An Employee-Owned Company

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CHCS: MCP DESKTOP USER GUIDE

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D/SIDDOMS

CHCS

COMPOSITE HEALTH CARE SYSTEM

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LIST OF EFFECTIVE PAGES

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Date	Page Number
28 Apr 1997	Title page (i)
28 Apr 1997	ii — xxiii
28 Apr 1997	1-1 — 1-16
28 Apr 1997	2-1 — 2-239
28 Apr 1997	3-1 — 3-19
28 Apr 1997	4-1 — 4-34
28 Apr 1997	5-1 — 5-231
28 Apr 1997	6-1 — 6-149
28 Apr 1997	7-1 — 7-33
28 Apr 1997	A1 — A-25
28 Apr 1997	B-1 — B-50
28 Apr 1997	C-1 —C-26

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CHCS: MCP DESKTOP USER GUIDE

Table of Contents

Page

1. INTRODUCTION 1-1

1.1. How to Use This Document 1-1
1.2. MCP Overview 1-1
1.3. MCP Menu Assignments 1-6
1.4. FileMan Access 1-7
1.5. Security Keys 1-7
1.6. Scheduled Task Jobs 1-7
1.7. MCP/PAS Mailgroups & Bulletins 1-7
1.8. Data Entry Screens 1-8
1.9. Action Bars 1-8
1.10. Accessing Online Help 1-9
1.11. OLUM 1-9
1.12. Site-specific questions that should be answered prior to MCP activation: 1-9
1.13. Other questions MCP users often ask: 1-10

2. FILE AND TABLE BUILDING AND MAINTAINANCE 2-1

2.1. File And Table For MCP Menu (FMCP) 2-5
2.1.1. Enrollment File/Table Maintenance Menu (ETAB) 2-5
2.1.1.1. Insurance Company Enter/edit (INSU) 2-5
2.1.1.2. PCM Assignment Reason Enter/Edit (PCMA) 2-10
2.1.1.3. Disenrollment Reason Enter/Edit (DISE) 2-12
2.1.1.4. MCP Forms Text Enter/Edit (FORM) 2-14
2.1.1.5. MCP Embosser Attribute Enter/Edit (EMBA) 2-17
2.1.1.6. MCP Embosser Cards Enter/Edit (EMBC) 2-20
2.1.1.7. MCP Embosser Type Enter/Edit (EMBT) 2-25
2.1.1.8. Enrollment Block Reason Enter/Edit (EBRE) 2-28
2.1.1.9. Enrollee Lockout Override Reason Enter/Edit(LORE) . . . 2-31
2.1.1.10. Enrollee DMIS ID Update (DMIS) 2-35
2.1.1.11. Clean Up DMIS ID Update (CLUP) 2-37
2.1.2. Facility File/Table Maintenance (FTAB) 2-39
2.1.2.1. MCP Division Profile Edit (DIVI) 2-40
2.1.2.2. MCP Office Enter/Edit (OFFI) 2-45
2.1.2.3. MCP Health Care Finder Profile Enter/Edit (HEAL) 2-48
2.1.2.4. ZIP Code Combinations Enter/Edit (ZIPC) 2-51
2.1.2.5. Catchment Area ZIP Code Enter/Edit 2-54

CHCS: MCP DESKTOP USER GUIDE

Table of Contents (continued)

Page

2.1.2.6. Facility Type Enter/Edit (FACI) 2-58
2.1.2.7. NAS Issuing Officer Enter/Edit (ISSO) 2-60
2.1.2.8. MCP Parameters Profile Enter/Edit (PARA) 2-63
2.1.2.9. UIC/PCM Maintenance Enter/Edit (UICP) 2-69
2.1.2.10. Reactivate MCP Enrollment 2-76
2.1.3. Provider Network File/Table Maintenance Menu (PTAB) 2-78
2.1.3.1. Department and Service File Enter/Edit (DEPT) 2-78
2.1.3.2. Place Of Care Enter/Edit (PLAC) 2-83
2.1.3.3. Provider Enter/Edit (PROV) 2-102
2.1.3.4. Group Enter/Edit (GROU) 2-110
2.1.3.5. Specialty Type Enter/Edit (SPEC) 2-115
2.1.3.6. Professional Category Enter/Edit (PROF) 2-118
2.1.3.7. Military Status Enter/Edit (MILI) 2-120
2.1.3.8. Audit Trail For Provider Network Menu (AUDI) 2-122
2.1.3.8.1. Agreement Data Changes (AGDC) 2-123
2.1.3.8.2. Place of Care Date Changes (LCDC) 2-124
2.1.3.8.3. Group Data Changes (GPDC) 2-126
2.1.3.8.4. Provider Data Changes (PRDC) 2-126
2.2. Provider Network Management Menu (PMCP) 2-127
2.2.1. Group Profile/agreements Enter Edit (GNET) 2-127
2.2.1.1. GNET – Place of Care Profile Entry 2-129
2.2.1.2. GNET – Agreements Entry 2-140
2.2.1.3. GNET – PROVIDERS 2-155
2.2.1.4. GNET - INACTIVATION 2-175
2.2.1.5. PCM ACTIVATION 2-180
2.2.2. Individual Provider Profile/Agreements Enter/Edit 2-187
2.2.3. Modify Group Agreement Effective Date (MNET) 2-194
2.2.4. Outputs and Network Management Reports Menu (ONET) 2-195
2.2.4.1. Group Management Reports Menu (GMRM) 2-195
2.2.4.1.1. #1 Group Member Roster 2-195
2.2.4.1.2. #2 Provider Group Report 2-198
2.2.4.1.3. #3 Provider List by Specialty 2-206
2.2.4.1.4. #4 PCM Enrollment Mix Discrepancy Statistical Summary 2-208
2.2.4.1.5. #5 PCM Enrollment Mix Discrepancy Report 2-210

CHCS: MCP DESKTOP USER GUIDE

Table of Contents (continued)

Page

2.2.4.2. Agreement Reports Menu (AMRM) 2-212
2.2.4.2.1. #1 Provider Alphabetic Agreement Roster 2-212
2.2.4.2.2. #2 Specialty Provider Agreement Roster 2-216
2.2.4.2.3. #3 Specialty Provider Agreement Summary 2-218
2.2.4.2.4. #4 Discount Provider Agreement Roster 2-219
2.2.4.2.5. #5 Expiration Date Provider Agreement Roster . . . 2-222
2.2.4.2.6. #6 ZIP Code Agreement Roster 2-225
2.2.4.3. Miscellaneous Network Reports Menu 2-228
2.2.4.3.1. Provider Batch Address Labels – Build Utility . . . 2-228
2.2.4.3.2. Provider Batch Address Labels – Print Utility 2-229
2.2.4.3.3. Discrepancy Avoidance Report 2-230
2.3. TaskMan Options 2-233
2.4. Mail Bulletins 2-236

3. PROVIDER NETWORK MANAGEMENT 3-1

3.1. Group Profile/Agreements Enter/Edit (GNET) 3-4
3.2. Individual Provider Profile/agreements Enter/edit (INET) 3-5
3.3. Modify Group Agreement Effective Date (MNET) 3-6
3.4. Outputs & Network Management Reports (ONET) 3-6
3.4.1. Group Management Reports Menu (GMRM) 3-6
3.4.1.1. Group Member Roster 3-7
3.4.1.2. Provider Group Report 3-8
3.4.1.3. Provider List by Specialty 3-9
3.4.1.4. PCM Enrollment Mix Discrepancy Statistical Summary . 3-10
3.4.1.5. PCM Enrollment Mix Discrepancy Report 3-11
3.4.2. Agreement Reports Menu (AMRM) 3-11
3.4.2.1. Provider Alphabetic Agreement Roster 3-11
3.4.2.2. Specialty Provider Agreement Roster 3-12
3.4.2.3. Specialty Provider Agreement Summary 3-13
3.4.2.4. Discount Provider Agreement Roster (obsolete under TRICARE) 3-13
3.4.2.5. Expiration Date Provider Agreement Roster 3-14
3.4.2.6. ZIP Code Agreement Roster 3-15
3.4.3. Miscellaneous Network Reports Menu (MMRM) 3-15
3.4.3.1. Provider Batch Address Labels - Build Utility 3-16
3.4.3.2. Provider Address Labels - Print Utility 3-17
3.4.3.3. Discrepancy Avoidance Report 3-17

CHCS: MCP DESKTOP USER GUIDE

Table of Contents (continued)

Page

4. DEERS FUNCTIONS AND PROCESSES. 4-1

4.1. DEERS Check (Enrollment/Family Member Screens) 4-1
4.2. DEERS Check (Non-Enrollment/Individual Screens) 4-8
4.3. Current DEERS Eligibility Display 4-13
4.4. Enrollees of USTF Managed Care Program 4-17
4.5. CHCS/DEERS Discrepant Data Check 4-19
4.6. Interactive DEERS Eligibility Request 4-24
4.7. DEERS Purge Parameter 4-27
4.8. PAS DEERS Ineligibility Report 4-30
4.9. MCP DEERS Ineligibility Report 4-32

5. ENROLLMENT PROCESSING 5-1

5.1. Enrollment Enter/Edit (EENR) 5-4
5.1.1. Enroll a Patient. 5-6
5.1.2. Assign a PCM 5-43
5.1.3. Enroll Family Members 5-54
5.1.4. Enter OHI Information 5-64
5.1.5. Enroll Family Members Into the MCP Using the Family Action 5-71
5.1.6. Assign an Exception Provider to an MCP Patient 5-80
5.1.7 .Renew a Patient's Enrollment 5-86
5.1.8. Cancel an Enrollment 5-89
5.2. Disenrollment (DENR) 5-92
5.3. Reciprocal Disenrollment Processing (RENR) 5-96
5.3.1. Reciprocal Enrollment/Disenrollment 5-96
5.3.2. Reciprocal Disenrollment 5-103
5.4. Conditional Enrollment Processing (CENR) 5-105
5.5. Print/Display Enrollment History (PENR) 5-110
5.6. Interactive Deers Eligibility Request (IENR) 5-113
5.7. Batch Enroll Active Duty (BENR) 5-120
5.7.1. Identify Potential Active Duty Candidates (IBER) 5-120
5.7.2. Update/Print/Enroll Potential AD Candidates (UBER) 5-123
5.7.3. Print Batch Enrollment Report (PBER) 5-126
5.7.4. Delete Potential Candidate List (DBER) 5-127

CHCS: MCP DESKTOP USER GUIDE

Table of Contents (continued)

Page

5.8. Multiple Batch Renewal and Disenrollment Functions (MENR) 5-129
5.8.1. Identify Candidates For Renewal Letter (IMER) 5-129
5.8.2. Batch Renewal and Disenrollment Processing (BMER) 5-133
5.8.2.1. Batch Renew MCP Enrollments 5-133
5.8.2.2. Batch Disenroll Candidates 5-137
5.8.3. Print Batch Renewal & Disenrollment Products (PMER) 5-142
5.8.3.1. Batch Renew & Disenroll Letter 5-143
5.8.3.2. Batch Renew & Disenroll Labels 5-146
5.8.3.3. Batch Renew & Disenroll Roster 5-149
5.8.4. Generate Individual Notification Letter & Label (GMER) 5-150
5.9. Outputs and Enrollment Maintenance Reports Menu (OENR) 5-152
5.9.1. DEERS/Enrollment Maintenance Reports Menu (DRPM) 5-153
5.9.1.1. MCP Conditional Enrollment Roster 5-153
5.9.1.2. Enrollment/Disenrollment Discrepancy Report 5-156
5.9.1.3. MCP DEERS Ineligibility Report 5-159
5.9.1.4. PAS DEERS Ineligibility Report 5-161
5.9.2. Enrollment Reports Menu (ERPM) 5-164
5.9.2.1. Family Batch Enrollment Labels Menu (LABL) 5-164
5.9.2.1.1. Family Batch Enrollment Labels Build Utility . . . 5-165
5.9.2.1.2. Family Batch Enrollment Labels Print Utility . . . 5-167
5.9.2.1.3. Incomplete Patient Address Report 5-168
5.9.2.2. Enrollment Rosters Menu (ROST) 5-171
5.9.2.2.1. AD Family Members by Unit Enrollment Roster . . 5-172
5.9.2.2.2. Alphabetic Enrollment Roster by Service 5-173
5.9.2.2.3. Case Management Program Enrollment Roster . . . 5-175
5.9.2.2.4. Change in Eligibility Enrollment Roster 5-175
5.9.2.2.5. Disenrollees for Period by Reason Code 5-177
5.9.2.2.6. Enrollment Roster Exception Conditions 5-178
5.9.2.2.7. Reciprocal Disenrollment by Reason Roster 5-180
5.9.2.2.8. Reciprocal Disenrollment Discrepancy Report 5-181
5.9.2.2.9. Track User Report 5-183
5.9.2.2.10. Enrollee Entitlement Discrepancy Report by Family 5-186
5.9.2.3. Enrollment Summaries Menu (SUMM) 5-189
5.9.2.3.1. Disenrollment Summary by Reason 5-189
5.9.2.3.2. Enrollment Summary Report (SUMM) 5-190
5.9.2.3.3. OHI Enrollment Summary (SUMM) 5-195
5.9.2.3.4. Patient Category Enrollment Summary 5-196

CHCS: MCP DESKTOP USER GUIDE

Table of Contents (continued)

Page

5.9.3. PCM Reports Menu 5-198
5.9.3.1. Available PCM Capacity by Provider Group 5-198
5.9.3.2. Enrollment Roster by PCM 5-201
5.9.3.3. PCM Activity Report 5-203
5.9.3.4. PCM Assignment Change Roster by Reason 5-203
5.9.3.5. PCM Assignment Change Summary 5-205
5.9.3.6. Default PCM/UIC Report 5-207
5.9.3.7. PCM Enrollment Mix Discrepancy Statistical Summary 5-209
5.9.3.8. PCM Enrollment Mix Discrepancy Report 5-212
5.9.4. MCP Enrollment Form (MEFM) 5-214
5.9.5. Address Label for Patient (APAL) 5-214
5.10. Batch PCM Assignment/Reassignment of Enrollees 5-214
5.10.1. Batch PCM Reassignment (BPCM) 5-216
5.10.2. Family PCM Reassignment 5-223
5.10.3.Active Duty Enrollee UIC Maintenance Report 5-229

6. MANAGING MCP PATIENT APPOINTMENTS 6-1

6.1. The Health Care Finder Menu (HMCP) 6-2
6.1.1. PCM Booking (PHCF) 6-3
6.1.2. Non-Enrolled Booking (NHCF) 6-32
6.1.3. Appointment Referral Booking (AHCF) 6-43
6.1.3.1. Enter an Appointment Referral for an Enrolled Patient 6-45
6.1.3.2. Find a Provider 6-58
6.1.3.3. Print appointment referral products 6-101
6.1.3.4.1. Print the Care Authorization Form 6-103
6.1.4. Enter Appointment Refusals (EHCF) 6-106
6.2. Display Patient Appointments (DMCP) 6-117
6.3. Cancellation By Patient (CMCP) 6-121
6.4. Health Care Finder Output Products And Reports 6-131
6.4.1. Output Products (OHCF) 6-131
6.4.1.1. MCP Enrollment Form 6-131
6.4.2. Print Patient Address Label (LHCF) 6-135
6.4.3. Health Care Finder Reports Menu (RHCF) 6-136
6.4.3.1. Agreement Type Referral Summary 6-136
6.4.3.2. Specialty Type Referral Summary 6-137

CHCS: MCP DESKTOP USER GUIDE

Table of Contents (continued)

Page

6.4.3.3. Provider Network List 6-139
6.4.3.4. PCM Activity Report 6-141
6.4.3.5. Provider Patient Workload Report 6-146
6.4.3.6. Refused Appointments Report 6-149

7. INTERACTIVE NON-AVAILABILITY STATEMENT (NAS)/CARE AUTHORIZATION PROCESSING 7-1

7.1. Interactive NAS Processing Menu (IMCP) 7-1
7.1.1. Non-Availability Statement Processing (NNAS) 7-2
7.1.1.1. Print or Cancel an Individual NAS 7-3
7.1.1.2. Issuing an NAS: 7-8
7.1.1.3. View NAS History 7-26
7.2. Reports for NAS (RNAS) 7-26
7.2.1. Printing a Report to a Spooled Document 7-26
7.2.2. Printing a Spooled Document 7-26
7.2.3. Branch of Service Summary Report (BNAS) 7-27
7.2.4. NAS Statistical Report (NNAS) 7-29
7.2.5. Reason for Issue by Patient Category Report (PNAS) 7-30
7.2.6. Reason for Issue Summary Report (SNAS) 7-32

CHCS: MCP DESKTOP USER GUIDE

List of Figures

Figure **Page**

2-1. Insurance Co Enter/Edit Screen 2-7
2-2. MCP PCM Assignment Reason Enter/Edit Screen. 2-12
2-3. MCP Disenrollment Reason Screen. 2-14
2-4. CP Forms Text 2-16
2-5. DG Embosser Attribute Edit Screen 2-19
2-6. DG Emboss Card Edit Screen 2-22
2-7. DG Embosser Type Edit Screen. 2-26
2-8. MCP Enroll Block Reason Screen 2-30
2-9. MCP Enrollee Lockout Override Reason Enter/Edit Screen 2-34
2-10. Enrollee DMIS ID Update Screen 2-36
2-11. MCP Division Name Prompt 2-42
2-12. SD Division Profile 2-43
2-13. CP Office Profile 2-47
2-14. MCP HCF Profile 2-50
2-15. CP ZIP Code Combinations Screen 2-52
2-16. DOD ZIP Code Enter Edit Screen 2-56
2-17. MCP Facility Type Screen 2-59
2-18. MCP NAS Issuing Officer Screen 2-62
2-19. MCP Parameters Profile Screen 2-66
2-20. UIC/PCM Maintenance Screen 2-71
2-21. UIC/PCM Maintenance screen with criteria selections 2-71
2-22. UIC/PCM Maintenance Screen w/POC 2-73
2-23. UIC/PCM Maintenance Screen w/Groups as PCMs 2-73
2-24. EDIT A UIC Screen 2-74
2-25. EDIT A UIC Screen with Data 2-75
2-26. Reactivate the Enrollment Option. 2-77
2-27. DOD DEPT and SVC Edit Screen 2-81
2-28. DOD Hospital Location Edit Screen 2-88
2-29. DOD Hosp Location Edit – Continuation Screen 2-89
2-30. GRP PL1a 2-91
2-31. GRP PL2a Place of Care Screen. 2-92
2-32. GRP PL3a Place of Care Screen. 2-94
2-33. SD Clinic Profile Screen 2-95
2-34. SD Clinic Profile – Continuation Screen 2-96
2-35. SD Clinic Profile -- Continuation Screen. 2-98
2-36. SD Clinic Profile –- Continuation 2-99
2-37. DOD Add Provider Screen 2-105
2-38. IND PROF1A Individual Provider Profile Screen 2-107

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure **Page**

2-39. IND PROF 3a - Individual Provider Profile 2-109
2-40. GROUP PRO1a Screen. 2-113
2-41. CP Provider Specialty Type Screen 2-117
2-42. CP Professional Category. 2-119
2-43. Military Status Screen 2-122
2-44. Agreement Data Changes Report 2-124
2-45. Places of Care Data Changes Report. 2-125
2-46. Group Data Changes Report 2-126
2-47. Provider Data Changes Report 2-127
2-48. GRP PRO1 - Provider Group Profile Screen 2-132
2-49. Provider Group Places of Care – GRP PL1 Screen 2-133
2-50. GRP PL2 - Provider Group Places of Care Screen 2-135
2-51. GRP PL3 – Provider Group Places of Care Screen 2-136
2-52. SD Clinic Profile Screen 2-137
2-53. SD Clinic Profile -- Continuation Screen. 2-138
2-54. SD Clinic Profile -- Continuation (Appointment Types). 2-139
2-55. Provider Group Profile/Agreement Maintenance Action Bar. 2-142
2-56. Provider Group Agreement History Screen 2-143
2-57. GRP AGREE2 - Provider Group Overall Discount Screen. 2-144
2-58. Individual Provider Agreement Participation Screen 2-146
2-59. Provider Group Agreement History Screen 2-147
2-60. Provider Group Specialty Exceptions Screen 2-149
2-61. Provider Group Procedure Exception Screen 2-150
2-62. Provider Group PCM Capacity Screen 2-151
2-63. Agreement Early Termination Reason Screen 2-153
2-64. Individual Provider Profile Screen 2-158
2-65. Individual Provider Profile - IND PROF1 Screen. 2-160
2-66. Individual Provider Profile - IND PROF3 2-161
2-67. Individual Provider Profile - IND PROF4 Screen. 2-162
2-68. Individual Provider Profile - IND PROF5 Screen. 2-163
2-69. Individual Provider Profile - IND PL1 Screen 2-164
2-70. Individual Provider Profile - IND PL2 Screen 2-165
2-71. Individual Provider Services Offered Profile Screen 2-166
2-72. CP NET HCP Profile - Continuation - Continuation Screen 2-167
2-73. Provider Appointment Types Display 2-169
2-74. Individual Provider Agreement Participation Screen 2-170
2-75. Individual Provider Agreement Exception History Screen 2-171
2-76. Individual Provider PCM Capacity Screen 2-173

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure		Page
2-77.	Provider Group Profile/Agreement Maintenance	2-176
2-78.	Provider Group Inactivate/Reactivate Maintenance Screen	2-177
2-79.	Inactivation/Reactivation of Place of Care Screen	2-178
2-80.	Place of Care Discrepancy Warning Message - Group	2-179
2-81.	GRP PRO1 – Provider Group Profile	2-182
2-82.	Individual Provider Profile, IND PL1 Screen	2-183
2-83.	CP NET HCP Profile Screen	2-184
2-84.	Provider Group PCM Capacities	2-185
2-85.	Individual Provider PCM Capacity Screen	2-186
2-86.	Individual Provider Profile/Agreement Maintenance Screen	2-189
2-87.	Group Member Roster	2-197
2-88.	Provider Group Report - Group Information	2-199
2-89.	Provider Group Report - Places of Care	2-200
2-90.	Provider Group Report - Agreements and Providers	2-201
2-91.	Provider Group Report - Primary Care Managers	2-202
2-92.	Provider List by Speciality	2-207
2-93.	PCM Enrollment Mix Discrepancy Statistical Summary	2-209
2-94.	PCM Enrollment Mix Discrepancy Report	2-211
2-95.	Provider Alphabetic Roster	2-213
2-96.	Specialty Provider Agreement Roster	2-217
2-97.	Specialty Provider Agreement Summary	2-218
2-98.	Discount Provider Agreement Roster	2-220
2-99.	Expiration Date Provider Agreement Roster	2-223
2-100.	ZIP Code Agreement Roster	2-226
2-101.	Discrepancy Avoidance Report	2-233
3-1.	Group Management Reports Menu	3-6
3-2.	Group Management Reports Menu	3-7
3-3.	Miscellaneous Network Reports Menu (MMRM)	3-15
4-1.	Select Patient Name Prompts	4-3
4-2.	Family Member Screen	4-4
4-3.	Family Member Screen	4-4
4-4.	CHCS Family Member Screen	4-5
4-5.	Family Member Screen (Second Family Member)	4-6
4-6.	Family Member Screen	4-10
4-7.	DEERS Eligibility Data	4-11
4-8.	DEERS Eligibility Data (View Action)	4-12
4-9.	Historical DEERS Eligibility Data Screen	4-13
4-10.	Current DEERS Eligibility	4-15

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure		Page
4-11.	Current DEERS Eligibility, Second Screen	4-16
4-12.	Current DEERS Eligibility Hard Copy Printout	4-17
4-13.	CHCS/DEERS Discrepancy Data Screen	4-21
4-14.	CHCS/DEERS Discrepancy Data Continued	4-22
4-15.	CHCS/DEERS Discrepancy Data (Station/Unit Selected)	4-23
4-16.	CHCS/DEERS Discrepancy Data (shows discrepancies in Station Unit data)	4-23
4-17.	CHCS/DEERS Discrepancy Data	4-24
4-18.	DEERS Post Eligibility Request	4-25
4-19.	DEERS Interactive Request Screen	4-26
4-20.	PAS DEERS Ineligibility Report (1 of 2)	4-28
4-21.	MCP DEERS Ineligibility Report	4-33
5-1.	Demographics Display Screen	5-8
5-2.	Patient - Initial Information Screen	5-9
5-3.	Family Member Screen	5-12
5-4.	Current DEERS Eligibility	5-17
5-5.	Current DEERS Eligibility, Second Screen	5-18
5-6.	Current DEERS Eligibility Hard Copy Printout	5-19
5-7.	Demographics Display Screen	5-19
5-8.	CHCS/DEERS Discrepancy Data Screen	5-22
5-9.	Sample DEERS Eligibility Data Screen for an Eligible Patient	5-24
5-10.	Mini Registration Screen	5-27
5-11.	Enrollment/Empanelment Information	5-31
5-12.	Allergy Enter/Edit Screen	5-32
5-13.	MCP Enrollment - - Continuation Screen	5-37
5-14.	MCP Enrollment Screen	5-41
5-15.	PCM Search Criteria Screen	5-44
5-16.	PCM Search Criteria (Change Search Criteria)	5-48
5-17.	PCM Assignment Screen	5-52
5-18.	Patient - Initial Information Screen	5-55
5-19.	Family Member Screen	5-57
5-20.	Family Member Demographics Move Screen	5-58
5-21.	Mini Registration Screen	5-59
5-22.	MCP Enrollment - - Continuation Screen	5-60
5-23.	MCP Enrollment Screen	5-61
5-24.	PCM Search Criteria (Change Search Criteria)	5-62
5-25.	PCM Direct Assignment Screen (Expanded Provider Record)	5-63
5-26.	PCM Direct Assignment Screen (Place of Care)	5-64

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure **Page**

5-27. Other Health Insurance Screen 5-66
5-28. Other Health Insurance Enter/Edit Screen 5-67
5-29. Other Health Insurance - Enter/Edit Screen 5-70
5-30. Other Health Insurance Screen 5-71
5-31. Current DEERS Eligibility Screen 5-74
5-32. Demographics Display Screen 5-75
5-33. Family Enrollment Screen 5-76
5-34. MCP Enrollment - - Continuation Screen 5-77
5-35. MCP Enrollment Screen 5-78
5-36. Case Management Screen 5-82
5-37. Case Management Enter/Edit Screen 5-83
5-38. MCP Exception Information - - Continuation Screen 5-84
5-39. Case Management Enter/Edit Screen - View Provider Information 5-86
5-40. MCP Renewal - - Continuation Screen 5-88
5-41. Disenrollment Screen 5-90
5-42. Disenrollment Screen 5-91
5-43. Disenrollment Screen 5-94
5-44. Family Member Screen 5-104
5-45. Conditional Enrollment Processing 5-106
5-46. Conditional Enrollment Processing Screen 5-107
5-47. DEERS Interactive Request Screen 5-109
5-48. Enrollment History Screen 5-112
5-49. Display Enrollment History Screen 5-113
5-50. DEERS Interactive Request Screen 5-116
5-51. DEERS Eligibility Data Screen 5-118
5-52. Potential Active Duty Candidate Update/Report 5-121
5-53. Identify Potential Active Duty Candidates Warning Message . . . 5-121
5-54. Potential Active Duty Candidate Update/Report 5-124
5-55. Potential Active Duty Candidate Update/Report Data Elements Updates 5-125
5-56. Print Batch Enrollment Report Screen 5-127
5-57. Delete Potential Candidate List Screen 5-128
5-58. Renewal Notification Letter Candidates Screen 5-131
5-59. Renewal Notification Letter Candidates Screen 5-132
5-60. Renewal & Disenrollment Processing Screen and Action Bar 5-134
5-61. Renewal Batch Processing Screen 5-136
5-62. Renewal & Disenrollment Processing Screen 5-138

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure **Page**

5-63. Renewal & Disenrollment Processing Screen 5-139
5-64. Renewal & Disenrollment Processing Screen 5-139
5-65. Sample Renewal Notification Letter 5-145
5-66. Batch Renewal & Disenrollment Labels Screen 5-146
5-67. Batch Renewal & Disenrollment Labels 5-147
5-68. Batch Renewal & Disenrollment Labels Screen 5-148
5-69. Generate Individual Notification Letters/Labels Screen 5-151
5-70. MCP Conditional Enrollment Roster. 5-155
5-71. Enrollment/Disenrollment Discrepancy Report 5-158
5-72. MCP DEERS Ineligibility Report 5-160
5-73. PAS DEERS Ineligibility Report 5-162
5-74. Family Batch Enrollment Labels. 5-166
5-75. Family Batch Enrollment Labels - Print Utility Screen 5-168
5-76. Incomplete Patient Address Report. 5-170
5-77. Enrollment Rosters Menu 5-171
5-78. Enrollment Roster for Active Duty Family Members by Unit 5-173
5-79. Alphabetic Enrollment Roster by Service Screen 5-174
5-80. Case Management Program Enrollment Roster. 5-175
5-81. Change in Eligibility Enrollment Roster. 5-177
5-82. Disenrollees for Period By Reason Report. 5-178
5-83. Enrollment Roster Exception Conditions Report 5-179
5-84. Reciprocal Disenrollment by Reason Roster 5-181
5-85. Reciprocal Disenrollment Discrepancy Report (Page 1 of 2) 5-183
5-86. Reciprocal Disenrollment Discrepancy Report (Page 2 or 2) 5-183
5-87. Track User Report by Family. 5-184
5-88. Track User Report by Patient Category Group. 5-185
5-89. Enrollee Entitlement Discrepancy Report (Page 1 of 2). 5-187
5-90. Enrollment Summaries Menu Screen 5-189
5-91. Disenrollment Summary By Reason Report 5-190
5-92. Enrollment Summary Report. 5-194
5-93. OHI Enrollment Summary Report 5-195
5-94. Patient Category Enrollment Summary Report (Enrollee Totals by Patient Category) 5-197
5-95. Patient Category Enrollment Summary Report (Patient Category by Service) 5-198
5-96. Available PCM Capacity by Provider Group. 5-200
5-97. Enrollment Roster by PCM 5-202
5-98. PCM Assignment Change Roster by Reason. 5-204

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure		Page
5-99.	PCM Assignment Change Summary	5-206
5-100.	Default PCM/UIC Report	5-208
5-101.	PCM Enrollment Mix Discrepancy Statistical Summary Report	5-210
5-102.	PCM Enrollment Mix Discrepancy Report	5-213
5-103.	Batch PCM Reassignment	5-218
5-104.	Batch PCM Reassignment Screen	5-219
5-105.	Batch PCM Search Criteria Screen	5-220
5-106.	Batch PCM Reassignment Screen	5-222
5-107.	Family PCM Reassignment Screen	5-224
5-108.	Demographics Display Screen	5-225
5-109.	Family PCM Reassignment	5-226
5-110.	Family Appointments with a Prior PCM Screen	5-229
5-111.	Active Duty Enrollee/UIC Maintenance Report	5-231
6-1.	Appointment Searches for MTF Group Providers	6-5
6-2.	PCM Booking Search Criteria Screen	6-8
6-3.	Current DEERS Eligibility Screen	6-9
6-4.	Demographics Display Screen	6-10
6-5.	Demographics Display Action Bar and Message for Non-Enrolled Patient	6-12
6-6.	PCM Booking Search Criteria Screen	6-13
6-7.	PCM MTF Booking Search Criteria Screen	6-14
6-8.	PCM MTF Booking Search Criteria Screen with Selectable Search Criteria	6-16
6-9.	Prompt to Select Acceptable Days of the Week for an Appointment	6-17
6-10.	PCM MTF Booking Search Criteria Screen (with selected search criteria filled in)	6-19
6-11.	PCM MTF Single Patient Booking Screen	6-20
6-12.	File Appointment Screen	6-21
6-13.	File Appointment Screen Continuation	6-22
6-14.	PCM Non-MTF Booking Search Criteria Screen	6-26
6-15.	Add an Appointment Slot Screen	6-27
6-16.	Add an Appointment Slot Screen	6-28
6-17.	Non-MTF Booking - Add Screen	6-29
6-18.	Add an Appointment Slot with One Slot Already Created	6-31
6-19.	Non-Enrolled Booking Search Criteria Screen	6-34
6-20.	Non-Enrolled Booking Search Criteria Screen	6-35

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure **Page**

6-21. Non-Enrolled Booking Search Criteria Screen 3 6-36
6-22. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar 6-38
6-23. Provider Name, MTF, External, Non-Network Provider Search Action Bar 6-39
6-24. Non-Enrolled Booking Search Criteria Screen with Available MTF Appointments. 6-40
6-25. Non-Enrolled MTF Booking Search Criteria Screen 6-41
6-26. Non-Enrolled MTF Single Patient Booking Screen 6-43
6-27. Appointment Referral Booking Screen 6-47
6-28. Interview/Referral Screen 6-49
6-29. First Completed Interview/Referral Screen 6-53
6-30. Interview/Referral -- Continued (Completed) 6-54
6-31. Interview/Referral -- Continued 2 6-56
6-32. Interview/Referral -- Continued 3 6-58
6-33. Add Appointment Referral Screen. 6-59
6-34. Provider Search Screen 6-61
6-35. Provider Search Screen 6-64
6-36. Provider Search Screen 6-65
6-37. MCP Individual Provider Discount Summary for an MTF Provider 6-68
6-38. Add Appointment Referral Screen. 6-69
6-39. MTF Booking Search Criteria Screen 6-70
6-40. MTF Single Patient Booking Screen 6-72
6-41. File Appointment Screen 6-74
6-42. File Appointment Screen (Continuation) 6-75
6-43. Provider Search Screen (with MTF Providers Displayed in the Select Window) 6-78
6-44. Add Appointment Referral Screen with Provider Eligibility Dates 6-79
6-45. Add Appointment Referral Screen. 6-83
6-46. Provider Search Screen 6-84
6-47. Provider Search Screen (for External Providers) 6-85
6-48. MCP Individual Provider Discount Summary Screen 6-87
6-49. MCP Individual Provider Specialty Exceptions Screen 6-88
6-50. MCP Individual Provider Procedure Exceptions Screen 6-89
6-51. MCP Provider Group Places of Care, Page 1 6-90
6-52. MCP Provider Group Places of Care, Page 2 6-91

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure **Page**

6-53. Add Appointment Referral Screen 6-92
6-54. Non-MTF Booking Search Criteria Screen 6-93
6-55. Add an Appointment Slot Screen 6-94
6-56. Add an Appointment Slot 2 6-96
6-57. File Appointment Screen 6-97
6-58. Place of Care Directions, Screen 1 of 2 6-98
6-59. Place of Care Directions/Comments, Screen 2 of 2 6-99
6-60. Provider Search Screen with Non-Network Providers 6-101
6-61. Generate Appointment Referral Products Screen 6-102
6-62. Care Authorization Form, Page 1 6-105
6-63. Care Authorization Form, Page 2 6-106
6-64. Appointment Refusals Screen (EHCF option) 6-108
6-65. Appointment Refusals with Selectable Search Criteria 6-110
6-66. Appointment Refusals Screen 6-111
6-67. Appointment Refusals Screen with Second Action Bar 6-113
6-68. Appointment Refusal - Secondary Screen 6-114
6-69. Appointment Refusal Printout 6-117
6-70. Display Patient Appointments 6-119
6-71. family Appointment History 6-120
6-72. Cancellation by Patient Search Criteria Screen 6-123
6-73. Cancellation by Patient Search Criteria Screen with Selectable Search Criteria 6-124
6-74. Cancellation by Patient Search Criteria Screen 6-125
6-75. Cancellation by Patient Search Criteria Screen with Search Criteria Entered 6-127
6-76. Cancel/Reschedule Patient Appointments Screen 6-128
6-77. Cancel/Reschedule Patient Appointments Screen Ready to Process First Selected Appointment 6-129
6-78. Managed Care Enrollment Form 6-134
6-79. Patient Address Label 6-135
6-80. Health Care Finder Reports Menu 6-136
6-81. Agreement Type Referral Summary by Specialty 6-137
6-82. Specialty Type Referral Summary 6-138
6-83. Provider Network List 6-140
6-84. Provider Network List (Continued) 6-141
6-85. PCM Activity Report by Provider Group 6-143
6-86. PCM Activity Report by Individual PCM 6-144
6-87. PCM Activity Report by Specialty 6-145

CHCS: MCP DESKTOP USER GUIDE

List of Figures (continued)

Figure **Page**

6-88. Provider Patient Workload Report by Provider Group. 6-147
6-89. Provider Patient Load Report by Provider 6-148
6-90. Refused Appointments Report 6-149
7-1. NAS Processing Initial Action Bar and First Prompt When Selecting by NAS Number 7-4
7-2. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name. 7-5
7-3. Processing DEERS Request Message 7-5
7-4. DEERS NAS Response Error Message 7-6
7-5. NAS Display Screen 7-6
7-6. Sample Mini Registration Screen 7-7
7-7. Non-Availability Statement Processing Initial Action Bar and Patient Selection Prompts 7-10
7-8. Current DEERS Eligibility Screen 7-12
7-9. Demographics Display Screen 7-13
7-10. NAS History Screen 7-15
7-11. NAS Issue Screen 7-17
7-12. NAS Issue Second Input Screen 7-20
7-13. Transaction Complete Message 7-21
7-14. DEERS Data Discrepancy Message. 7-21
7-15. NAS Display Screen 7-22
7-16. Nonavailability Statement for an Enrolled Patient 7-24
7-17. Nonavailability Statement for a Non-Enrolled Patient 7-25
7-18. Branch of Service Summary Report 7-28
7-19. Monthly Statistical Report. 7-29
7-20. Reason for Issue by Patient Category Report 7-31
7-21. Reason for Issue Summary Report 7-33

List of Diagrams

Diagram

CHCS ENROLLMENT: Active Duty All Sites and Non-Active Duty in Regions 1, 2, 5, and 6 . . . . . A-25

CHCS: MCP DESKTOP USER GUIDE

List of Tables

Table **Page**

A-1. File Access Codes for Common, PAS, and MCP Files A-3
A-2. Access Code Legend A-6
A-3. MCP Security Keys..... A-7
A-4. Direct Care Provider Agreement Types and Eligible Patient Types A-14
A-5. External (Non-MTF) Provider Agreement Types and Eligible Patient Types A-16
A-6. Non-Network/Exception Provider Agreement Type and Eligible Patient Types A-17

CHCS: MCP DESKTOP USER GUIDE

List of Reports

Sample Report **Page**

Agreement Data Changes Report 2-124
Places of Care Data Changes Report 2-125
Group Data Changes Report 2-126
Provider Data Changes Report 2-127
Group Member Roster 2-197
Provider Group Report - Group Information 2-199
Provider Group Report - Places of Care 2-200
Provider Group Report - Agreements and Providers 2-201
Provider Group Report - Primary Care Managers 2-202
Provider List by Speciality 2-207
PCM Enrollment Mix Discrepancy Statistical Summary 2-209
PCM Enrollment Mix Discrepancy Report 2-211
Provider Alphabetic Roster 2-213
Specialty Provider Agreement Roster 2-217
Specialty Provider Agreement Summary 2-218
Discount Provider Agreement Roster 2-220
Expiration Date Provider Agreement Roster 2-223
ZIP Code Agreement Roster 2-226
Discrepancy Avoidance Report 2-233
PAS DEERS Ineligibility Report 4-28
MCP DEERS Ineligibility Report 4-34
Potential Active Duty Candidate Update/Report 5-121
Potential Active Duty Candidate Update/Report 5-124
MCP Conditional Enrollment Roster 5-155
Enrollment/Disenrollment Discrepancy Report 5-158
MCP DEERS Ineligibility Report 5-160
PAS DEERS Ineligibility Report 5-162
Incomplete Patient Address Report 5-170
Enrollment Roster for Active Duty Family Members by Unit 5-173
Case Management Program Enrollment Roster 5-175
Change in Eligibility Enrollment Roster 5-177
Disenrollees for Period By Reason Report 5-178
Enrollment Roster Exception Conditions Report 5-179
Reciprocal Disenrollment by Reason Roster 5-181
Reciprocal Disenrollment Discrepancy Report 5-183
Track User Report by Family 5-184
Track User Report by Patient Category Group 5-185
Enrollee Entitlement Discrepancy Report 5-187

CHCS: MCP DESKTOP USER GUIDE

List of Reports (continued)

Sample Report **Page**

Disenrollment Summary By Reason Report 5-190
Enrollment Summary Report. 5-194
OHI Enrollment Summary Report. 5-195
Patient Category Enrollment Summary Report (Enrollee
Totals by Patient Category). 5-197
Patient Category Enrollment Summary Report
(Patient Category by Service) 5-198
Available PCM Capacity by Provider Group 5-200
Enrollment Roster by PCM 5-202
PCM Assignment Change Roster by Reason. 5-204
PCM Assignment Change Summary 5-206
Default PCM/UIC Report 5-208
PCM Enrollment Mis Discrepancy Statistical
Summary Report 5-210
PCM Enrollment Mix Discrepancy Report 5-213
Batch PCM Reassignment 5-218
Family PCM Reassignment 5-226
Active Duty Enrollee/UIC Maintenance Report 5-231
Agreement Type Referral Summary by Specialty. 6-137
Specialty Type Referral Summary. 6-138
Provider Network List 6-140
PCM Activity Report by Provider Group 6-143
PCM Activity Report by Individual PCM 6-144
PCM Activity Report by Specialty 6-145
Provider Patient Workload Report by Provider Group. 6-147
Provider Patient Load Report by Provider 6-148
Refused Appointments Report 6-149
Branch of Service Summary Report. 7-28
Monthly Statistical Report 7-29
Reason for Issue by Patient Category Report 7-31
Reason for Issue Summary Report 7-33

CHCS: MCP DESKTOP USER GUIDE

1. INTRODUCTION

1.1 How to Use This Document

This comprehensive reference manual for CHCS Managed Care Program (MCP) users is organized as follows:

- Introduction
- File and Table Building and Maintenance/Provider Network Functions
- DEERS Functions and Processes
- Enrollment Processing
- Managing MCP Patient Appointments
- Interactive Non-Availability State (NAS)/Care Authorization Processing
- Appendices.

