technical requirements, only one accumulator will be required- a fiscal year accumulator.</p>
Section 3 – Point of Service Option	Not applicable
Addendum A – Benefits and Beneficiary Payments Under the TRICARE Program	None*
Addendum B – Pharmacy Benefits Program – Cost-Shares	None*
<i>Chapter 3 – Operational Requirements</i>	
Section 1 – Reimbursement of Individual health Care Professional and Other Non-Institutional health Care Providers	<p>Exception: The procedures of the chapter are not required for reimbursement of network providers; however, compensation methodologies that deviate from the accepted contract proposal methodology and are detrimental to the TRICARE beneficiary or the government may be rejected by TMA. This most likely refers to methods such as capitation disapproved in Chapter 1. Capitation must be approved for a commercial plan at full risk.</p> <p>Note. For reimbursement on non-network providers, any method outside of the allowable charge method (e.g., use of fee schedules) must be approved by TMA</p>

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 2 – Hospital and Other Institutional Reimbursement	Note. Section states that the procedures outlined are not required for network providers. Section also references state-determined rates; however, if the state determined rate results in a payment greater than the hospital’s normal billed charge, we are prohibited from using the state-determined rate.
Section 3 – Discounts	None*
Section 4 – Payment Reduction	None*
Section 5 – Reimbursement Administration	Note. Requires contractors to follow instructions of Chapter 3 when reimbursing all non-network providers
<i>Chapter 4 – Double Coverage</i>	
Section 1 – Double Coverage	None*
Section 2 – Double Coverage Review and Processing of Claims	Exception: Monthly OHI reporting to the Pharmacy Data Transaction Service is not stipulated in the technical requirement.
Section 3 – Coordination of Benefits	None*
Section 4 – Specific Double Coverage Actions	None*
<i>Chapter 5 – Allowable Charges</i>	
Section 1 – Allowable Charges – Non-Network Providers	None*
Section 2 – Locality-Based Reimbursement Rate Waiver	None*
Section 3 – Allowable Charges – CHAMPUS Maximum Allowable Charges (CMAC)	None*
Section 4 – Individual Consideration Cases	None*
Section 5 – Payment for Professional /Technical Components of Diagnostic Services	None*
Chapter 6 – Diagnostic Related Groups (DRGs)	
Section 1 – Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (General)	Note. Applies to contract for OOA services only
Section 2 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (General Description of System)	Note. Applies to contract for OOA services only
Section 3 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Basis of Payment)	Note. Applies to contract for OOA services only
Section 4 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Applicability of the DRG System)	Note. Applies to contract for OOA services only
Section 5 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Determination of Payment Amounts)	Note. Applies to contract for OOA services only