This document is not designed to serve as a training manual and is not supported by the CHCS Training Database.

1.2 MCP Overview

The MCP software is designed to assist the Department of Defense (DOD) initiative to:

- Establish TRICARE area-wide health care delivery systems
- Improve accessibility to care
- Improve cost-effectiveness of health care
- Support the administrative policies of the TRICARE program.

MCP provides an integrated Direct Care and civilian provider network. Premium patient care is provided by allowing patients to enroll in a streamlined network of providers, medical treatment facilities, and civilian services.

Those network providers who have agreed to participate in the MCP program offer TRICARE enrolled patients complete, managed, preventative, routine, and emergency care.

TRICARE shares some characteristics with commercial managed care, but doesn't directly parallel any managed care network. It most closely resembles a mixed model health maintenance organization (HMO).

The Benefits of Catchment-Wide Integration

Catchment-wide Integration is the terminology used to describe the DOD requirement to integrate the Direct Care System and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits into a single, coordinated effort under the control of local facility commanders. It contains the following elements:

- TRICARE Prime - an HMO option, which enrolls and assigns patients to a Primary Care Manager (PCM). The PCM must authorize all specialty care. Fixed fees are charged per visit and inpatient care is free, based on beneficiary eligibility. This plan is mandatory for all active duty personnel in a catchment area and is also available on an elective basis to eligible beneficiaries.

- TRICARE Extra - a point-of-service Preferred Provider Option (PPO). At any time, an eligible beneficiary may elect to use a specified network provider. Co-payments are reduced. Both the beneficiary and the government benefit from lower negotiated rates. Pre-authorization requirements apply for specified procedures and admissions.

- TRICARE Standard - fee for service, resembling indemnity insurance. Full choice of providers/services/facilities with a slightly higher co-payment and a deductible. Pre-authorization requirements apply, for specified procedures and all admissions.

MCP enables the medical treatment facility (MTF) to:

- Assign beneficiaries to selected PCMs

- Establish a military and civilian health care provider network (Provider Network Management)

- Provide beneficiaries with two cost-saving alternatives (Extra & Prime) while still maintaining the current standard benefits option.

Provider Network Management

The Provider Network Management feature of MCP allows each site to record and maintain searchable records and current information on providers including:

- Individual providers
- Military and civilian groups
- Negotiated agreements and discounts
- Defined provider exceptions to negotiated discounts
- Provider schedule availability
- Addresses, phone numbers, and directions to Places of Care
- Contract compliance controls.

MCP Enrollment

MCP Enrollment enables sites to:

- Assign beneficiaries who choose the HMO plan with a PCM, based on specialty, location, and gender preferences
- Check the enrollees eligibility on the Defense Eligibility Enrollment Reporting System (DEERS)
- Notify DEERS that the beneficiary is enrolled in a specific catchment area (this information is necessary for accurate claims processing)
- Enroll or disenroll all family members
- Document other health insurance (OHI)
- Identify beneficiaries under case management
- Support administration of TRICARE program policy and regulations.

Patient Care Management

The health care finder (HCF) module of the MCP program is utilized to identify the provider resources needed to provide the required care for a specific patient. It applies to all members, with referral and priority requirements differing based on the option selected by the member. It includes:

- Appointment scheduling for enrolled and non-enrolled patients to military or civilian facilities and PCMs
- Referral processing
- Referral tracking
- Non-network authorizations
- Benefits explanation.

Non-Availability Statement (NAS) Processing

MCP enables the site users to issue NASs for patients who are authorized to seek treatment outside the facility.

A variety of summary and statistical reports are provided to the sites for improved program control.

MCP Links to DEERS

MCP shares information with the external DEERS. DEERS is the central eligibility data base for DOD health care. Eligibility information for MCP is obtained from DEERS; enrollment information is transferred to DEERS from the primary enrolling system (CHCS).

In addition to determining eligibility prior to enrollment or booking functions, the data between the two systems (CHCS and DEERS) are analyzed for discrepancies, and the results are made available for user action. Other information that may affect decisions for enrollment, such as Uniformed Service Treatment Facility (USTF) membership, is submitted to users of MCP.

DEERS checks/updates may be invoked automatically during enrollment or HCF requested as needed. Eligibility displays, captured from a DEERS check performed within the last five day period, are stored in CHCS and available to MCP users in Enrollment and HCF or the user may request eligibility data as of

today. Additionally, historical DEERS eligibility, consisting of up to 10 segments of the DEERS segments, are available to MCP users to view or print.

Note: DEERS data is protected and cannot be manually changed by the user through the primary operating system. Address data is an exception and can be updated in DEERS through CHCS.

Patient Appointment and Scheduling Subsystem (PAS)

MCP supports the full appointment and scheduling requirements of the facility using the PAS functionality of CHCS. MCP is linked to PAS.

PAS provides a comprehensive system for scheduling and tracking patient appointments. Profiles and schedules are defined and maintained for the clinics, divisions and facilities; booking functions are performed; management workload and statistical reports are generated; and automated medical record tracking links the patient's record into all the ancillary services of the hospital facilities.

An array of programs designed for the emergency room allows the fast-moving environment of the hospital emergency room to interface with the records and databases of the hospital facilities for this service without sacrificing the requirements for accurate and up-to-date data necessary for efficient patient care.

Disposition processing options and the check-out and patient instructions options within this segment make this Emergency Room functionality self-contained. End-of-Day Processing (EOD) is also a part of this module, assuring that the scheduled activity for each day is processed to completion.

Additionally, a full interface to the Registration options is made available within this menu, allowing the emergency room to independently handle all incoming patients.

1.3 MCP Menu Assignments

The following guidelines, FileMan access codes, and security keys are used to assign menus to MCP users:

– **MCP F/T POC - Systems Manager Menu (EVE) Restricted**

Primary Menu Option: Managed Care Program Menu [MCP MAIN MENU]

Secondary Menu Options: Menu Management Menu [XUMAINT]

FileMan Access Codes:	#SsA
Security Keys:	CPZ CCP CPZ NET CPZ FILE CPZ AGRMOD CPZ ADHOC

– **MCP HCFs**

Primary Menu Option:	Managed Care Program Menu [MCP MAIN MENU]
Secondary Menu Options:	End-of-Day Processing/Editing [SD EOD EDITING] Operational Reports Menu [SD OPER REPORTS]
FileMan Access Codes:	&s Security Keys:CPZ MCP CPZ CASE CPZ NAS CPZ PCM LABEL
Clinic Access (PAS Booking Keys):	SD (BOOKING AUTHORITY) SD (CHANGE AUTHORITY) SD (OVERBOOK AUTHORITY)

1.4 FileMan Access

Some files and some fields within the files are protected with FileMan access security. The user must have one of the file access codes assigned in the User file record to read, write, delete, copy, or add (utilizing Learn As You Go –LAYGO) to the file.

Each subsystem within CHCS has specific FileMan access codes. Generally, uppercase codes specify supervisor access and usually permit both read and write access. Lowercase codes specify standard user access and usually permit read-only access. Each subsystem defines the use of the related code.

Table A-1 in Appendix A lists the Common, PAS, and MCP files and the associated FileMan access codes needed to read, write, or LAYGO into each file. Note that only one of the codes specified is needed for access. After a FileMan access code has been added or edited, the user must perform a restart session to initiate the new access codes.

1.5 Security Keys

In addition to the protection provided by FileMan access codes, access to MCP menu options is controlled by several security keys that must be assigned to authorized users. Table A-3 in Appendix A lists and describes each of the MCP security keys.

1.6 Scheduled Task Jobs

There are several menu options on the Systems Manager Menu (EVE) that allow CHCS to automatically generate certain reports, bulletins, and update enrollment transactions. See Section 2.3, TaskMan Options, and Appendix A for additional information.

1.7 MCP/PAS Mailgroups & Bulletins

MCP mail bulletins are system-generated whenever a process occurs or fails to occur; e.g., Batch Enrollments Completed or Batch Reassignment Unsuccessful. These bulletins can be sent to one mail group or to separate mail groups. Your system manager is responsible for setting up mail groups and attaching bulletins to those groups. See Section 2.4, Mail Bulletins, and Appendix A for additional information.

1.8 Data Entry Screens

Each data entry screen has one or more of the following types of windows:

Display Window	Found at the top of the screen and usually contains information that is for display purposes and cannot be altered. For appointment booking functionality, the display window usually includes patient demographic information.
Select Window	Found in the middle of the screen and contains a variety of detail information that varies from screen to screen.
Interact Window	Found at the bottom of the screen and contains the action bar, and occasionally other information.

1.9 Action Bars

An action bar presents a linear display of predefined user choices, or actions. When chosen, these actions determine the direction to take when using MCP. You make your selections by entering the character(s) within the parentheses, then pressing <Return>. The selected function is performed, then control is returned to the action bar.

Default values appear at the end of the action bar prompt, followed by a double slash (//). They may be selected by pressing <Return>. If there is no default, you must make a selection or quit this action bar by pressing either <Q> or a caret <^>, then pressing <Return>.

Three kinds of help can be requested at an action bar:

- A single question mark (?) requests general application help which may, optionally, be followed by detailed help.
- When available, a single question mark followed by valid input; e.g., ?C for (C)hange Search Criteria requests the detailed help for that action. Two question marks (??) requests help which gives specific information
- Three question marks (???) requests the On-Line User Manual (OLUM).

1.10 Accessing Online Help

You can access four kinds of on-line help in CHCS:

- A single question mark (?) entered in a field or at a prompt requests general application help which may, optionally, be followed by detailed help.

- When available, a single question mark followed by valid input; e.g., ?C for (C)hange Search Criteria requests the specific detailed help for the specified action.

- Two question marks (??) entered in a field or at a prompt provides specific information about the data required for valid entries at that field or prompt. Two question marks entered at an action bar provides specific information about that action bar.

- Three question marks (???) entered in a field or at a prompt requests the OLUM. Three question marks at a menu option prompt displays a brief description of each option on that menu.

1.11 OLUM

OLUM covers all CHCS functionalities, the system, MailMan, and FileMan Ad Hoc reporting options. OLUM provides the menu hierarchy, functional descriptions, step-by-step instructions for each option, and sample screens and reports.

1.12 Site-specific questions that should be answered prior to MCP activation:

- Who are the PCMs? Are they individual providers or provider groups? Are they military or civilian?

- Who are the NAS issuing officers?

- Will enrollment be restricted to only those patients residing within the catchment area?

- Do non-MTF places of care require patient and radiology records to be pulled?

- How will the HCF receive the referrals from the PCMs?

- How will the HCF receive instructions to modify the referrals; e.g., increase the number of authorized visits?

- How will the PCM notify the HCF that an enrolled patient is now a case management patient?
- Who does the HCF notify if a patient must be assigned to a case manager who does not appear in the system?
- Who does the HCF notify if OHI patient information must be added for a new insurance company that does not appear on the system?
- What appointment types are accepted by civilian network providers?
- How will enrollment forms, care authorization forms, and NAS forms be handled for each patient at this facility? For instance, will they be mailed to the patient, or filed in each patient's records?

1.13 Other questions MCP users often ask:

- Can any file be modified?

  Answer: No. Standard files are installed with all entries complete. They cannot be modified by the site (i.e., DOD standard files). Those files that can be modified are discussed in this course.

- Does a new HCF need to be assigned to an MCP office?

  Answer: Yes. When you add a new HCF to the Health Care Finder file, you must specify an MCP office. This allows the proper HCF information to be displayed on the Care Authorization Form.

- If enrollment is restricted to only those patients residing within the catchment area, can a patient who resides outside the catchment area be enrolled?

  Answer: If you hold the CPZ ZIP security key, you are prompted to override the restricted enrollment and can proceed with the patient's enrollment. If you do not have this security key, the prompt does not display and you cannot enroll the patient.

- What are the four flags that must be set in order to activate a provider group as a PCM?

  Answer: Actually there are only three flags that must be set to YES in order to activate a provider group as a PCM.

  The first flag, the Activate Provider Group field on the Provider Group Profile screen one, must be set to YES.

The second flag, which confirms the specialties associated with the group under the PCM heading, must to be set to YES. You access this field by choosing the Edit action on the action bar for the Individual Provider Profiles screen and selecting the Group Provider to edit. After confirming the information on the Group Profile screen and exiting the Place of Care field, you can set the field under the PCM heading to YES.

The third flag, the Activate Group PCM field on the Provider Group PCM capacity screen, must be set to YES. You access this field by choosing Enrollment Mix on the agreements action bar, and selecting the agreement type(s) for which the provider will be serving as a PCM.

There is a fourth flag, which, when set to YES, activates an individual provider within the group as a PCM. If only the group is to be a PCM and not the individual providers, this flag is not required.

- When entering a new agreements for a provider group, where does the user obtain the fiscal intermediary (FI) notified date?

  Answer: This information is normally provided by the Contracts staff.

- What prevents a PCM from displaying on a picklist during a PCM search when you know that they are supposed to be there?

  Answer: The PCM search process is very specific and all search criteria must be exact. If the wrong specialty or location is entered or if the PCM is not defined correctly with all flags, the PCM name will not appear.

- What is the difference between CHCS registration, DEERS registration, and MCP enrollment?

  Answer: **CHCS registration** is the act of entering a beneficiary into local CHCS system by way of the Mini or Full Registration option. Full registration is usually only entered on a patient who has been admitted as an inpatient into an MTF.

  DEERS registration is the act of entering a military beneficiary into DEERS in order for the patient to receive military health care benefits. Enrollment takes place at the military base, not on CHCS.

  Any time a beneficiary's name is entered into CHCS, CHCS queries the DEERS database to ensure the beneficiary is eligible to receive military health care benefits.

If the beneficiary receives care outside the MTF and submits a CHAMPUS claim, an FI checks the DEERS database to ensure that the beneficiary is eligible to receive CHAMPUS reimbursement benefits.

MCP enrollment is the act of enrolling a beneficiary in the TRICARE Program using the MCP Enrollment option on CHCS. A beneficiary voluntarily enrolls in this alternative health care delivery system instead of receiving the standard military health care benefits package. The beneficiary is assigned to a PCM, who provides primary care and makes referrals to specialists when medically appropriate.

Local Empanelment Mode allows a site to conduct managed care activities on a local level without changing the non-active duty beneficiaries' Alternate Care Value (ACV) on the DEERS database. Using local empanelment, non-active duty beneficiaries would receive the standard CHAMPUS benefits, but would have the enhancement of a PCM and other managed care activities. The MCP beneficiary enrollment information is not sent to DEERS, although standard CHAMPUS eligibility information is available from DEERS. In many regions, local empanelment in CHCS is used in conjunction with full enrollment in DEERS by the contractor system so that both CHCS and the Managed Care Support Contract (MCSC) systems have enrollment data.

Note: While in local empanelment mode, enrollment and disenrollment transactions are sent to the DEERS for active duty beneficiaries, as in the DEERS Enrollment mode.

DEERS Enrollment Mode allows a site to formally conduct managed care activities; enrollment and disenrollment transactions are sent to DEERS, changing the beneficiaries' ACV and Defense Medical Information Systems Identification (DMIS ID). The FI can view the ACV, and thereby the enrollment status, for a beneficiary when processing CHAMPUS claims. Full enrollment may include changes to the standard CHAMPUS benefits and enrollment fees, depending upon managed care policies set by Health Affairs. Full enrollment using CHCS also documents the MTF (DMIS ID) where the beneficiary receives primary care.

- What is the difference between an MTF Provider, an external provider, and a Non-Network Provider?

  Answer:

  MTF Providers

  MTF providers are both military and civilian. The latter have partnership agreements to provide care within the MTF. Whenever possible, MTF providers are used.

  External Providers

  External providers are civilians with agreements to deliver health care, at discounted rates, to Military Health Service System (MHSS) beneficiaries at the provider's place of care.

  External providers are used when military care is unavailable. The agreements with external providers are negotiated to obtain the highest quality services for the lowest rates.

  Non-Network Provider

  A provider who is not a member of the network; i.e., has not signed a network agreement and does not offer a negotiated discount for services.

  Exception Provider

  A provider who is not a member of the network but who has been identified to give specialized treatment to an enrolled patient since this provider has previously provided care for a patient and disruption of that care would be detrimental to the patient.

  A non-MCP provider group can be created for the exception provider.

  Only Service Available (OSA) Provider

  A provider who offers a specialty or service unique to the area. OSA providers can be exception providers. They appear on picklists when searching by specialty and location.

- Can you search for a specific clinic in non-enrolled booking?

  Answer: Yes, if the clinic is defined as a provider group. The software does not currently include clinic as search criteria. After the search criteria are entered, Provider Search displays as an action on the Non-enrolled Booking action bar. Once you select Provider Search, the system allows you to search for a specific provider, MTF provider only, External Network provider and/ or Non-Network provider. The clinic field displays on the Non-Enrolled Booking Search Criteria screen after the provider is selected from a picklist.

- Is the appointment type required for provider searches?

  Answer: No. But if you leave the field blank, depending on which type of search you have selected, a list of providers displays that match the referral regardless of the appointment types assigned to them, showing their first available appointment for any appointment type.

  Entering an appointment type for an MTF provider search excludes providers without schedules but displays the MTF provider that meets the search criteria along with the first available appointment date.

- What prevents a provider, that you know should be there, from displaying on a picklist during a provider search?

  Answer: The provider search process is very specific. All search criteria must be exact. If the wrong specialty or location are entered, the provider name does not appear. If you enter an appointment type that the provider does not have, the provider name does not appear. Try searching again without specifying an appointment type to see if the provider name appears.

- How do I book to a External Network provider using MCP?

  Answer: After you have entered the search criteria, select the External action from the Provider Search action bar, and select a provider you want to use, set up a three-way telephone conference call between the patient, the provider's office, and yourself. When the provider's office and the patient have agreed upon a date and time, add an appointment slot with that date and time, then book the appointment.

- When I book a patient to either an External or a Non-Network provider, who checks the patient into the provider's office and performs EOD processing?

  Answer: Booking to either an External or an Non-Network provider does not require patient check-in or EOD processing. Once you have booked an appointment to an External or a Non-Network provider, the appointment status is automatically set to booked, and the appointment displays as booked on the Display Patient Appointment screen.

- Why doesn't the NAS information appear on the NAS History screen right after I issue a new NAS and print it?

  Answer: The NAS History screen contains information requested from DEERS at the time you started the session and does not reflect your subsequent actions.

  When you quit the History screen and reenter the patient name, the system again requests the NAS History from DEERS and contains the new NAS information. This also occurs when you cancel an NAS.

- There are two places of care and only one clinic place of care that displays the appointments for the PCM. How can we display all the appointments for both clinics?

  Answer: You can only enroll to one place of care. Therefore, for a PCM group, only one clinic displays. To display all the appointments for all clinics, first build one PAS template with appointment types for one clinic. Then build an MCP group with two places of care and attach providers as PCMs to the group. To give workload credit for the second place of care, at the EOD, assign a MEPRS code for the appointment type.

- Why can’t I retrieve civilian MTF provider appointments when searching for a non-enrolled booking appointment?

  Answer: No civilian provider schedules.

- Why are provider schedules for the specialty clinics unavailable for appointment referral booking even though the providers appear in PAS?

  Answer: In order for provider schedules for specialty clinics to display during appointment referral booking, the specialty clinic must be identified as an MCP group and providers must be attached to this group through the GNET option on the Provider Network Management menu.

- Can a provider be an individual PCM in two different PCM groups with two different places of care?

  Answer: No.

- Can a provider be a part of two different PCM groups?

  Answer: Yes, but the provider cannot be the PCM for two different places of care.

2. FILE AND TABLE BUILDING AND MAINTAINANCE

Brief Outline

2.1 File And Table For MCP Menu (FMCP) 2-5
2.1.1 Enrollment File/Table Maintenance Menu (ETAB) 2-5
2.1.1.1 Insurance Company Enter/edit (INSU) 2-5
2.1.1.2 PCM Assignment Reason Enter/Edit (PCMA) 2-10
2.1.1.3 Disenrollment Reason Enter/Edit (DISE). 2-12
2.1.1.4 MCP Forms Text Enter/Edit (FORM). 2-14
2.1.1.5 MCP Embosser Attribute Enter/Edit (EMBA) 2-17
2.1.1.6 MCP Embosser Cards Enter/Edit (EMBC). 2-20
2.1.1.7 MCP Embosser Type Enter/Edit (EMBT). 2-25
2.1.1.8 Enrollment Block Reason Enter/Edit (EBRE) 2-28
2.1.1.9 Enrollee Lockout Override Reason Enter/Edit (LORE) . 2-31
2.1.1.10 Enrollee DMIS ID Update (DMIS) 2-35
2.1.1.11 Clean Up DMIS ID Update (CLUP) 2-37
2.1.2 Facility File/Table Maintenance (FTAB) 2-39
2.1.2.1 MCP Division Profile Edit (DIVI) 2-40
2.1.2.2 MCP Office Enter/Edit (OFFI) 2-45
2.1.2.3 MCP Health Care Finder Profile Enter/Edit (HEAL) . . 2-48
2.1.2.4 ZIP Code Combinations Enter/Edit (ZIPC). 2-51
2.1.2.5 Catchment Area ZIP Code Enter/Edit 2-54
2.1.2.6 Facility Type Enter/Edit (FACI) 2-58
2.1.2.7 NAS Issuing Officer Enter/Edit (ISSO) 2-60
2.1.2.8 MCP Parameters Profile Enter/Edit (PARA) 2-63
2.1.2.9 UIC/PCM Maintenance Enter/Edit (UICP) 2-69
2.1.2.10 Reactivate MCP Enrollment 2-76
2.1.3 Provider Network File/Table Maintenance 2-78
2.1.3.1 Department and Service File Enter/Edit (DEPT) 2-78
2.1.3.2 Place Of Care Enter/Edit (PLAC) 2-83
2.1.3.3 Provider Enter/Edit (PROV) 2-102
2.1.3.4 Group Enter/Edit (GROU). 2-110
2.1.3.5 Specialty Type Enter/Edit (SPEC) 2-115
2.1.3.6 Professional Category Enter/Edit (PROF) 2-118
2.1.3.7 Military Status Enter/Edit (MILI) 2-120
2.1.3.8 Audit Trail For Provider Network Menu (AUDI). 2-122

2.1.3.8.1 Agreement Data Changes (AGDC) 2-123
2.1.3.8.2 Place of Care Date Changes (LCDC) 2-124
2.1.3.8.3 Group Data Changes (GPDC) 2-126
2.1.3.8.4 Provider Data Changes (PRDC). 2-126
2.2 Provider Network Management Menu (PMCP) 2-127
2.2.1 Group Profile/agreements Enter Edit (GNET) 2-127
2.2.2 Individual Provider Profile/Agreements Enter/Edit 2-187
2.2.3 Modify Group Agreement Effective Date (MNET) 2-194
2.2.4 Outputs and Network Management Reports. 2-195
2.2.4.1 Group Management Reports Menu (GMRM) 2-195
2.2.4.1.1 #1 Group Member Roster 2-195
2.2.4.1.2 #2 Provider Group Report 2-198
2.2.4.1.3 #3 Provider List by Specialty 2-206
2.2.4.1.4 #4 PCM Enrollment Mix Discrepancy 2-208
2.2.4.1.5 #5 PCM Enrollment Mix Discrepancy Report. 2-210
2.2.4.2 Agreement Reports Menu (AMRM). 2-212
2.2.4.2.1 #1 Provider Alphabetic Agreement Roster 2-212
2.2.4.2.2 #2 Specialty Provider Agreement Roster. 2-216
2.2.4.2.3 #3 Specialty Provider Agreement Summary 2-218
2.2.4.2.4 #4 Discount Provider Agreement Roster 2-219
2.2.4.2.5 #5 Expiration Date Provider Agreement Roster 2-222
2.2.4.2.6 #6 ZIP Code Agreement Roster 2-225
2.2.4.3 Miscellaneous Network Reports Menu 2-228
2.2.4.3.1 Provider Batch Address Labels – Build Utility. 2-228
2.2.4.3.2 Provider Batch Address Labels – Print Utility 2-229
2.2.4.3.3 Discrepancy Avoidance Report. 2-230
2.3 TaskMan Options 2-233
2.4 Mail Bulletins 2-236

Introduction

Before enrollment and booking take place using the MCP module of CHCS, the Files and Tables must be completed as well as linking several files together using the GNET menu option.

Some files come populated requiring minimal or no data entry. Others may not require entry if the MTF does not plan to utilize these resources.

Creating Primary Care Managers (PCMs)

Issues to consider before associating the places of care and providers with provider groups.

1. Will the group be a PCM?
2. Will the providers be PCMs as well?
3. Will the group have only one place of care (clinic) or will it have multiple places of care?
4. If the group is a PCM and the providers are not, ALL provider schedules will display.
5. If the group is a PCM and some but not all providers are PCMs, only schedules for providers designated as PCMs will display.
6. If the group is not a PCM and some providers are PCMs with assigned enrollees, only the individual PCM schedules display.
7. If MCP groups will be PCMs, the UIC/PCM link must be established with the group after it has been designated a PCM if the group treats active duty.

To Designate a Provider Group as a PCM

1. Access the GNET option on the Provider Network Management Menu.
2. Enter the Provider Group name at the *Select Provider Group* prompt.
3. Enter “YES” at the *Activate Group Provider* field and press <Next Screen>.
4. Press <Return> to accept the default (A)greements action.
5. Enter “M” to choose the Enrollment (M)ix action.
6. Select the Agreement Type(s) and press <Return>.
7. For each Agreement Type selected, enter “YES” at the *Activate Group PCM* field on the Provider Group PCM Capacity screen and press <Next Screen> twice.
8. File the data.

To Designate an Individual Provider as a PCM

1. Access the GNET option on the Provider Network Management Menu.
2. Enter the Provider Group name at the *Select Provider Group* prompt.
3. Press <Next Screen> to access the Provider Group Profile/Agreement Maintenance action bar.
4. Enter “P” to choose the (P)roviders action.
5. Enter “X” to choose the Agreement e(X)ceptions action.
6. Select the provider(s) to designate as PCM(s).

For each provider selected:

1. Enter “M” to choose the Enrollment (M)ix action.
2. Select the Agreement Type(s) and press <Return>.

For each Agreement Type selected for that provider:

1. Enter “YES” at the *PCM* field.
2. Press <Next Screen> twice and file the data

File building sequence at new MCP Sites is as follows:

1. FTAB – Facility File/Table Maintenance Menu.

Several files require input and others no entry or minimal entry is required.

2. ETAB – Enrollment File/Table Maintenance Menu

Files are already populated so that no data or minimal new data is required. All files here should be reviewed for MTF customization.

3. PTAB – Provider Network File/Table Maintenance Menu

Several files require entries or require that a user press <Return> to advance through all fields. Others require little or no data entry but should be reviewed.

4. GNET – Group Profile/Agreement Enter/Edit

Files established or reviewed in FTAB, ETAB, and PTAB are linked in this option to complete the file/table build.

5. TASKMAN OPTIONS – Several TaskMan options must be scheduled by the System Specialist/DBA for the MCP module to function as designed.

6. MCP MAIL BULLETINS – Mail groups must be established by the Database Administrator (DBA) and Mail Bulletins tasked to alert MCP users of activities and changes to the MCP files.

7. All other MCP Files are populated as entries are made through the MCP software in the ordinary course of business.

Business Rules:

MTF Clinics and providers must be accessed through MCP. Press <Return> to advance through all fields to establish them in the MCP software. Do not use <DO>, <NEXT>, or <F10> during this process. This ensures all pointers in the software are established in MCP.

Determine if the enrollment mode will be full DEERS ENROLLMENT or LOCAL EMPANELMENT. The DEERS mode sends a transaction for all enrollment transactions on all patients in the MCP Patient file. LOCAL EMPANELMENT mode sends transactions only for active duty beneficiaries.

Contact the Lead Agent of your region to verify the enrollment mode to use.

Establish who the PCMs are and whether enrollments/empanelments will be to a Group (Team) or to individual providers.

If enrolled to a Group (Team), providers may be added or deleted from the Group without having to reassign beneficiaries. Enrollment/empanelments to an individual provider require reassignment of patients when the provider moves.

If Group is a PCM:

- Schedules display for all providers in the Place of Care the patient is enrolled to.
- When assigned a PCM, patient is linked to the provider, an individual place of care, and a provider specialty.

2.1 File And Table For MCP Menu (FMCP)

2.1.1 Enrollment File/Table Maintenance Menu (ETAB)

Introduction

Site definable parameters are not established through these menus. MTFs upgrading from 4.41 to version 4.51 must use option DMIS (section 6.1.10) to send the enrolling division of all enrolled patients to DEERS.

No special file build sequence is necessary in these menus. Most files are already populated and may only require minimal or no additional build.

2.1.1.1 Insurance Company Enter/edit (INSU)

Menu Path: PAS Menu → MAN → FMCP → ETAB → INSU

Security Keys:

CPZ CCP
CPZ FILE
Fileman Code "A"

Required Fields:

Insurance company name
Insurance Co File Short Name

Application Description:

This option allows you to enter new insurance companies into CHCS. This file is built primarily by Patient Administration (PAD) for use by PAD users when registration information is recorded. This insurance file is also referenced during enrollment processing.

Business Rules:

Before Managed Care enters a new insurance company, ensure PAD is aware and compliant.

Enter data strictly along PAD guidelines.

Duplicate entries should never be made in this file.

Entries may not be deleted by you. DO NOT PRACTICE in this file.

If unsure of the data to enter or if the data is unknown, DO NOT enter anything and refer this to PAD.

Important Site Considerations:

The MTF must decide whether PAD will allow TRICARE to make entries into this file. This is a PAD file for third party billing.

Data Entry Process:

<u>To enter a new insurance company</u>

Access the INSU option

Enter name of new Insurance Company

Enter a short unique name for this new company

Complete the INSURANCE COMPANY – ENTER/EDIT screen

File the data entered

Enter another insurance co if necessary or exit the option

Access the INSU option

Enter name of new Insurance Company

Enter the name of the new insurance company and press <Return>. If this is a new insurance company, the system asks you to verify that it is new.

Enter a short unique name for this new company

This name should be an abbreviated name of the insurance company, 3-14 characters long and must be unique. This short name may be used to look up insurance companies and displays on Third Party Collections (TPC) reports.

After entering the short Insurance Co File Name, the Insurance Company - Enter/Edit screen displays (refer to Figure 2-1. Insurance Co Enter/Edit Screen, page 2-7).

Complete the Insurance Company – Enter/Edit screen.

```
INSURANCE CO FILE: INSURA                    INSURANCE COMPANY - ENTER/EDIT

      Insurance Company Name: AAA INSURANCE CO.
                    Qualifier:
  Short Name (Standard Code): INSURA                     Attorney?
            TPOCS Print Type:                 Unknown Ins Company?

   Blue Cross/Blue Shield Code:              Date Last Updated: 20 Jun 2001
Electronic Data Interface Code: 13579            Inactive Date: 24 Jun 2001

 Claims Address: 329 MORRISEY DRIVE
           City: SAN DIEGO                 State: CALIFORNIA  Zip: 92123

 Claims Contact Person: Ms. Helen Craig
        Phone Number 1: (619) 555-2332        ext: 143
        Phone Number 2:                       ext:
            FAX Number: (619) 555-7155

      Standard Comment:

    Local Comment:
```

Figure 2-1. Insurance Co Enter/Edit Screen

1. Insurance Company Name.

   Defaults the name entered initially (e.g., AAA INSURANCE CO). (Refer to Figure 2-1. Insurance Co Enter/Edit Screen, page 2-7)

2. Qualifier.

   Optional, but may be used to provide additional company information such as a region thereby distinguishing it from other companies with the same name.

3. Short Name.

   System required and should default from the initial screen entry. This is a unique identifier for this company and may also be used as a quick lookup code.

4. Attorney.

   Should be set to YES if this entry is a law firm/attorney intended for use by PAD on Copying Charge receipts. This field is optional and may be left blank.

5. TPOCS Print Type.

   Optional and is intended as a code to identify the type of claim form used for billing by the Third Party Outpatient Collection System (TPOCS). DO NOT ENTER DATA in this field and forward to PAD for completion.

6. Unknown Ins Co.

   Should be set to YES if this company is to be used as placeholder for patients whose insurance carrier is not known. It is recommended that only a single entry in the insurance table be identified and used for this purpose.

   This field enables sites to track those policies which require follow-up before they can be billed. Patient policies assigned the UNKNOWN company will be listed on the Report of Policies with Unknown Companies for resolution.

7. Blue Cross/Blue Shield.

   Optional, free text field for a code used by some Blue Cross/Blue Shield plans. Bypass this field if the code is unknown by pressing <Return>.

8. Date Last Updated.

   Automatically defaulted by the system. No data entry is required or allowed.

9. Electronic Data.

   Optional, used to identify this insurance company in the event that claims are billed electronically. Bypass this field if unknown.

10. Inactive Date.

    The date a company is considered inactive in CHCS. This field is optional and may be bypassed.

11. Claims Address.

    Should be the address for submitting claims. This field may be bypassed if the address is unknown.

12. ZIP Code.

    The cursor advances to this field and enters the City and State fields from the ZIP code entry.

13. Claims Contact Person.

    The person at the insurance company who serves as the primary contact for your MTF.

14. Phone Number 1, Phone Number 2, and Fax Number.

    The numbers for this insurance company and should be entered Area Code-Prefix-line Number. The fields should contain the direct extension number of the primary contact.

15. Standard Comment.

    Bypassed and no data entry allowed.

16. Local Comment.

    Store any other data you may wish to keep for this insurance company. This is a free text field of up to 60 characters.

File the data entered

When you complete data entry you may file this screen and exit to the *Select Insurance* prompt.

Enter another insurance company if necessary or exit the option.

Repeat the process for any other insurance company. You may edit an insurance company by accessing the desired company through this menu option. All fields are editable.

Functionality Interactions

This is a PAD file. Entries in this file affect PAD, Medical Services Accounting (MSA), and TPC. Be sure you coordinate with PAD prior to making new entries or editing existing entries.

Pharmacy may also obtain information from this file as well as propose new entries for their TPC programs. They should contact PAD and have them provide the information.

Troubleshooting:

If you are unable to enter an insurance name while in the functionality, this file should be reviewed to ensure the entry was made and the company is active.

2.1.1.2 PCM Assignment Reason Enter/Edit (PCMA)

Menu Path: PAS Menu → MAN → FMCP → ETAB → PCMA

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

PCM Assignment Reason
Description

Application Description:

This option is used to enter codes for reasons a beneficiary may want to change their PCM.

Business Rules:

- This contains entries that should not be modified.
- These codes are to be used when changing a PCM or reassigning to a different PCM. They are not for the initial assignment.
- You may add new codes through this option if needed at your MTF.

Other Important Considerations:

The MTF should be aware they may add to the reasons already stored in CHCS if desired.

Data Entry Process:

To enter a new PCM ASSIGNMENT REASON

Access the PCMA option
Enter the new code
Complete the MCP PCM Assignment Reason screen
File the new code
Repeat the process for other codes needed
Access the PCMA menu option
Enter the new code

Access the PCMA option

Enter the new code

At the *Select PCM ASSIGNMENT REASON* prompt enter the code to be used for the new reason (e.g., PCS for provider PCS'ed) and verify that you want to add a new code for this file. The system displays the MCP PCM Assignment Reason Enter/Edit screen (refer to Figure 2-2. MCP PCM Assignment Reason Enter/Edit Screen, page 2-12).

Complete the MCP PCM Assignment Reason Enter/Edit screen

The Code field displays the code you entered in the previous screen.

```
MCP ASSIGNMENT REASON: AX                        MCP PCM ASSIGNMENT REASON

                  MCP PCM ASSIGNMENT REASON ENTER/EDIT

=========================================================================

                Code: AW
        Description: BENEFICIARY OUT OF AGE RANGE FOR PCM.

Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-2. MCP PCM Assignment Reason Enter/Edit Screen

1. Edit the Code field, if desired.

2. Enter the Code Description.

   The Description field is a description of the code and must be between 3 to 40 characters long. This field is a system required field and may be edited anytime in this option.

Functionality Interaction:

This file does not affect any other functionality.

Troubleshooting:

If the desired code is not found in CHCS when reassigning a PCM, review this file to determine if the entry is in the file.

2.1.1.3 Disenrollment Reason Enter/Edit (DISE)

Menu Path: PAS Menu → MAN → FMCP → ETAB → DISE

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Disenrollment Reason
Description

Application Description:

This option is used to enter new reasons why enrolled beneficiaries may disenroll from TRICARE Prime.

Business Rules:

– Existing entries should not be changed.

Other Important Considerations:

The MTF should review the existing file entries and decide whether to create new ones or use existing entries.

Data Entry Process:

To enter a new Disenrollment Reason

Access the DISE option

Enter the new code

Complete the MCP Disenrollment Reason screen

File the data

Enter another Disenrollment reason if needed

Access the menu option DISE

Access the DISE option

Enter the new code

Enter the code for the new reason at the *Select DISENROLLMENT REASON* prompt. Verify that you want to add a new reason.

Complete the MCP Disenrollment Reason screen

```
MCP DISENROLLMENT REASON: DE                    MCP DISENROLLMENT REASON


                     MCP DISENROLLMENT REASON ENTER/EDIT
==========================================================================

               Code: DE
        Description: DISENROLLMENT/EXPIRATION




Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-3. MCP Disenrollment Reason Screen

1. The CODE displays the code you previously entered and may be edited.
2. The DESCRIPTION field is a system required field 3-40 characters long and is the reason for disenrollment.

File the data

Once you complete the data entry you may file this reason.

Enter another Disenrollment reason if needed

You may repeat the process for other new reasons or exit this option.

Functionality Interactions:

This file does not affect any other functionality.

Troubleshooting:

If a reason for disenrollment cannot be found during a disenrollment, review this file to ensure the entry was made.

2.1.1.4 MCP Forms Text Enter/Edit (FORM)

Menu Path: PAS Menu → MAN → FMCP → ETAB → FORM

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Type of Form

Application Description:

This option contains the text of the following forms: Care Authorization Forms (CAFs) used in the Health Care Finders menus; Disenrollment and Renewal Notification letters used in the Multiple Batch Renewal and Disenrollment Functions; and Enrollment forms printed after a patient is enrolled.

Business Rules:

- The format used for these forms appears on either a CAF, notification letter, or an enrollment form whenever any of the forms are generated.
- A form must be completed through this option before it may be used.
- The format used for these forms is not division specific, but is shared by all divisions.

Other Important Considerations:

The MTF must decide what information to include in each form. Each form should be printed and reviewed for accuracy.

The MTF must be aware that some forms are initially blank and must be edited prior to use.

Since none of the forms is division specific, all MTFs must concur on the text to be used with these forms. The system administrator may create a site- specific security key for this option.

The CAF is the form used by PCMs to authorize the care of TRICARE Prime enrollees by civilian/ specialty providers.

Data Entry Process:

To edit a FORM

Access the menu option FORM

Enter the Form to be edited

Edit the text as desired

File the data

Enter another form to edit or exit the option

Access the menu option FORM Enter the Form to be edited

Enter the name of the form desired at the *Select TYPE OF FORM* prompt. The form must already exist in this option. No new entries are allowed.

Edit the text as desired

Edit the form selected on screen CP Forms Text screen (refer to Figure 2-4. CP Forms Text, page 2-16).

```
MCP FORM TEXT: CAF-DIRECT CARE                                  CP FORMS TEXT

   Maximum Text Lines: 7
 This Care Authorization covers necessary specialty care directed by the
 primary care provider and authorized by the Primary Care Manager.  The
 care covered may be provided either within the MTF or by one of the
 civilian network providers.

 As a MCP HMO Option participant, the patient is responsible for cost
 shares accrued during this episode of care.





Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-4. CP Forms Text

1. Existing entries which may be edited are:

CAF-ACTIVE DUTY
CAF-CHAMPUS ELIGIBLE
CAF-DIRECT CARE
CAF-MCP/ACTIVE DUTY
CAF-MCP CHAMPUS ELIGIBLE
CAF-MEDICARE
CAF-NON-ENROLLED/ACTIVE DUTY
CAF-NON-ENROLLED/CHAMPUS ELIGIBLE
CAF-NON-ENROLLED/DIRECT CARE ONLY
CAF-OTHER
CAF-SUPPLEMENTAL CARE DIAGNOSIS
DISENROLLMENT NOTIFICATION
ENROLLMENT FORM
RENEWAL NOTIFICATION

2. The wording in each form may be changed if the MTF desires but may not be more lines than what appears at the top of the form in this option.

3. Any of the forms may print on two pages if longer than 20 lines.

4. Once editing is complete, you may file the data and continue to the next entry.

5. You may repeat the process by entering another form or exit the option.

Functionality Interactions:

No other functionality is affected.

Troubleshooting:

If a form is incorrect for your facility, you may edit it through this option.

2.1.1.5 MCP Embosser Attribute Enter/Edit (EMBA)

MENU PATH: PAS Menu → MAN → FMCP → ETAB → EMBA

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Select EMBOSSER ATTRIBUTES
Type of Embosser

Application Description:

This option allows you to associate software attribute codes that are inherent with different embossers without having to hard code the attributes and codes for each type of embosser. The codes can be literal text strings or an interpreted variable such as $C(13) that is sent to the embosser.

Business Rules:

– Contact the system specialist for assistance.

Other Important Considerations:

PAD software uses this file. You should contact PAD as well as the system specialist before making any entries.

Data Entry Process:

To enter or edit Embosser attributes

Access the EMBA option

Enter the EMBOSSER TYPE ATTRIBUTE

Complete the DG Embosser Attribute Edit screen

File the data

Enter another Embosser Attribute or exit the option

Access the EMBA option

Enter the EMBOSSER TYPE ATTRIBUTE

The system displays the DG Embosser Attribute Edit screen (refer to Figure 2-5. DG Embosser Attribute Edit Screen, page 2-19).

Complete the DG Embosser Attribute Edit screen

```
EMBOSSER TYPE ATTRIBUTES: DOUBLE HEIGHT        DG EMBOSSER ATTRIBUTE EDIT

 ATTRIBUTE: DOUBLE HEIGHT
 STARTING CODE: (
 ENDING CODE: )
 TYPE OF EMBOSSER: DATACARD 310 (OPEN)
 STATUS: ACTIVE









Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-5. DG Embosser Attribute Edit Screen

1. The ATTRIBUTE is used to format the card. Enter the special print characteristic used by the embosser type to format the emboss card. This defaults from the initial entry.

2. The STARTING CODE. Enter the starting code associated with the referenced type attribute obtained from the embosser user manual. The code is either an interpreted or literal string.

3. The ENDING CODE. Enter the ending code associated with the referenced type attribute obtained from the embosser user manual. The code is either an interpreted or literal string.

4. Enter the TYPE OF EMBOSSER associated with this attribute (e.g., DATASOUTH 310 open). The embosser type should already be listed in the file. Enter double question marks (??) to display a list to choose from.

5. The STATUS field indicates whether this attribute is active or inactive.

File the data

File the data when complete.

Enter another Embosser Attribute or exit the option

Repeat the process for any other attributes necessary or exit the option.

Functionality Interactions:

Embossers may also be entered into this file through the PAD software. Coordinate with PAD personnel to avoid conflicts.

PAS may also use this file through the ER menus.

Troubleshooting:

If your embosser does not work, contact the systems specialist.

2.1.1.6 MCP Embosser Cards Enter/Edit (EMBC)

Menu Path: PAS Menu → MAN → FMCP → ETAB → EMBC

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

EMBOSSER FORMAT
TYPE of EMBOSS CARD
TYPE OF EMBOSSER

Application Description:

This option allows you to define the type of embosser cards that may be generated by the subsystem, and the information to be embossed on each card. It allows you to build or modify a print template for the card embosser.

You may use this option to edit the fields to be displayed on an embosser card as well as displaying or printing a test card.

Other Important Considerations:

PAD and PAS software also allow printing of embosser cards. Do not edit existing entries in this file.

Data Entry Process:

To enter/edit/test Emboss Card format:

Access the EMBC option
Select the action bar options (E)dit or (T)est
Enter the EMBOSSER FORMAT name
Complete the DG Emboss Card Edit screens
File the data
Check for format problems if desired
Display a test card if desired
Print an embossed card if desired and able to
Edit/test another format or quit to exit the option

Access the menu option EMBC

Select the action bar options (E)dit or (T)est

Choose an option from the following action bar:

Select (E)dit Emboss Card Format, (T)est Emboss Card Format, (Q)uit:

Enter the EMBOSSER FORMAT name

If you select (E) enter the EMBOSSER FORMAT NAME and proceed to DG Emboss Card Edit screen (refer to Figure 2-6. DG Emboss Card Edit Screen, page 2-22). If you select (T), bypass steps 4 and 5.

Complete the screen DG EMBOSSER CARD EDIT screens

```
EMBOSSER FORMAT: INPATIENT                              DG EMBOSS CARD EDIT

 NAME: INPATIENT

 DIVISION(S):
 DIV A - TRAINING HOSPITAL


 NUMBER OF ROWS IN FORMAT: 9           NUMBER OF EMBOSS CARDS: 1
 TYPE OF EMBOSS CARD: INPATIENT
 TYPE OF EMBOSSER: DATACARD 310 (OPEN)
 TYPE OF PATIENT:
 DEFAULT EMBOSSER DEVICE: 2377
 STATUS: ACTIVE                        SHORT NAME:
 Select PRINT FIELDS:
 ADMISSION DATE
 AGE
 CLINICAL SERVICE
 FMP
 MTF CODE
 NAME
 PATIENT CATEGORY DESCRIPTION
 RANK
 REGISTER NUMBER
 RELIGION
 SEX
 SSN WITH DASHES
 WARD ABBREVIATION
```

Figure 2-6. DG Emboss Card Edit Screen

1. Verify the NAME or edit the name of the EMBOSSER FORMAT.

2. DIVISION(S): Enter the Division this card will be used in or leave blank if it is to be used for all divisions.

3. The NUMBER OF ROWS IN FORMAT is the number of lines of print each card will use including blank lines.

4. Enter the NUMBER OF EMBOSS CARDS to be printed for each patient.

5. The TYPE OF EMBOSS CARD is used to limit the possible selection of print fields which pertain to the emboss card selected. The choices are:

   I Inpatient cards.
   O Outpatient cards.

U Unspecified. TRICARE membership cards should use this TYPE. This entry limits the possible selections of print fields to just inpatient or outpatient.

6. Enter the TYPE OF EMBOSSER used; e.g., DATASOUTH 310. Enter double question marks (??) to display a picklist of embossers available. If the correct one is not found, it may be entered into CHCS through the menu option EMBT (Menu path: PAS System Menu → MAN → FMCP → ETAB → EMBT).

7. TYPE OF PATIENT. Enter type of patient this card is intended for or leave blank if used by both sponsors and family members.

   D Family member
   S Sponsor

8. DEFAULT EMBOSSER DEVICE is used if there is a default device for this card. If there is no default device and the field is left blank, you are prompted for a device when printing cards.

9. STATUS indicates whether the referenced embosser card is ACTIVE or INACTIVE.

10. Enter a short name that identifies this embosser format. The short name can be used as a quick lookup.

11. Enter the print fields which are to print on this emboss card. The list of selectable print fields varies depending on the type of emboss card specified earlier (INPATIENT/OUTPATIENT/UNSPECIFIED). Enter double question marks (??) to display the choices. Each new print field requires completion of several fields in the subscreen, DG EMBOSS CARD EDIT – CONTINUATION.

    DG EMBOSS CARD EDIT – CONTINUATION.

    FIELD: The name of the print field which displays on the emboss card.

    ROW: Defines the row on which the label print field is placed.

    COLUMN: Defines the column in which the first character of the print field displays.

    TITLE: Optional-Displays in front of the selected print field; e.g., AGE: 16. If no title, then the data prints without a title.

LITERAL TEXT: Permits free text, 1-80 characters, for site definable needs; e.g., PERSONAL DATA/PRIV ACT 1974.

LENGTH: This is the length of the print field specified on the card; e.g., 30.

Select ATTRIBUTE: This field may be left blank. Enter double question marks to display the choices available. Attributes affect numeric type fields such as SSN, FMP. An example attribute is:

DOUBLE HEIGHT DATACARD 310 (OPEN) ACTIVE

File this screen and repeat the process for each print field desired.

File the data

File the data when completed.

Check for format problems if desired

Check for card format errors by accepting the default and viewing the card format. You can check the format only once. Use (T)est afterwards.

Display a test card if desired

Display a test emboss card by accepting the default at the next prompt, *Do you wish to check for format problems on the emboss card? YES//* If changes are necessary you may return to edit.

Print an embossed card if desired and able to

You can print a card by accepting the following default and entering an embosser at the following prompt.

Edit/test another format or quit to exit the option

Repeat the process at the action bar by selecting (E)dit or (T)est to test the card format on screen. Enter (Q)uit to exit this option.

Functionality Interactions:

PAD and PAS users can generate embossed cards and share the format; therefore, any change to these formats may affect other users. Do not change existing entries.

Troubleshooting:

If your embosser does not work, contact the systems specialist.

2.1.1.7 MCP Embosser Type Enter/Edit (EMBT)

Menu Path: PAS Menu → MAN → FMCP → ETAB → EMBT

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Embosser Type Name
Starting Code Type
Ending Code Type
CRLF Type
MAXCOL
MAXROW

Application Description:

The Embosser type should be defined by a systems specialist.

This option allows you to define embosser equipment types. This file tells the embosser equipment when to start and end data printing, spacing, indent, maximum number of columns and rows. This file comes with defaults that may be modified.

Business Rules:

- The system specialist should assist with this file.
- Do not edit or delete existing entries. They may be in use by another functionality.

Other Important Considerations:

This is a shared file with PAD and PAS. Do not change existing entries.

Data Entry Process:

<u>To enter or edit a new Embosser Type</u>

Access the EMBT option

Enter the Embosser name (Example: DATACARD 310)

Complete DG Embosser Type Edit screen

File the data

Enter another embosser type if necessary

Access the EMBT option

Enter the Embosser name (Example: DATACARD 310)

Complete the DG Embosser Type Edit screen

```
EMBOSSER TYPE: ADVANTAGE 250 (OPEN)                 DG EMBOSSER TYPE EDIT

 NAME: ADVANTAGE 250 (OPEN)
 STARTING CODE: <
 STARTING CODE TYPE: LITERAL
 ENDING CODE: >
 ENDING CODE TYPE: LITERAL
 CRLF: $C(13)                           CRLF TYPE: INTERPRETED
 SPACE:                                 INDENT: 0
 MAXCOL: 32                             MAXROW: 11
 NON PRINTABLE CHARACTERS: ~`!@#$%&*()_+={}[]:;"|\?><



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-7. DG Embosser Type Edit Screen

1. NAME: Verify that the embosser name is correct.

2. STARTING CODE: This code is used to tell the embosser that the following data is to be printed on the emboss card. This can be an actual character that the embosser recognizes or it can be a MUMPS programming variable that must be interpreted. The code is 1-60 characters and is determined by the embosser equipment and format used; e.g., <.

3. STARTING CODE TYPE: This is a code that tells the embosser whether the STARTING CODE is literal text (text written to the embosser) or interpreted (text that must be interpreted as a MUMPS variable).

   I Interpreted
   L Literal

4. ENDING CODE: This code is used to tell the embosser that no more data is to be printed on the emboss card. This can be an actual character that the embosser recognizes or it can be a MUMPS programming variable that must be interpreted.

5. ENDING CODE TYPE: This is a code that tells the embosser whether the ENDING CODE is literal text (text written to the embosser) or interpreted text that must be interpreted as a MUMPS variable.

   I Interpreted
   L Literal

6. CRLF: This code tells the embosser that the end of the line has been reached and forces a carriage return (CR)/line feed (LF). The code can be characters recognized by the embosser, or it can be MUMPS code that must be interpreted.

7. CRLF TYPE: This is a code that tells the embosser whether the CRLF CODE is a literal text written to the embosser or interpreted text that must be interpreted as a MUMPS variable.

   I Interpreted
   L Literal

8. SPACE: These are literal characters used to tell the embosser that a space is to be printed. This can be actual characters that the embosser recognizes. It cannot be a MUMPS variable that will have to be interpreted. It is 1-30 characters. The code depends on the embosser model. Example: {

9. INDENT: This is the number of columns that the emboss card should be indented before it prints the first character. If the site does not make an entry, the system enters in a zero (0). You should enter at least 2, to keep the printed characters off the edge of the card.

10. MAXCOL: This is the maximum number of characters that the emboss card can have on a given line. This includes the indented characters, headers, fields, and literal text. This can also serve as a left margin. This setting depends on the size of the card. If a card can handle 32 characters per line

at 10 characters per inch, as in the basic card format for the DataCard, it may be wise to make the MAXCOL 30 characters, allowing two for keeping text off the edge of the card. Example: 30

11. MAXROW: This is the maximum number of rows for the emboss card normally between 9 and 11 lines. The printed format always starts at the top of the card so any number less than the maximum removes lines from the bottom of the card.

12. NON PRINTABLE CHARACTERS: These are the characters that the embosser uses to control printing. The characters entered in this field will not print on the card. The "^" character cannot be entered into this field; it is assumed that this is not a printable character. All lowercase characters will be translated to uppercase, therefore, they do not need to be added to this field. Examples: !@#$%&*()_+={}[]:"|;'.?<>.

File the data

File this data when completed.Enter another embosser type if necessary

Enter another embosser type or exit this option.

Functionality Interactions:

PAD and PAS can also print embosser cards and share the formats. Do not change existing entries.

Troubleshooting:

If your embosser will not work, contact the Systems Specialist.

2.1.1.8 Enrollment Block Reason Enter/Edit (EBRE)

Menu Path: PAS Menu → MAN → FMCP → ETAB → EBRE

Security Keys:

CPZ CCP
CPZ FILE
CPZ Batch Enroll– For users performing Batch Enroll.
CPZ Identify AD – " " " " "

Required Fields:

Enrollment Block Reason
Description

Application Description:

This option allows you to enter a new enrollment block reason code and description for use with the Batch Active Duty Enrollment option in the Enrollments menu.

Business Rules:

- Existing entries may not be modified.
- The MTF should review this file and enter new reasons, if desired, for use with the Batch Enrollments function.
- While performing the Batch Enroll function, CHCS checks each potential candidate's record for these block codes. If any exist in the patient record, no enrollment takes place.

Other Important Considerations:

Since the AD Batch Enrollment option is performed for all divisions, the MTF policy should include a clear definition of the use of each block code.

Data Entry Process:

To enter a new enrollment block reason code

Access the EBRE option
Enter the new Enrollment Block Reason Code
Complete the MCP Enroll Block Reason screen
File the code by pressing return until you return to a menu

Access the ERBE option

Access the menu option ERBE to enter a new Enrollment Block code.

Enter the new Enrollment Block Reason Code

At the *Select ENROLLMENT BLOCK REASON* prompt enter the new 3-4 character long code desired or the code to edit. Existing values are:

AGR	PCM AGREEMENT NOT ACTIVE
CAP	INSUFFICIENT CAPACITY FOR PCM
DEER	NO DEERS ELIGIBILITY RESPONSE RECEIVED
DIS	ALREADY DISENROLLED
ENR	ALREADY ENROLLED
ENT	ENTITLEMENT DISCREPANCY
INEL	PATIENT INELIGIBLE ON DEERS
OTH	OTHER
PCAT	PATIENT CATEGORY CODE HAS CHANGED
PCM	NO DEFAULT PCM FOR THE UIC
PCS	CANDIDATE HAS LEFT THE AREA
REN	ALREADY RENEWED
UIC	NOT A VALID UIC

The system displays the MCP Enroll Block Reason screen (refer to Figure 2-8. MCP Enroll Block Reason Screen, page 2-30).

Complete the MCP Enroll Block Reason screen

The code you entered at the *Select ENROLLMENT BLOCK REASON* prompt is entered into the code field on this screen. The cursor is at the description field.

```
MCP ENROLLMENT BLOCK REASONS: DIS                 MCP ENROLL BLOCK REASON


                 MCP ENROLLMENT BLOCK REASON ENTER/EDIT

==========================================================================

               Code: DIS
       Description: ALREADY DISENROLLED





Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-8. MCP Enroll Block Reason Screen

1. If you need to edit the code field, press the up-arrow key to position the cursor at that field.

2. Enter description.

   This is a system-required field that is 3-45 characters long and describes the reason for this Block during Batch Enrollment.

3. There are 9 other choices used by the system only and cannot be seen except through FileMan.

File the code by pressing <Return> until you return to a menu

You may repeat the process for any other block desired or exit this option

Functionality Interactions:

No other functionality is affected.

Troubleshooting:

If an enrollment block reason cannot be found during the Batch Enrollment process, review this file to ensure the block reason was entered.

2.1.1.9 Enrollee Lockout Override Reason Enter/Edit (LORE)

Menu Path: PAS Menu → MCP → FMCP → ETAB → LORE

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Code Description
Enrollee Lockout Override Reason
MCP Enrollee Lockout Override Reason Code

Application Description:

This option allows you to enter new override reasons indicating explanations for the decision to book a specialty care appointment without authorization or to book a primary care appointment with a provider other than the enrolled patient's PCM.

ENROLLEE LOCKOUT refers to CHCS functionality that allows a facility to define when a user is able to appoint enrollees to a provider in a clinic (ENROLLEE LOCKOUT switch) and also to define a clinic as providing specialty care, primary care or both. When the switch is activated, a user cannot appoint enrollees for primary care clinics when the provider selected is not their PCM, unless the user overrides. The override information, including the user name, reason for override, and date is recorded. If an override is not entered, the system displays the PCM name and phone number and message on the screen to notify the clerk to inform the patient that the appointment must be made with their PCM or with PCM authorization.

PAS utilizes the ENROLLEE LOCKOUT to prevent a TRICARE Prime enrollee from being booked to a clinic other than his own PCM's or to be booked for specialty care without an Appointment Referral. The PAS users may override the lockout if desired, but must enter a reason code when doing so. The codes entered through this menu option are the codes PAS users must use to override the lockout.

Business Rules:

- The MTF must decide if more reasons are needed.
- An override reason must be entered every time a user in PAS overrides the ENROLLEE LOCKOUT message.

Other Important Considerations:

The MTF must decide if the Enrollee Lockout will be utilized.

You must review the file to determine if additional entries are required.

Data Entry Process:

<u>To enter a new Enrollee Lockout Override Reason code</u>

Access the LORE option

Enter the Enrollee Lockout Override code desired

Complete the MCP Enrollee Lockout Override Reason Enter/Edit screen

File the data

Enter a new code or exit the option

Access the LORE option

Enter the ENROLLEE LOCKOUT Override Reason code

Enter the new Enrollee Lockout Override code desired at the *Select ENROLLEE LOCKOUT OVERRIDE REASON* prompt. Enter double question marks (??) to display the following list of choices:

AEP	AIR EVACUATION PATIENT
AOP	AUTHORIZATION OTHER THAN PCM
EBN	ENHANCED BENEFIT
EMR	EMERGENCY
PNA	PCM NOT AVAILABLE

Existing codes cannot be edited.

The system displays the MCP Enrollee Lockout Override Reason Enter/Edit screen with the cursor at the code field (refer to Figure 2-9. MCP Enrollee Lockout Override Reason Enter/Edit Screen, page 2-34).

Complete the MCP Enrollee Lockout Override Reason Enter/Edit screen

```
MCP ENROLLEE LOCKOUT OVERRIDE   MCP ENROLLEE LOCKOUT OVERRIDE REASON
ENTER/EDIT


              MCP ENROLLEE LOCKOUT OVERRIDE REASON ENTER/EDIT
 ========================================================================

               Code: EMR
        Description: EMERGENCY
```

Figure 2-9. MCP Enrollee Lockout Override Reason Enter/Edit Screen

1. Press <Return> to verify that this is the correct code.

   At the *MCP ENROLLEE LOCKOUT OVERRIDE REASON DESCRIPTION* prompt, enter a reason why the user may override the lockout and book an enrollee. This is a required field 3-45 characters long.

2. Press <Return> to verify that this is the correct description

File the data

Once the data is entered, you may file it.

Enter a new code or exit the option

Enter another new reason or exit this option.

Functionality Interaction:

See application description.

Troubleshooting:

If an override code is not found when attempting to override the Lockout, review this file to ensure the entry exists.

2.1.1.10 Enrollee DMIS ID Update (DMIS)

Menu Path: PAS Menu → MCP → FMCP → ETAB → DMIS

Security Keys:

CPZ CCP
CPZ FILE
CPZ PARAMETERS

Required Fields:

None Required.

Application Description:

This option is used to send updated enrollment transactions for enrollees in either all divisions or a specified division. The DMIS ID of the Enrolling Division is then recorded on patients' enrollment records in DEERS.

With version 4.5, the DMIS ID of the enrolling division is transmitted to DEERS for all existing enrollees and for new enrollments. This option has been designed to update all existing enrollments on a one-time basis. This option should be required by exception only and does not exist in CHCS versions prior to 4.5.

If a DMIS ID is changed for an enrolling division, this option may be used to update all enrollments in that division to DEERS.

The DMIS ID of all Medical Center Divisions are uneditable, beginning with CHCS Version 4.5.

Business Rules:

- This option is to be used initially to force the DMIS ID of each patient's enrolling division to DEERS. After the initial transmittal, the only action will be individual updates as enrolling divisions are corrected on a patient.

- After the initial transmission, this option is to be used subsequently only in the event an enrolling division's DMIS ID changes.

- There is no File and Table build for this option.

- Forewarn IMD/MID/Computer room personnel that this option will transmit enrollment transactions to DEERS for ALL TRICARE

Enrollees and will impact system performance and eligibility checking.

– Verify the DMIS ID with DEERS/EDS before the initial tasking to ensure CHCS and DEERS have the same DMIS ID for each division in their files.

Data Entry Process:

To update the DMIS ID

Access the DMIS option

Complete the action desired in Enrollee DMIS ID Update screen

File the data

Exit the option

Access the DMIS option

Complete the action desired in Enrollee DMIS ID Update screen (refer to Figure 2-10. Enrollee DMIS ID Update Screen, page 2-36)

```
                          ENROLLEE DMIS ID UPDATE


Enrolling Division:




                       The Enrollee DMIS ID Update
              will send update enrollment transactions to DEERS
               for all MCP Enrollees in the specified Division.




Select (A)ll Enrolling Divisions, or (Q)uit: A//
```

Figure 2-10. Enrollee DMIS ID Update Screen

Initial Action Bar

Select (A)LL Enrolling Divisions, or (Q)uit: A//

1. Select A for All Divisions if this is the initial action.

   Initially, if you select the (A)ll action, you receive a message that the process is resource intensive and you are asked whether you want to continue. The system then begins the task and continues until complete.

2. If a subsequent action the action bar will be:

Select (O)ne Enrolling Division, or (Q)uit:O//

In subsequent taskings, you receive the prompt for (O)ne followed by the prompt to select the Enrolling Division to process. The middle screen displays the message that the process transmits updated enrollment transactions for all TRICARE Enrollees.

File the data

Exit the option

Functionality Interactions:

DEERS and CHCS must have the same DMIS ID of each enrolling division in their tables. Verify before tasking.

Troubleshooting:

After CHCS Version 4.5 is installed, if the DMIS ID is wrong for a division, the DMIS ID may be changed only with Support Center help. You can only send the DMIS ID of the patient's enrolling division in CHCS to DEERS through this option. This option does not change a patient's enrolling division.

2.1.1.11 Clean Up DMIS ID Update (CLUP)

Menu Path: PAS Menu → MAN → FMCP → ETAB → CLUP

Security Keys:

CPZ CCP
CPZ FILE
CPZ PARAMETERS

Required Fields:

There are no required fields.

Application Description:

This option is used to reset the system in the event the DMIS ID UPDATE process fails to finish due to a system crash or a TaskMan error. This option stops the job previously scheduled and allows you to restart the DMIS ID UPDATE process from the beginning.

Business Rules:

– This option is to be used only in the event the DMIS ID UPDATE process fails.

Other Important Considerations:

This option is to be used only to correct a failed DMIS ID UPDATE process.

Data Entry Process:

To restart the DMIS ID Update

Access the CLUP option

Restart the DMIS ID UPDATE process

Exit the option CLUP

Access the menu option CLUP

Restart the DMIS ID Update process

1. There is no data entry or File and Table build associated with this option.
2. After accessing this option, a message displays telling you this option is to be used when the DMIS ID Update process has failed and that this option will reset it to the beginning. No data is affected by sending another update action to DEERS. Simply restart the option if desired.

Exit the option

Functionality Interaction:

No other functionality is affected.

Troubleshooting:

This option is a troubleshooting option for the DMIS ID UPDATE process. If this option does not restart the process, you must call the Support Center.

2.1.2 Facility File/Table Maintenance (FTAB)

Site Definable Parameters:

The MCP enrollment mode for all divisions must be set through the menu option PARA. It is NOT division specific.

The host division on the platform must have the MCP Division field set to "YES" in the Division Profile. All other divisions must leave this field blank. In version 4.4 and earlier, the DMIS ID of the MCP division is stored on patient records in CHCS. In CHCS Version 4.5, the DMIS ID of the patients' enrolling divisions are transmitted to DEERS and are seen on their enrollment history.

File build sequence for new sites should be:

1. DIVI – MCP Division Profile Edit (2.1.2.1)
2. PARA – MCP Parameters Profile Enter/Edit (2.1.2.8)
3. OFFI – MCP Office Enter/Edit (2.1.2.2)
4. HEAL – MCP Health Care Finder Profile (2.1.2.3)
5. UICP – UIC/PCM Maintenance Enter/Edit (2.1.2.9) may only be built <u>after</u> the provider network has been built in the option GNET.
6. The remaining files require no special execution sequence other than completion before activation except for the file built in option UICP.

2.1.2.1 MCP Division Profile Edit (DIVI)

Menu Path: PAS Menu → MAN → FMCP → FTAB → DIVI

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Medical Center Division
Facility
Division
Abbreviation

Application Description:

This options allows you to edit or view the division profiles within the facility and to specify which division will be designated the MCP Division. The data includes all division specific data for the MTF.

Business Rules:

- Only one division may be designated as the MCP Division.
- The person with access to this option should have the division designated as the MCP Division as an allowable division in their user file.
- The person entering the data must be signed on to the correct division (MCP Division). The division appearing by default is the one you are currently signed on to.
- The division designated the MCP Division should be the one associated with the SITE ID in the DEERS SITE PARAMETERS.
- New divisions cannot be created through this option. New divisions should be built through the common files by the Data Base Administration (DBA)/systems personnel.
- You must press <Return> to advance through all the fields as well as enter necessary data to establish software pointer relationships.

- No changes to existing data should be made here. Data changes should be referred to the Data Base Administrator for resolution through Common Files.
- Data should only be entered in the MCP Division field. Any other blank field requiring data should be bypassed by moving the cursor with the down-arrow key.

Other Important Considerations:

This field is meant for use by the TRICARE Civilian Network.

The site must decide which division will be the MCP Division. One division should not make the decision for others. Normally the host site will be designated the MCP Division. In CHCS Version 4.4, the DMIS ID of the MCP Division is transmitted to DEERS for enrollments. CHCS Version 4.5 will transmit the DMIS ID of each patient's enrolling division.

Once the MCP Division field has data, the site should consider locking this menu option (DIVI) with a site-specific security key to prevent any inadvertent data changes affecting the entire site.

Data Entry Process:

<u>To enter a new MCP division</u>

Access the DIVI option

Access the correct Division

Complete the data on SD Division Profile screen

File the data

Exit the DIVI option

Access the DIVI option

Access the correct Division

When accessing this option, the division you are signed on to defaults to the screen shown in Figure 2-11. MCP Division Name Prompt, page 2-42. If there is no default or you are not sure, you may enter two question marks (??) at the *Select MEDICAL CENTER DIVISION NAME* prompt to display available divisions.

```
MCP Division Profile Edit

Select MEDICAL CENTER DIVISION NAME: DIV A - TRAINING HOSPITAL//
```

Figure 2-11. MCP Division Name Prompt

After you enter the division name, the system displays the SD Division screen shown in Figure 2-12. SD Division Profile, page 2-43.

Complete the data on SD Division Profile screen

You must press <Return> to advance through all the fields except the MCP Division field, where you should enter "YES." All other divisions should be set to "NO" or left blank.

```
MEDICAL CENTER DIVISION: DIV A - TRAINING HOSPITAL   SD DIVISION

               Facility: TRAINING MEDICAL TREATMENT FACILITY
               Division: DIV A - TRAINING HOSPITAL
           Abbreviation: DIVA
          Building Name:
        Building Number:
         Street Address: 1610 CONSTITUTION AVE
                    ZIP: 20307
                   City: WASHINGTON
                  State: DISTRICT OF COLUMBIA
    Patient Record Pull: 1 day(s)
  Radiology Record Pull: 1  day(s)
 Schedule Hold Duration: 2  day(s)
         PAS Mail Group:
          Group ID Code: 0037
           DMIS ID Code: 0037
           MCP Division: YES
  Default to remind Patients of other Appts/Wait List Requests: YES
Enable DX/PX Coding for Outpatient Encounters in this Division:
```

Figure 2-12. SD Division Profile

1. Press <Return> to advance through all the fields to establish software pointers.

2. Enter "YES" at the MCP Division field.

   The MCP Division is intended for use by non-MTF clinics (civilian places of care).

   DO NOT make any changes to any other field. Contact the Database Administrator if another field appears to be incorrect.

   Workload reports are broken down by division.

File the data

Exit the option

Functionality Interactions:

The file accessed by this menu option (DIVI) is a Common File directly affecting all functionalities. It is strongly recommended that this option not be used for practice in the "live system."

DEERS interacts frequently with MCP and affects all TRICARE enrollments. The DMIS ID in this menu should never be changed by users in CHCS Versions 4.4 and earlier. The DMIS ID is uneditable in CHCS Version 4.5.

Troubleshooting:

There have been very few problems of significance associated with the MCP Division flag set incorrectly. Problems have occurred as a consequence of users changing site/PAS parameters through this option. Access to this option should be severely limited or denied once the MCP Division Flag is set. Some associated problems are noted below.

Problem – Incorrect division designated the MCP Division locally. Does not affect enrollments as the DEERS SITE ID dictates which division's DMIS ID is used.

Solution – Access the incorrect division and change the MCP Division to "NO." After exiting this division, access the correct division and enter "YES" at the MCP Division field.

Problem – DMIS ID used by the MCP Division is invalid or deactivated in DEERS. Patients' enrollments are coded Invalid in CHCS.

Solution – Contact the Support Center.

Problem – DMIS ID incorrectly mapped by EDS to the DEERS SITE ID. MCP enrollments are invalid in CHCS due to reason "Invalid Site ID."

Solution – Systems personnel initiate Trouble Call with EDS (DEERS).

Problem – Unable to change the MCP Division field from "NO" to "YES."

Solution – Find the division with the MCP Division field set to YES and change it to NO. Return to the correct division and enter YES.

2.1.2.2 MCP Office Enter/Edit (OFFI)

Menu Path: PAS Menu → MAN → FMCP → FTAB → OFFI

Security Keys:

CPZ FILE
CPZ CCP

Required Fields:

MCP Office
Supervisor

Application Description:

This option is used to create MCP TRICARE Offices for the HCFs or the persons/ offices responsible for booking appointments, issuing Care Authorization Forms, processing Batch PCM Reassignments, Batch Disenrollments/Renewals. The MTF may refer to these offices as Service Centers or any other designation. More than one "MCP office" may be created. Each office has a supervisor.

Business Rules:

- Any number of MCP/TRICARE Offices may be created.
- Only offices that book appointments, process Care Authorization forms, Batch PCM Reassignments, and Renewal/Disenrollment letters should be built here.
- Supervisors should be in the User file. The same person may be a supervisor in more than one office.

Other Important Considerations:

The MTF must decide how many and which offices will be allowed to process Care Authorization Forms, Batch PCM Reassignments, and Renewal/Disenrollment letters.

Will the MTF or TRICARE contractors issue Care Authorization Forms when a PCM refers a patient to a specialist, outside provider, or non-network provider?

Data Entry Process:

To enter a new TRICARE/MCP office

Access the OFFI option

Enter the name of the TRICARE Office

Complete the CP Office Profile screen

File the data

Exit the OFFI option

Access the OFFI option

Enter the name of the new TRICARE Office

At the *MCP Office* prompt, enter the name you wish to assign to your office. Enter the name of the new TRICARE Office or of an existing office to edit. That name prints on Care Authorization Forms issued by this office.

After you enter the TRICARE office name, the system displays the CP Office Profile screen (refer to Figure 2-13. CP Office Profile, page 2-47).

Complete the CP Office Profile screen

```
MCP OFFICE: OFFICE OF HEALTH CARE FINDER                CP OFFICE PROFILE

 MCP OFFICE: OFFICE OF HEALTH CARE FINDER
 MCP OFFICE SUPERVISOR: TRAINING,MANAGER
 STREET ADDRESS: 678 DUPONT CIRCLE
 ZIP: 20307
 CITY: WASHINGTON
 STATE: DISTRICT OF COL
 OFFICE PHONE: (442)234-0987
 OFFICE LOCATION:
 OFFICE HOURS: M-F 9-5




Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-13. CP Office Profile

1. The MCP OFFICE field is a system required field and is the name given to the TRICARE Office you are creating; e.g., Managed Care Office. The name entered prints on Care Authorization Forms, Batch Reassignment notifications, or Renewal/Disenrollment letters.

2. MCP OFFICE SUPERVISOR field should contain the name of the supervisor for this office. That name must be in the CHCS User file.

3. STREET ADDRESS field is a non-required free text field. Enter the address for the MTF, if this is an MTF office, in this field.

4. ZIP field should contain the ZIP code where the office is located. This should be a valid ZIP code recognized in CHCS. Once a ZIP code is entered, the system automatically fills the City and State fields.

5. CITY field defaults when a valid ZIP code is entered. This field may also contain a free text entry.

6. STATE field defaults from the ZIP code but may also be a free text entry.

7. OFFICE PHONE is a non-required free text field. This should be the office phone number and prints on the CAF if data is entered.

8. OFFICE LOCATION field is a non-required free text description of where the office is located; e.g., 3rd Floor, Ste. A. This information does not print on the CAF.

9. OFFICE HOURS is a free text non-required field and does not print on the Care Authorization Form.

File the data

File the screen after you have completed the data entry or edits.

Exit the OFFI option

Enter a new office or exit this option if finished.

Functionality Interactions:

This file does not affect any other functionality in CHCS. The only processes affected in MCP by this office(s) are printing Care Authorization Forms which may be used to authorize care with civilian providers, notification letters of PCM reassignment, and TRICARE renewal or disenrollment notices.

Troubleshooting:

If the MCP office information does not appear on the Care Authorization Form or notification letters, ensure that the office data has been entered in CHCS.

2.1.2.3 MCP Health Care Finder Profile Enter/Edit (HEAL)

Menu Path: PAS Menu → MAN → FMCP → FTAB → HEAL

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Health Care Finder

Application Description:

This option is used to enter the names of the HCFs associated with all MCP Offices and whose names print on the Care Authorization Forms.

Business Rules:

- The names of the HCFs must exist in the CHCS User file.
- The MCP OFFICE for the HCFs must be built first.

Other Important Considerations:

If the MTF plans to use Care Authorization Forms, the Health Care Finder file should be built.

The MTF must decide who may be designated HCFs. Only those users who issue Care Authorization Forms should be in this file regardless of their title.

Data Entry Process:

To enter a new Health Care Finder

Access the HEAL option

Enter the Health Care Finder name

Complete the screen CP HCF Profile

File the screen

Exit the option

Access the HEAL option

Enter the Health Care Finder name

At the *Select HEALTH CARE FINDER* prompt, enter the name of the person who will be an HCF. This name must already exist in the CHCS User file.

The system displays the CP HCF Profile screen (refer to Figure 2-14. MCP HCF Profile, page 2-50).

Complete the screen CP HCF Profile

This screen collects data on valid HCFs.