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 6 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (DRG Weighing Factors)	Note. Applies to contract for OOA services only
Section 7 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Adjusted Standardized Amounts)	Note. Applies to contract for OOA services only
Section 8 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Adjustments to Payment Amounts)	Note. Applies to contract for OOA services only
Section 9 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Information Provided by TMA)	Note. Applies to contract for OOA services only
Section 10 - Hospital Reimbursement – TRICARE/CHAMPUS DRG – Based Payment System (Charges to Beneficiaries)	Note. Applies to contract for OOA services only
Addendum A – Health Benefit Program Agreement	Note. Applies to contract for OOA services only
Addendum B – (FY 2006) – Fiscal Year 2006 TRICARE/CHAMPUS Adjusted Standardized Amounts	Note. Applies to contract for OOA services only
Addendum B - (FY 2007) – Fiscal Year 2007 TRICARE/CHAMPUS Adjusted Standardized Amounts	Note. Applies to contract for OOA services only
Addendum B - (FY 2008) – Fiscal Year 2008 TRICARE/CHAMPUS Adjusted Standardized Amounts	Note. Applies to contract for OOA services only
Addendum C - (FY 2006) – Diagnosis Related Group (DRGs), DRG Relative Weights, Arithmetic and Geometric Mean Lengths-Of-Stay, and Short-Stay Outlier Thresholds	Note. Applies to contract for OOA services only
Addendum C – (FY 2007) – Diagnosis Related Group (DRGs), DRG Relative Weights, Arithmetic and Geometric Mean Lengths-Of-Stay, and Short-Stay Outlier Thresholds (Effective for Admissions on or After 10/01/2006)	Note. Applies to contract for OOA services only
Addendum C - (FY 2008) – Diagnosis Related Group (DRGs), DRG Relative Weights, Arithmetic and Geometric Mean Lengths-Of-Stay, and Short-Stay Outlier Thresholds (Effective for Admissions on or After 10/01/2007)	Note. Applies to contract for OOA services only
<i>Chapter 7 – Mental Health</i>	
Section 1 – Hospital Reimbursement – TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System	Note. This policy applies to reimbursing network and non-network providers who are not subject to the Medicare PPS or are exempt from the TRICARE reimbursement system. TMA must approve another methodology for network providers. State waivers are available. “Accepted for reimbursing non-network providers.”
Section 2 – Psychiatric Partial Hospitalization Program Reimbursement	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 3 – Substance Use Disorder Rehabilitation Facilities Reimbursement	Note. Inpatient SUDRF applies to contract for OOA services only since payment is based on the DRG system. Policy says Partial Hospitalization is reimbursed on a prospectively determined per diem.
Section 4 – Residential Treatment Center (RTC) Reimbursement	None*
Addendum A – Table of Regional Specific Rates for Psychiatric Hospitals and Units with Low TRICARE Volume (FY 2006 - FY 2008)	None*
Addendum B – Table of Maximum Rates for Partial Hospitalization Programs (PHPs) Prior to Implementation of OPPI, and Thereafter, Freestanding Psychiatric PHP Reimbursement (FY 2006-2008)	None*
Addendum C – Participation Agreement for Substance Use Disorder Rehabilitation Facility (SUDRF) Services for TRICARE/CHAMPUS Beneficiaries	Note. Accept as a guide
Addendum D – TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders (SUDRFs)	None*
Addendum E – Participation Agreement for Residential Treatment Center (RTC)	Note. Accept as a guide
Addendum F – Guidelines for the Calculation of Individual Residential Treatment Center (RTC) Per Diem Rates	None*
Addendum G – (FY 2006) – TRICARE – Authorized Residential Treatment Centers – For Payment of Services Provided on or after 10/01/2005	Not applicable
Addendum G – (FY 2007) – TRICARE – Authorized Residential Treatment Centers – For Payment of Services Provided on or after 10/01/2006	Not applicable
Addendum G – (FY 2008) – TRICARE – Authorized Residential Treatment Centers – For Payment of Services Provided on or after 10/01/2007	Not applicable
Addendum H – TRICARE/CHAMPUS Standards for Residential Treatment Centers (RTCs) Serving Children and Adolescents	None*
Addendum I – Participation Agreement for Hospital-Based Psychiatric Partial Hospitalization Program Services	None*
Addendum J – Participation Agreement for Freestanding Psychiatric Partial Hospitalization Program Services	None*
Chapter 8 – Skilled Nursing Facilities (SNFs)	Note. Effective dates for this chapter are listed as TBD