```
MCP HCF: PENNY,ALEX N                                        CP HCF PROFILE

 HCF: PENNY,ALEX N
 HCF PHONE:
 MCP OFFICE: OFFICE OF HEALTH CARE FINDER




Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-14. MCP HCF Profile

1. Press <Return> to verify the name of the HCF.

   HCF field defaults with the name entered at the HEALTH CARE FINDER prompt. This is a system-required field and must be a name already existing in the CHCS User file.

   Verify the name of the HCF entered.

2. Enter HCF phone.

   This is an optional, free-text field.

3. Enter MCP Office name.

   This field should be defined through the OFFI option (MCP Office). If no office is entered, the name of the HCF does not appear in the HCF file.

File the screen

File the screen when the data entry is complete.

Exit the HEAL option

Enter a new HCF or exit the HEAL option if completed.

Functionality Interaction:

The names entered in this menu option must exist in the User file. Also, the names cannot be edited and changed through this option.

No other functionality of CHCS is affected by this file. The names of HCFs who actually book the appointment for either primary or specialty care display on the appropriate Care Authorization Forms.

Troubleshooting:

If a HCFs name does not appear on the Care Authorization Form, ensure a valid office is entered for that HCF in this menu option.

2.1.2.4 ZIP Code Combinations Enter/Edit (ZIPC)

Menu Path: PAS Menu → MAN → FMCP → FTAB → ZIPC

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Select ZIP CODE COMBINATION
Code

Application Description:

This option allows you to create and edit ZIP Code combinations under a unique name. This unique combination of ZIP codes can then be used in TRICARE (MCP) Booking and PCM assignment options as a search criteria for providers rather than searching by individual ZIP codes.

Business Rules:

- ZIP Codes used must be valid ZIP Codes in CHCS.
- To create a combination, you must enter both a unique name and the ZIP Codes you want included under that ZIP Code Combination.

Other Important Considerations:

ZIP Code combinations may be used to aid in a provider search in the PCM assignment and MCP booking options. The MTF must decide what combinations to use, and ZIP Codes to include. Combinations are not necessary for MCP to function, but are a valuable tool for provider searches.

Data Entry Process:

To enter a new ZIP Code combination

Access the ZIPC option

Enter the name of the ZIP Code Combination

Complete the CP ZIP Code Combinations screen

File the data

Enter another ZIP Code Combination or exit the option

Access the ZIPC option

Enter the name of the ZIP Code Combination

You should enter the desired name for the combination; e.g., NORTH SAN DIEGO.

The system displays the CP ZIP Code Combinations screen (refer to Figure 2-15. CP ZIP Code Combinations Screen, page 2-52).

Complete the CP ZIP Code Combinations screen

```
MCP ZIP CODE COMBINATIONS: BETHESDA                CP ZIP CODE COMBINATIONS

                  Identifier: BETHESDA
 Programmer Access Required:

 Code    City                                      State
  20814  BETHESDA                                  MARYLAND
  20815  CHEVY CHASE                               MARYLAND
  20816  BETHESDA                                  MARYLAND
  20817  BETHESDA                                  MARYLAND
  20824  BETHESDA                                  MARYLAND
  20825  CHEVY CHASE                               MARYLAND
  20827  BETHESDA                                  MARYLAND



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-15. CP ZIP Code Combinations Screen

1. The Identifier field defaults from the ZIP Code Combination name entered on the previous screen and is editable at any time.

2. The cursor bypasses the next field which requires programmer access.

3. The cursor is positioned under the word "Code." Press <Return> once to move the cursor one space to the right. Enter a valid ZIP Code.

4. City and State default from the ZIP Code entered.

   To enter a second and succeeding ZIP Codes, repeat the procedure in step 3.

   There is no limit to the number of ZIP Codes allowed in a combination.

5. **Editing** – ZIP Codes may be added or deleted in the screen CP ZIP CODE COMBINATIONS. To delete a ZIP Code:

   – Place the cursor on the code to delete.

   – Press the remove/delete key or press <PF1>, and then the backspace/ delete key.

File the data

Enter another ZIP Code Combination or exit the option

Functionality Interactions:

This file affects no other functionality other than MCP.

Troubleshooting:

If a provider in a particular area fails to display during a search, review this file to determine whether the provider's office (Place of Care) ZIP Code is contained in a combination.

2.1.2.5 Catchment Area ZIP Code Enter/Edit

Menu Path: PAS → MAN → FMCP → FTAB → CAZC

Security Keys:

CPZ CCP
CPZ FILE
CPZ ZIP – This security key is not necessary to enter or edit data. It is necessary only if users are allowed to override residential enrollment restrictions set through PARA and through this option. (Refer to section 2.1.2.8, page 2-63)

Required Fields:

Select ZIP CODE

Application Description:

This option allows you to define your catchment area by ZIP Code as well as define and edit your patient enroll and provider network areas. You may define multiple catchment areas if you are in an overlapping catchment area.

Business Rules:

– When a patient is enrolled, CHCS screens the patient's address for an allowable ZIP Code if the MCP Parameters (option PARA) is set to restrict enrollment by residential address.

– The provider network may be established within a specified area if defined here.

Other Important Considerations:

The catchment area for the MTFs may be defined here, but must be for all MTFs using this CHCS Network and CHCS host. It is not site-specific or division-specific.

This option is used in conjunction with the site parameters, refer to section 2.1.2.8, page 2-63 to restrict TRICARE enrollments.

The MTF must decide if TRICARE Prime enrollment will be restricted to patients residing within a defined area. The defined area may be expanded by adding ZIP Codes.

CHCS must contain the local address of patients rather than their established home of record, which prevents patient enrollment if this option is activated and they live outside the area.

If there is more than one MTF on the local network, the use of this option must be coordinated because it will affect all users. This option is not site- or division-specific.

Although not designed to affect other functionalities, other CHCS functionalities at some MTFs have used this option to create catchment areas prior to MCP activation. By using adhoc reports, they have been able to generate reports of value to themselves. If you plan to use this option and another department has already been using it, you should inform that department of possible changes.

Data Entry Process:

To enter a new catchment area ZIP Code

Access the CAZC option
Enter a valid ZIP Code to include in the catchment area
Complete the DOD ZIP Code Enter Edit screen
File the data
Enter a new ZIP Code or exit the option

Access the CAZC option

Enter a valid ZIP Code to include in the catchment area

At the *Select ZIP CODE* prompt, enter a valid ZIP Code within the catchment area you wish to define.

The system displays the DOD ZIP Code Enter Edit screen, refer to Figure 2-16. DOD ZIP Code Enter Edit Screen, page 2-56.

Complete the DOD ZIP Code Enter Edit screen

```
ZIP CODE: 20032                                    DOD ZIP CODE ENTER EDIT

 ZIP CODE: 20032
 P.O. CAITY: WASHINGTON
 STATE: DISTRICT OF COLUMBIA
 MODIFIED CITY:
 PROVIDER NETWORK AREA:
 PATIENT ENROLL AREA:





Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-16. DOD ZIP Code Enter Edit Screen

1. ZIP CODE: The ZIP Code you entered previously defaults to the first field.
2. P.O. CITY: This field defaults the name of the ZIP Code of the corresponding city. This is an uneditable field.
3. STATE: This field defaults the name of the state from the ZIP Code. This is an uneditable field.
4. MODIFIED CITY: This field may be used to edit the CITY field or used as an alternate for the P.O. CITY field since that field is uneditable.
5. PROVIDER NETWORK AREA: This field allows you to define by provider place of care (clinic) ZIP Code, those providers who are part of the MCP Provider Network. You may enter either YES or NO in this field. This is not a system required field and may be edited at any time. If no data is entered, CHCS assumes a NO.
6. PATIENT ENROLL AREA: This field allows you define by patients' home residence ZIP Codes, those codes which are part of the patient enrollment area for the TRICARE Program (MCP). If the option PARA is set to "restricting enrollments by residential address," ZIP Codes defined here will screen patient enrollments to allow enrollment/empanelment only within the ZIP Codes entered here.

You may enter either YES or NO in this field. This field may be edited at anytime. This is not a system required field and may also be left blank if desired.

File the data

You may file this ZIP Code and repeat the process with another ZIP Code that will become part of the catchment area.

Enter a new ZIP Code or exit the option

Functionality Interactions:

See Other Important Considerations.

Troubleshooting:

Problem – This file should be blank initially. If entries exist, another functionality other than MCP may have used it for their own purposes.

Solution – This file is editable and should be changed to correctly reflect the MTF catchment area.

Problem – Users performing enrollments may receive a message that the patient's ZIP Code is Invalid

Solution – Look at that patient's ZIP Code in this option to verify whether their ZIP Code is set to YES and if the option PARA restricts residential enrollment. If so, review the patient's home address in CHCS and determine if it is a local or Home of Record address.

Problem – Users performing enrollments are unable to enroll patient after ZIP Codes are defined and restricted in PARA.

Solution – User may not possess the security key CPZ ZIP.

2.1.2.6 Facility Type Enter/Edit (FACI)

Menu Path: PAS Menu → MAN → FMCP → FTAB

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Facility Type
Description

Application Description:

This file contains entries used to describe a Place of Care (clinic) in MCP. The file comes already populated with entries but new ones may be added if desired. Entries from this file are required when building an MCP Place of Care but is an informational field only. Existing entries can be inactivated but not deleted.

Business Rules:

- A Place of Care that sees all types of patients should be designated a MULTI-SERVICE (MSC) Facility.
- A place of care that sees only one type of patient; e.g., Cardiology should be designated a SINGLE SERVICE (SSC) Facility.
- All other facilities should be designated according to their description.

Other Important Consideration:

Determine if more Facility Types should be added to the MCP Facility Type file. You may print the file as an ad hoc report by using the FileMan Print option. Print the MCP Facility Type file, sorting by code and printing the Code and Description.

This file may be used later to report on the different types of facilities to which you refer patients.

Data Entry Process:

To enter a new Facility Type

Access the FACI option

Enter the Facility Type Name

Complete the MCP Facility Type screen

File the data

Enter another Facility Type or exit the option

Access the FACI option

Enter the Facility Type Name

At the *Select FACILITY TYPE* prompt, enter a 2-3 character code to describe the facility and verify that it is a new Facility Type. The system displays the MCP Facility Screen (refer to Figure 2-17. MCP Facility Type Screen, page 2-59).

Complete the MCP Facility Type screen

```
MCP FACILITY TYPE: AMB                                    MCP FACILITY TYPE

                       MCP FACILITY TYPE ENTER/EDIT

==========================================================================

                Code: AMB
         Description: AMBULANCE SERVICE





Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-17. MCP Facility Type Screen

1. CODE: Verify the name of the Facility Type
2. DESCRIPTION: Free text field that is an expansion of the code and describes the facility.
3. Existing entries may be edited by entering the code.

File the data

You may exit by filing the new code.

Enter another Facility Type or exit the option

Enter a new Facility Type and repeat the process for any new ones you wish to enter or exit the option.

Functionality Interactions:

No other functionality or file is affected by this file.

Troubleshooting:

This file usually does not present any problems and may be edited at anytime.

2.1.2.7 NAS Issuing Officer Enter/Edit (ISSO)

Menu Path: PAS → MAN → FMCP → FTAB → ISSO

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

NAS Issuing Officer Name
Title
Military Rank OR Civilian Rank

Application Description:

The person(s) authorized to sign NASs must be entered in this file. Only names entered here are available as the Issuing Officer(s) on a NAS.

Business Rules:

- Only persons authorized by the hospital commander to sign NASs are entered in this file.
- The person authorized to sign the statements may also be the same one creating an NAS in CHCS.
- The persons entered here do not have to be in the CHCS User file.
- The MTF must decide who is authorized to sign an NAS. Persons currently authorized to do so may continue as long as their names are entered into this file.
- This file is blank prior to activation and must be built prior to activating the use of NAS through CHCS.

Data Entry Process:

To enter a new Issuing Officer

Access the ISSO option
Enter the name of the new Issuing Officer
Complete the MCP NAS Issuing Officer screen
File the data
Enter a new Issuing Officer name or exit the option

Access the ISSO option

Enter the name of the new Issuing Officer

1. At the *Select NAS ISSUING OFFICER* prompt, enter the name of the person authorized to sign NASs. Enter the last name first and then the first name and middle initial; e.g., SMITH,JOHN A. Upper case or lower case is satisfactory, but be sure of the spelling. DO NOT enter a space between the comma and the first name and DO NOT put a period after the middle initial.
2. Once filed, the name cannot be edited, inactivated, or deleted using this option.

3. At the *NAS ISSUING RANK* prompt, enter a military rank or CIVILIAN preceded by a service affiliation; e.g., NCIVILIAN for navy affiliated civilians. In the case of a non-service affiliated civilian, enter XCIVILIAN. Do not enter anything in this field for a civil service rate.

Complete the MCP NAS Issuing Officer Screen

```
NAS ISSUING OFFICER: JOHNSON,RICHARD                    MCP NAS ISSUING OFFICER


                      NAS ISSUING OFFICER ENTER/EDIT
 ==============================================================================

 Name:            JOHNSON,RICHARD

 Title:           ADMIN OFFICER

 Military Rank:   COLONEL                        Civilian Rank:





Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-18. MCP NAS Issuing Officer Screen

1. NAME: The name of the person you are entering defaults to the first field.

2. TITLE: A system required field. The entries for this file are already stored in CHCS but may be added to if the title you enter is not contained in CHCS. If not in the files, the system verifies by displaying the new title in a window in the center of the screen and asking if you are adding a NEW TITLE. If a new title, verify it is new.

3. MILITARY RANK: Defaults from the previous screen if entered. In the case of civil service employees bypass this field by pressing <Return>.

4. CIVILIAN RANK: You may enter the appropriate GS rank for Civil Service personnel; e.g., GS07 in this field. Leave this field blank for military personnel.

File the data

Enter a new Issuing Officer name or exit the option

Functionality Interaction:

Users may only add to the CHCS Title file if given the FileMan code "#".

Entries from the CHCS files Military Grade Rank and the Federal Civil Service Paygrade are used in this option.

The Issuing Officer field is a mandatory field when entering an NAS in CHCS and is included in every NAS transaction to DEERS.

Troubleshooting:

Problem – Unable to display a name while trying to issue a NAS.

Solution – Check this file to ensure entries have been made.

Problem – A user is unable to enter a new title while entering the name of an Issuing Officer.

Solution – Review that user's CHCS account for the proper FileMan code.

Problem – An Issuing Officer's name is misspelled.

Solution – DBA must correct the name through FileMan.

2.1.2.8 MCP Parameters Profile Enter/Edit (PARA)

Menu Path: PAS Menu → MAN → FMCP → FTAB → PARA

Security Keys:

CPZ CCP
CPZ FILE
CPZ PARA
CPZ ZIP*

* Users who hold this security key can override the Residential restrictions set here.

Required Fields:

Enrollment Mode
Hours for running Batch Enrollment*
Day of Month to perform Monthly Eligibility checks*
Date to Perform Annual Eligibility Checks*

* Not system required, but necessary for MCP to function correctly.

Application Description:

This option allows you to enter and edit MCP enrollment parameters for the local CHCS network. It allows you to designate whether to operate in Local Empanelment or full DEERS Enrollment mode, restrict enrollment by residential address, and/or by patient category. It also establishes hours for running batch enrollments and dates for annual active duty eligibility checks.

Business Rules:

- If DEERS enrollment is used, DEERS enrollment transactions occur for all patient categories.
- If LOCAL EMPANELMENT is used, a DEERS enrollment transaction is transmitted only for active duty patients.
- The MCP Division field must be set to "YES" in the designated division (option DIVI, sec 2.1.2.1) in order to access this menu option (PARA).

Other Important Considerations:

The CHCS Network must decide which Enrollment mode is appropriate. Site staff should ask the region's Lead Agent for direction. All sites in a region should be in the same mode.

If using DEERS Enrollment in CHCS, a TRICARE contractor will be unable to enroll the patient through their own system. The reverse is true if the TRICARE contractor system performs the enrollments; then CHCS will be set to local empanelment mode.

DEERS transactions occur for active duty military regardless of the enrollment mode utilized. Active duty enrollments are not affected by the enrollment mode and are always sent to DEERS.

If using Local Empanelment, TRICARE enrollment in DEERS for non-active duty patients will not be updated by CHCS. The TRICARE contractor may perform this function in this setup.

If the Enrollment Mode is changed from the Local Empanelment mode to DEERS Enrollment, the *Do you wish to Disenroll/Disempanel all non-active duty MCP enrollees?* prompt displays. If you answer "YES," CHCS begins the process and no enrollments can occur until the process is completed. All active duty enrollees remain enrolled.

If the enrollment mode is changed in error, the time and effort to re-enroll beneficiaries could be considerable. The security key locking this option should be severely restricted to 2-3 people at most.

If the enrollment mode is changed from enrollment mode to local empanelment, a prompt displays:

Do you wish to disenroll all active duty enrollees? No//

The user should accept the default of "NO." **CAUTION: This is a very restricted area. Be careful not to disenroll all your active duty.**

If restricting by residential address, the catchment area ZIP Codes must be defined in the option CAZC (refer to section 2.1.2.5, page 2-54).

Restricting enrollment by ZIP Code or by patient beneficiary type should be decided by the Hospital Commander or the Managed Care Office.

Data Entry Process:

To enter TRICARE program parameters

Access the PARA option
Complete the MCP Parameters Profile screen
File the data

Access the PARA option

Complete the MCP Parameters Profile screen

When accessing this option, the first screen is the MCP Parameters Profile screen. The DMIS ID of the MCP Division that is mapped to the DEERS Site ID by EDS defaults in the upper left hand corner. (Refer to Figure 2-19. MCP Parameters Profile Screen, page 2-66.)

```
MCP PARAMETERS: 0037                                MCP Parameters Profile



 Catchment Area Name: DIV A - TRAINING HOSPITAL
 Catchment Area DMIS ID: 0037
                                     Enrollment Mode: LOCAL EMPANELMENT

         Restrict Enrollment by Residential Address: NO
 Restrict Enrollment for Active Duty Family Members: NO
      Restrict Enrollment for Retired Beneficiaries: NO
     Restrict Enrollment for Retired Family Members: NO

                 Hours for running Batch Enrollment: 2100 to 0400

 Active Duty DEERS Eligibility Parameters:

           Date to Perform Annual Eligibility Checks:
  Day of Month to Perform Monthly Eligibility Checks:



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-19. MCP Parameters Profile Screen

1. CATCHMENT AREA NAME: Defaults with the division previously designated as the MCP Division. This field is not editable in this option.

2. CATCHMENT AREA DMIS ID: This field is not editable and defaults with the DMIS ID of the MCP Division.

3. ENROLLMENT MODE: Determines which enrollment transactions are transmitted to DEERS. If Local Empanelment is used, only active duty transactions are transmitted to DEERS. Non-active duty beneficiary transactions receive only an eligibility transaction and do not appear in DEERS as TRICARE-enrolled.

   If DEERS Enrollment is used, an enrollment transaction is transmitted to DEERS for all patients so that patients display as enrolled in MCP/ TRICARE if the enrollment is successful.

4. RESTRICT ENROLLMENT BY RESIDENTIAL ADDRESS: Normally set at "NO." If set to "YES," ZIP Codes considered in the catchment area must be defined through the menu option CACZ described in section 2.1.2.5. Users allowed to override this restriction must be assigned the security key CPZ ZIP.

5. RESTRICT ENROLLMENT FOR ACTIVE DUTY FAMILY MEMBERS: Normally set to "NO." If the restriction is desired, this field must be changed to "YES." CHCS prevents active duty family members from enrolling in TRICARE.

6. RESTRICT ENROLLMENT FOR RETIRED BENFICIARIES: Normally set to "NO." If the restriction is desired, this field must be changed to YES. CHCS prevents retired beneficiaries from enrolling in TRICARE.

7. RESTRICT ENROLLMENT FOR RETIRED FAMILY MEMBERS: Normally set to "NO." If the restriction is desired, this field must be changed to "YES." CHCS prevents retired family members from enrolling in TRICARE.

8. HOURS FOR RUNNING BATCH ENROLLMENTS: Requires a start time and a stop time. The start time must be after 2100 so that CHCS is not affected during normally busy hours. The stop time must be no later than 0400 to prevent severe affects during the day. If the Batch process has not finished the tasking, the job is halted for the day and begun again the next night at the regular start time where it left off the previous night.

9. DATE TO PERFORM ANNUAL ELIGIBILITY CHECKS: Requires a date that CHCS will use to identify active duty enrollees who have been enrolled more than three years in TRICARE at your facility, send a DEERS transaction on them, and update their end eligibility date.

10. DAY OF THE MONTH TO PERFORM MONTHLY ELIGIBILITY CHECKS: Must be the date of the month when CHCS identifies and sends a DEERS transaction on active duty Enrollees whose enrollment expires the following month. If DEERS has a new eligibility date for them, their enrollment record is modified to reflect the new end enrollment date. A date after the 5th of the month and before the 25th is recommended to prevent DEERS from being overloaded with eligibility requests. If this field and the previous one are not completed, the nightly process CP ENROLLMENT BULLETIN will not update any enrollments.

File the data

File the data and exit the option.

Functionality Interactions:

Enrollment processing is controlled by the parameters set in this option and may affect all MCP files. Areas affected are:

Enrollments
Disenrollments
Batch Enrollments
AD Eligibility Checks
CP ENROLLMENT BULLETIN (Nightly TaskMan process)
DEERS Eligibility
TRICARE and Claims payments
Reciprocal Disenrollments
Batch Renewal/Disenrollment functions.

No other CHCS functionality is affected by this option.

Troubleshooting:

Problem – Certain beneficiaries are not being enrolled.

Solution – Review this option and remove the restriction on that Beneficiary Type.

Problem – Batch Enrollments do not appear to be working

Solution – Review the Hours for running Batch AD Enrollments and enter/edit the hours.

Problem – You receive a mail bulletin that the CP ENROLLMENT BULLETIN cannot run. (CHCS Version 4.5)

Solution – Review the dates to perform eligibility checks and enter dates in the Date to Perform Annual Eligibility Checks and Day of Month to Perform Monthly Eligibility Checks fields shown in Figure 2-17, MCP Parameters Profile Screen (version 4.5 only).

Once established, these parameters should not require resetting often unless the MTF desires to restrict enrollment for certain segments of the patient population. This option is locked with the CPZ PARA security key and should be restricted.

2.1.2.9 UIC/PCM Maintenance Enter/Edit (UICP)

Menu Path: PAS Menu → MAN → FMCP → FTAB → UICP

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

PCM if direct assignment
Specialty and Location if search selected
UIC

Application Description:

The UIC/PCM Maintenance file is used to establish links between a PCM and the Unit for which he/she/Group is responsible. If the linkage is established through this option, the system enters a defaulted PCM for active duty patients during the enrollment process.

Business Rules:

- The link is set up using the standard Unit Identification Code (UIC) established by DOD and contained in CHCS.
- One PCM can be responsible for multiple UICs.
- One UIC cannot be assigned to multiple PCMs.
- The UIC used must be in the Unit Ship ID File. Free text entries made during CHCS patient registration are not valid entries and do not appear in this file.
- The PCMs used here must already be designated PCMs through the menu option GNET (see Section 2.2.1.3). The PCM Provider Network must be established for this link to be established.

Other Important Considerations:

The MTF must decide whether to establish the UIC/PCM links. While the linkage can save valuable time by automatically assigning a PCM to active duty, the Unit Ship ID file must be updated and maintained.

This link is valuable only for active duty enrollments. Non-active duty Beneficiaries must still be enrolled individually. If the MTF desires to enroll all family members to the same PCM, only the sponsor's enrollment benefits from this function.

Data Entry Process:

To link a PCM with a UIC (Unit)

Access the UICP menu option

Enter the search criteria

Select the PCM to link

Select and add a UIC to link to this PCM

Quit and return to the initial action bar

Repeat the process or exit the option

Access the UICP Menu Option

The first screen (refer to Figure 2-20. UIC/PCM Maintenance Screen, page 2-71) is divided into three segments with no default data. The top portion of the screen is for search criteria elements. The middle portion is blank. The bottom portion contains the action bar for use throughout this option and differs as selections are made and data is entered.

The action bar initially displays a choice to (Q)uit the menu option if you do not desire to continue, assign Units to a PCM (D)irectly if the PCM is known and the units to assign to him are known as well, or institute a search (C) if the PCMs are unknown.

```
                              UIC/PCM MAINTENANCE

       PCM:                                  Location:
 Specialty:                            Agreement Type:









Select (C)hange Search Criteria, (D)irect, or (Q)uit: C//
```

Figure 2-20. UIC/PCM Maintenance Screen

Enter the search criteria

1. Press <Return> to accept the default (C)hange Search Criteria action.

   The system displays selectable search criteria in the middle window (refer to Figure 2-21. UIC/PCM Maintenance screen with criteria selections, page 2-71).

```
                              UIC/PCM MAINTENANCE

       PCM:                                  Location:
 Specialty:                            Agreement Type:
──────────────────────────────────────────────────────────────────────────────
   Agreement Type
   Specialty
   Location
   Default Search Criteria




──────────────────────── Specialty and Location are Required ──────────────────
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 2-21. UIC/PCM Maintenance screen with criteria selections

1. Use <Select> to determine the search criteria. Specialty and Location are required to institute a search. There is no action bar on this screen.

   When the criteria has been selected you receive a series of prompts to enter the choices selected above. When entering "Location" you may use either ZIP Codes, separated by commas, or ZIP Code combinations (If created in the menu option ZIPC. Refer to section 2.1.2.4, page 2-51).

   (D)irect Search:

   If the (D)irect search is selected from the initial action bar, you are prompted to enter a specific PCM. Once the PCM is entered, the middle window displays the name and pertinent data of the selected PCM. You may expand the information by pressing <F9> or "select" the PCM by pressing <Select>.

   After selecting a PCM, the system allows you to enter or edit UICs with which to link the PCM. All subsequent screens display as described above in (C)hange Search Criteria.

Select the PCM to link

An additional action now displays on the action bar as the default.

Select(C)hange Search Criteria,(D)irect,(S)earch or (Q)uit: S//

When the search is completed all providers designated as PCMs who meet the search criteria display along with certain elements from their profiles (See below).

CS	–	Credentialing Status (Board Certified, etc.)
Cat	–	Category (MD, PA, RN, etc.)
Specialty	–	Family Practice, OB, etc.
Agr	–	Agreement (MTF, Contract, SUP)
Locat	–	Location (ZIP Code of their clinic)
Sex	–	M/F
Disc	–	Discount (90%, MTF, etc.)
Avail	–	MCP Patient enrollments slots open for this PCM.

Use <Select> to choose a PCM or you may elect to expand any of the PCMs to view more information. You may view additional information by positioning the cursor next to the PCM you are interested in and pressing <F9>. Information available is assignment preference and place of care (refer to Figure 2-22. UIC/PCM Maintenance Screen w/POC, page 2-73).

```
                              UIC/PCM MAINTENANCE

       PCM:                                Location: DISTRICT OF COLUMBIA
 Specialty: FAMILY PRACTICE/PRIMARY C Agreement Type:
-------------------------------------------------------------------------------
   Provider                CS Cat   Specialty        Agr Locat Sex Disc   Avail
_______________________________________________________________________________
   ARRIBA,GILBERT M        E  MD    FAMILY PRACTICE  MTF 20301  M  MTF       485
   BEALE,SHARON M          B  MD    FAMILY PRACTICE  MTF 20301  F  MTF       485
   CRAWFORD,KYLE M            NPC   PRIMARY CARE NUR MTF 20301  M  MTF       485
   DELL,ALICE M               MD    FAMILY PRACTICE  MTF 20301  F  MTF       485
   EDROZO,FRANK M             NPC   PRIMARY CARE NUR MTF 20301  M  MTF       485
   FIESTA,LUISA M             PA    FAMILY PRACTICE/ MTF 20301  F  MTF       485
   GOTT,JOHN M                PA    FAMILY PRACTICE/ MTF 20301  M  MTF       485
   FAM MED MTF                      FAMILY PRACTICE/ MTF 20301     MTF       474
+  BAXTER,SHARON M         B  MD    FAMILY PRACTICE  MTF 20301  F  MTF       474

Use SELECT key to select PCM to be assigned
Press F9 key to view Assignment Preferences, Place of Care, or Watch Codes
```

Figure 2-22. UIC/PCM Maintenance Screen w/POC

```
                              UIC/PCM MAINTENANCE

       PCM:                                     Location: NETWORK
 Specialty: DERMATOLOGY                  Agreement Type:
-----------------------------------------------------------------------
   Provider                CS Cat   Specialty       Agr Locat Sex Disc   Avail
_______________________________________________________________________
   DERMATOLOGY A              OTH   DERMATOLOGIST   MTF 23708    MTF    UNLIM



Use SELECT key to select PCM to be assigned
Press F9 key to view Assignment Preferences, Place of Care, or Watch Codes
```

Figure 2-23. UIC/PCM Maintenance Screen w/Groups as PCMs

Select and add a UIC to link to the PCM

After the PCM has been selected, the WC/PCM maintenance action bar redisplays with an additional action (U)ICs as the default.

Select (C)hange Search Criteria, (D)irect, (S)earch, (U)ICs, or (Q)uit: U//

If you accept the default, you access a new screen and new action bar.

```
                                    EDIT A UIC

       PCM: PEKNY,JAMES M                    Location: 20307
 Specialty: FAMILY PRACTIC/PRIMARY C Agreement Type:
-------------------------------------------------------------------------
   UIC Code  Description
_________________________________________________________________________
_________________________________________________________________________
Select (A)dd UIC, (D)elete UIC, (V)iew UIC, or (Q)uit: A//
```

Figure 2-24. EDIT A UIC Screen

Select (A)dd UIC, or (Q)uit: A//

If you accept the default, the cursor is positioned in the middle of the screen and allows you to enter a "New UIC" code from the Unit Ship ID file. You may enter the UIC code; e.g., N21225 or a partial name such as "Walter" for Walter Reed.

At the <--Add a new UIC Code here prompt, enter the name of the Unit, its Code (UIC) or a partial description. You may enter a ZIP Code also and select from the picklist. Repeat the process to link other units to this PCM.

– Verify the UIC code entered. The cursor is then positioned one line down and is ready to accept another UIC (refer to screen below).

```
                                    EDIT A UIC

       PCM: PEKNY,JAMES M                    Location: 20307
 Specialty: FAMILY PRACTICE/PRIMARY C Agreement Type:
-------------------------------------------------------------------------------
   UIC Code  Description
_______________________________________________________________________________

   W2DH03    W REED AMC CO C
                                      <-- Add a new UIC Code here



_______________________________________________________________________________

Enter a valid UIC code from the Unit Ship ID file (5-8 characters)
or enter a partial description
```

Figure 2-25. EDIT A UIC Screen with Data

If you enter a unit that is already assigned to another PCM, you are asked if you want to reassign. If you answer "yes", that unit is reassigned to this PCM. Reassigning the PCM WILL NOT reassign the patients.

When you have completed entering UICs, a new action bar displays:

Select (A)dd UIC, (D)elete UIC, (V)iew UIC, or (Q)uit: Q//

Any of the three choices above positions the cursor in the middle window and allows you perform the following actions:

> (V)iew UIC: Allows you to display PCM UICs with no data changes permitted.
>
> (D)elete UIC: Allows you to "select" a UIC to unlink from this PCM. After selection you are asked "Delete W2DH03 No//". You must change the defaulted "No" to "Yes".
>
> (A)dd UIC: Allows you to link additional Units to this PCM.
>
> (Q)uit: Allows you to exit the EDIT A PCM screen.

Quit and return to the Initial action bar

Repeat the process or exit the option

Functionality Interaction:

Any patient registration through any functionality may affect this menu option. If patients are registered with units that do not match entries in the Unit Ship ID file by changing the default in Mini Registration from "Accept Unit as is? No//" to "YES," the link will not be effective. You will have to manually enter a PCM during a TRICARE enrollment.

This option does not link incorrect UICs with a PCM.

Troubleshooting:

Problem: CHCS will not accept a UIC.

Solution: Review the Unit Ship ID file to determine if the Unit is correct.

Problem: A Unit is not found in the CHCS UIC file.

Solution: Report it to DBA who can add entries to this file if necessary.

The Unit Ship ID file is very large and is maintained by DOD. By the time it is input into CHCS, the data may not be totally correct. Units are constantly moving, activated, or deactivated.

2.1.2.10 Reactivate MCP Enrollment

Menu Path: PAS Menu → MAN → FMCP → FTAB → RACT

Security Keys:

CPZ CCP
CPZ FILE
CPZ PARAMETERS

Required Fields:

There are no required fields.

Application Description:

The option RACT allows you to reactivate the enrollment process if the Batch Enrollment process was aborted while in the enrollment mode.

This is not part of File/Table for TRICARE. It is a maintenance function.

Business Rules:

– If a Batch Enrollment is aborted during the enrollment process, this allows you to restart the process.

Other Important Considerations:

This option will probably be used infrequently. The security key should be assigned to only certain individuals who also have access to the MCP Parameters.

Data Entry Process:

To reactivate the Batch Enrollment Option

Access the RACT option

Complete the Reactivate the Enrollment Option screen

Exit the option

Access the menu option RACT

Complete the Reactivate the Enrollment Option screen

After accessing this option, a message displays (refer to Figure 2-26. Reactivate the Enrollment Option, page 2-77) indicating the actions you must take to reactivate the Batch Enrollment process. After the message, you are asked whether you are sure you want to Reactivate the process.

```
REACTIVATE THE ENROLLMENT OPTION


This option will reactivate the ENROLLMENT Option if the batch
disenrollment
process is aborted and the enrollment mode is still in the original mode.

To restart the batch disenrollment first reactivate the enrollment option
and then restart the change of enrollment mode in MCP parameters file.


Are you sure you want to reactivate the Enrollment option?
```

Figure 2-26. Reactivate the Enrollment Option

1. Answer the question, "*Are you sure you want to reactivate the Enrollment option?"*

2. If you answer 'Yes", the system responds with "Done!" and allows you to exit the option.

Exit the option

Functionality Interactions:

DEERS transactions resume if Batch Enrollment is restarted.

No other functionality is affected.

Troubleshooting:

This option is a troubleshooting tool to restart the Batch Enrollment process. If it does not work as designed, call the Support Center.

2.1.3 Provider Network File/Table Maintenance Menu (PTAB)

File Build Sequence:

1. DEPT – Department and Service File (DEPT)

2. PLAC – Place of care (PLAC)

3. PROV – Provider Enter/Edit (PROV)

4. GROU – Group Enter/Edit (GROU)

5. All other files under the menu option PTAB may be built in any sequence before MCP Activation.

2.1.3.1 Department and Service File Enter/Edit (DEPT)

Menu Path: PAS → MCP → FMCP → PTAB → DEPT

Security Keys:

CPZ CCP
CPZ FILE

Required Field:

Department and Service Name
Code
Dept (if this is a Service)
Division (if this is a Department)

Application Description:

This option allows you enter/edit department and service data in the Department and Service file. A department is the top level of a two-level hierarchy, and a service is the lower level. All places of care (clinics) must be in the Hospital Location file and must be connected to a department and service. No data should be entered by TRICARE for MTF locations. This option should be used only for civilian places of care and only to create the MCP Department and MCP Service.

Business Rules:

- The civilian clinics (places of care) must be built in the hospital location file as a Non-MTF, non-count location.
- The TRICARE/MCP Department and TRICARE/MCP Service must be built prior to building civilian clinics.

Other Important Considerations:

TRICARE non-MTF places of care (Civilian offices) must be entered in the Hospital Location file and connected to a department and service. One generic department and one generic service must be built, if not done so already, to establish pointer relationships in the software.The TRICARE/MCP department and service should be established for the civilian places of care.

Because the Department and Service file is a critical file, access to this option should be locked with a site specific security key. If the TRICARE/MCP department and service have already been built, you should not need access to this file.

MTF clinics should already be built through PAS/Common Files. If new MTF clinics must be established or a new MTF department and service established, they should be built through Common Files.

Any new TRICARE/MCP department and service built through this option should be consistent with MTF naming conventions.

Data Entry Process:

To enter a new Department and/or Service

Enter the department name
Complete the DOD DEPT AND SVC EDIT screen
File the data
Repeat the process to enter a service
File the data
Enter another department or service name or exit the option

Access the DEPT option

Enter the department name

Enter the name of the department and verify that you are entering a new department.

The name should be fewer than 28 characters.The department should be built first; e.g., TRICARE DEPARTMENT.

When you enter the department name, the system displays the DOD Dept and SVC Edit Screen (refer to Figure 2-16. DOD ZIP Code Enter Edit Screen, page 2-56).

Complete the DOD DEPT AND SVC EDIT screen

```
DEPARTMENT AND SERVICE: TRICARE DEPARTMENT                DOD DEPT AND SVC EDIT

 NAME: TRICARE DEPARTMENT

 CODE:

 DEPT NAME:

 ABBREVIATION:

 Select DIVISION:




 INACTIVE FLAG:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-27. DOD DEPT and SVC Edit Screen

1. NAME: Displays the name entered at the previous prompt.

2. CODE: A system required field.This field specifies whether this entry is a Service or a Department. The Department must be built before the Service since the Service must point to an existing Department. The choices in this field are:

   S SERVICE
   D DEPARTMENT
   DIV DIVISION

   You may only enter "S" or "D". DIV can no longer be used in CHCS. The DEPT NAME field should be left blank if the entry being built is a Department. If the entry is a Service, the name of the Department this Service points to should be entered.

3. ABBREVIATION: A non-required field and may be used as a lookup code.

4. DIVISION: A system required field for Departments, but not for Services. This field should contain the name of the Medical Center Division that uses this Department or Service. For the TRICARE/MCP Department/Service this should contain the division designated the MCP Division.

5. INACTIVE FLAG: Normally used only if this department/ service is inactivated. In that case the entry should be 1 = INACTIVE. If this field is left blank, the system assumes this department/service is ACTIVE.

File the data

Repeat the process to enter a Service

1. All fields are essentially the same except for those mentioned here.

2. DEPT NAME: Should contain the name of the department this service points to for workload credit.

3. DIVISION: A Service should not have a division entered in this field. This field is for use by departments only.

File the data

Enter another Department or Service or exit the option

You may edit or inactivate the entry through this menu option.

Functionality Interactions:

This file is a Common File affecting all functionalities of CHCS. TRICARE (Managed Care) should contact DBA for guidance or ask DBA to make the appropriate entries. If no guidance is forthcoming, Managed Care only needs an MCP Department and one MCP Service for the civilian places of care (clinics). All MTF clinics/places of care are usually already built.

Because it is critical to CHCS, this option should be locked with a site specific security key after the necessary initial MCP entries have been made.

Troubleshooting:

Problem – Department and Service are built incorrectly.

Solution – Notify DBA.

Problem – The workload count is inaccurate.

Solution – Ensure the MCP Department/Service is attached to the MCP Division.

Problem – MEPRS workload is inaccurate.

Solution – Review this file to ensure it is built correctly; review the place of care profile for the civilian offices to ensure they are built as O NON-MTF clinic, associated with an FC** MEPRS code, and built as a non-count clinic. Print the Provider Group Report to verify this data (refer to Figure 2-81, page 2-182).

2.1.3.2 Place Of Care Enter/Edit (PLAC)

Menu Path: PAS Menu → MAN → FMCP → PTAB → PLAC

Security Keys:

CPZ CCP
CPZ FILE
Fileman Code S to add new civilian places of care

Required Fields:

(If entering a new place of care):

MCP Place of Care
Hospital Location Abbreviation
Hospital Location Type
Hospital Location Division
Facility
Service
MEPRS Code
Street Address
ZIP
Type of Facility
Enrollee Lockout
Type of Care (if Enrollee Lockout is "Yes")
Clinic Type

Roster Production
Prepare Reminder Notice
Activation Status

(If entering existing PAS Clinic):

MCP Place of Care
Any of the above fields where there is no data entered.

Application Description:

This option allows you to create a new MCP place of care (clinic) or edit and view the record of an existing MCP Place of Care. You may also access the Clinic Profile Edit option and update the PAS Profile. This option allows you to populate the Hospital Location file and the MCP Place of Care file which points to the Hospital Location file. Existing PAS locations will need to be accessed through this option (PLAC) to review and complete additional fields specific to MCP.

Business Rules:

- A clinic must be entered/accessed through this option to populate the MCP place of care profile.
- If hospital locations already exist in the system (PAS Profile data complete), only MCP place of care data needs to be entered.
- If the PAS Profile already exists, you should not edit any existing data through this menu option. Edit only MCP place of care information here.
- The Hospital Location Name field should not be longer than 15 characters to avoid truncation. If the name must be edited for MTF PAS clinics to comply with this rule, PAS should do it through their profile option.
- MTF PAS clinics (hospital locations) must have the LOCATION TYPE field set to CLINIC. Civilian places of care must have this field set to MCP NON–MTF.
- Workload for MTF PAS clinics should be set up to be counted. Civilian places of care should be set up as a Non-Count place of care with an F MEPRS Code because they are not part of the MTF.

– While building a place of care or accessing an MTF clinic under this option, you MUST press <Return> to advance through all fields the first time through to establish MCP pointer relationships. DO NOT use <Do>, <F10> then FILE, or <Next> as pointer relationships may not be established in the files. If keystrokes other than <Return> are needed, they will be included in the field description. Once an MCP Place of Care has been built and pointer relationship established, you may use the function keys mentioned above when accessing this file for review or editing.

Other Important Considerations:

PAS Clinics should be notified whenever the clinics are edited through MCP. Accessing them and advancing through each field to set the pointers is not editing.

When performing the MCP File and Table build, TRICARE/MCP should coordinate with PAS for any site specific PAS guidelines.

Civilian places of care will be necessary to build the TRICARE Provider Network. The MTF can document appointments made with civilian providers if they and their offices are built in MCP. Any civilian provider appointment already made may be entered in CHCS through MCP and displayed as booked on the patient's record if the civilian places of care are built.

Before entering new civilian locations, review existing entries in this file to preclude entering duplicate places of care.

Data Entry Process:

<u>To enter a new TRICARE/MCP place of care</u>

Access the menu option PLAC

Enter the name of the Place of Care

Complete the DOD HOSP LOCATION EDIT screen

Complete the DOD HOSP LOCATION EDIT – CONTINUATION screen

Complete the GRP PL1a screen

Complete the GRP PL2a screen

Complete the GRP PL3a screen

Complete the Clinic Profile

Complete the SD CLINIC PROFILE screen

Complete the SD CLINIC PROFILE – CONTINUATION screen

Complete the SD CLINIC PROFILE – CONTINUATION (Appointment Types) screen

Complete the SD CLINIC PROFILE – CONTINUATION (Appointment definition) screen

Complete the Clinic Profile entry

File the data

Enter a new Place of Care or exit the option

Access the PLAC option

Enter the name of the place of care

1. Enter the name of the place of care. This is a direct entry into the Hospital Location file as well as into the MCP Place of Care file. This should be the formal name of this clinic.

2. Verify that you are entering a new Hospital Location.

3. Enter a Hospital Location Abbreviation, 1-6 characters in length. This is not a required field.

4. Enter a brief HOSPITAL LOCATION DESCRIPTION. A non-required data field used to describe this clinic. It may be left blank but should have data entered.

5. Enter the HOSPITAL LOCATION TYPE. A system required field. It identifies the classification of this hospital location. All hospital locations in CHCS are classified through this field and interact differently with other functions and options based on this classification. TRICARE/MCP civilian places of care must be entered as "O" MCP NON-MTF. MTF PAS clinics accessed through MCP must have this field set to "C" CLINIC or "S" for Same Day Surgery.

6. Enter a HOSPITAL LOCATION DIVISION. For TRICARE/MCP civilian places of care, this field contains the division designated as the MCP Division. MTF Clinics should continue to use the division they were built in. TRICARE/MCP civilian places of care should be built through the MCP Division only. Do not change an existing division for PAS clinics.

7. Enter a MEPRS code. For MCP civilian places of care this will be an FC** MEPRS code. MTF clinics should already have an associated MEPRS code. Under no circumstances, should TRICARE edit this field for PAS clinics. You should contact the office at your MTF handling MEPRS for definitive guidance on the correct MEPRS code to use for the civilian non-MTF places of care.

Complete the screen DOD HOSP LOCATION EDIT

```
HOSPITAL LOCATION: INTERNAL MED CLINIC                    DOD HOSP LOCATION EDIT

 NAME: DIABETES CLINIC                    ABBREV: DIAB

 DESCRIPTION:                               LOCATION TYPE: CLINIC

 FACILITY:

 SERVICE:

 DIVISION: NAVAL HOSPITAL

 BLDG NAME:

 BLDG NUMBER:                               TELEPHONE:

 STREET ADDRESS:                            ZIP:

 CITY: WASHINGTON

 STATE: DISTRICT OF COLUMBIA

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-28. DOD Hospital Location Edit Screen

1. NAME: Defaults from the previous entries and is not editable. It should be recognizable within the first 15 characters.

2. ABBREV: Defaults from the previous entry and is editable. If the abbreviation is changed here, it also changes in the Hospital Location file.

3. DESCRIPTION: Defaults from the previous entry if entered. This field is optional but does provide further definition and description of the hospital name.

4. LOCATION TYPE: A critical, system-required field described in step 2 above. MCP places of care must be either a location type of CLINIC or Same Day Surgery for MTF PAS clinics or MCP NON-MTF for civilian places of care. No other location type should be used here by TRICARE. TRICARE should never change this field once it is set.

5. FACILITY: System required and identifies the MTF for this place of care. The entry here should be your MTF name.

6. SERVICE: System required and is the clinical area this place of care/clinic is associated with. The only entry allowed here is from the Department and Service file and must be a SERVICE; e.g., TRICARE SERVICE. Services are linked to departments.

7. DIVISION: Defaults from the previous screen.

8. The fields BLDG NAME, BLDG NUMBER, TELEPHONE, STREET ADDRESS, and ZIP are not required in this screen but will be required in the Place of Care Profile later. This information should be entered here if available to save time. Overseas locations may enter the closest APO/FPO ZIP Code and record the actual city name in screen GRPL3a as a workaround.

9. The CITY and STATE fields default from the ZIP Code if entered in the previous field. When this field is completed and you press <Return>, the system continues to the next screen, DOD HOSP LOCATION EDIT – CONTINUATION.

Complete the screen DOD HOSP LOCATION EDIT – CONTINUATION

```
HOSPITAL LOCATION: INTERNAL MED CLINIC    DOD HOSP LOCATION EDIT -- CONTINUATION

 DEFAULT DEVICE:

 SPECIALTY:                                   MEPRS CODE: AAAA

 PROMPT FOR REQUESTING SERVICE:             COST POOL CODE:

 ENROLLEE LOCKOUT:

 TYPE OF CARE:

 Select KEY PERSON:

 Select DUPLICATE CHECKING ORDER TYPE:

INACTIVE FLAG:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-29. DOD Hosp Location Edit – Continuation Screen

1. DEFAULT DEVICE: An optional field that allows you to enter a printer that defaults whenever a lab or X-ray report is printed to this clinic/place of care.

2. SPECIALTY: An optional field. Enter the provider speciality most commonly used in this place of care.

3. MEPRS code: A required field. All clinic workload is associated with this four character code. Non MTF places of care (civilian offices) should use a FC** MEPRS code assigned by your MEPRS office. PAS clinics should already have a code assigned by MEPRS. This code should never be changed without MEPRS office permission.

4. REQUESTING SERVICE: Used as a parameter for booking. If set to "YES," this prompt displays at the time of booking so the MEPRS code of the requesting service may be entered. This is recommended for clinics that do a majority of their work through referrals. If in doubt, you may leave it blank.

5. COST POOL CODE: Required only if a MEPRS code is not used. This is used occasionally when resources are shared. All TRICARE civilian places of care should leave this field blank.

6. ENROLLEE LOCKOUT: A system-required field in CHCS Version 4.5. Prior CHCS versions do not have this field. If this field is set to "YES," patient appointment processes in MTF PAS clinics are subject to MCP booking rules and may require an MCP Appointment Referral before a TRICARE patient can be booked to that PAS clinic or require that an enrollee book primary care appointments with their PCM. If set to "NO," there is no MCP interaction. TRICARE civilian places of care may be set either way since they are not affected by the PAS software booking rules.

7. TYPE OF CARE: Also new with CHCS Version 4.5. It is not required if the ENROLLEE LOCKOUT is set to "NO." If that field is set to "YES," this field must be defined. The choices are:

   S = Specialty Clinic
   P = Primary Care Clinic
   B = Specialty and Primary Care Clinic
   If no entry is made, this field defaults to "B" for both at time of installation for all MTF places of care.

8. KEY PERSON: Optional for the name of the main point of contact for this location. This is normally used by Lab and X-ray. If filled in, the name should be in the CHCS User file. TRICARE civilian places of care should leave this blank since none of their personnel are CHCS users.

9. DUPLICATE ORDER CHECKING: An optional field for MTF clinics. This field is used with certain order types in CHCS. For TRICARE purposes, this field may be left blank without affecting any other functionality.

10. INACTIVE FLAG: Used only when the clinic is obsolete. The only entry possible is INACTIVE. If left blank, CHCS assumes this clinic/place of care is ACTIVE.

11. File this screen.

    The system displays the GRP PL1a screen (refer to Figure 2-30. GRP PL1a, page 2-91).Complete the screen GRP PL1a.

The fields in this screen should default from the DOD HOSP LOCATION EDIT screen if entered there. The fields here are Place of Care Name, Location Abbrev, Building Name, Building Number, Street Address, City, State, ZIP, and telephone number.

```
HOSPITAL LOCATION: INTERNAL MED CLINIC                          GRP PL1a

                                  PLACE OF CARE

 ======================================================================

             Name: INTERNAL MED CLINIC
  Location Abbrev: INTER
    Building Name:
  Building Number:
   Street Address: 6885 16TH STREET
              Zip: 20307
             City: WASHINGTON
            State: DISTRICT OF COL
            Phone: 202 271-5851



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-30. GRP PL1a

1. Enter street address and ZIP code.

   You cannot file this screen without entering a street address and ZIP Code.

   If all the fields have data, press <Return> to advance through all of the fields. DO NOT use <DO>, <NEXT SCREEN>, or <PREV SCREEN> to

move between screens while performing File and Table build to ensure MCP Place of Care pointer relationships are established.

When you press <Return> after entering the phone number, the system displays the GRP PL2a screen (refer to Figure 2-31. GRP PL2a Place of Care Screen, page 2-92).

Complete the GRP PL2a screen

```
MCP PLACE OF CARE: INTERNAL MED CLINIC                          GRP PL2a

                                  PLACE OF CARE


=========================================================================

       Type of Facility: MULTISERVICE CLINIC
           Appt Contact: Appointment Clerk
               DMIS ID#: 0037     WALTER REED AMC

-----------------------------Hours of Service--------------------------
 Day of Week              AM                        PM
  MONDAY            0800 -  1200             1201  -  1700
  TUESDAY           0800 -  1200             1201  -  1700
  WEDNESDAY         0800 -  1200             1201  -  1700
  THURSDAY          0800 -  1200             1201  -  1700
+ FRIDAY            0800 -  1200             1201  -  1700



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-31. GRP PL2a Place of Care Screen

1. TYPE OF FACILITY: A system required field that is informational only. Most places of care are setup as MULTISERVICE or SINGLE SERVICE. Enter two questions marks (??), to display other choices.

2. APPT CONTACT: Optional and should be the name of the person in the place of care to contact for appointments.

3. DMIS ID #: Required field that defaults from the Medical Center Division being used. This field is not editable from this screen.

4. HOURS OF SERVICE: Not required and is informational only. The cursor is positioned at the extreme left of the field. To enter a day of the week:

   a. Press <Return> and move the cursor one space to the right.

   b. Enter the day of the week desired here.

   c. The cursor then moves to the AM field. Enter hours in military time from 0001 to 1200.

      The PM field requires the times between 1201 and 2400.

   The days and times entered here should reflect the clinic/ place of care operating hours.

5. File the Hours of Service.

   The system displays the GRP PL3a screen (refer to Figure 2-32. GRP PL3a Place of Care Screen, page 2-94).

Complete the screen GRP PL3a

The fields DIRECTIONS TO PLACE OF CARE and COMMENTS ON PLACE OF CARE are free text, informational, non-required fields. Information entered here may be printed when:

- Enrolling to TRICARE
- Booking appointments through TRICARE/MCP
- Printing a Care Authorization Form.

They may also display when expanding the place of care associated with a provider during a provider search in MCP.

These fields give directions to patients or provide them with special information such as handicap accessibility. Keep in mind that the person requesting an appointment may not be familiar with the area and may need this information.

```
MCP PLACE OF CARE: INTERNAL MED CLINIC                          GRP PL3a

                                  PLACE OF CARE


==========================================================================

-------------------------Directions to Place of Care--------------------
 Proceed north on 16th Street and exit right on Alaska Avenue.
 Walter Reed Army Medical Center is on the right.



--------------------------Comments on Place of Care---------------------
 Handicapped parking and wheelchair access is available.



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-32. GRP PL3a Place of Care Screen

1. Enter directions to place of care.
2. Enter comments on place of care.
3. File the data.

Complete the Clinic Profile

The system prompts you if you want to enter a PAS clinic profile for this place of care.

If you answer "NO," at the *Enter PAS Clinic Profile for this Place Care? Yes//* prompt, you may exit this option back to the menu.

Answer "YES" if this is a new TRICARE place of care. If new, it does not have a PAS profile and does not display through PAS options such as EOD. You also are not able to book appointments nor define enrollment capacities for individual providers.

After you answer "YES" to the previous prompt, the system prompts you to select (A)ctive, (I)nactive, or (Quit).

Press <Return> to accept the default (A)ctive.

If you accept the default, you proceed to the SD Clinic Profile screen (refer to Figure 2-33. SD Clinic Profile Screen, page 2-95). This also allow you to complete a PAS profile for this clinic so that it is accessible through the PAS options as well as MCP options.

Complete the SD Clinic Profile Screen

```
HOSPITAL LOCATION: ACUTE CR MTF                          SD CLINIC PROFILE

                 Name: ACUTE CR MTF
         Abbreviation: ACCM
             Facility: WALTER REED AMC WASHINGTON DC
             Division: DIV A - TRAINING HOSPITAL
        Building Name:
      Building Number:
       Street Address: 6885 16TH STREET
                  ZIP: 20307
                 City: WASHINGTON
                State: DISTRICT OF COLUMBIA
      Clinic Location:
 Clinic Availability:
            Telephone: 202 271-5851
    Enrollee Lockout: YES
        Type of Care: BOTH SPECIALTY AND PRIMARY CARE
             Service: PRIMARY CARE SERVICE
           Department: PRIMARY CARE DEPARTMENT
            Specialty:
           MEPRS Code: BGAA


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-33. SD Clinic Profile Screen

1. The following fields are defaulted from the place of care screen if data is entered:

   NAME = Clinic/place of care Name
   ABBREVIATION = Unique short code for the clinic. May have a specific letter for naming convention.
   FACILITY = MTF Facility this clinic is associated with.
   BUILDING NAME, BUILDING NUMBER, STREET ADDRESS, ZIP, CITY, STATE, TELPHONE.
   ENROLLEE LOCKOUT = YES or NO
   TYPE OF CARE = P,S,or B if ENROLLEE LOCKOUT is YES
   SERVICE = From the Dept and Service File
   DEPARTMENT = From the Dept and Service File

SPECIALTY = Provider specialty
MEPRS CODE = From the MEPRS file

2. CLINIC LOCATION: A free text, informational, non-required field for the area of the MTF or building where the clinic is located; e.g., 1st floor/Suite B.

3. CLINIC AVAILABILITY: A free text, informational, non-required field displaying the operational hours of that clinic/place of care.

4. File this screen and continue to the next screen (refer to Figure 2-34. SD Clinic Profile – Continuation Screen, page 2-96).

Complete the screen SD Clinic Profile – Continuation

```
HOSPITAL LOCATION: ACUTE CR MTF                SD CLINIC PROFILE -- CONTINUATION

           Wait List Activated:            Maximum Wait List Days:       day(s)
  Wait List Provider Mandatory:           Wait List Hold Duration:       day(s)
     Auto Wait List Processing:            Schedule Hold Duration:       day(s)
 Prompt for Requesting Service:               Patient Record Pull:       day(s)
                   Clinic Type:             Radiology Record Pull:       day(s)
            Check Holiday File:                 Roster Production:       day(s)
                Cost Pool Code:           Prepare Reminder Notice:       day(s)
             Activation Status:                Available Schedule:       day(s)
      Clinic Appt Instructions:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-34. SD Clinic Profile – Continuation Screen

1. WAIT LIST ACTIVATED: Activates the Wait-List for a clinic if set to 1 for "YES." Non-MTF MCP places of care should set this to "NO"since civilian offices do not maintain wait lists or have access to CHCS. TRICARE/MCP should not change this setting for MTF Clinics. If set to "NO", the wait list parameters are bypassed (items 2-5).

2. MAXIMUM WAIT LIST DAYS: Not accessed by Non-MTF clinics.

3. WAIT LIST PROVIDER: Mandatory field. If set to "YES," when entering a wait list request, the user must enter the names of the provider the wait list request is for. TRICARE should not change this setting for MTF Clinics.

4. WAIT LIST HOLD DURATION: Designates how long a patient will remain on the Wait List. This field should be set to zero (0) for non-MTF clinics since civilian clinics do not have access to CHCS. TRICARE should not change this setting for MTF Clinics.

5. AUTO WAIT LIST PROCESSING: If set to "YES," wait lists will automatically be processed if schedules were created for wait list processing only (slot status set to "wait"). TRICARE should not change this setting for MTF Clinics.

6. SCHEDULE HOLD DURATION: The number of days before the appointment FROZEN slots are automatically changed to OPEN. The non-MTF locations should set this to zero (0) since they have no schedules in CHCS.

7. REQUESTING SERVICE: Displays a prompt asking for the Requesting Service when booking appointment if this is set to "YES." You can enter a MEPRS code which can report workload. An adhoc report could capture this information if the data was required for non-MTF places of care. You can enter "YES" or leave the field blank.

8. PATIENT RECORD PULL: The number of days in advance of an appointment a patient's record should be pulled. Unless the MTF allows patient records to be sent to civilian offices, set this field to zero (0) for TRICARE places of care.

9. CLINIC TYPE: Controls whether workload from this clinic is counted. Civilian workload is not reportable under MEPRS so this field should be set to zero (0) for NON-COUNT. PAS clinics set this field set to COUNT.

10. RADIOLOGY RECORD PULL: The number of days in advance of an appointment a patient's record should be pulled. This field should be set to zero (0) for TRICARE places of care.

11. CHECK HOLIDAY FILE: Allows CHCS to skip holidays when schedules are built and appointment slots created. Non-MTF locations should set this to "NO" since CHCS does not maintain civilian schedules.

12. ROSTER PRODUCTION: The number of days before an appointment that the system prints appointment rosters. Set this field to NO for NON-MTF locations since CHCS does not maintain civilian schedules.

13. ACTIVATION STATUS: Controls whether a place of care is an Active Clinic in CHCS. This should be set to 1 - ACTIVATED for all clinics and TRICARE places of care that are active.

14. AVAILABLE SCHEDULE: The minimal number of days a schedule is available in CHCS. This field is not applicable to non-MTF clinics and may be bypassed by pressing <Return>.

15. CLINIC APPT INSTRUCTIONS: Enter generic brief patient instruction for this clinic. This field is not applicable to non-MTF clinics and may be bypassed by pressing <Return>.

    The system displays the next screen (refer to Figure 2-35. SD Clinic Profile -- Continuation Screen, page 2-98).

Complete the screen SD Clinic Profile – Continuation (Appointment Types)

```
HOSPITAL LOCATION: ACUTE CR MTF          SD CLINIC PROFILE -- CONTINUATION

 Select APPOINTMENT TYPE:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-35. SD Clinic Profile -- Continuation Screen

1. Enter appointment type.

   You may enter the appointment type desired for this clinic. MTF clinics may already have this information defaulted and you may bypass this screen entirely by pressing the down-arrow key until the *FILE* prompt displays. Exit by pressing <Return>.

2. Enter duration.

   If a valid appointment type such as NEW is entered, the system displays a small window with the *APPOINTMENT TYPE DURATION* prompt.

   You may specify the length of this appointment type in minutes. CHCS will create slots of that length when booking to this place of care.

   After entering appointment duration, the system displays the last SD Clinic Profile screen (refer to Figure 2-36. SD Clinic Profile –- Continuation, page 2-99).

Complete the screen SD Clinic Profile – Continuation (Appointment definition)

```
APPOINTMENT TYPE: NEW                    SD CLINIC PROFILE -- CONTINUATION

                Duration:                                Status:
           Workload Type:                   Referral Required:
     Pull Patient Record:                Pull Radiology Record:
 Produce Encounter Forms:                 Send Reminder Notice:
    Total # of Overbooks:          Max # of Overbooks Per Slot:
            Instructions:
 Select BOOKING AUTHORITY:



 Select APPT CHANGE AUTHORITY:


 Select OVERBOOK AUTHORITY:



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-36. SD Clinic Profile –- Continuation

1. DURATION: Defaults from the previous screen and may be edited here.

2. STATUS: Displays the word ACTIVE but the appointment type does not become active until you advance through the field and highlight it.

3. WORKLOAD TYPE: Defaults to COUNT, but must be changed to Non-Count for civilian places of care since Non-MTF places of care are not included in the MTF workload report.

4. REFERRAL REQUIRED: Optional. If set to "YES," this field becomes optional during booking. If set to "NO," the field is not accessible.

5. PULL PATIENT RECORD: Requires data. If set to "YES," the patient's record is required for this appointment type and is pulled "X" number of days prior to appointment. Most Non-MTF locations are set to "NO" unless MTF policy requires otherwise.

6. PULL RADIOLOGY RECORD: Requires data. If set to "YES," the patient's record is pulled "X" number of days prior to appointment. Most Non-MTF clinic locations are set to "NO" unless MTF policy requires otherwise.

7. SEND REMINDER NOTICE: If set to "YES," an appointment reminder mailer is generated and mailed.

8. PRODUCE ENCOUNTER FORM: Allows you to produce a single SF600 form if set to "YES." Encounter Form is batched for all pending appointments with this appointment type. Non-MTF facilities do not have access to CHCS so this field should be set to "NO" for them.

9. The remaining fields may be left blank for TRICARE civilian places of care since the MTF does not have access to non-MTF place of care booking schedules. MTF PAS clinics enter this data through the PAS module. DO NOT make any changes for them.

Complete the Clinic Profile entry

CLINIC-TO-PROVIDER APPOINTMENT TYPE TRANSFER screen

Prompt: ***Transfer newly added appointment type(s) to Provider Profile(s)? No//***

If there are no providers within the place of care yet, accept the default.

File the data

Enter a new place of care or exit the option

To enter an existing PAS Clinic as a MCP place of care

Access the menu option PLAC

Enter the name of the Place of Care

Complete the DOD HOSP LOCATION EDIT screen

Complete the DOD HOSP LOCATION EDIT – CONTINUATION screen

Complete the GRP PL1a screen

Complete the GRP PL2a screen

Complete the GRP PL3a screen

Complete the Clinic Profile

Complete the SD CLINIC PROFILE screen

Complete the SD CLINIC PROFILE – CONTINUATION screen

Complete the SD CLINIC PROFILE – CONTINUATION (Appointment Types) screen

Complete the SD CLINIC PROFILE – CONTINUATION (Appointment definition) screen

Complete the Clinic Profile entry

File the data

Enter a new Place of Care or exit the option

Access the menu option PLAC

Enter the name of the place of care

1. Select (E) to access the next screen. ALL PAS Clinics must be defined as MCP places of care.

Return/Complete all remaining screens

Press <Return> to advance through all the fields and complete data where needed or missing. DO NOT change any data.

File the data

Enter another clinic or exit the option

Functionality Interactions:

This option interacts with PAS file and table. It is imperative that the MCP file and table build process not change any data already entered for the MTF clinics. Any contemplated changes should be made by PAS.

All clinics/MCP places of care require MEPRS codes to accuratly count workload. Non-MTF places of care should use a FC** code requested from your MEPRS office.

Troubleshooting:

Be sure all Non-MTF places of care are NON-COUNT clinics and their Appointment Types are NON-COUNT as well.

Verify all data for Non-MTF clinics so that addresses and phone numbers are correct.

Verify that the "Service" field in the Place of Care Profile contains a Service and not a Department.

2.1.3.3 Provider Enter/Edit (PROV)

Menu Path: PAS Menu → MAN → FMCP → PTAB → PROV

Security Keys:

CPZ CCP
CPZ FILE
Fileman code # or P

Required Fields:

Provider Name
Provider Flag
Provider Location
Provider Class

Provider ID
Rank
Specialty
Professional Catgeory

Application Description:

This option allows you to enter a new MCP provider and associated profile data to a clinic/place of care, or to edit or view records of existing individual providers assigned to a clinic/place of care. The data includes military status, specialties, professional category, and languages. Additionally, you can use this option to inactivate or reactivate the provider at the clinic level. After inactivating data, the system allows you to generate and print the Discrepancy Avoidance Report if discrepancies exist.

Business Rules:

- MTF providers must be entered through the User file by DBA, Facility Quality Assurance (FQA), or someone designated to maintain this file. The MCP Provider (PROV) option should not be used to enter new MTF providers because of credentialing issues.

- Non-MTF providers (civilian TRICARE providers) may be entered through this MCP option if no MTF conflict arises.

- TRICARE civilian providers must be in the MCP provider file to enable them to be associated with a civilian place of care and an MCP group. This allows booking to them through the TRICARE/MCP booking options.

- MCP Profiles for all providers must be established through this menu option to set file pointer relationships. All providers, MTF and civilian, must be accessed through this menu option to be entered into the MCP provider file.

Other Important Considerations:

Personnel with access to this option are able to enter new providers and update any existing providers in CHCS and may affect provider file data adversely if done incorrectly.

For software purposes, civilian providers should only be assigned specialties in the 900 numbered series to avoid creating a Standard Inpatient Data Record (SIDR) number (used for inpatient reporting purposes).

All civilian providers who are members of the network should be entered in CHCS as well as those non-network providers who may be seen by DOD beneficiaries.

It is very important not to enter duplicate providers in CHCS. Verify with DBA that the provider you are entering has not previously been entered.

Data Entry Process:

To enter a new provider into CHCS and MCP

Access the PROV option

Enter the provider name

Complete the DOD ADD PROVIDER screen

Complete the IND PROF1a screen

Complete the IND PROF3a screen

File the data

Enter another provider or exit the option

Access the PROV option

Enter the provider name

1. Enter the name of the new provider and verify that you are entering a new provider.

2. If the provider was previously entered into CHCS you receive the *(E)dit the profile, (I)nactivate/ Reactivate or (Q)uit* prompt. If you select (E)dit, you proceed to the screen IND PROF1a Individual provider Profile (refer to Figure 2-37. DOD Add Provider Screen, page 2-105).

Complete the DOD Add Provider screen

```
PROVIDER: NEWCOMB,JOHN                                    DOD ADD PROVIDER

 Provider Flag:

 Provider Specialty(s):



 HCP SIDR-ID:        Provider Location:
 Provider Class:

 Provider ID:        Provider DOB:
 Provider SSN:

 Provider DEA#:           Provider HCP#:
 Provider Clinic Id:
 Provider Department Id Code:





Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-37. DOD Add Provider Screen

1. PROVIDER FLAG: Required field. Designates whether the person entered is a provider or not for order entry. The choices are:

   0 NOT A PROVIDER
   1 PROVIDER
   C MCP GROUP

   If set to "1," PROVIDER, this name displays on picklists of authorized providers. Set this field to "1" for civilian providers entered for TRICARE purposes.

   Providers with a value set to zero (0), NOT A PROVIDER, may enter orders on behalf of a doctor but do not display on an authorizing HCP picklist. Do not use zero (0) for TRICARE providers.

   The choice "C" MCP GROUP cannot be used at all.

2. PROVIDER SPECIALTY: This is not a required field, but provider specialities should be entered for all providers. The MCP software searches for appointments by provider speciality as one criteria. All specialties in CHCS are identified by a 3-digit number. It is recommended that external

providers use a specialty in the 900 series if they will never see inpatients at the MTF. This prevents them from being assigned a SIDR number or appearing on the SIDR report. If a 900 series is used, the system bypasses the next field and moves to PROVIDER LOCATION.

3. HCP SIDR-ID: Used for inpatient reporting. This is not used by TRICARE and should not have data for civilian providers who do not have provider privileges at the MTF. This field is automatically filled by CHCS from the specialty entered. It is bypassed if a 900 series specialty is used.

4. PROVIDER LOCATION: Required field. This is another critical field that points to the Hospital Location file (clinics and places of care). This should be the clinic/place of care this provider is normally assigned.

   For MTF providers, this is the outpatient clinic which reports their workload based on the clinic's MEPRS code. For TRICARE civilian providers, this is their office/place of care.

   You may enter the clinic/place of care name, the clinic MEPRS code (FC** for civilian places of care), or CHAMPUS SUPPORT for civilian places of care. This field provides a critical link between the provider and a clinic/ place of care.

5. PROVIDER CLASS: Required field that should be entered with OUTSIDE PROVIDER for TRICARE providers. When the class, OUTSIDE PROVIDER, is used, CHCS requires an MTF provider's signature for inpatient orders if this doctor's name is used as an authorizing HCP.

6. PROVIDER ID: Required field 2-6 characters in length. This field provides a unique identifying code for the providers. Before entering any data, ascertain the ID naming convention at your MTF. Everyone entering providers into CHCS should use the same convention. A suggested format is the first five letters of the last name and the 1st initial (e.g., SMITHJ for Jane Smith) or the first four letters and the first two letters of the first name.

   If after entering the code, the system does not accept the code and displays question marks, that code is probably already used. In that case enter a derivative of the format

7. DOB: The provider's date of birth is an optional field. Enter it if you know it.

8. PROVIDER SSN: Optional. Most civilian providers are reluctant to disclose their SSN. If entered, it may be used as a lookup and defaults to the MCP Profile.

9. PROVIDER DEA#: Optional. MTF pharmacies generally require this number and physicians are usually willing to supply it to an MTF. The Drug Enforcement Administration (DEA) number may also be used as a provider look-up tool. The number entered here must be a valid and unique number. If the number provided is not valid per DEA requirements, CHCS will not accept the entry.

10. PROVIDER HCP#: Optional. May be a state license number or a unique number assigned by your MTF for tracking purposes. This is not necessary for MCP.

11. PROVIDER CLINIC ID: Optional. For TRICARE purposes, this field may be left blank.

12. PROVIDER DEPARTMENT ID: Optional. May be left blank for TRICARE purposes.

13. File this screen and continue to the next screen (refer to Figure 2-38. IND PROF1A Individual Provider Profile Screen, page 2-107).

Complete the IND PROF1a screen

```
PROVIDER: NEWCOMB,JOHN                                          IND PROF1a

                        INDIVIDUAL PROVIDER PROFILE


=========================================================================

             SSN#:                           DEA#:
           Gender:                           Rank:
  Military Status: AD
   Signature Line:

 Specialty(s):
  CARDIOLOGIST


                                     HCP SIDR-ID: 014112
 Languages:


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-38. IND PROF1A Individual Provider Profile Screen

1. SSN#: Optional. The number default to this field if entered in the previous screen for new providers. If not previously entered, it may be entered here.

2. DEA#: Optional. The DEA number defaults if entered previously as a new provider. This number is entered as two uppercase characters followed by seven digits.

3. GENDER: Optional. Gender is required for provider searches. If not entered yet, enter the sex of the provider if known.

4. RANK: System-required field. This should be the military rank of the provider. Non-MTF TRICARE civilian providers should be entered here as XCIV (Civilian non-service affiliated). This is an informational field only.

5. MILITARY STATUS: Status defaults from the provider's rank. This field is informational only.

6. SIGNATURE LINE: This is an optional field. The signature line prints on the Care Authorization Form if entered. This should be "Firstname Lastname, MD; e.g., Clark B. Kent, MD.

7. SPECIALTY: Not a system-required field; however, this field is necessary for MCP to function properly. MCP utilizes this field for provider searches. If previously entered while entering a new provider, the specialty defaults in this field. If there is no entry, you may enter a specialty here from the 900 series number to prevent the SIDR number from being created. Multiple specialties may be entered.

8. LANGUAGE: Optional; however, this field should be populated if a provider speaks other than English. Language may be used as a criteria for provider searches. If used, the system marks the provider meeting the language criteria during a search with a tilde(~).