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 1 – Skilled Nursing Facility (SNF) Reimbursement	<p>Note. Until SNF PPS is effective, policy allows contractor to follow any payment methodology for hospitals that are not subject to the DRG system or the mental health per diem system.</p> <p>Note/Exception: See below</p>
Section 2 - Skilled Nursing Facility (SNF) Prospective Payment System (PPS)	<p>Note. Policy discusses “SNF Pricer” and that TMA will provide the required “pricer cartridge” , the wage index rates, and the SNF PPS rates.</p> <p>Exception: Policy requires SNF to be Medicare-certified and to have entered into a participation agreement directly with TRICARE. Given that we are responsible for network development, we can agree to ensure that any contracted SNF is JCAHO accredited, consistent with the exception to the TRICARE participation agreement allowed for VA SNFs,</p>
Addendum A – RUG-III	Note. Accepted if SNF PPS is required
Addendum B – (FY 2006) Illustration of Per Diem Rate Calculation for SNF for Fiscal Year 2006	Note. Accepted if SNF PPS is required
Addendum B – (FY 2007) Example of Computation of Adjusted PPS Rates and SNF Payment for Fiscal Year 2007	Note. Accepted if SNF PPS is required
Addendum B – (FY 8 Example of Computation of Adjusted PPS Rates and SNF Payment for Fiscal Year 2008	Note. Accepted if SNF PPS is required
Addendum C – Fact Sheet Regarding Consolidate Billing and Ambulance Services	Note. Accepted if SNF PPS is required
Addendum D – (FY 2006) Case-Mix Adjusted Federal Rates – Fiscal Year 2006	Note. Accepted if SNF PPS is required
Addendum D – (FY 2007) Case-Mix Adjusted Federal Rates – Fiscal Year 2007	Note. Accepted if SNF PPS is required
Addendum D – (FY 2008) Case-Mix Adjusted Federal Rates – Fiscal Year 2008	Note. Accepted if SNF PPS is required
Addendum E – (FY 2006) Transition Wage Indexes for SNFs – Fiscal Year 2006	Note. Accepted if SNF PPS is required
Addendum E – (FY 2007) Wage Indexes for Urban Areas for SNFs Based on CBSA labor market Ares - Fiscal Year 2007	Note. Accepted if SNF PPS is required
Addendum E – (FY 2008) Wage Indexes for Urban Areas for SNFs Based on CBSA labor market Ares - Fiscal Year 2008	Note. Accepted if SNF PPS is required
Addendum F - (FY 2007) Wage Indexes for Rural Areas for SNFs Based on CBSA Labor Market Areas – Fiscal Year 2007	Note. Accepted if SNF PPS is required