Complete the IND PROF3a screen

```
MCP PROVIDER: NEWCOMB,JOHN                                        IND PROF3a

                        INDIVIDUAL PROVIDER PROFILE


=========================================================================

                      UPIN#:
                CHAMPUS NBR:
     Professional Category:




Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-39. IND PROF 3a - Individual Provider Profile

1. UPIN#: Optional, free text field, limited to 3-6 characters. This is a unique identifier used for billing Medicare. If Medicare billing by MTF becomes a possibility, this number may be important.

2. CHAMPUS NBR: Optional, free text field. This should be the Provider ID number used to file claims with CHAMPUS. CHAMPUS assigns this number to participating, authorized providers.

3. PROFESSIONAL CATEGORY: System-required field that indicates the level of professional training this provider has received; e.g., PHYSICIAN (OTHER THAN SURGEON). Possible entries are contained in the PROFESSIONAL CATEGORY file and may be added to if necessary. Enter two question marks (??) to display a list of Professional Categories to choose from.

File the data

Enter another provider or exit the option

Functionality Interactions:

This option interfaces with all functionalities of CHCS. The MCP Provider file is a Common File extremely critical to CHCS. It is very important that MCP clarify with QA or DBA, what parameters they should enter during data entry.

Other functionalities use this file to either process orders during Order Entry or for appointment booking. In most MTFs, entry into this file is strictly controlled because of its importance to the entire platform.

Troubleshooting:

> **Problem:** When adding a new provider, if you receive a message that a unique provider ID is already in use by "____", it is indication this provider was DBA inactivated but is already in CHCS.
>
> **Solution:** The same message may display at the SSN field for the same reason. In this case, do not continue entry and create duplicate providers. Use the abort key (F10) and then contact the DBA to have the provider reactivated.

MCP provider searches depend on various criteria. If unable to locate a specific provider, review that provider's file to ensure the specialty and place of care are correct. If this data is correct, review the MCP Provider Group file to ensure location (ZIP Code for place of care), and agreement data are correct. You should also ensure that the provider specialty for the specified provider, is included under the specialty type that is being used to perform the provider search. The Provider Group Report prints all provider data elements and is a useful tool for verification of correct provider setup.

If you are unable to locate an MTF provider through MCP, review the MCP PROVIDER file to ensure the provider was also entered in the MCP Provider file.

2.1.3.4 Group Enter/Edit (GROU)

Menu Path: PAS Menu → MAN → FMCP → PTAB → GROU

Security Keys:

> CPZ CCP
> CPZ FILE

Required Fields:

> Provider Group
> Short Group ID
> Provider Type

Application Description:

This option allows you to edit or create a new Provider Group. The Provider Group is used to connect providers, agreement types, places of care (clinics) and payment information through the option GNET. Once built, the group serves as the anchor for enrollments, booking, referrals, and PCM activities in the MCP module

Business Rules:

- An MCP Provider Group may be the same and named the same as an MCP Place of Care, but a Place of Care does not have to be an MCP Group. A place of care may belong to multiple groups and a group may practice at multiple places of care.
- An MCP Provider Group may be a clinic, a Group Provider, or an individual provider. A group should not be an inpatient facility per Health Affairs (HA) Policy.
- MCP Provider Groups may also be utilized for bookings, especially for civilian groups who may work on a contractual basis. Supplemental Care patients may also be referred to MCP Provider Groups.
- MTF clinics that act as PCMs can be entered into CHCS as MCP Provider Groups and set up as Group Providers.
- The MCP place of care may be the same as the Group but exists as an MCP Place of Care and MCP Provider Group.
- Civilian TRICARE providers who practice individually should be entered as an MCP Group.
- An MTF individual provider, not a member of a group, must be set up as an individual MCP Provider Group. It does not matter if the provider is a PCM or not. A provider that is an invididual practice must be set up as a group.

Other Important Considerations:

You should first decide several local issues before building any groups. Issues to decide are:

- Will the MCP Provider group be a PCM?
- Will all provider group members be PCMs as well?

- Will the MCP Provider group have only one place of care (clinic) or will it have multiple places of care?
- If the group is a PCM and the provider members are not, ALL provider schedules display.
- If the MCP Provider group is a PCM and some but not all group members are PCMs, only schedules for providers designated as PCMs display and you are only able to set patient capacities for providers designated as PCMs.
- If the group is not a PCM and some group members are PCMs with assigned enrollees, only the assigned PCM schedules display.

If MCP Provider Groups are PCMs, the UIC/PCM link must be established with the group after it has been designated a PCM if active duty are to be assigned to that PCM.

Data Entry Process:

Access the GROU option
Enter the name of the group
Complete the GROUP PRO1a screen
File the data
Enter another group or exit the option

Access the GROU option

Enter the name of the group

1. At the *PROVIDER GROUP* prompt, enter the name of the group e.g., TRISTAR MED GROUP and verify that you are entering a new group. This may be the name of an MTF provider group (TEAM #1), the name of an MTF clinic, which is the name of the provider group as well, the clinic (FAMILIY PRACTICE), a civilian group/office (TRISTAR MEDICAL GROUP), or an MTF/civilian individual provider.

   The system displays the GROUP PR01a Screen (refer to Figure 2-40. GROUP PRO1a Screen, page 2-113).

Complete the GROUP PRO1a screen

```
                  Screen(  ) GROUP PRO1a
-------------------------------------------------------------------
MCP PROVIDER GROUP: TRISTAR MED GROUP                      GROUP PRO1a

                              PROVIDER GROUP PROFILE
===================================================================
             Provider Group Name: TRISTAR MED GROUP
                  Short Group ID: TMG
                         Tax ID#: 95-2345679
                  CHAMPUS Number: 3567227
             Provider Type: NETWORK PROVIDER GROUP

 Payment Address 1: PO BOX 4567
 Payment Address 2: 123 N MAIN ST
       Payment Zip: 92137
      Payment City: SAN DIEGO
     Payment State: CALIFORNIA
     Payment Phone: (619)535-2345
   Payment Contact: BILLING CLERK

Ask for Help = HELP     Screen Exit = F10    File/Exit = DO
-------------------------------------------------------------------
```

Figure 2-40. GROUP PRO1a Screen

1. PROVIDER GROUP NAME: Verify that the name of the group is correct and does not require additional data entry. The name defaults in this field from the Provider Group prompt.

2. SHORT GROUP ID: This field is free text and requires an entry between 3-20 characters long. A short ID based on the group name is recommended; e.g.,TRIMGP.

3. TAX ID#: If a civilian group has a tax number used for billing purposes, that number may be entered here. This is not a required field.

4. CHAMPUS Number: This is a free text field and not required. Civilian groups that bill CHAMPUS are given a number by CHAMPUS for claims adjudication. That number may be entered here but is not required.

5. PROVIDER TYPE: This is a required field. This field identifies the group's MCP association; whether the group is in the Network or not; whether it is an institution or provider. Most entries will be NETWORK PROVIDER GROUP or NON-NETWORK PROVIDER GROUP. Choices are:

   NIS NETWORK INSTITUTION/SERVICE
   NGP NETWORK PROVIDER GROUP
   XIS NON-NETWORK INSTITUTION/SERVICE

XGP NON-NETWORK PROVIDER GROUP
OIS ONLY SERVICE INSTITUTION/SERVICE
OGP ONLY SERVICE PROVIDER GROUP

6. PAYMENT ADDRESS 1: Free text, optional field. Although the field is not required to build the group initially, the address is required when connecting the group with providers and places of care. This is the address of the office where claims or billing issues are to be sent. In the case of an MTF group, this would be the address of the MTF or of the clinic.

7. PAYMENT ADDRESS 2: This is a free text field which may be used if the previous field is insufficient for the address.

8. ZIP CODE: Not a required field in this screen but required when connecting the network. The ZIP Code for the outpatient MTF, clinic or civilian payment office for this group should be entered here.

9. PAYMENT CITY: Automatically populated when the ZIP Code is entered in the previous field.

10. PAYMENT STATE: Automatically populated when the ZIP Code is entered.

11. PAYMENT PHONE: Not a required field in this screen but required when connecting the network. This is the number that patients or others should call when contacting the group or clinic.

12. PAYMENT CONTACT: This field only appears in this screen and is for information only. This field identifies a POC for a external group offices to address claims processing issues.

File the data

Enter another Group or exit the option.

If you have completed the place of care and provider profiles, you may now begin associating these files through the GNET option (see Section 2.2.1).

Functionality Interactions:

Data entered through this option sets pointers to other files but does not affect any other CHCS functionality. The MCP Provider Group serves as an anchor to link the MCP providers and MCP places of care together for Enrollments and Patient Booking through MCP.

Files which must be populated prior to data entry here:

1. MCP PROVIDER TYPE (#8567) This file is already populated and is uneditable. Based on the provider type, specialty type and location, and type of search selected, the provider displayed is the one in the specified specialty whose individual agreements include that patient type.

Troubleshooting:

Setting up the MCP Provider Group normally presents few problems. Most problems are associated with identifying the group as a PCM through the GNET option (see Section 2.2.1).

2.1.3.5 Specialty Type Enter/Edit (SPEC)

Menu Path: PAS Menu → MAN → FMCP → PTAB → SPEC

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Provider Specialty Type
Code

Application Description:

This option allows you to enter a new MCP provider specialty type that groups provider specialties together for provider searches. You may also edit/view existing MCP provider specialty types. Through this option, you may build combinations of provider specialties to include multiple professionals under a particular specialty type. You can also enter or delete provider specialties for the selected specialty type. You cannot inactivate or delete a specialty type.

Business Rules:

- Any new MCP specialty type must have at least one entry from the Provider Specialty file to be effective.
- Provider Specialty may be deleted from a specialty type file entry.
- Deleting a provider specialty from a specialty type through this option does not delete it from the Provider Specialty file.

Other Important Considerations:

This file allows you to group provider specialties under a specialty type.

This file is of particular importance to MCP, since specialty type is used in MCP to conduct provider searches in Health Care Finder. If a provider's specialty is not listed under a specialty type in this file, you will be unable to find a provider with that provider specialty when you search for appointments.

This file has numerous entries and should be reviewed for completeness.

Data Entry Process:

To enter a new provider specialty type

Access the SPEC option

Enter the specialty type

Complete the CP Provider Specialty Type screen

File the data

Enter another specialty type or exit the option

Access the SPEC option

Enter the specialty type

1. Enter the provider specialty type desired and verify that you are entering a new specialty type.

   The system displays the CP Provider Specialty Type screen (refer to Figure 2-41. CP Provider Specialty Type Screen, page 2-117).

Complete the CP Provider Specialty Type screen

```
MCP PROVIDER SPECIALTY TYPE: CARDIOLOGIST, PEDIATRI  CP PROVIDER SPECIALTY
TYPE

 Specialty Type: CARDIOLOGIST, PEDIATRIC

 Code   Description
  043   CARDIOLOGIST, PEDIATRIC



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-41. CP Provider Specialty Type Screen

1. SPECIALTY TYPE: Defaults from the previous entry and is the name of the specialty type.

2. SPECIALTY CODE: Requires a code from the Provider Specialty file.

   Press <Return> once to advance the cursor one space to the right and enter the 3- digit code desired. This should be a 900 series code if this entry is intended for external civilian providers.

3. DESCRIPTION: Automatically filled from the code entered in the previous field.

4. Repeat the process in step 2 until all the desired codes for this specialty are entered.

File the data

1. Exit to the *Select* prompt.

Enter another Specialty type or exit the option

Functionality Interactions:

This file does not affect any other functionality.

Troubleshooting:

Problem – Unable to locate a provider based on his provider specialty.

Solution - Review this file to ensure the provider specialty is correctly grouped within the Provider Specialty Type Enter/Edit option. If correct,

then review other files such as the Provider file and Group network to verify the provider specialty is set correctly for a provider. Also check the provider agreement, patient type and location.

2.1.3.6 Professional Category Enter/Edit (PROF)

Menu Path: PAS Menu → MAN → FMCP → PTAB → PROF

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Professional Category
Description

Application Description:

The Professional Category Enter/Edit option allows you to enter a new professional category, or to edit the description of an existing provider professional category. The Professional Category Code field can only be edited if you are adding a new professional category during the current session.

Business Rules:

– Existing Professional Categories may not be edited, deleted, or inactivated. You may only add to the exiting file.

Other Important Considerations:

Users must be able to distinguish between categories. MCP personnel should review this file to decide if new entries are needed.

Data Entry Process:

<u>To enter a new Professional Category</u>

Access the PROF option

Enter the professional category

Complete the CP Professional Category screen

File the data

Enter another professional category or exit the option

Access the PROF option

Enter the professional category

Enter the Professional Category and verify that you are entering a new one. The system displays the CP Professional Category screen (refer to Figure 2-42. CP Professional Category, page 2-119).

Complete the CP Professional Category screen

```
PROFESSIONAL CATEGORY: TA                          CP PROFESSIONAL CATEGORY

 Professional Category Code: TA
                Description:





Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-42. CP Professional Category

1. PROFESSIONAL CATEGORY CODE: Defaults from the previous entry and maybe edited if incorrect.

2. DESCRIPTION: Expanded description of the category code entered.

3. When completed, press <Return> and file this entry.

4. You may repeat the process for any other new entry desired.
5. Once filed, a Professional Category cannot be deleted.

File the data

Enter another professional category or exit the option

Functionality Interactions:

This file does affect any other CHCS functionality.

Troubleshooting:

There are no known problems associated with this file.

2.1.3.7 Military Status Enter/Edit (MILI)

Menu Path: PAS Menu → MAN → FMCP → PTAB → MILI

Security Keys:

CPZ CCP
CPZ FILE

Required Fields:

Code
Description

Application Description:

This option allows you to enter a new military status code and description, or to edit the description of an existing military status. Examples of military status are:

AD	ACTUVE DUTY
CI	CIVILIAN
NG	NATIONAL GUARD
RC	RECALLED TO ACTIVE DUTY
RS	RESERVES

Business Rules:

– This file is for use in the MCP provider profile. Entries must exist in the Military Status file before they may be used in the provider profile.

Other Important Considerations:

This file is used for informational purposes only.

Data Entry Process:

To enter a new Military Status

Access the MILI option
Enter a new Military Status
Complete the Military Status screen
File the data
Another Military Status or exit the option

Access the MILI option

Enter a new Military Status

1. At the *Select MILITARY STATUS* prompt, enter a new military status code or the one you wish to edit; e.g., AD.

   Verify that you are entering a new Military Status. Press <Return> to proceed to the Military Status screen (refer to Figure 2-43. Military Status Screen, page 2-122).

Complete the Military Status screen

```
MILITARY STATUS: AD                                          MILITARY STATUS

                         MILITARY STATUS ENTER/EDIT

=========================================================================

           Code: AD
    Description:



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-43. Military Status Screen

1. CODE: Defaults from the previous prompt and may be edited.
2. DESCRIPTION: System required field and should be an expanded description (3-60 characters in length) of the code previously entered.

File the data

Enter another Military Status or exit the option

Functionality Interactions:

This file affects CHCS quality assurance functionality and the common files.

Troubleshooting:

None required.

2.1.3.8 Audit Trail For Provider Network Menu (AUDI)

Menu Path: PAS Menu → MAN → FMCP → PTAB → AUDI

This menu contains the options which allow you to generate audit trail reports of data changes in group and provider agreements, places of care, provider groups, and providers.

Site Definable Parameters:

Your MTF must have the Audit Trail turned on for these reports to be generated.

2.1.3.8.1 Agreement Data Changes (AGDC)

Menu Path: PAS Menu → MAN → FMCP → PTAB → AUDI → AGDC

Contents:

This option allows you to generate a report showing an audit trail of changes in group and provider agreement data. You may specify One, Multiple, or All agreements. For group agreements, you may specify One, Multiple, or All groups to include in the report. For provider agreements, you may specify One, Multiple, or All groups and One, Multiple, or All providers to include in the report.

Use/Frequency:

As often as needed. This report is a troubleshooting tool.

```
WALTER REED AMC                                    21 Jan 2001@1312 Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                       AGREEMENT DATA CHANGES AUDIT TRAIL
                   MULTIPLE AGREEMENTS/MULTIPLE GROUPS/ALL PROVIDERS
                  Data Changes from 01 Jan 1995 to 01 Jan 2001

 Data Elements: 2 Selected                        Agreements:7 Selected
      Provider: ALL                             Data Elements:8 Selected
==========================================================================
Provider Group
  Provider
    Agreement Type                                      Effective Dates
      Data Element
--------------------------------------------------------------------------
TORRES HEALTH CARE GROUP
  DILLINGER,DONALD
   CON-CONTRACT                                31 Aug 1996 - 30 Aug 1997
     IND STOP DATE:
     Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
       Old:
       New: 29 Aug 1997

     IND OVERALL DISCOUNT PERCENT
     Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
       Old:
       New: 10

     IND START DATE
     Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
       Old:
       New: 30 Aug 1995

    NET-CIVILIAN NETWORK PROVIDER            10 Jun 1996 - 10 Jun 1997
      IND STOP DATE
      Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
        Old:
        New: 13 Jun 1997

      IND OVERALL DISCOUNT PERCENT
      Change Date/Time: 14 Oct 1996 @ 1122  User ID: TURNER,STEVEN
        Old:
        New: 99
```

Figure 2-44. Agreement Data Changes Report

2.1.3.8.2 Place of Care Date Changes (LCDC)

Menu Path: PAS menu → MAN → FMCP → PTAB → AUDI → LCDC

Contents:

This option allows you to print a report showing an audit trail of changes in place of care data. You may specify One, Multiple, or All places of care to include in the report.

Use/Frequency:

As often as needed. This report is a troubleshooting tool.

```
WALTER REED AMC                                  21 Jun 2001@1315   Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                     PLACE OF CARE DATA CHANGES AUDIT TRAIL
                  Data Changes from 21 Jun 2001 to 21 Jun 2001

Place of Care: All Places of Care selected
Data Elements: 9
=========================================================================
Place of Care
  Data Element
-------------------------------------------------------------------------
ACUTE CR MTF
  DMIS ID
    Change Date/Time: 21 Jun 2001@1057          User ID: SLATER,PAMELA
                 Old: 6015 CMHA FT. MONMOUTH
                 New: 0037 WALTER REED AMC

NEW ACUTE CR MTF
  DMIS ID
    Change Date/Time: 21 Jun 2001@1130          User ID: SLATER,PAMELA
                 Old:
                 New: 0037 WALTER REED AMC
```

Figure 2-45. Places of Care Data Changes Report

2.1.3.8.3 Group Data Changes (GPDC)

Menu Path: PAS menu → MAN → FMCP → PTAB → AUDI → GPDC

Contents:

This option allows you to print a report showing an audit trail of changes in provider group data. You may specify One, Multiple, or All provider groups to include in the report.

Use/Frequency:

As often as needed. This report is a troubleshooting tool.

```
WALTER REED AMC                                    21 Jun 2001@1319 Page 1
           Personal Data - Privacy Act of 1974 (PL 93-579)
             PROVIDER GROUP NAME CHANGES AUDIT TRAIL
                  Data Changes from 22 Apr 2001 to 21 Jun 2001

Provider Group: INACTIVATE PROVIDER GROUP 1
=========================================================================
Change Date/Time: 18 Jun 2001 @ 1310      User ID: TURNER,STEVEN
  Old Name:
  New Name: INACTIVATE PROVIDER GROUP 1
```

Figure 2-46. Group Data Changes Report

2.1.3.8.4 Provider Data Changes (PRDC)

Menu Path: PAS Menu → MAN → FMCP → PTAB → AUDI → PRDC

Contents:

This option allows you to print a report showing an audit trail of changes in provider data. You may specify One, Multiple, or All providers to include in the report.

Use/Frequency:

As often as needed. This report is a troubleshooting tool.

```
WALTER REED AMC                                    21 Jun 2001@1324  page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)

                       PROVIDER DATA CHANGES AUDIT TRAIL
                  Data Changes from 01 Jan 1995 to 01 Jan 2001

     Provider: 333 Selected
Data Elements: 4 Selected
=========================================================================
Provider
  Group
    Data Element
-------------------------------------------------------------------------
ABRAHAM,JOHN
  CARDIOLOGY PNH
    INACTIVATION DATE
      Change Date/Time: 18 Oct 1996@1414    User ID: HANOVER,KAREN
        Old: 19 Oct 1996
        New: 19 Oct 1996

    INACTIVATION DATE
      Change Date/Time: 18 Oct 1996@1410    User ID: HANOVER,KAREN
        Old
        New: 19 Oct 1996

ESPINOZA,RUBEN
  SHARP MAIN GROUP
    INACTIVATION DATE
      Change Date/Time: 14 Oct 1996@1359    User ID: ANDERSON,PAULINE
        Old: 12 Oct 1996
        New: 11 Oct 1996

    INACTIVATION DATE
      Change Date/Time: 13 Oct 1996@1522    User ID: ANDERSON,PAULINE
        Old:
        New: 12 Oct 1996
```

Figure 2-47. Provider Data Changes Report

2.2 Provider Network Management Menu (PMCP)

2.2.1 Group Profile/agreements Enter Edit (GNET)

Menu Path: PAS Menu → MAN → PMCP → GNET

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT

CPZ LOWCAP
CPZ NET

Application Description:

This option allows you to associate places of care, agreements, and providers with a provider group. It allows you to edit or view the MCP Provider group profile for a selected provider group, and to enter, edit, or view associated clinic profiles for the places of care.

You may also enter, edit, terminate, and/or renew group agreements. For any agreement, you may enter, edit, and/or delete procedures and specialty exceptions. You may also add or edit PCM enrollment mix data.

You may enter, edit, or view individual provider profiles. For a given provider, you may enter, edit, or delete data for provider agreements. For a given group agreement, you may indicate whether the provider member participates in it, edit the date or discount rate for the provider, enter procedure and specialty exceptions, and add or edit PCM enrollment mix data, PCM assignment limitations, PCM age limitations, and PCM comments.

You may also inactivate or reactivate a place of care within the group, a provider within the group, or a provider within a place of care, and print a Discrepancy Avoidance Report.

This option is used to designate the PCMs, whether they are the group, individual, or both.

File Sequence Build:

The following files must be built through the PTAB menu prior to accessing the GNET option and completing the Provider Network:

Department/Service
Division
MCP Place of Care
MCP Provider
MCP Provider Group

To complete the Group Profile/Agreements, follow this sequence in the GNET option:

Place(s) of Care profile completed.
Group Agreements entered and Enrollment Mix set
providers attached to the group, places of care, and agreements/PCM enrollment mix set if desired.

Other Important Considerations:

Issues to decide before associating the places of care and providers with the groups:

1. Will the MCP Provider group be a (group provider) PCM?
2. Will the individual providers in the group be PCMs as well?
3. Will the MCP Provider group have only one place of care (clinic) or will it have multiple places of care?
4. If the MCP Provider group is a PCM and does not have a schedule and the individual providers in the group are not, ALL provider schedules will display.
5. If the MCP Provider group is a PCM and does not have a schedule, and some but not all providers in the group are PCMs, only schedules for providers designated as PCMs will display.
6. If the MCP Provider group is not a PCM and some providers are PCMs with assigned enrollees, only the individual assigned PCM schedules display.
7. If MCP Provider groups are PCMs, the UIC/PCM link must be established with the group after it has been designated a PCM if the group treats active duty.

2.2.1.1 GNET – Place of Care Profile Entry

Menu Path: PAS → MCP → PMCP → GNET → Select Provider Group

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

Required Fields:

Provider Group Name

Application Description:

This phase of GNET connects the place(s) of care profile to a group and allows you to edit the provider group profile and the place of care data.

Business Rules:

- At least one place of care must be entered in the provider group profile through this option for the group to be in effect.
- The name of the place of care may be the same as the MCP Provider group but will exist in both the MCP Place of Care and MCP Provider Group files.
- A group may have more than one place of care

Other Important Considerations:

If there is more than one place of care in a group, provider members may be assigned to one or more places of care.

Data Entry Process:

<u>To complete the provider group profile</u>

Access the GNET option

Enter the name of the provider group you plan to work on

Complete the GRP PRO1, Provider Group Places of Care Screen

Complete the GRP PL1, Provider Group Places of Care Screen

Complete the GRP PL2, Provider Group Places of Care Screen

Complete the GRP PL3, Provider Group Places of Care Screen

Enter PAS clinic profile information

Complete SD Clinic Profile Screen

Complete SD Clinic Profile – Continuation screen

Complete SD Clinic Profile -Continuation screen (Appointment types)

File the data

Enter another place of care or file and continue to Provider Agreements

Access the GNET option

Enter the name of the provider group you plan to work on

1. At the *Select Provider Group* prompt, enter the name of the group you are building. The system then proceeds to the next screen, Provider Group Profile GRP PRO1 (refer to Figure 2-48. GRP PRO1 - Provider Group Profile Screen, page 2-132).

Complete the GRP PRO1 – Provider Group Profile screen

All the information displayed on this screen defaults from the Group profile created in the GROU option.

```
MCP PROVIDER GROUP: ACUTE CR MTF                                GRP PRO1

                           PROVIDER GROUP PROFILE


=========================================================================
          Short Group ID: ACCM
                 Tax ID#:
          CHAMPUS Number:
           Provider Type: NETWORK PROVIDER GROUP
 Activate Group Provider: NO

 Payment Address 1: 6625 16th Street
 Payment Address 2:
       Payment Zip: 20307
      Payment City: WASHINGTON
     Payment State: DISTRICT OF COL
     Payment Phone: 202 427-1201       Payment Contact: Billing Officer

  Places of Care:
```

Figure 2-48. GRP PRO1 - Provider Group Profile Screen

1. Press <Return> to advance through all fields until you reach the bottom of the screen. Stop at the Places of Care field. This field should be blank.

Note: The Activate Group Provider field, will be set at "NO," but can be changed to "YES." If "YES," this field designates whether this Provider Group will act as a provider throughout MCP and PAS, have patients assigned as their Primary Care Manager, have referrals assigned through Appointment Referral Processing and PAS appointments booked to them.

---

2. Verify that the address and phone number are correct. Enter missing information if available.

3. Press the down-arrow key to position the cursor below the Places of Care field.

4. Enter the name of the place of care (clinic) to associate with this group.

Note: The Places of Care field will initially be blank. Be sure that the place of care you enter is correct. Once entered, the place of care can never be deleted. You can inactivate a place of care from a group at anytime, but you can never delete.

After you enter the place of care name press <Return>. The system displays the Provider Group Places of Care – GRP PL1 (refer to Figure 2-49. Provider Group Places of Care – GRP PL1 Screen, page 2-133). When the cursor is positioned below the name of the place of care, the system bypasses this screen.

Complete the GRP PL1, Provider Group Places of Care Screen

Data describing this place of care is entered on this screen and the following continuation screens.

```
HOSPITAL LOCATION: ACUTE CR MTF                                    GRP PL1

                         PROVIDER GROUP PLACES OF CARE

 Provider Group: ACUTE CR MTF

=========================================================================

                       Name: ACUTE CR MTF
      Location Abbreviation: ACCM
               Building Name:
             Building Number:
              Street Address: 6885 16TH STREET
                         Zip: 20307
                        City: WASHINGTON
                       State: DISTRICT OF COL
                       Phone: 202 271-5851



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-49. Provider Group Places of Care – GRP PL1 Screen

1. NAME: Required field that defaults from the place of care name prompt. This is an uneditable field. Edits may be done through the menu option PLAC. The cursor bypasses this field.

2. LOCATION ABBREVIATION: System-required, editable field. This field is associated with the abbreviation given a hospital location in the Hospital Location file. The default is that abbreviation. You may press <Return> to continue. If you edit the location abbreviation here, you are also editing the location abbreviation in the Hospital Location file.

3. BUILDING NAME: Optional field that can be bypassed. If you have the information available, you should enter the name of the building here.

4. STREET ADDRESS: Required field that should default from the entry in the PLAC option. This is an editable field if the address is incorrect.

5. ZIP: Required, editable field that defaults from the ZIP Code entered through the PLAC option.

6. The CITY and STATE fields are uneditable but may be changed through the ZIP Code entry.

7. PHONE: Required, editable field. The phone number entered through the PLAC option defaults here. If not entered previously, you must enter it here before the system allows you to file this screen.

   Once you file this screen, the system displays the next screen, Provider Group Places of Care - GRP PL2 (refer to Figure 2-50. GRP PL2 - Provider Group Places of Care Screen, page 2-135).

Complete the GRP PL2, Provider Group Places of Care Continuation Screen.

Additional data about the place of care may be entered here, including hours or service.

The place of care and provider group name display at the top, left side of the screen.

```
MCP PLACE OF CARE: ACUTE CR MTF                                    GRP PL2

                        PROVIDER GROUP PLACES OF CARE

 Provider Group: ACUTE CR MTF

==========================================================================

          Type of Facility: MULTISERVICE CLINIC
         Appt Contact Name: Appointment Clerk
                   DMIS ID: 0037  WALTER REED AMC

 ------------------------------Hours of Service-------------------------
  Day of Week            AM                        PM
  MONDAY            0800 -  1200             1201  -  1700
  TUESDAY           0800 -  1200             1201  -  1700
  WEDNESDAY         0800 -  1200             1201  -  1700
  THURSDAY          0800 -  1200             1201  -  1700
+ FRIDAY            0800 -  1200             1201  -  1700


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-50. GRP PL2 - Provider Group Places of Care Screen

1. TYPE OF FACILITY: Defaults from the data entered through the PLAC option. This is a system required, editable field. This field is described in Section 2.1.3.2, Complete the GRP PL2a screen, page 2-92.

2. The remaining fields on this screen are optional and are informational only. This information can be printed through several MCP menu options. The fields display the appointment contact name and hours of operation for that place of care. Press <Return> to advance through all the fields to ensure MCP pointers are set. Once completed, file and proceed to the next screen, GRP PL3 - Provider Group Places of Care (refer to Figure 2-51. GRP PL3 – Provider Group Places of Care Screen, page 2-136).

Complete the GRP PL3, Provider Group Places of Care Screen

All fields in this screen are free-text and informational for use when printing directions to a place of care for TRICARE patients. All information here defaults from data entered through the PLAC option.

```
MCP PLACE OF CARE: ACUTE CR MTF                                    GRP PL3

                        PROVIDER GROUP PLACES OF CARE

 Provider Group: ACUTE CR MTF

==========================================================================

 -------------------------Directions to Place of Care--------------------
 Proceed north on 16th Street and exit right on Alaska Avenue.
 Walter Reed Army Medical Center is on the right.



 --------------------------Comments on Place of Care---------------------
 Handicapped parking and wheelchair access is available.



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-51. GRP PL3 – Provider Group Places of Care Screen

1. If previously entered, press <Return> to advance through all the fields.

   When completed and you have reached the bottom of the screen, you are prompted to enter PAS profile information.

Enter PAS Clinic Profile information

At the *Do you want to enter/edit PAS Clinic Profile information now? Yes//* prompt, press <Return> to accept the "YES" default and continue building the group.

At the *Select (A)ctive, (I)nactive appointment types, or (Q)uit: A//* prompt, press <Return> to access the next screen, SD Clinic Profile (refer to Figure 2-52. SD Clinic Profile Screen, page 2-137).

Complete SD Clinic Profile Screen

All information displayed in these fields is defaulted from data entered through the PLAC option. If any data is missing, edit the information through the PLAC option.

```
HOSPITAL LOCATION: ACUTE CR MTF                          SD CLINIC PROFILE

                 Name: ACUTE CR MTF
         Abbreviation: ACCM
             Facility: WALTER REED AMC WASHINGTON DC
             Division: DIV A - TRAINING HOSPITAL
        Building Name:
      Building Number:
       Street Address: 6885 16TH STREET
                  ZIP: 20307
                 City: WASHINGTON
                State: DISTRICT OF COLUMBIA
      Clinic Location:
  Clinic Availability:
            Telephone: 202 271-5851
     Enrollee Lockout: YES
         Type of Care: BOTH SPECIALTY AND PRIMARY CARE
              Service: PRIMARY CARE SERVICE
           Department: PRIMARY CARE DEPARTMENT
            Specialty:
           MEPRS Code: BGAA


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-52. SD Clinic Profile Screen

1. Press <Return> to advance through all fields until the next screen, SD Clinic Profile -- Continuation displays (refer to Figure 2-53. SD Clinic Profile -- Continuation Screen, page 2-138).Complete the SD Clinic Profile -- Continuation screen.

Complete the SD Clinic Profile -- Continuation screen

The SD Clinic Profile -- Continuation screen displays the clinic parameters that affect booking, wait lists, schedules and record tracking.

All information should be defaulted from data entered through the PLAC option.

```
HOSPITAL LOCATION: ACUTE CR MTF             SD CLINIC PROFILE -- CONTINUATION

           Wait List Activated: YES        Maximum Wait List Days:   200 day(s)
  Wait List Provider Mandatory: YES       Wait List Hold Duration:     7 day(s)
     Auto Wait List Processing: YES        Schedule Hold Duration:     2 day(s)
 Prompt for Requesting Service: YES           Patient Record Pull:     1 day(s)
                   Clinic Type: COUNT       Radiology Record Pull:     1 day(s)
            Check Holiday File: YES             Roster Production:     1 day(s)
                Cost Pool Code:           Prepare Reminder Notice:     4 day(s)
             Activation Status: ACTIVATED      Available Schedule:    30 day(s)
      Clinic Appt Instructions: Arrive 10 minutes early.



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-53. SD Clinic Profile -- Continuation Screen

1. Review this screen and ensure that all data is correct. You may also use the PLAC option to edit data.

2. Press <Return> to advance through all the fields. If you cannot advance through a field by pressing <Return>, use the down-arrow key to bypass the field.

   After advancing through all the fields, the system displays the next screen, Figure 2-54. SD Clinic Profile -- Continuation (Appointment Types), page 2-139.

Complete screen SD Clinic Profile -- Continuation (Appointment Types)

This last screen displays all appointment types selected for this place of care through the PLAC option.

```
HOSPITAL LOCATION: ACUTE CR MTF          SD CLINIC PROFILE -- CONTINUATION

 Select APPOINTMENT TYPE:
 CON
 FOL
 NEW
 T-CON*


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-54. SD Clinic Profile -- Continuation (Appointment Types)

1. Review the information. If incorrect, you may also access the PLAC option to edit.

File the data

You do not have to access any of the appointment types and may bypass them by pressing the down-arrow key until you can file the data.

Enter another place of care or file and continue to Provider Agreements

After filing the data, the system returns you to the original screen GRP PRO1 and positions the cursor one slot below the place of care name. You can add additional places of care. If you press <Return> while the cursor is in this initial position, the system allows you to file this information and continue on to the next phase of building a group network, i.e., entering provider agreements.

Functionality Interactions:

While building network providers, you should not edit any area of the PAS and MCP profiles, but you must press <Return> to advance through all fields to ensure pointers are set. You may need to add some information, but do not edit information unless specifically mentioned above.

The places of care and providers entered in a group must match. The providers must be in the PAS profiles of those clinics.

Troubleshooting:

Problem – Problems are encountered with the profiles.

Solution – Edit the profile information through the GNET or the PLAC options.

2.2.1.2 GNET – Agreements Entry

Menu Path: PAS Menu → MAN → PMCP → GNET

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

Application Description:

The agreement data entered should be the agreement types used by all providers within this group. Agreement types are applicable to certain Patient/Beneficiary types.

Business Rules:

- Providers may participate with certain agreement types restricting them to certain patient types. Refer to Appendix A, Table A-5. External (Non-MTF) Provider Agreement Types and Eligible Patient Types.

- Enrollees may be assigned only to PCMs who are parties to an allowable agreement type for their patient type status; e.g., AD may not be enrolled to providers who are parties only to PIC agreements.

- Providers may be parties to more than one agreement type.

- Only those agreement types that are assigned a PCM status by the site will be allowable for PCM assignment. If the group is a PCM, only the agreements so designated by the site are allowable for enrollment purposes. If providers are to be PCMs, then only the PCM agreements in which they participate will allow patients to be assigned to them.

Other Important Considerations:

When selecting the agreement to assign PCM status, remember that providers with desired specialties display as allowable only for the patients associated with the agreement type; e.g., PIC is not an allowable agreement type for AD so that any provider whose specialty was desired but who only participated in a PIC agreement would not display for selection. Refer to Appendix A, Table A-5. External (Non-MTF) Provider Agreement Types and Eligible Patient Types.

Prior to terminating a group or provider agreement type, reschedule any patient appointments currently booked with the provider with that agreement type.

Maintaining agreements requires constant monitoring especially with civilian, non-MTF providers. The MTF may assume the maintenance of these agreements in accordance with terms of the TRICARE contract.

Managed care policies that can be set and enforced through the agreements are: enrollment mix, beneficiary mix, age constraints, and total beneficiaries allowed for the group per agreement.

Data Entry Process:

To enter a new agreement for a provider group

Access the GNET option

Enter the name of the provider group

Access the Provider Group Profile/Agreement Maintenance screen and the (A)greements action

Complete screen Provider Group Agreement History actions

Quit the Provider Group Profile/Agreement Maintenance screen or access the providers

Exit the option or continue defining the providers

Access the GNET option

Enter the name of the provider group

Complete the group profile in the previous section

Access the screen Provider Group Profile/Agreement Maintenance and the action (A)greements

Access the GNET option

Enter the name of the provider group

Access the Provider Group Profile/Agreement Maintenance screen and the (A)greements action

The system displays the GRP PRO1 screen with the cursor at the Short Group ID field (refer to Figure 2-48. GRP PRO1 - Provider Group Profile Screen, page 2-132).

1. Press the down-arrow key until the cursor is under the last place of care name and then press <Return>.

2. File the data.

   The system displays the Provider Group Profile Agreement Maintenance screen with the action bar shown in Figure 2-55. Provider Group Profile/ Agreement Maintenance Action Bar, page 2-142.

```
Action Bar: Select (A)greements, (P)roviders, (I)nactivate/
Reactivate, or (Q)uit: A//
```

Figure 2-55. Provider Group Profile/Agreement Maintenance Action Bar

1. Press <Return> to accept the default (A)greements action.

   The system displays the Provider Group Agreement History Screen (refer to Figure 2-56. Provider Group Agreement History Screen, page 2-143).

Complete Provider Group Agreement History Screen actions

The Provider Group Agreement History screen is a three-part screen.The top portion displays the provider group name. The middle portion displays fields labeled Agreement Type, Effective Date, Stop date, Overall Discount, FI Notified, Except, PCM. The bottom part is the action bar. The action bar will displays only two prompts initially. You may press <Return> to accept the default (A)dd action or enter "Q" for Quit.

```
                         PROVIDER GROUP AGREEMENT HISTORY


Provider Group: ACUTE CR MTF
--------------------------------------------------------------------------------
 Agreement  Effective                        Overall      FI
   Type       Date          Stop Date      Discount  Notified      Except   PCM




Select (A)dd, or (Q)uit Agreements: A//
```

Figure 2-56. Provider Group Agreement History Screen

1. Press <Return> to accept the default (A)dd action.

   The middle portion of the screen displays the <---*NEW Agreement may be added here* prompt.

2. Enter the agreement [con] and press <Return>.

   There must be at least one agreement type entered for the group.

3. Enter "YES" at the *Are you adding 'CON' as a new AGREEMENT TYPE (the 1st for this MCP PROVIDER GROUP)?* prompt.

   When you enter "YES," you are prompted to enter the date this agreement becomes effective.

4. Enter the effective date for the new agreement type.

   Enter the start date of the agreement. If this is an MTF agreement, enter "T" for today, a past date, or a future date if desired.

   After entering a date press <Return>. The next query is whether you are adding this date as a new period of agreement for this agreement type.

5. Enter "YES" at the *Are you adding '21 Jun 2001' as a new PERIOD OF AGREEMENT (the 1st for this AGREEMENT TYPE)?* prompt.

   When you answer "YES," the system displays a subscreen, GRP AGREE2 – Provider Group Overall Discount (refer to Figure 2-57. GRP AGREE2 - Provider Group Overall Discount Screen, page 2-144).

   The top portion of this screen displays the effective date chosen for this agreement, screen name, and provider group name. The second portion displays the agreement type, effective date, stop date, overall discount, and FI notification date. You may move from field to field by pressing the <Return> key or the up- and down-arrow keys.

   The fields, Agreement Type and Effective Date have data defaulted from the previous screen and cannot be edited. The cursor is positioned at the Stop Date field.

```
PERIOD OF AGREEMENT: 01 Jan 2001                                GRP AGREE2

                        PROVIDER GROUP OVERALL DISCOUNT

 Provider Group: ACUTE CR BC
 ---------------------------------------------------------------------
 Agreement            Effective                        Overall         FI
 Type                  Date          Stop Date      Discount     Notified

=====================================================================
 CON                  01 Jan 2001     01 Jan 2005    CA - 60%



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO    INSERT OFF
```

Figure 2-57. GRP AGREE2 - Provider Group Overall Discount Screen

1. The Stop Date field will have a defaulted date of one year from the agreement start date entered in the previous screen. You should edit this date if this agreement/Memorandum of Understanding (MOU) is for a shorter or longer period.

2. Enter discount.

   The Overall Discount should be any discount this group will provide for MTF-referred patients and is expressed in percent (%). The default is CA for CHAMPUS Allowable but may be changed to U for Usual and Customary charges. MTF agreement type will always default to 100% of CA. All other

agreement types will have a blank field allowing you enter the correct discount, if any. A discount is necessary and may be edited later. In earlier CHCS versions, the discount was important because the higher discounts displayed first during provider searches. CHCS Version 4.5 now displays providers differently and is covered in another section. A discount of zero (0) percent for civilian providers indicates the specific provider is a non-network provider with an agreement type of NON.

3. Enter date when Fiscal Intermediary (FI) was notified.

   FI Notified is the date the Fiscal Intermediary (Region Lead Agent in most cases) was notified of this agreement. If there is no FI, you may leave this field blank.

4. File the data.

   After filing this screen, if the group does not yet have providers attached, the system returns you the Provider Group Enrollment History screen and to the prompt to enter a new agreement type. (Refer to Figure 2-56. Provider Group Agreement History Screen, page 2-143). You may enter a new agreement at the Provider Group Agreement History screen and repeat the above process for each agreement the members of this group may participate in.

   If the group already has providers attached, the system displays the Individual Provider Agreement Participation screen with the provider names displayed in the middle window (refer to Figure 2-58. Individual Provider Agreement Participation Screen, page 2-146).

```
                    INDIVIDUAL PROVIDER AGREEMENT PARTICIPATION

    Provider Group: ACUTE CR BC
    Agreement Type: CIVILIAN NETWORK PROVIDER
Dates of Agreement: 01 Jan 2001  -  31 Dec 2001
  Overall Discount: 68%
-------------------------------------------------------------------------------
   Provider Name

   ARRIBA,GILBERT M
   BEALE,SHARON M
   CRAWFORD,KYLE M
   DELL,ALICE M
   EDROZO,FRANK M
   FIESTA,LUISA M
+  GOTT,JOHN M

Use SELECT key to select individual provider(s) who do NOT participate in this
group agreement.  If all providers in this group participate in this agreement,
press <RETURN> to continue.
```

Figure 2-58. Individual Provider Agreement Participation Screen

1. Press <Select> to mark the providers who DO NOT participate in this NEW agreement.

   If providers have not been attached to this provider group, this screen does not display.

2. Press <Return> twice to exit the Individual Provider Agreement Participation screen. The Provider Group Agreement History Screen (refer to Figure 2-59. Provider Group Agreement History Screen, page 2-147).

The Provider Group Agreement History Screen

All information entered in the subscreen now displays on the Provider Group Agreement History screen

```
                        PROVIDER GROUP AGREEMENT HISTORY


Provider Group: ACUTE CR BC
-------------------------------------------------------------------------------
 Agreement  Effective                        Overall      FI
   Type       Date          Stop Date       Discount  Notified      Except   PCM

   PIC      01 Jan 2001     01 Jan 2005     CA- 40%
   MTF      01 Jan 2001     01 Jan 2005     CA-100%                           Y
   CON      01 Jan 2001     01 Jan 2005     CA- 60%




Select (A)dd, (E)dit, (S)pecialty Exceptions, (C)PT-4 Exceptions,
       Enrollment (M)ix, (T)erminate, (R)enew, or (Q)uit Agreements: Q//
```

Figure 2-59. Provider Group Agreement History Screen

The Display Window displays the provider group name

The Select Window displays type of agreement, overall discount, and agreement effective dates, overall discount percent, and FI Notification date, specialty exceptions, and whether the group is a PCM for any of the agreement types.

The Interact Window contains an action bar with the following actions:

A)dd: Allows you return to the middle window to add new agreements.

(E)dit: Allows you to edit existing agreements seen in the middle portion. The cursor moves into the middle portion and allows you to move up and down as desired using the up- and down- arrow keys. When you identify the desired agreement, press <Select>. An asterisk (*) displays next to your selection. Press <Return> to access the subscreen for editorial purposes.

(S)pecialty Exceptions: Allows you enter a provider specialty that this agreement has a pricing exception for; e.g., a family practice group has a different discount for OB-GYN. If you select this choice, the system displays the Provider Group Specialty Exceptions subscreen (refer to Figure 2-60. Provider Group Specialty Exceptions Screen, page 2-149).

(C)PT-4 Exceptions: This action allows you to enter procedures the provider supplies at a special discount. When you select this action, the system displays the Provider Group Procedure Exceptions screen where you can add a block of

procedures or a single procedure (refer to Figure 2-61. Provider Group Procedure Exception Screen, page 2-150).

Enrollment (M)ix: This action allows you to designate the maximum number of patients this group may enroll by agreement type and to designate the agreement as a PCM agreement. If this group and its providers are not to be PCMs, this action may be bypassed. If the providers are to serve as PCMs, then this action should be selected. When you select this action, the cursor is repositioned in the middle window, allowing you to select the agreement to define. Press <Select> to mark the agreement you want to define. Press <Return> to activate your selection. The system displays the subscreen, Provider Group PCM Capacity (refer to Figure 2-62. Provider Group PCM Capacity Screen, page 2-151).

(T)erminate: This action allows you to enter a termination date for an agreement. If selected, the cursor is positioned in the middle window, allowing you to select the agreement to terminate. After selection, the system displays the subscreen, Agreement Early Termination Reason (refer to Figure 2-63. Agreement Early Termination Reason Screen, page 2-153). After an agreement termination date, that agreement in the specified provider group is no longer available for PCM assignment.

(R)enew: This action allows you to enter a renewal date and a stop date.

The Provider Group Specialty Exceptions screen

The Provider Group Specialty Exceptions screen displays when you choose the (S)pecialty Exceptions action on the Provider Group Agreement History action bar.

```
                        PROVIDER GROUP SPECIALTY EXCEPTIONS

    Provider Group: ACUTE CR BC
    Agreement Type: CONTRACT
Dates of Agreement: 01 Jan 2001  -  01 Jan 2005
  Overall Discount: CA- 60%
--------------------------------------------------------------------------------
   Specialty                      Effective                 Discount    FI
   Description                      Date       Stop Date    Percent  Notified




------------------------------ No Exception data found ------------------------------
Select (A)dd, or (Q)uit Specialty Exceptions: A//
```

Figure 2-60. Provider Group Specialty Exceptions Screen

The Display Window of this screen lists the provider group name, a specific agreement type, dates of the agreement and overall discount rate.

The Select Window shows the description of the exception specialty, effective date, stop date, percent discount applicable to this specialty, and when the FI was notified.

The Interact Window contains an action bar with the choices to (A)dd a specialty or (Q)uit. If there are already exception specialties listed in the select window, you will have additional choices to (E)dit or (D)elete.

1. When you choose the (A)dd action, the system positions the cursor in the select window.

2. After adding the specialty, you are asked if this is a new specialty. If you answer "YES" the system displays a second subscreen, Provider Group Specialty Exception – GRP EXE1 (refer to Figure 2-60. Provider Group Specialty Exceptions Screen, page 2-149).

3. Add a discount for this speciality.

4. Select the (Q)uit action to return to the Provider Group Agreement History screen.

The Provider Group Procedure Exceptions screen

The system displays the Provider Group Procedure Exceptions screen when you choose the (C)PT-4 Exceptions action on the Provider Group Agreement History screen.

```
                      PROVIDER GROUP PROCEDURE EXCEPTIONS

    Provider Group: ACUTE CR BC
    Agreement Type: PARTNER INTERNAL
Dates of Agreement: 01 Jan 2001  -  01 Jan 2005
  Overall Discount: CA- 40%
-------------------------------------------------------------------------------
   CPT-4                                Effective     Stop    Disc/         FI
   Code   Description                     Date       Date     Fee       Notified




                             No Exception data found
Select (B)lock add, (S)ingle add, or (Q)uit Procedure Exceptions: S//
```

Figure 2-61. Provider Group Procedure Exception Screen

The Display Window lists the provider group name, agreement type, dates of the agreement and overall discount rate for the agreement.

The Interact Window lists the CPT-4 Code for procedure exceptions, procedure descriptions, effective date, stop date, discount/fee, and date FI was notified.

The Select Window is an action bar with three actions: (B)lock add, (S)ingle add, or (Q)uit.

1. If you select the (B)lock action:

   a. You are prompted for a starting CPT Code and then an ending CPT Code.

   b. After both are entered, the system displays a subscreen, Proc Block. Edit the defaulted start and stop dates (from the Agreement) and enter a fee or different discount fee.

2. If you select the (S)ingle action, the system displays the subscreen, GRP EXE3 after selecting a single CPT code. Here you may enter a discount fee or percentage discount for this specific procedure.

3. You may then return to the Provider Group Procedure Exception Screen (refer to Figure 2-61. Provider Group Procedure Exception Screen, page 2-150) where you will now see additional action bar choices to (E)dit and (D)elete Procedure Exceptions.

Choose the (Q)uit action to return to the Provider Group Agreement History.

The Provider Group PCM Capacity screen

When you choose the Enrollment (M)ix action on the Provider Group Agreement History action bar, the system displays the Provider Group PCM Capacity screen with the cursor at the Maximum Patient Capacity field.

This screen displays the provider group name, the agreement type you selected from the Provider Group Agreement History screen, the agreement start and stop dates, and whether the group has been activated as a PCM.

Capacities for PCMs should be coordinated with the MOUs in the TRICARE contract to make sure they are consistent.

```
                          PROVIDER GROUP PCM CAPACITY

     Provider Group: ACUTE CR BC
     Agreement Type: CON - CONTRACT
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
 Activate Group PCM: NO

 Maximum Patient Capacity:           Age Range to Apply Overall:     -
           Total Assigned:
================================================================================
                                                                Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
--------------------------------------------------------------------------------
  ACTIVE DUTY                           -
  ACTIVE DUTY FAMILY MEMBER             -
  RETIREE                               -       0
  RETIREE FAMILY MEMBER                 -       0
  OTHER                                 -




 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-62. Provider Group PCM Capacity Screen

1. Enter maximum patient capacity.

   This number should be the maximum number of patients that can be assigned to this PCM for this agreement. **(If left blank, the capacity defaults to unlimited.)**

2. Enter age range to apply to all patient types.

   This number should be the minimum and maximum age to assign for this agreement.

3. The system bypasses the Total Assigned field, which is not editable. The Total Assigned field is incremented and decremented by the system as patients are enrolled/disenrolled to this PCM agreement type.

4. Enter enrollment mix.

   Enter beneficiary types that will be enrolled to this agreement. If a beneficiary type is not entered here, the system will not allow enrollment of any beneficiaries of that type to this PCM agreement. The beneficiary types are:

ADY	Active Duty
AFM	Active Duty Family Member
RET	Retiree
RFM	Retiree Family Member
OTH	Other

   For each beneficiary type entered, complete steps 5-10.

5. Enter age range.

   Age range is a optional field that allows you to limit PCM assignment by age for this agreement type. If blank, no restrictions by age.

6. Enter capacity.

   This is an optional field that allows you to limit PCM assignment by beneficiary type for this agreement type. If blank, capacity is unlimited up to the PCM's maximum overall capacity. If the PCM's overall capacity is blank also, capacity is unlimited up to the group's overall capacity.

7. Total Assigned is an uneditable field that is constantly changing as the patient population is assigned and reassigned to this PCM.

8. Pat Out of Age Range, also uneditable, indicates there are patients assigned to this PCM who are outside the age range allowed for this agreement type.

9. Enter assignment limitations.

   This is a free text, optional field that allows you to enter comments on the assignment limitations.

10. Enter PCM assignment comments.

    This is also a free text, optional field.

11. File the data.

    The system returns you to the Provider Group Agreement History screen.

The Agreement Early Termination Reason screen

When you choose the (T)erminate action on the Provider Group Agreement History screen, the system displays the Agreement Early Termination Reason screen shown in Figure 2-63. Agreement Early Termination Reason Screen, page 2-153.

The top window of this screen lists the provider group name, the agreement type, and the effective dates of the agreement. The cursor is positioned at the New Stop Date field just below the double dotted line.

```
PERIOD OF AGREEMENT: 01 Jan 2001                                GRP AGREE2

                        AGREEMENT EARLY TERMINATION REASON

     Provider Group: ACUTE CR BC
     Agreement Type: CON - CONTRACT
 Dates of Agreement: 01 Jan 2001  -  01 Jan 2005

=========================================================================
               New Stop Date: 01 Jan 2005
            Date FI Notified:

 Reason for terminating agreement earlier than expiration date:


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-63. Agreement Early Termination Reason Screen

1. Enter a new stop date.

   This date defaults with the original stop date. It may be changed here to either earlier or later than the original date. If earlier than the original date, a response in the Reason for Early Termination field is required.

2. Enter date FI notified.

   This field stores the date the FI was notified of the agreement termination.

3. Enter reason for early termination.

   This is a free text field required on early terminations.

4. File the data.

   After you file the data, the system returns you to the Provider Group Agreement History screen.

After all provider group agreement data has been entered, the Provider Group Agreement History screen shows all of the agreements with start and stop dates, discounts and which (if any) agreements for the group are designated as PCM agreements. The Except field will remain blank unless the following exceptions for the specified group agreement have been entered:

Agreements with Specialty Exceptions (displays an "S").

Agreements with CPT code Exceptions (displays a "C").

Exit the Agreements action by entering "Q" for (Q)uit at the Provider Group Agreement History action bar.

The system redisplays the Group Profile/Agreement Maintenance screen (refer to Figure 2-55. Provider Group Profile/Agreement Maintenance Action Bar, page 2-142. Choose the (P)rovider action and add/edit the group providers.

Exit the option or continue defining the providers

Functionality Interactions:

PAS appointment booking interacts with MCP.

Troubleshooting:

If a patient cannot be assigned a PCM, check:

- The agreement enrollment mix to see if the capacity has been reached.
- Is the beneficiary type one that this PCM and agreement type can support?
- Has the agreement expired or does it have a future effective date? A beneficiary may be assigned a PCM on a future date provided the PCM agreement start date is earlier than the enrollment start date.

2.2.1.3 GNET – PROVIDERS

Menu Path: PAS System Menu →MAN →PMCP →GNET

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

Application Description:

This phase of building a provider network identifies the individual providers attached to the place(s) of care within a group. This phase defines provider agreement participation, exceptions, and enrollment mix allowed if the individual provider is designated a PCM. If the group is to be a PCM, this option is used to define those areas as well.

Business Rules:

- All providers for the place of care must be defined here including the group provider if it is to be a PCM.
- MTF providers defined as being in this place of care, must also be assigned to the corresponding PAS Clinic through PAS software.
- If reassigned from one MTF place of care to another, providers must be inactivated from the first MTF place of care and then redefined in the new MTF place of care from this menu option or the INET option.

– Providers may participate in more than one agreement type. For example, a provider may participate in an MTF agreement and a CON agreement.

Other Important Considerations:

Details of an agreement/MOU with civilian providers may be maintained through this option for utilization in Supplemental Care and Managed Care cases.

Maintenance of the group requires constant attention as providers and agreements are in a constant state of flux.

Data Entry Process:

To associate providers with a provider group

Access the GNET option

Enter the group name

Access the (P)roviders action on the Provider Group Profile/Agreement Maintenance action bar

Complete the Individual Provider Profile Screen

Complete the Individual Provider Profile Screen – IND PROF1

Complete the Individual Provider Profile Screen – IND PROF3

Complete the Individual Provider Profile Screen – IND PROF4

Complete the Individual Provider Profile Screen – IND PROF5

Complete the Individual Provider Profile Screen (Place of Care) – IND PL1

Complete the Individual Provider Profile Screen (Place of Care) – IND PL2

Complete the Individual Provider Services Offered Profile Screen

Complete the CP NET HCP Profile – Continuation Screen

Complete the Individual Provider Agreement Participation Screen

Complete the Individual Provider Agreement Exception History Screen

Quit the (P)roviders action

Quit and exit the option

Access the GNET option

Enter the group name

The system displays the Provider Group Profile Screen (refer to Figure 2-48. GRP PRO1 - Provider Group Profile Screen, page 2-132).

1. Press <Next Screen> to bypass the Provider Group Profile screen.

   The system displays the Provider Group Profile/Agreement Maintenance screen (refer to Figure 2-55. Provider Group Profile/Agreement Maintenance Action Bar, page 2-142).

Access the (P)roviders action on the Provider Group Profile/Agreement Maintenance screen

If providers have not been defined, a message displays above the action bar indicating that providers must be entered for the provider group records to be complete.

When you access the (P)roviders action, the system displays the Individual Provider Profile screen (refer to Figure 2-64. Individual Provider Profile Screen, page 2-158).

Complete the Individual Provider Profile screen

```
                        INDIVIDUAL PROVIDER PROFILE


Provider Group: ACUTE CR MTF
-------------------------------------------------------------------------------
   Provider Name
_______________________________________________________________________________
   AUSTIN,GILBERT M



_______________________________________________________________________________
Select (A)dd, (E)dit Profile, Agreement e(X)ceptions, or (Q)uit Providers: A//
```

Figure 2-64. Individual Provider Profile Screen

The Display Window at the top of the Individual Provider Profile screen displays the provider group name.

The Select Window is blank if no providers have been entered. If any providers have been entered, this window displays their names.

The Interact Window contains an action bar with only two actions initially: (A)dd and (Q)uit. If at least one provider has been entered, two additional actions are available: (E)dit Profile and Agreement e(X)ceptions.

(A)dd: This action allows you to add new providers to this provider group.

(E)dit: When you select this action, the system positions the cursor in the Select Window allowing you choose a provider profile to edit. Mark the selection by pressing <Select>. After selecting a provider press <Return> to advance through all the Individual Provider Profile screens for that provider.

Agreement e(X)ceptions: When you select this action, the system positions the cursor in the Select Window, allowing you to choose a provider and edit the exception data. If the group is a PCM, the system does not allow you to edit group agreement exception data from this action.

To add a provider to the group

1. Select the (A)dd action.

   When you select the (A)dd action, the system positions the cursor in the Select Window to the left of the <--*NEW provider may be added here* prompt.

2. Enter the name of the new provider for this place of care.

   The provider name should already have been entered into the Provider and MCP Provider files through the PROV option. You will be unable to enter the provider name here until the provider has been entered through the PROV option (Menu Path: PAS System Menu ➔ MAN ➔ FMCP ➔ PTAB ➔ PROV).

3. Press <Return> to verify the new provider's name.

4. At the Transfer all Group Places of Care to [PROVIDER NAME]? No// prompt, enter "Y" for yes if the provider works in all of the places of care in the group.

   If the provider does not work at all the group places of care, press <Return> to accept the "No" default. When you accept the "No" default, the system prompts you through each group place of care, allowing you to confirm whether or not to transfer that place of care to the provider. This process links the provider with the places of care he may work in within the group. MTF providers must also have schedules in the clinics they are linked to. Schedules are built using the PAS software.

   After transferring places of care to the provider, the system displays the next screen, IND PROF1 - Individual Provider Profile (refer to Figure 2-65. Individual Provider Profile - IND PROF1 Screen, page 2-160).

Complete the Individual Provider Profile Screen – IND PROF1

The IND PROF1 screen displays the provider SSN, and other miscellaneous data about an individual provider.

All provider information required for the IND PROF1 screen has been previously entered through the PROV option, and defaults from the IND PROF1a screen into the IND PROF1 screen.

```
PROVIDER: AUSTIN,GILBERT M                                        IND PROF1

                        INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF

=========================================================================

              SSN#: 654-66-2833             DEA#:
            Gender: MALE                    Rank: CAPTAIN
   Military Status: ACTIVE DUTY
    Signature Line: GILBERT M. AUSTIN MD

  Languages:
  SPANISH



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-65. Individual Provider Profile - IND PROF1 Screen

1. Press <Return> to adavance through all fields in the IND PROF1 screen.

   Any edits required should be done through the PROV option.

   When you press <Return> at the Language field, the system displays the Individual Provider Profile - IND PROF3 screen (refer to Figure 2-66. Individual Provider Profile - IND PROF3, page 2-161).

Complete the Individual Provider Profile – IND PROF3

The IND PROF4 screen displays identification and professional data about a provider.

All the information in IND PROF3 also defaults from data entered through the PROV option.

```
MCP PROVIDER: AUSTIN,GILBERT M                                  IND PROF3

                       INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF

==========================================================================

                     UPIN#: AUSTGM
               CHAMPUS NBR:
    Professional Category: PHYSICIAN (OTHER THAN SURGEON)



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 2-66. Individual Provider Profile - IND PROF3

1. Press <Return> to advance through all fields in the IND PROF1 screen.

   Any edits required should be done through the PROV option.

   When you press <Return> at the Professional Category field, the system displays the Individual Provider Profile - IND PROF4 screen (refer to Figure 2-67. Individual Provider Profile - IND PROF4 Screen, page 2-162).

Complete the Individual Provider Profile – IND PROF4 screen

Information defaults into the IND PROF4 screen from previously entered group information.

```
MCP GROUP PROVIDER: AUSTIN,GILBERT M                                IND PROF4

                      INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF
 ==============================================================================

                  Tax ID#:
            Provider Type: NETWORK INDIVIDUAL PROVIDER

 Payment Address 1: 6625 16th Street
 Payment Address 2:
       Payment Zip: 20307
      Payment City: WASHINGTON
     Payment State: DISTRICT OF COL
     Payment Phone: 202 427-1201
   Payment Contact: Billing Officer



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-67. Individual Provider Profile - IND PROF4 Screen

The following fields are in this screen:

1. TAX ID#: Optional. This should be the tax number for this provider if available. Not currently used in CHCS.

2. PROVIDER TYPE: Required field. The choices are NETWORK, NON-NETWORK, or SINGLE SERVICE Provider. MTF providers and civilian TRICARE providers are always NETWORK.

3. The remaining fields are Payment Address, ZIP, City, State, Phone, and Contact Person. These fields should contain default information previously entered. If not, you may enter group data in these fields. Do NOT change defaulted data. Edit either the place of care (PLAC) or the group (GROU).

4. Press <Return> to advance through all fields.

   After you press <Return> at the last field, the system displays the Individual Provider Profile - IND PROF5 screen (refer to Figure 2-68. Individual Provider Profile - IND PROF5 Screen, page 2-163).

Complete the Individual Provider Profile – IND PROF5 screen

The IND PROF5 screen displays the places of care where this provider works and that have been transferred to him/her. You can only enter places of care for the provider that are linked to the specific provider group. The place of care must be entered at the group level before it can be assigned to a provider within the same group.

```
MCP GROUP PROVIDER: AUSTIN,GILBERT M                              IND PROF5

                       INDIVIDUAL PROVIDER PROFILE

 Provider Group: ACUTE CR MTF

==========================================================================

 Places of Care:
 ACUTE CR MTF


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-68. Individual Provider Profile - IND PROF5 Screen

1. Position the cursor at the desired place of care and press <Return> to access the next screen, Individual Provider Profile - IND PL1 (refer to Figure 2-69. Individual Provider Profile - IND PL1 Screen, page 2-164).

Complete the Individual Provider Profile – IND PL1 screen

The IND PL1 screen displays this provider's specialties at this place of care if they have been previously entered through the PROV option.

```
PLACE OF CARE: ACUTE CR MTF                                          IND PL1

                      INDIVIDUAL PROVIDER PROFILE

       Provider: AUSTIN,GILBERT M
 Provider Group: ACUTE CR MTF
 ==============================================================================

  Specialty(s):
  FAMILY PRACTICE PHYSICIAN



        Position cursor next to the Specialty to edit and press <RETURN>
       or to add a new entry go beneath the last line and press <RETURN>
```

Figure 2-69. Individual Provider Profile - IND PL1 Screen

1. Specialties can be added at this time.

2. Press <Return> to continue to the next screen, IND PL2 (refer to Figure 2-70. Individual Provider Profile - IND PL2 Screen, page 2-165).

   If you press <Next Screen> or <DO>, the system returns to the initial Individual Provider Profile screen.

Complete the Individual Provider Profile – IND PL2 screen

The IND PL2 screen displays the hours of operation for the provider's place of care. This information defaults from the place of care information entered through the PLAC option.

.

```
PLACE OF CARE: ACUTE CR MTF                                          IND PL2

                      INDIVIDUAL PROVIDER PROFILE

       Provider: AUSTIN,GILBERT M
 Provider Group: ACUTE CR MTF
 ==============================================================================

 ------------------------------Hours of Service-------------------------------

  Day of Week            AM                        PM
  MONDAY            0800 -  1200             1201  -  1700
  TUESDAY           0800 -  1200             1201  -  1700
  WEDNESDAY         0800 -  1200             1201  -  1700
  THURSDAY          0800 -  1200             1201  -  1700
  FRIDAY            0800 -  1200             1201  -  1700
                         -                         -

       Position cursor next to the Day of Week to edit and press <RETURN>
       or to add a new entry go beneath the last line and press <RETURN>
```

Figure 2-70. Individual Provider Profile - IND PL2 Screen

1. You may edit this information by positioning the cursor where desired and then making changes.

2. Press <Return> to advance through the fields to access the next screen, Individual Provider Services Offered Profile (refer to Figure 2-71. Individual Provider Services Offered Profile Screen, page 2-166).

Complete the Individual Provider Services Offered Profile screen

```
                    INDIVIDUAL PROVIDER SERVICES OFFERED PROFILE

      Provider: AUSTIN,GILBERT M
 Place of Care: ACUTE CR MTF
Provider Group: ACUTE CR MTF
-------------------------------------------------------------------------------
   CPT-4
   Code   Description
_______________________________________________________________________________




___________________________ No Service(s) Offered found ___________________________
Select (B)lock add, (S)ingle add, or (Q)uit CPT-4 Codes: Q//
```

Figure 2-71. Individual Provider Services Offered Profile Screen

The Individual Provider Services Offered Profile screen displays the provider's name, place of care, and provider group in the Display Window. The Select Window displays CPT codes and their descriptions if the data was entered previously. The Interact Window contains the action bar with the following actions:

(B)lock add: This action allows you to enter multiple blocks of CPT codes for this provider without exiting the action. If you choose this action, you are then prompted to enter a beginning CPT code and then an ending CPT code. You can enter as many blocks of CPT codes as needed.

(S)ingle add: This action allows you to enter only one CPT code for this provider before exiting the action.

(Q)uit CPT-4 codes: This action allows you to exit the Individual Provider Services Offered Profile screen.

If one or more procedures have already been entered for this provider, two additional actions are available:

(V)iew: Allows you to view a procedure's expanded description. To view a procedure, position the cursor next to that procedure and press <F9>.

(D)elete: Allows you to delete a procedure from the provider's profile. Position the cursor beside the procedure, press <Select>, then press <Return>. Press <Return> again at the prompt, *Are you sure you want to delete'[procedure number]' as a Service Offered? No//.*

1. Enter or edit procedures as required according to the actions described above.

2. When finished, press <Return> at the prompt to add another CPT code.

3. Press <Return> to accept the (Q)uit default action.

4. Respond to the prompt, *Do you want to enter/edit PAS Provider Profile information now? Yes//*

   If you answer "NO" initially, you receive a message that "no appointments can be booked for this provider until PAS provider profile information is completed."

   If you answer "YES," you receive the following prompt:

5. Select (A)ctive, (I)nactive appointment types.

   If you select (A)ctive type, the system displays the CP NET HCP Profile – Continuation - Continuation screen (refer to Figure 2-72. CP NET HCP Profile - Continuation - Continuation Screen, page 2-167).

Complete the CP NET HCP Profile – Continuation – Continuation screen

```
PROVIDER: AUSTIN,GILBERT M   CP NET HCP PROFILE -- CONTINUATION -- CONTINUATION

 PROVIDER: AUSTIN,GILBERT M
 CLINIC HOURS: 0800-1700
 LOCATION:
 MAX # OF PATIENT APPTS PER DAY: 100
 APPT ARRIVAL ADVANCE TIME: 10 minutes
 PROVIDER INSTRUCTIONS:
 PRINT ROSTER WITH OPEN APPTS: NO, SHOW BOOKED APPTS ONLY
 INACTIVATION DATE:




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-72. CP NET HCP Profile - Continuation - Continuation Screen

This screen may be blank initially until data is entered. This information pertains to the place of care the provider is linked to. The fields are:

1. PROVIDER: Displays the provider name defaulted from previous entry. When you press <Return> at this field, the system displays a secondary screen that allows you to add a title, provider MEPRS code, duty phone, home phone, and facsimile number if not entered previously through another option.

2. CLINIC HOURS: This is an optional, free text field for entering the provider's hours of operation.

3. LOCATION: This is an optional field for entering the office/room location for this provider.

4. MAX # OF APPTS PER DAY: This is a required field if not previously entered. The number entered here determines the maximum number of appointments that may be scheduled to this provider daily. The number should be high enough to accommodate the maximum number of patients the provider's schedule allows.

5. APPT ARRIVAL ADVANCE TIME: This is an optional, informational field to advise patients how many minutes prior to the actual appointment they should arrive in the clinic.

6. PROVIDER INSTRUCTIONS: This is an optional, informational field to advise patients of special instructions.

7. PRINT ROSTER WITH OPEN APPTS: This is a required field. MTF clinics may elect to show Open slots and booked appointments or only booked appointments by entering either "YES" or "NO."

8. INACTIVATION DATE: A date entered in this field inactivates a provider from a clinic on that date.

9. Respond appropriately to the following prompts:

   Want to transfer all appt types from the clinic profile? YES//

   If you answer "NO," the system displays the next screen where you enter appointment types for this provider.

10. If you accept the "YES" default, the system displays additional prompts:

    Want to display all appointment types first? NO//

Want to automatically transfer ALL appointment types? NO//

If you respond "YES" to either of these two prompts, the system continues through each appointment type in the clinic (group) profile, asking if you want to automatically transfer that appointment type to this provider:

11. *Want to automatically transfer appointment type NEW? YES//*

After responding to the last prompt, the system displays the list of appointment types transferred to this provider as shown in Figure 2-73. Provider Appointment Types Display, page 2-169.

```
PROVIDER: ARRIBA,GILBERT M CP NET HCP PROFILE--CONTINUATION-- ONTINUATION

 Select APPOINTMENT TYPE:
 CON
 FOL
 NEW
 T-CON*



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 2-73. Provider Appointment Types Display

1. Position the cursor on an appointment type and press <Return> to display the appointment type profile.

2. Press the down-arrow key to bypass the appointment types and file the data.

3. After you file the data, press <Return> until you reach the Individual Provider Agreement Participation screen (refer to Figure 2-74. Individual Provider Agreement Participation Screen, page 2-170).

Complete the Individual Provider Agreement Participation screen

This screen displays all the agreements with which this group is associated. Individual providers do not need to participate in all the agreements, but may do so.

If a provider is a PCM, the provider must be a participant of an agreement that has the PCM field set to Y.

```
                    INDIVIDUAL PROVIDER AGREEMENT PARTICIPATION

      Provider: AUSTIN,GILBERT M
Provider Group: ACUTE CR MTF
-------------------------------------------------------------------------------
 Agreement  Effective                      Overall      FI
   Type       Date          Stop Date     Discount  Notified      Except   PCM

 * PIC      01 Jan 2001     01 Jan 2005   CA- 40%
   MTF      01 Jan 2001     01 Jan 2005   CA-100%                           Y
 * CON      01 Jan 2001     01 Jan 2005   CA- 60%





Use SELECT key to select the group agreements in which this provider does NOT
participate.  If the provider participates in all of the group agreements, press
<RETURN> to continue.
```

Figure 2-74. Individual Provider Agreement Participation Screen

1. If a provider does NOT participate in an agreement, position the cursor beside that agreement and press <Select> to mark the non-participating agreement with an asterisk (*).

   Agreements marked with an asterisk (*) on this screen will NOT appear on the provider's Individual Agreement Exception History.

2. If the provider participates in all the agreements, press <Return> and exit this screen to the Individual Provider Profile and the action bar (refer to 2-158.

3. Select the Agreement e(X)ceptions action from the Individual Provider Profile action bar.

   The system displays in the Select Window of the Individual Provider Profile screen, a list of providers linked to this provider group. If this is the first provider entered for the group, only that provider name is listed.

4. Position the cursor beside the provider name and press <Select>. Press <Return> to display the provider's Individual Provider Agreement

Exception History (refer to Figure 2-75. Individual Provider Agreement Exception History Screen, page 2-171).

Complete the Individual Provider Agreement Exception History screen

The Individual Provider Agreement Exception History screen displays all the agreements from the group in which the provider participates. The fields displayed are:

Agreement Type
Effective Date
Stop Date
Overall Discount
FI Notified
Except
PCM

You can edit the data for this provider only. The same data elements will remain unchanged at the group level.

```
                 INDIVIDUAL PROVIDER AGREEMENT EXCEPTION HISTORY

      Provider: AUSTIN,GILBERT M
Provider Group: ACUTE CR MTF
-------------------------------------------------------------------------------
 Agreement  Effective                      Overall      FI
   Type       Date          Stop Date     Discount  Notified      Except   PCM

   MTF      01 Jan 2001     01 Jan 2005   CA-100%                           Y









Select (P)articipation Status, (E)dit Agreement, (S)pecialty Exceptions,
       (C)PT-4 Exceptions, Enrollment (M)ix, or (Q)uit Exceptions: E//
```

Figure 2-75. Individual Provider Agreement Exception History Screen

Action bar choices are:

<u>(P)articipation Status</u>: This action allows you to select agreements in which the provider presently participates. Press <Select> to mark the non-participating

agreements. You can deselect the agreement by positioning the cursor on the agreement and pressing <Select> again.

(E)DIT: This action allows you to choose an agreement to edit for this provider. Press <Select> to mark the agreements. You can deselect the agreement by positioning the cursor on the agreement and pressing <Select> again. Any changes you make to this agreement will be solely for this provider.The Agreement will remain unchanged at the group level.

(S)pecialty Exceptions: This action allows you to add a specialty that has a different discount rate than the group agreement specifies. Select the agreement desired and the system displays the Individual Provider Specialty Exceptions screen. At the prompt, enter the specialty and in the discount field enter the appropriate discount.

(C)PT-4 Exceptions: This action allows you to enter a CPT-4 procedure or a group of procedures that this provider offers at a different discount than the group agreement. Select the agreement desired and enter the code(s) offered at a different discount.

ENROLLMENT (M)IX: This action allows you to define this provider as a PCM, enter a maximum capacity for him/her, designate which beneficiary types they will see, and limit enrollments by age range if desired.

1. Position the cursor beside the agreement to edit for this provider, press <Select>, then press <Return>.

   The system displays the Individual Provider PCM Capacity screen (refer to Figure 2-76. Individual Provider PCM Capacity Screen, page 2-173).

Complete the Individual Provider PCM Capacity screen

PCM capacities are established by beneficiary categories and by age on this screen.

The first four fields at the top of this screen show the provider name, provider group name, agreement type, and dates of the agreement. The cursor is positioned at the PCM field.

```
                        INDIVIDUAL PROVIDER PCM CAPACITY

           Provider: ENRIQUEZ,FRANK M
     Provider Group: ACUTE CR MTF
     Agreement Type: MTF - MTF STAFF
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
                PCM: YES

 Maximum Patient Capacity: 500     Age Range to Apply Overall:     -
           Total Assigned: 1
===============================================================================
                                                                Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
-------------------------------------------------------------------------------
  ACTIVE DUTY                            -       250         1
  ACTIVE DUTY FAMILY MEMBER              -       250
  RETIREE                                -
  RETIREE FAMILY MEMBER                  -
  OTHER                                  -

 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-76. Individual Provider PCM Capacity Screen

1. Enter "YES" or "NO" at the PCM field to indicated whether this specific provider is designated as a PCM.

2. Enter maximum patient capacity.

   The default is 500.

3. Enter the age default range of patients this provider will accept. The default will be applied to all patient types.

For each patient type, complete steps 4-6:

4. Enter the age range and capacity for each of the patient types this provider will see.

   The total assigned fields are maintained automatically by the system, as patients are enrolled, disenrolled, or reassigned to a different provider/ provider group.

   The system displays the second page of the Individual Provider PCM Capacity screen.

5. Enter assignment limitations, if any.

6. Enter assignment comments, if any.

   These are optional word processing fields to describe any assignment limitations specific to this provider.

Quit the (P)roviders action

Enter (Q)uit at every action bar until you reach the *Select Provider Group* prompt.

Quit and exit the option

Press <Return> at the *Select Provider Group* prompt to return to the Provider Network Management menu.

The procedures above for entering new agreements and new providers are also the procedures to edit agreements and providers agreements within the group. The procedure for activating a PCM is listed in the following section.

Functionality Interactions:

Entering Agreements and Providers is essential for MCP Booking and Enrollments. If not entered correctly for the expectations desired, MCP patients may not be enrolled as desired.

Schedules for MCP "MTF" providers are built using the PAS functionality. Based on the search criteria entered when booking appointments in MCP, the appropriate MTF provider schedules will display.

Troubleshooting:

If providers cannot be seen when assigning a PCM to an enrolled patient or when booking, you must go through each agreement and provider profile to ensure they are PCMs, capacity is correct, they are attached to the correct place of care, and they have the correct specialty. The Provider Group Report will print this data so it can be reviewed easily for a selected provider (refer to Figure 2-89. Provider Group Report - Places of Care, page 2-200).

If unable to enroll a patient because of "Network" data, review the enrollment mixes for the group/provider as well as the agreement and specialty of the provider.

2.2.1.4 GNET - INACTIVATION

Menu Path: PAS Menu → MAN → PMCP → GNET → Provider Group → Screen GRP PRO1 → Screen PROVIDER GROUP PROFILE/AGREEMENT MAINTENANCE → (I)nactivate/Reactivate

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

Required Fields:

Inactivation Date
Reason for Inactivation/Reactivation

Application Description:

This action is used to inactivate a place of care, or Individual Providers within MCP. This does not inactivate them for DBA or inactivate them in PAS if present there.

Business Rules:

- The inactivation/reactivation date must be in the future.
- Patients may not be assigned to the providers or place of care being inactivated.
- There may not be any booked appointments, referrals or wait list requests at the provider places of care being inactivated.

Data Entry Process:

<u>To Inactivate/Reactivate a group or provider place of care or an individual provider through the GNET menu option</u>

Access the GNET option

Access the Provider Group Inactivate/Reactivate Maintenance screen

Complete the inactivation/reactivation action desired

Exit the option

Access the GNET option

1. Enter the group name to access the Group Provider Profile screen.
2. Press <Next Screen> to access the Provider Group Profile/Agreement Maintenance screen.

Access the Provider Group Inactivate/Reactivate Maintenance screen

```
                    PROVIDER GROUP PROFILE/AGREEMENT MAINTENANCE



Provider Group: ACUTE CR MTF
_______________________________________________________________________________



_______________________________________________________________________________
Select (A)greements, (P)roviders, (I)nactivate/Reactivate, or (Q)uit: A//
```

Figure 2-77. Provider Group Profile/Agreement Maintenance

1. Select the (I)nactivate/Reactivate action on the Provider Group Profile/ Agreement Maintenance action bar.

   The system displays the Provider Group Inactivate/Reactivate Maintenance screen (refer to Figure 2-78. Provider Group Inactivate/ Reactivate Maintenance Screen, page 2-177).

Complete the inactivation/reactivation action desired

The Provider Group Inactivate/Reactivate Maintenance Screen allows you to choose whether to inactivate or reactivate an individual provider, an individual provider's place of care, or a group place of care.

```
                PROVIDER GROUP INACTIVATE/REACTIVATE MAINTENANCE


Provider Group: ACUTE CR MTF
________________________________________________________________________________________________________________
________________________________________________________________________________________________________________
Select (G)roup Place of Care, (P)rovider Place of Care, (I)nactivate Provider,
       or (Q)uit: Q//
```

Figure 2-78. Provider Group Inactivate/Reactivate Maintenance Screen

Actions on the Provider Group Inactivate/Reactivate Maintenance action bar are:

(G)roup Place of Care: Allows you to inactivate a place of care for all providers within the group.

(P)rovider Place of Care: Allows you to inactivate a place of care for a specific provider.

(I)nactivate Provider: Allows you to inactivate a provider.

(Q)uit: Allows you to quit and return to the Provider Group Profile/Agreement Maintenance.

To Inactivate/reactivate a group place of care

1. Select the (G)roup Place of Care action on the Provider Group Inactivate/ Reactivate Maintenance action bar.

   The system displays the Place of Care Inactivation/Reactivation in One Group Screen with a list of places of care for that group in the Select Window.

2. Position the cursor beside the place of care you want to inactive/reactivate and press <Select>.

   The system displays the Inactivation/Reactivation of Place of Care screen (refer to Figure 2-79. Inactivation/Reactivation of Place of Care Screen, page 2-178).

```
                INACTIVATION/REACTIVATION OF PLACE OF CARE

Provider Group: ACUTE CR MTF
 Place of Care: ACUTE CR MTF
==========================================================================


Inactivation Date:
Reactivation Date:

Reas on for Inactivation/Reactivation:





 Help = HELP     Exit = F10    File/Exit = DO                  INSERT OFF
```

Figure 2-79. Inactivation/Reactivation of Place of Care Screen

1. Enter the inactivation or reactivation date.

   If the current date lies between the inactivation date and the reactivation date, or if there is an inactivation date before today's date without a reactivation date, then the place of care is considered inactive.

   If the current date lies on or after the reactivation date, or if there are no inactivation and reactivation dates, then the place of care is considered active.

   The system allows you to enter dates only on or after the current date.

2. Enter reason for inactivation or reactivation.

   If discrepancies are present, the systems displays them (refer to Figure 2-80. Place of Care Discrepancy Warning Message - Group, page 2-179). You can then generate the Discrepancy Avoidance report if discrepancies exist.

Discrepancies must be resolved before you can inactivate/reactivate a place of care.

If there are no discrepancies, CHCS allows you to inactivate the group place of care.

```
Checking for Place of Care Discrepancies.......