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum F - (FY 2008) Wage Indexes for Rural Areas for SNFs Based on CBSA Labor Market Areas – Fiscal Year 2008	Note. Accepted if SNF PPS is required
Addendum G – Letter to Skilled Nursing Facility (SNF) RE: New Participation Agreement	Exception: See exception for Section 2
Chapter 9 – Ambulatory Surgery Centers (ASCs)	
Section 1 – Ambulatory Surgical Center (ASC) Reimbursement Prior to Implementation of OPPS, and Thereafter, Freestanding ASCs, and Non-OPPS Facilities	None*
Addendum A – TRICARE-Approved Ambulatory Surgery Procedures On or Before 10/31/2003	None*
Addendum B – TRICARE-Approved Ambulatory Surgery Procedures On or After 11/01/2003	None*
<i>Chapter 10 – Birthing Centers</i>	
Section 1 – Freestanding and Hospital-Based Birthing Center Reimbursement	None*
Addendum A – Birthing Center Rate Non-Professional Component	None*
<i>Chapter 11 - Hospice</i>	
Section 1 – Hospice Reimbursement – General Overview	None*
Section 2 - Hospice Reimbursement – Coverage/Benefits	None*
Section 3 - Hospice Reimbursement – Conditions for Coverage	None*
Section 4 - Hospice Reimbursement – Guidelines for Payment of Designated levels of Care	None*
Addendum A – (FY 2006) – Fiscal Year 2006 Rates for Hospice Care	None*
Addendum A – (FY 2007) – Fiscal Year 2007 Rates for Hospice Care	None*
Addendum A – (FY 2008) – Fiscal Year 2008 Rates for Hospice Care	None*
Addendum B – (FY 2006) – Hospice Rate Information – FY 2006 Hospice Wage Indexes for Urban Areas	None*
Addendum B – (FY 2007) – Hospice Rate Information – FY 2007 Hospice Wage Indexes for Urban Areas	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum B – (FY 2008) – Hospice Rate Information – FY 2008 Hospice Wage Indexes for Urban Areas	None*
Addendum C – (FY 2006) – Hospice Rate Information – FY 2006 Hospice Wage Indexes for Rural Areas	None*
Addendum C – (FY 2007) – Hospice Rate Information – FY 2007 Hospice Wage Indexes for Rural Areas	None*
Addendum C – (FY 2008) – Hospice Rate Information – FY 2008 Hospice Wage Indexes for Rural Areas	None*
Addendum D – (FY 2006) – Crosswalk at Counties by States for Fiscal Year 2006	
Addendum E – Participation Agreement for Hospice Program Services for TRICARE/CHAMPUS Beneficiaries	Note. Accept as a guideline
<i>Chapter 12 – Home Health Care</i>	Note. Effective dates for this chapter are listed as TBD Note. Table header note
Section 1 – Home Health Benefit Coverage and Reimbursement – General Overview	Note. Policy requires use of the home health agency (HHA) Pricer software (software modules in TRICARE claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems)..
Section 2 – Home Health Care – Benefits and Conditions for Coverage	None*
Section 3 – Home Health Benefit Coverage and Reimbursement – Assessment Process	None*
Section 4 – Home Health Benefit Coverage and Reimbursement – Prospective Payment Methodology	None*
Section 5 – Home Health Benefit Coverage and Reimbursement – Primary Provider Status and Episodes of Care	None*
Section 6 - Home Health Benefit Coverage and Reimbursement – Claims and Billing Submission Under HHA PPS	None*
Section 7 - Home Health Benefit Coverage and Reimbursement – Pricer Requirements and Logic	None*
Section 8 - Home Health Benefit Coverage and Reimbursement – Medical Review Requirements	None*
Addendum A – Definitions and Acronym Table	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum B – Home Health (HH) Consolidated Billing Code List - Non-Routine Supply (NRS) Codes	None*
Addendum C – Home Health (HH) Consolidated Billing Code List - Therapy Codes	None*
Addendum D – CMS Form 485 – Home Health Certification and Plan of Care Data Elements	None*
Addendum E – Primary Components of a Home Care Patient Assessment	None*
Addendum F – Outcome and Assessment Information Set (OASIS-B1)	None*
Addendum G1 – OASIS Items Used for Assessments of 60-Day Episodes Beginning Prior to January 1, 2008	None*
Addendum G2 – OASIS Items Used for Assessments of 60-Day Episodes Beginning On or After January 1, 2008	None*
Addendum H – ICD9-CM Diagnosis Codes for HHRG Assignment	None*
Addendum I – Home Health Resource Group (HHRG) Worksheet	None*
Addendum J1 – HIPPS Table for Pricer - For Episodes Beginning Prior to January 1, 2008	None*
Addendum J2 – HIPPS Table for Pricer - For Episodes Beginning On or After January 1, 2008 (First Four Positions of HIPPS Code)	None*
Addendum J3 – HIPPS Table for Pricer - For Episodes Beginning On or After January 1, 2008 (All Five Positions of HIPPS Code)	None*
Addendum K – HAVEN Reference Manual	None*
Addendum K – HAVEN Reference Manual	None*
Addendum L – (CY 2006) - Annual HHA PPS Rate Updates - Calendar Year 2006	None*
Addendum L – (CY 2007) - Annual HHA PPS Rate Updates - Calendar Year 2007	None*
Addendum L – (CY 2008) - Annual HHA PPS Rate Updates - Calendar Year 2008	None*
Addendum M – (CY 2006) - Annual HHA PPS Wage Index Updates - Calendar Year 2006	None*
Addendum M – (CY 2007) - Annual HHA PPS Wage Index Updates - Calendar Year 2007	None*
Addendum M – (CY 2008) - Annual HHA PPS Wage Index Updates - Calendar Year 2008	None*
Addendum N – Data Elements Used in Determination of Outlier Payments	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum O – Diagnoses Associated with Each of the Diagnostic Categories Used in Case-Mix Scoring (CY 2008)	None*
Addendum P – Diagnoses Included in the Diagnostic Categories Used for the Non-Routine Supplies (NRS) Case-Mix Adjustment Model	None*
Addendum Q – Code Table for Converting Julian Dates to Two Position Alphabetic Values	None*
Addendum R – Examples of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)	None*
Addendum S – Input/Output Record Layout	None*
Addendum T – Decision Logic Used by the Pricer for Episodes Beginning On or After January 1, 2008	None*
Chapter 13 – Outpatient Prospective Payment System (OPPS) – Ambulatory Payment Classifications (APCs)	
Section 1 – General	None*
Section 2 – Billing and Coding of Services Under APC Groups	None*
Section 3 – Prospective Payment Methodology	None*
Section 4 – Claims Submission and Processing Requirements	None*
Section 5 – Medical Review and Allowable Charge Review Under the Outpatient Prospective Payment System (OPPS)	None*
Addendum A1 – Development Schedule for TRICARE OCE/AAPC Quarterly Update	None*
Addendum A2 – OPPS OCE Notification Process for Quarterly Updates	None*
Chapter 14 – Sole Community Hospitals	
Section 1 – Sole Community Hospitals (SCHs)	None*
Chapter 15 – Critical Access Hospitals (CAHs)	
Section 1 – Critical Access Hospitals	None*

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Table 4 – TRICARE Systems Manual 7950.1, August 1, 2002; through Change 57 dated March 6, 2008

Chapter/Section	Exceptions and Rationale
<i>Chapter 1 – General ADP Requirements</i>	
Section 1.1 – General ADP Requirements	3.2-3.2.4 DPs will use the Disaster Recovery outlined in their respective ATOs.
Addendum A – DoD 5200.2-R, January 1987 - AP6.Appendix 6	None*
Addendum B – FIPS PUB 140-2 –Security Requirements for Cryptographic Modules	None*
Chapter 2 – TRICARE Encounter Data (TED)	
Section 1.1 – Data Reporting – TRICARE Encounter Data Record Submission	Not applicable
Section 1.2 – Data Reporting – Provider File Record Submission	Not applicable
Section 1.3 – Data Reporting – Pricing File Record Submission	Not applicable
Section 2.1 – Data Requirements – Overview	Not applicable
Section 2.2 – Data Requirements – Data Element Layout	Not applicable
Section 2.3 - Data Requirements – Header Record Data	Not applicable
Section 2.4 - Data Requirements – Institutional/Non-Institutional Record Data Elements (A-D)	Not applicable
Section 2.5 - Data Requirements – Institutional/Non-Institutional Record Data Elements (E-L)	Not applicable
Section 2.6 - Data Requirements – Institutional/Non-Institutional Record Data Elements (M-O)	Not applicable
Section 2.7 - Data Requirements – Institutional/Non-Institutional Record Data Elements (P)	Not applicable
Section 2.8- Data Requirements – Institutional/Non-Institutional Record Data Elements (Q-S)	Not applicable
Section 2.9 - Data Requirements – Institutional/Non-Institutional Record Data Elements (T-Z)	Not applicable
Section 2.10 - Data Requirements – Provider Record Data	Not applicable
Section 3.1 – General Edit Requirements – Overview	Not applicable
Section 4.1 – Header Edit Requirements (ELN 000-099)	Not applicable
Section 5.1 – Institutional Edit Requirements (ELN 000-099)	Not applicable

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Section 5.2 – Institutional Edit Requirements (ELN 100-199)	Not applicable
Section 5.3 – Institutional Edit Requirements (ELN 200-299)	Not applicable
Section 5.4 – Institutional Edit Requirements (ELN 300-399)	Not applicable
Section 5.5 - Institutional Edit Requirements (ELN 400 – 499)	Not applicable
Section 6.1 - Non-Institutional Edit Requirements (ELN 000 – 099)	Not applicable
Section 6.2 - Non-Institutional Edit Requirements (ELN 100 – 199)	Not applicable
Section 6.3 - Non-Institutional Edit Requirements (ELN 200 – 299)	Not applicable
Section 6.4 - Non-Institutional Edit Requirements (ELN 300 – 399)	Not applicable
Section 7.1 – Provider Edit Requirements (ELN 000 – 099)	Not applicable
Section 7.2 – Provider Edit Requirements (ELN 100 – 199)	Not applicable
Section 8.1 – Financial Edit Requirements	Not applicable
Addendum A – Data Requirements – Country and /or Islands Codes	Not applicable
Addendum B - Data Requirements – State Codes	Not applicable
Addendum C - Data Requirements – Provider’s Major Specialty Codes	Not applicable
Addendum D - Data Requirements – Type of Institution Codes	Not applicable
Addendum E - Data Requirements – Other Special Procedure Codes	Not applicable
Addendum F - Data Requirements – Procedure Code for Type of Service	Not applicable
Addendum G - Data Requirements – Place of Service/Type of Service Allowable Relationships	Not applicable
Addendum H - Data Requirements – Adjustment/Denial Reason Codes	Not applicable
Addendum I - Data Requirements – Revenue Codes	Not applicable
Addendum J - Data Requirements – Contract Area of Responsibility	Not applicable
Addendum K - Data Requirements – Pay Plan Code Valid Values	Not applicable
Addendum L - Data Requirements – Dependent Elements & Values for rank Code, Sponsor Pay Category	Not applicable
Addendum M - Data Requirements – Health Care Delivery Plan Coverage Code Values	Not applicable
Addendum N - Data Requirements - Default Values for Complete Claim Denials	Not applicable

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum O – UB-04/UB-92 Conversion Table – To Be Used For Reporting Non-Institutional TED Records	Not applicable
Addendum P – Data Requirements – MTF Enrolling DMIS IDs	Not applicable
Chapter 3 - DEERS	
Section 1.1 – Scope	None*
Section 1.2 – Referenced Documents	None*
Section 1.3 – DEERS Concepts and Definitions	None*
Section 1.4 – Interface Overview	None*
Section 1.5 – DEERS Functions	None*
Section 1.6 – Defense Manpower Data Center (DMDC) Support	None*
Section 1.7 – Test Environment	None*
Addendum A – Acronyms and Abbreviations	None*
Addendum B – Glossary of Selected Terms	None*
Addendum C – Health Care Delivery Program (HCDP) - Figures	None*
Addendum D – Business Rules	None*
Addendum E – DEERS Type 3 Response Record Data Element Definition	None*
Addendum F – Newborn Placeholder Request Process for TRICARE Retail Pharmacy (TRRx) and Pharmacy Data Transaction System (PDS)	None*
Chapter 4 – MHS Referral and Authorization System	
Section 1.1 – MHS Referral and Authorization System	Not Applicable
Addendum A DEERS Nonavailability Statement File Layout and Corresponding 278 Locations	Not Applicable
Addendum B - Example 278 NAS	Not Applicable

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EXCEPTIONS TO MANUALS INCORPORATED BY REFERENCE

Chapter/Section	Exceptions and Rationale
Addendum C - 278 NAS Message Layout	Not Applicable

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ATTACHMENT 11
FINAL JOHNS HOPKINS CAPITATION RATES USED FOR BASE PERIOD

- Exhibit 1**
- Exhibit 2**
- Exhibit 3**
- Exhibit 4**
- Exhibit 5**
- Exhibit 6**
- Exhibit 7**
- Exhibit 8**
- Exhibit 9**
- Exhibit 10**
- Exhibit 11**
- Exhibit 12**
- Exhibit 12**
- Exhibit 13**
- Exhibit 14**
- Exhibit 15**
- Exhibit 16**
- Exhibit 17**
- Exhibit 18**