WARNING: Place of Care can not be inactivated due to the following reasons:

     * Patients are assigned to PCMs at the selected Place of Care.
     * There are booked appointments, referrals and/or wait list requests
       for providers at the selected Place of care.
     * This is a providers only Place of Care.

            Please refer to the Discrepancy Avoidance Report



Press <RETURN> to continue
```

Figure 2-80. Place of Care Discrepancy Warning Message - Group

To inactivate/activate a provider place of care

1. Select the (P)rovider Place of Care action at the Provider Group Inactivate/ Reactivate Maintenance action bar.

   The system displays the Individual Provider Profile Inactivate/Reactivate screen with a list of places of care for the group in the Select Window.

2. Position the cursor beside the place of care you want to inactivate and press <Select>.

   The system replaces the places of care with a list of providers linked to the place of care you just selected. Names of currently active providers are bolded.

3. Position the cursor beside the provider for whom you want to inactivate that place of care and press <Select> and then press <Return>.

   The system displays the Inactivation/Reactivation of Place of Care Screen (refer to Figure 2-79. Inactivation/Reactivation of Place of Care Screen, page 2-178).

4. Enter the inactivation/reactivation date.

   Inactivation/reactivation dates must be in the future.

   If there are discrepancies, the system will display a warning message (refer to Figure 2-80. Place of Care Discrepancy Warning Message - Group, page 2-179).

   Discrepancies must be resolved before you can inactivate/reactivate a place of care.

   If there are no discrepancies, CHCS allows you to inactivate the group place of care.

Exit the option

Functionality Interactions:

There are no interactions with any other functionality.

Troubleshooting:

Inactivated entries will remain visible when accessing groups and places of care. They will be appear dimmed and should not interfere in the normal processes.

2.2.1.5 PCM ACTIVATION

Menu Path: Please refer to the path specified for each of the four PCM Flags.

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

Application Description:

Designating an individual provider or a group provider as a PCM is done through this menu option and may be done as the group is built or afterwards. This section is presented separately to provide as little confusion as possible. **There are four (4) flags to set to YES when designating PCMs**; however, not all of them are required to be set to YES.

Business Rules:

- PCMs must be defined before any Enrollments/Empanelments can start.
- PCMs must be defined before establishing UIC/PCM links.
- PCMs must be defined as NETWORK provider types.
- If the Individual PCMs work at more than one place of care within a group, enrolled patients may only be seen at one place of care.
- If the group provider does not have a schedule, and all individual providers in the group are PCMs, all schedules for all providers will display in PCM Booking.
- If the group provider does not have a schedule, and only some individual providers in the group are PCMs, only the schedules for the PCMs in the group will display.
- If the patient's PCM is an individual provider, only that provider's schedule will display.

Other Important Considerations:

The MTF must decide before hand whether or not groups will be PCMs. If so, will some or all providers be PCMs? Schedules display according to who are designated as PCMs and whether the group provider has a schedule.

If a group has multiple places of care and a provider acting as a PCM works at more than one location, the MTF must decide which place of care to send the enrollees to and enroll them to that place of care.

Data Entry Process:

<u>To create PCMs</u>

Create the GROUP PROVIDER AS A PCM
Create the GROUP PCM SPECIALTIES
Create the PCM AGREEMENT TYPES
Create the INDIVIDUAL PCM PROVIDERS
GROUP PROVIDER AS A PCM

Menu Path: PAS → MAN → PMCP → GNET → Provider Group → Activate Group Provider: **YES**

Access the menu option GNET and enter the group name at the *Provider Group* prompt . The first screen accessed is the screen GRP PRO1 – PROVIDER GROUP PROFILE. This screen allows the user to define demographic and place of care information.

```
MCP PROVIDER GROUP: ACUTE CR MTF                                        GRP PRO1

                            PROVIDER GROUP PROFILE

 ==============================================================================
          Short Group ID: ACCM
                 Tax ID#:
          CHAMPUS Number:
           Provider Type: NETWORK PROVIDER GROUP
 Activate Group Provider: YES

 Payment Address 1: 6625 16th Street
 Payment Address 2:
       Payment Zip: 20307
      Payment City: WASHINGTON
     Payment State: DISTRICT OF COL
     Payment Phone: 202 427-1201       Payment Contact: Billing Officer

  Places of Care:
  ACUTE CR MTF



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 2-81. GRP PRO1 – Provider Group Profile

1. The Activate Group Provider field should be set to YES to make the group a PCM. **This is the first flag to set**. Use the down-arrow key to move down the screen and bypass the place of care field. File and access the next screen PROVIDER GROUP PROFILE/AGREEMENT MAINTENANCE.

GROUP PCM SPECIALTIES

Menu Path: PAS → MAN → PMCP → GNET → Provider Group → Bypass Place of care → (P)roviders → (E)dit → Select Group

Select (P)roviders from the action bar and access the INDIVIDUAL PROVIDER PROFILE. The name of the group now displays among the individual providers because of the first flag set.

Select (E)dit from the action bar and select the group provider. The system then accesses the screen IND PROF – GROUP PROVIDER PROFILE. This screen displays defaulted information from the group profile such as address and the Place(s) of Care. Press <Return> until the system access the next screen. Do not press <Do> or <Next> to access this screen, IND PL1 – INDIVIDUAL PROVIDER PROFILE.

```
PLACE OF CARE: ACUTE CR MTF                                          IND PL1

                      INDIVIDUAL PROVIDER PROFILE

       Provider: ACUTE CR MTF
  Place of Care: ACUTE CR MTF
 Provider Group: ACUTE CR MTF
=========================================================================
  Specialty(s)                                            PCM
-------------------------------------------------------------------------
  FAMILY PRACTICE PHYSICIAN                               YES
  FAMILY PRACTICE/PRIMARY CARE                            NO
  PRIMARY CARE NURSE PRACTITIONER QUALIFIED               NO




                 Position cursor next to the last entry and
                     Press the Down Arrow key to exit.
```

Figure 2-82. Individual Provider Profile, IND PL1 Screen

1. Screen IND PL1 displays all specialties represented by the individual providers in the group. To the right of the Specialties displayed is the PCM field with all entries set to NO initially. Set the PCM field to YES for each provider specialty linked to the group provider. **This is the second flag to set**.

2. Position the cursor next to the desired specialty and press <Return> to reach the PCM field. After the desired specialties have been activated, you must exit this screen using the down-arrow key.

3. Next you will receive a prompt to enter PAS Profile information on the group Provider and then Appointment Types. If you answer "YES," the system displays a new action bar:

   Select (A)ctive, (I)nactive appointment types, or (Q)uit: A//

4. Press <Return> to accept the (A)ctive action and display the CP NET HCP PROFILE (refer to 2-184).

```
PROVIDER: ACUTE CR MTF   CP NET HCP PROFILE -- CONTINUATION -- CONTINUATION

 PROVIDER: ACUTE CR MTF
 CLINIC HOURS:
 LOCATION:
 MAX # OF PATIENT APPTS PER DAY:  100
 APPT ARRIVAL ADVANCE TIME:    minutes
 PROVIDER INSTRUCTIONS:
 PRINT ROSTER WITH OPEN APPTS:  YES, print rosters with open appts
 INACTIVATION DATE:
```

Figure 2-83. CP NET HCP Profile Screen

1. When completed, you will receive prompts to accept the Appointment types from the place of care. When completed and filed, you are returned to the screen IND PROF. The cursor in this screen is positioned at the place of care. If you press <Return>, you are returned to the specialty screen. Use the down-arrow key instead to file the data.

2. Repeat this process for each place of care linked to the group provider.

PCM AGREEMENT TYPES

Menu Path: PAS → MAN → PMCP → GNET → Provider Group → Bypass Place of care → (A)greements → Enrollment (M)ix → Select Agreement Type → Activate Group PCM: **YES**

```
                          PROVIDER GROUP PCM CAPACITY

     Provider Group: ACUTE CR MTF
     Agreement Type: MTF - MTF STAFF
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
 Activate Group PCM: YES

 Maximum Patient Capacity:500        Age Range to Apply Overall:     -
           Total Assigned:15
===============================================================================
                                                                Total     Pat Out of
 Enrollment Mix                     Age Range   Capacity   Assigned   Age Range
-------------------------------------------------------------------------------
  ACTIVE DUTY                           -       250        11
  ACTIVE DUTY FAMILY MEMBER             -       250        4
  RETIREE                               -       0
  RETIREE FAMILY MEMBER                 -       0
  OTHER                                 -




 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-84. Provider Group PCM Capacities

1. After selecting and accessing the desired Agreement type to set the flag, the cursor will be positioned at the ACTIVATE GROUP PCM field. Set this to YES to activate the group agreement. **This is the 3rd flag to set**.

2. You may also set capacities for this agreement if not done so yet.

INDIVIDUAL PCM PROVIDERS

Menu Path: PAS → MAN → PMCP → GNET → Provider Group → Bypass Place of care → (P)roviders → Agreement E(X)ceptions → Select provider desired → Enrollment (M)ix → Select Agreement Type → PCM: **YES**

This screen allows you to define an individual provider as a PCM and establish enrollment capacities.

```
                        INDIVIDUAL PROVIDER PCM CAPACITY

           Provider: ENRIQUEZ,FRANK M
     Provider Group: ACUTE CR MTF
     Agreement Type: MTF - MTF STAFF
 Dates of Agreement: 01 Jan 2001 - 01 Jan 2005
                PCM: YES

 Maximum Patient Capacity: 500     Age Range to Apply Overall:     -
           Total Assigned: 1
================================================================================
                                                          Total     Pat Out of
 Enrollment Mix                    Age Range   Capacity   Assigned   Age Range
--------------------------------------------------------------------------------
  ACTIVE DUTY                          -       250        1
  ACTIVE DUTY FAMILY MEMBER            -       250
  RETIREE                              -
  RETIREE FAMILY MEMBER                -
  OTHER                                -



 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 2-85. Individual Provider PCM Capacity Screen

1. To set up an individual Provider as a PCM, access the (P)roviders, then the Agreement e(X)ceptions and finally Enrollment (M)ix. Select the Agreement Type this provider will participate in as a PCM and set the field PCM to YES. **This is the 4th flag to set**.

2. If all the providers within the group are PCMs, it is not necessary to set the individual provider PCM flags. The system assumes that all providers in the group are PCMs.

Troubleshooting:

Most problems occur when the wrong flag is set or not enough are set. If unable to access the desired PCM or the desired specialty, review all flags to ensure they are set correctly. The most commonly forgotten flag is the specialty.

Review your MTF policy as to whom or what the PCMs will be and adjust your groups as necessary.

2.2.2 Individual Provider Profile/Agreements Enter/Edit

Menu Path: PAS Menu → MAN → PMCP → INET

Security Keys:

CPZ CCP
CPZ FILE
CPZ AGREEMENT
CPZ LOWCAP
CPZ NET

Required Fields:

The required fields are the same as those in GNET.

Application Description:

The Individual Provider Profile/Agreements Enter/Edit option allows you to enter or edit individual provider profile and agreement data for selected MCP providers. In addition, you can inactivate or reactivate MCP providers or the providers' places of care. A provider can also be added as a new member to an existing MCP provider group. While adding or editing places of care, you can use the Provider Profile Enter/Edit option to update provider profiles, since no appointments can be booked for the provider until PAS provider profile information is entered.

Business Rules:

See the business rules in section 2.2.1 (GNET)

Other Important Considerations:

Any action taken through this menu option may also be done through the Group Profile/Agreements Enter/Edit (GNET) menu option.

Data Entry Process:

<u>To add a new member to an existing MCP Provider Group</u>

Access the INET option on the Provider Network Management Menu

Enter the provider name to process

Select the (A)dd action on the Individual Provider Profile/Agreement Maintenance Screen actiion bar

Enter the new Provider Group name and verify that the provider name and group name are correct

Transfer some, all, or none of the group places of care to the provider

Press <Return> through the Individual Provider Profile -- IND PROF1 screen

Press <Return> through the Individual Provicer Profile -- IND PROF3 screen

Press <Return> through the Individual Provicer Profile -- IND PROF4 screen

Select the provider's place(s) of care on the Individual Provider Profile – IND PROF5 screen

Press <Return> at the provider's specialty on the Individual Provider Profile – IND PL1 screen

Enter hours of service on the Individual Provider Profile -- IND PL2 screen

Enter procedures offered by the provider

Enter PAS Profile information

Enter Active appointment types

Access the INET option on the Provider Network Management Menu

The system displays the Individual Provider Profile/Agreement Maintenance screen (refer to 2-189).

```
                INDIVIDUAL PROVIDER PROFILE/AGREEMENT MAINTENANCE

      Provider:
Provider Group:
_____________________________________________________________________________




_____________________________________________________________________________
Select Provider:
```

Figure 2-86. Individual Provider Profile/Agreement Maintenance Screen

Enter the provider name to process

After you enter and verify the provider name, the system replaces the *Select Provider* prompt with this action bar:

> Would you like to (A)dd '[PROVIDER NAME]' to a new group,
> (C)ontinue to process as a member of [GROUP NAME]'
> or (Q)uit: C//

Select the (A)dd action on the Individual Provider Profile/Agreement Maintenance Screen action bar

The system replaces the action bar with the *Select new Provider Group* prompt.

Enter the new Provider Group name and verify that the provider and group names are correct

The system asks if you want to transfer all group places of care to this provider. The default is "NO." If the provider does not work at all places of care for this provider group, accept the "NO" default.

Transfer some, all, or none of the group places of care to the provider

When you accept the "NO" default at the previous prompt, the system prompts you, one by one, to indicate which of the group places of care to transfer to this provider. Press <Return> to accept the "YES" default for each place of care where the provider works. Otherwise, enter "N" for NO.

When you have responded to the last prompt to transfer places of care, the system displays the Individual Provider Profile -- IND PROF1 screen (refer to 2-160).

Press <Return> to advance through the Individual Provider Profile -- IND PROF1 screen

Refer to Figure 2-65. Individual Provider Profile - IND PROF1 Screen, page 2-160.

Press <Return> to exit the Language field.The system displays the Individual Provider Profile, IND PROF3 screen (refer to 2-161).

Press <Return> to advance through the Individual Provider Profile -- IND PROF3 screen

Refer to Figure 2-66. Individual Provider Profile - IND PROF3, page 2-161.

Press <Return> at the Professional Category field. The system displays the Individual Provider Profile -- IND PROF4 screen (refer to 2-162).

Press <Return> to advance through the Individual Provider Profile -- IND PROF4 screen

Refer to Figure 2-67. Individual Provider Profile - IND PROF4 Screen, page 2-162.

Press <Return> at the Payment Contact field. The system displays the Individual Provider Profile -- IND PROF5 screen (refer to Figure 2-68. Individual Provider Profile - IND PROF5 Screen, page 2-163)

Select the provider's place(s) of care on the Individual Provider Profile -- IND PROF5

Refer to Figure 2-68. Individual Provider Profile - IND PROF5 Screen, page 2-163.

Press <Return> at the provider's place of care. The system displays the Individual Provider Profile -- IND PLI screen (refer to Figure 2-69. Individual Provider Profile - IND PL1 Screen, page 2-164).

Press <Return> at the provider's specialty on the Individual Provider Profile -- IND PLI1 screen

Refer to Figure 2-69. Individual Provider Profile - IND PL1 Screen, page 2-164.

Press <Return>, the system displays the Individual Provider Profile -- IND PL2 screen (refer to Figure 2-70. Individual Provider Profile - IND PL2 Screen, page 2-165).

Enter hours of service on the Individual Provider Profile Profile -- IND PL2 screen

Refer to Figure 2-70. Individual Provider Profile - IND PL2 Screen, page 2-165.

Press <Return> to exit this screen. The system displays the Individual Provider Services Offered Profile screen (refer to 2-166).

Enter procedures offered by the provider at this place of care

Refer to Figure 2-71. Individual Provider Services Offered Profile Screen, page 2-166.

At the Individual Provider Services Offered Profile screen, you can choose to add procedures as a block or singly, view procedures, delete procedures, or quit.

Enter PAS Profile information

When you finish entering procedures, the system asks if you want to enter/edit the provider's PAS profile information. If you enter "N" for NO, the following message is displayed:

> **WARNING** No appointments can be booked for this Provider until PAS Provider Profile information is entered!
>
> Press <RETURN> to continue

If you accept the YES default, the system displays the following action bar:

> Select (A)ctive, (I)nactive appointment types, or (Q)uit: A//

Enter Active appointment types

When you accept the (A)ctive default, the system displays the CP NET HCP Profile screen (refer to Figure 2-72. CP NET HCP Profile - Continuation - Continuation Screen, page 2-167).

Complete the CP NET HCP PROFILE -- Continuation --Continuation screen

Refer to Figure 2-72. CP NET HCP Profile - Continuation - Continuation Screen, page 2-167.

Answer all the prompts for each appointment type displayed

For each place of care, you may enter/edit the Specialty(s) and Hours of Service fields, then process CPT-4 codes to indicate the procedures offered by the provider.

If you enter C, you proceed into the INDIVIDUAL PROVIDER PROFILE AGREEMENT MAINTENANCE screen seen in GNET.

The action bar seen in this screen is:

Select (E)dit profile, Agreement e(X)ceptions, (I)nactive Provider, (P)lace of Care Inactivate/Reactivate, or (Q)uit Provider:

1. (E)dit allows you to edit the MCP Profile.
2. Agreement e(X)ceptions allows you to edit the agreements for this provider. (Refer to section 2.2.1.3 GNET PROVIDERS, Data Entry Process # C, page 2-155)
3. (I)nactivate Provider allows you to inactivate an individual provider as in GNET section 2.2.1.4, page 2-175.
4. (P)lace of Care Inactivate/Reactivate allows you to inactivate a provider from a place of care as in GNET section 2.2.1.4.
5. You may enter Q to quit and exit.

Initial Data Entry:

Individual Provider Profile/Agreement Maintenance screen

Enter the provider's name, last name first. If the provider does not yet belong to a provider group, you must add the provider to a new provider group before proceeding to the initial action bar. If the provider already belongs to one provider group, you can either proceed directly to the initial action bar, or add the provider to another provider group before proceeding to the initial action bar. If the provider belongs to more than one provider group, you must select the provider group to be used before proceeding to the initial action bar.

(A)dd to a Provider Group:

If you add the provider to a provider group, you will be prompted to edit the provider profile. First, the system will prompt you to indicate whether to transfer all group places of care, individual places of care, or none at all to the provider.

Enter the Provider Profile Enter/Edit option to enter the information for the provider profile. Provider profile data is required before appointments can be booked for the provider. This procedure will be performed for each place of care entered for the provider. You may then continue editing, file the data entered, or quit this action without filing.

If the provider is inactivated, you will see an initial action bar that enables you to reactivate the provider using the INACTIVATE PROVIDER action or quit the initial action bar. If you elect to quit, it will return to the initial *Select PROVIDER* prompt where you can select another provider to process, or exit the option.

If the provider is activated, the initial action bar will allow you to edit the provider profile, process agreement exceptions, inactivate the provider, inactivate or reactivate the place of care, or quit the provider action. If you elect to quit at this action bar, the system will return to the initial *Select PROVIDER* prompt where you may select another provider to process, or exit the option.

(C)ontinue

Use the INET Option to Edit an Individual Provider Profile

If you edit the provider profile at the initial action bar, the system will display the Individual Provider Profile screens and allow data entry for the profile data fields. If you make changes to the Places of Care field(s), it will allow you to enter the Provider Profile Enter/Edit option to update the provider profile information as described in the previous section.

> Note: The individual provider profile can be edited using either the Group Profile/Agreements Enter/Edit (GNET) option or the Individual Provider Profile/Agreements Enter/Edit (INET) option. The INET option is not used to create a new provider profile. It can, however, be used to add a provider to a group. The provider's specialties and languages, gender, military rank, military status, and professional category should be entered using the Provider Enter/Edit option on the Provider Network File/Table Maintenance Menu. Use the INET option, instead of GNET, when updating an individual provider's profile.
>
> This will save time because the group profile screens do not display.

After making changes, you may file the data entered, continue editing, or to exit this action without filing. After either filing or exiting without filing, you will return to the initial action bar.

Functionality Interactions:

There is no interaction with any other functionality.

Troubleshooting:

Please refer to the section on GNET for troubleshooting processes.

2.2.3 Modify Group Agreement Effective Date (MNET)

Menu Path: PAS Menu → MAN → PMCP → MNET

Application Description:

The Modify Group Agreement Effective Date option allows you to modify the effective date of an agreement for a provider group. Each modification causes the system to produce an agreement history record; these records are numbered and sorted in chronological order. This option also allows you to view the agreement history records.

Data Entry Process:

Overview:

The system enables you to proceed through the Managed Care Program Menu to the Provider Network Management Menu and select the Modify Group Agreement Effective Date option.

Action Bar: (S)earch Criteria, (V)iew Agreement History, or (Q)uit

The system prompts you to begin by selecting an action from the main action bar. This action bar enables you to select either to specify search criteria for an agreement search, to view an agreement history record, to enter a new effective date for the current provider group agreement, or to quit the option.

Main Action Bar, Search Criteria

The system displays such search criteria as group and agreement type. The system prompts you to select the criteria to enter. The group and agreement type criteria are mandatory. The system then prompts you to enter data for each of the criteria selected.

Then the system lists all agreements meeting the search criteria, and prompts you to select the desired agreement.

Then the system returns to the action bar described in the "MAIN ACTION BAR" section.

Main Action Bar, View Agreement History:

The system displays a list of the agreements for the group and prompts the user to select the agreement history record to view. Then the system displays the MCP View Modified Agreements screen. This screen displays data such as provider group, agreement type, agreement original start date, agreement amended start date, agreement original stop date, PCM count, referral count, discount rate, fee base, PCM status, and original date FI notified.

When you are finished with this screen, the system returns to the action bar described in the "MAIN ACTION BAR" section.

Main Action Bar, New Agreement Effective Date:

The system prompts you to accept the default effective date already on record for the selected agreement or to enter a new agreement effective date. The system then allows you to proceed with the change or to exit the action. If you elect to proceed, the system automatically generates a mail message as notification of the change.The system then returns to the action bar described in the "MAIN ACTION BAR" section.

Main Action Bar, Quit:

The system allows you to select quit at the main action bar to exit the option.

2.2.4 Outputs and Network Management Reports Menu (ONET)

2.2.4.1 Group Management Reports Menu (GMRM)

2.2.4.1.1 #1 Group Member Roster

Menu Path: PAS Menu → MAN → PMCP → ONET → GMRM → #1

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Group Member Roster option allows you to print a roster listing TRICARE provider groups, TRICARE providers within groups, and specialties and agreements pertaining to the providers. You can selectively generate the roster for one, multiple, or all provider groups.

Use/Frequency:

As needed.

Report Sample:

```
WALTER REED AMC                                        21 Jun 2001@1422    Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                               GROUP MEMBER ROSTER
                                   ACUTE CR MTF
GROUP DMIS ID(S): 6015                        GROUP TAX ID:
================================================================================
Provider Name                   UPIN         Tax ID           DMIS ID
    Specialty
    Agreement Type                                Effective Dates      Disc %
================================================================================
ALCALA,GILBERT M                ALCAGM                        6015
    FAMILY PRACTICE PHYSICIAN
    CON - CONTRACT                                01Jan01-01Jan05      CA-60%
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

AUSTIN,GILBERT M                AUSTGM                        6015
    FAMILY PRACTICE PHYSICIAN
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF
    PIC - PARTNER INTERNAL                        01Jan01-01Jan05      CA-40%

BATES,SHARON M                  BATESM                        6015
    FAMILY PRACTICE PHYSICIAN
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

CARBONARA,KYLE M                CARBKM                        6015
    PRIMARY CARE NURSE PRACTITIONER QUALIFIED
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

DANSON,ALICE M                  DANSAM                        6015
    FAMILY PRACTICE PHYSICIAN
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

ENRIQUEZ,FRANK M                ENRIFM                        6015
    PRIMARY CARE NURSE PRACTITIONER QUALIFIED
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

FINTO,LUISA M                   FINTLM                        6015
    FAMILY PRACTICE/PRIMARY CARE
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

GABRIEL,JOHN M                  GABRJM                        6015
    FAMILY PRACTICE/PRIMARY CARE
    MTF - MTF STAFF                               01Jan01-01Jan05      MTF

PONY,ALAN O                     34634                         6015
    FAMILY PRACTICE PHYSICIAN
    CON - CONTRACT                                01Jan01-01Jan05      CA-60%

PUNTA,ARLENE P                  83274                         6015
    FAMILY PRACTICE PHYSICIAN
    PIC - PARTNER INTERNAL                        01Jan01-01Jan05      CA-40%
```

Figure 2-87. Group Member Roster

2.2.4.1.2 #2 Provider Group Report

Menu Path: PAS Menu → MAN → PMCP → ONET → GMRM → #2

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Provider Group Report option allows you to print a report by selected TRICARE provider group(s) and report section(s). You can select to print the report for One, Multiple, or All provider groups, and within the selected group(s), you can specify the section(s) to print.

The following sections are available for selection to be printed: group information, places of care, agreements and providers, PCMs, group level exceptions, and individual provider exceptions. Each section requested is printed on a separate page.

Use/Frequency:

As needed. This report should be run whenever a provider, particularly a PCM, is updated in the File and Table Build functions. The report should be used to validate the completeness and correctness of the total information set up for the provider. This report should be used to verify that:

- all places of care have been set up and are activated
- places of care are not duplicated
- groups and their members are appropriately defined and activated
- all specialties have been indicated for the provider and provider group
- individual provider agreement start and stop dates are within the group agreement start and stop dates
- the group is designated as a PCM if any group member is a PCM
- PCM enrollment mixes/capacities are set up correctly

- PCM capabilities have been entered correctly at the group and group member levels, including definition of the correct places of care and appropriate **specialties** indicated as primary care for the provider
- the maximum PCM capacities are set up consistently for the group and for each group member
- general verification of all provider data as needed.

Report Sample:

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 1

                Personal Data - Privacy Act of 1974 (PL 93-579)
                             PROVIDER GROUP REPORT
                           *** Group Information ***

GROUP:  ACUTE CR MTF
==============================================================================
           Short Group ID:  ACCM
                  Tax ID#:
              CHAMPUS Nbr:
        MCP Provider Type:  NETWORK PROVIDER GROUP


        Payment Address 1:  6625 16th Street
        Payment Address 2:
             Payment City:  WASHINGTON
            Payment State:  DC
         Payment Zip Code:  20307
            Payment Phone:  202 427-1201
          Payment Contact:  Billing Officer
```

Figure 2-88. Provider Group Report - Group Information

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 2

                Personal Data - Privacy Act of 1974 (PL 93-579)
                             PROVIDER GROUP REPORT
                             *** Places of Care ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
            Place of Care:  ACUTE CR MTF
            Building Name:
          Building Number:
           Street Address:  6885 16TH STREET
                     City:  WASHINGTON
                    State:  DC
                 Zip Code:  20307
               Appt Phone:  202 271-5851
         Type of Facility:  MULTISERVICE CLINIC
                 Division:  DIV A - TRAINING HOSPITAL
               Department:  PRIMARY CARE DEPARTMENT
                  Service:  PRIMARY CARE SERVICE
               MEPRS Code:  BGAA
           Cost Pool Code:
              Clinic Type:  COUNT
            Location Type:  CLINIC
 Clinic Appt Instructions:  Arrive 10 minutes early.

Appt Type/         Workload      Referral   Pull Patient   Send
  Instructions     Type          Required   Record         Reminder
================================================================================
CON                COUNT            Y           Y             Y
FOL                COUNT            N           Y             Y
NEW                COUNT            Y           Y             Y
T-CON*             COUNT                        Y
```

Figure 2-89. Provider Group Report - Places of Care

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 3

                Personal Data - Privacy Act of 1974 (PL 93-579)
                             PROVIDER GROUP REPORT
                        *** Agreements and Providers ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
                                                Effective    Stop       Overall
Agreement  Agreement Name                         Date       Date       Discount
_________  _________ ____                      _________   ____       ________
CON        CONTRACT                             01 Jan 01  01 Jan 05    CA- 60%
MTF        MTF STAFF                            01 Jan 01  01 Jan 05    CA-100%
PIC        PARTNER INTERNAL                     01 Jan 01  01 Jan 05    CA- 40%

GROUP INDIVIDUAL PROVIDERS
_____ __________ _________

 Provider
    Place of Care                          Specialty
    * Denotes Inactive Provider.

 ALCALA,GILBERT M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 AUSTIN,GILBERT M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 BATES,SHARON M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 CARBONARA,KYLE M
    ACUTE CR MTF                           PRIMARY CARE NURSE PRACTITIONER QUALI

 DANSON,ALICE M
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 ENRIQUEZ,FRANK M
    ACUTE CR MTF                           PRIMARY CARE NURSE PRACTITIONER QUALI

 FINTO,LUISA M
    ACUTE CR MTF                           FAMILY PRACTICE/PRIMARY CARE

 GABRIEL,JOHN M
    ACUTE CR MTF                           FAMILY PRACTICE/PRIMARY CARE

 PONY,ALAN O
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN

 PUNTA,ARLENE P
    ACUTE CR MTF                           FAMILY PRACTICE PHYSICIAN
```

Figure 2-90. Provider Group Report - Agreements and Providers

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 4

                Personal Data - Privacy Act of 1974 (PL 93-579)
                             PROVIDER GROUP REPORT
                        *** Primary Care Managers ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
Provider                    Agreement dates            Agrmt      Total    Total
  Beneficiary Cat             Age Range                Type     Capacity Assigned
--------------------------------------------------------------------------------
AUSTIN,GILBERT M             -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                             -                        MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                           01Jan01 - 01Jan05          MTF         500        4
  ADY ACTIVE DUTY                                                  500        3
  AFM ACTIVE DUTY FAMILY                                           500        1
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0
BATES,SHARON M               -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                             -                        MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                             01Jan01 - 01Jan05          MTF         500        4

  ADY ACTIVE DUTY                                                  500        3
  AFM ACTIVE DUTY FAMILY                                           500        1
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0
```

Figure 2-91. Provider Group Report - Primary Care Managers

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 5

                Personal Data - Privacy Act of 1974 (PL 93-579)
                            PROVIDER GROUP REPORT
                        *** Primary Care Managers ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
Provider                    Agreement dates            Agrmt      Total    Total
  Beneficiary Cat             Age Range                Type     Capacity Assigned
--------------------------------------------------------------------------------
CARBONARA,KYLE M             -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                             -                        MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                           01Jan01 - 01Jan05          MTF         500        3

  ADY ACTIVE DUTY                                                  500        1
  AFM ACTIVE DUTY FAMILY                                           500        2
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0


DANSON,ALICE M               -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                             -                        MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                           01Jan01 - 01Jan05          MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0
```

Figure 2-91. Provider Group Report - Primary Care Managers (continued)

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 6
                Personal Data - Privacy Act of 1974 (PL 93-579)
                             PROVIDER GROUP REPORT
                          *** Primary Care Managers ***
GROUP:  ACUTE CR MTF  (continued)
==============================================================================
Provider                    Agreement dates            Agrmt      Total    Total
  Beneficiary Cat             Age Range                Type     Capacity Assigned
------------------------------------------------------------------------------
ENRIQUEZ,FRANK M             -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                             -                         MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                           01Jan01 - 01Jan05           MTF         500        1

  ADY ACTIVE DUTY                                                  500        1
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

FINTO,LUISA M                -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                             -                         MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                           01Jan01 - 01Jan05           MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0
```

Figure 2-91. Provider Group Report - Primary Care Managers (continued)

```
WALTER REED AMC                                    21 Jun 2001@1427   PAGE 7

                Personal Data - Privacy Act of 1974 (PL 93-579)
                            PROVIDER GROUP REPORT
                         *** Primary Care Managers ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
Provider                    Agreement dates            Agrmt      Total    Total
  Beneficiary Cat             Age Range                Type     Capacity Assigned
--------------------------------------------------------------------------------
GABRIEL,JOHN M               -                         CON         UNL        0

  ADY ACTIVE DUTY                                                  UNL        0
  AFM ACTIVE DUTY FAMILY                                           UNL        0
  OTH OTHER                                                        UNL        0
  RET RETIREE                                                      UNL        0
  RFM RETIREE FAMILY MEM                                           UNL        0

                              -                         MTF         500        0

  ADY ACTIVE DUTY                                                  500        0
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0

                            01Jan01 - 01Jan05           MTF         500        3

  ADY ACTIVE DUTY                                                  500        3
  AFM ACTIVE DUTY FAMILY                                           500        0
  OTH OTHER                                                        500        0
  RET RETIREE                                                      500        0
  RFM RETIREE FAMILY MEM                                           500        0


WALTER REED AMC                                    21 Jun 2001@1427   PAGE 8

                Personal Data - Privacy Act of 1974 (PL 93-579)
                            PROVIDER GROUP REPORT
                         *** Group Level Exceptions ***

GROUP:  ACUTE CR MTF  (continued)
================================================================================
```

Figure 2-91. Provider Group Report - Primary Care Managers (continued)

2.2.4.1.3 #3 Provider List by Specialty

Menu Path: PAS Menu → MAN → PMCP → ONET → GMRM → #3

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Provider List by Specialty option allows you to print reports listing providers by provider type and specialty. The report totals TRICARE providers by provider type and by specialty

You can select to print reports for network providers, and for One or Multiple or All specialties, or to print reports for One, Multiple or All TRICARE provider types and by One, Multiple or All specialties.

Use/Frequency:

As needed. This report should be run to determine if all specialties are appropriately covered by the network. The report allows you to evaluate the types of agreements in the network and the distribution across specialties, as well as expiration dates and discounts.

Report Sample:

WALTER REED AMC 21 Jun 2001@1531 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)
Provider List By Specialty

Provider Type: NETWORK PROVIDER GROUP

Specialty / Provider Group / Agreement Type	Place(s) of Care	POC Phone / Effective Date	POC ZIP Code / Stop Date	Disc %	Except
FAMILY PRACTICE/PRIMARY CARE					
ACUTE CR BC	ACUTE CR BC	202 361-4241	20301		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
ACUTE CR MTF	ACUTE CR MTF	202 271-5851	20307		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
ADULT PR CR BC	ADULT PR CR BC	202 361-4245	20301		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
ADULT PR CR MTF	ADULT PR CR MTF	202 271-5850	20307		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
AMB CARE MTF	AMB CARE MTF	202 271 -5853	20307		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
AMB CR BC	AMB CR BC	202 361-4244	20301		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
ENT CLINIC	ENT CLINIC	202 272-5855	20307		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
FAM PRAC ASSOC	FAM PRAC ASSOC	301 544-1232	20817		
NET - CIVILIAN NETWORK PROVIDER		01 Jan 01	01 Jan 05		CA-15%
FAM PRAC BC	FAM PRAC BC	202 361-4240	20301		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
FAM PRAC MTF	FAM PRAC MTF	202 271-5850	20307		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
GEN MED BC	GEN MED BC	202 361-4242	20301		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
INT MED BC	INT MED BC	202 361-4243	20301		
MTF - MTF STAFF		01 Jan 01	01 Jan 05		MTF
INT MED MTF	INT MED MTF	202 271-5852	20307		

Figure 2-92. Provider List by Speciality

2.2.4.1.4 #4 PCM Enrollment Mix Discrepancy Statistical Summary

Menu Path: PAS Menu → MAN → PMCP → ONET → GMRM → #4

Alternate Menu Paths: PAS → MAN → OMCP → PRPT → #7

PAS → MAN → EMCP → OENR → PRPM → #7

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The PCM Enrollment Mix Discrepancy Statistical Summary option allows you to generate and print reports identifying PCMs whose patient loads exceed their PCM capacity for one or more beneficiary categories or who have beneficiaries assigned to them whose ages are outside of the PCM's assigned age range preferences. The system allows you to sort by PCM or by group. Within each PCM or group, the system sorts by agreement. The report identifies PCM beneficiary categories that have discrepancies with an asterisk and displays the numeric value of the discrepancies.

The system allows you to sort by group or by PCM and to select One, Multiple, or All of the selected category. The report lists the groups alphabetically and, within each group, lists the providers alphabetically. It includes a statistical summary of the group's capacity and age range preferences and associated patient load, as well as the statistics for each of the providers within the selected group. The report sorted by PCM lists alphabetically all PCMs who have discrepancies and includes a statistical summary of their capacity, age range preferences and associated patient load. The report does not include groups or individual providers who have no discrepancies. The report indicates the number of enrollees who are overassigned or whose age exceeds the authorized age range for the PCM.

Use/Frequency:

Monthly/As needed

Report Sample:

```
TRIPLER ARMY MEDICAL CENTER                    24 Oct 1995@1440    Page 1

                Personal Data - Privacy Act of 1974 (PL 93-579)
                     PCM ENROLLMENT MIX DISCREPANCY STATISTICAL SUMMARY
                                     by PROVIDER group

Provider GROUP: WOLLIN GROUP PCM CAPACITY
-------------------------------------------------------------------------------
 Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996
      Group PCM: YES

Maximum Patient Capacity:    30         Age Range to Apply Overall: 1 - 2
          Total Assigned:    17
===============================================================================
                                                     Total      Pat out of
PCM Beneficiary Category    Age  Range   Capacity     Assigned   Age Range
-------------------------------------------------------------------------------
ACTIVE DUTY                 1    -   2        30            11           8
ACTIVE DUTY FAMILY MEMBER   1    -   2         0
RETIREE                     1    -   2         0
RETIREE FAMILY MEMBER       1    -   2         0
OTHER                       1    -   2         0            6 *          2
===============================================================================
        THE FOLLOWING INDIVIDUAL PROVIDERS WITHIN THIS GROUP HAVE EITHER
                CAPACITY OR AGE RANGE DISCREPANCIES AS INDICATED.
```

```
                                                                    Page 2
       Provider: WOLLIN,MAGDALENA
 Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996

Maximum Patient Capacity:    18         Age Range to Apply Overall: 16 -
          Total Assigned:    17
===============================================================================
                                                     Total      Pat out of
PCM Beneficiary Category    Age  Range   Capacity     Assigned   Age Range
-------------------------------------------------------------------------------
ACTIVE DUTY                 16   -            0                        8
ACTIVE DUTY FAMILY MEMBER   16   -                         11
RETIREE                     16   -
RETIREE FAMILY MEMBER       16   -
OTHER                       16   -            0            6 *          2
===============================================================================



(*) indicates # of beneficiaries Assigned is greater than Capacity
```

Figure 2-93. PCM Enrollment Mix Discrepancy Statistical Summary

2.2.4.1.5 #5 PCM Enrollment Mix Discrepancy Report

Menu Path: PAS Menu → MAN → PMCP → ONET → GMRM → #5

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

This report includes the statistics from the PCM Enrollment Mix Discrepancy Summary Report and the names of the individual beneficiaries who are currently assigned to PCMs in categories where the number of assigned beneficiaries exceed the PCMs capacity for that catgeory, or whose age is outside the PCM's age range preference.

You may choose to sort the report by PCM, by TRICARE Provider Group, or by beneficiary.

Use/Frequency:

As needed

Report Sample:

PORTSMOUTH NH 15 Jun 1995@1530
Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)
PCM ENROLLMENT MIX DISCREPANCY REPORT
by PCM

PCM: BENJAMIN,ARTHUR

Provider Group: DE ANZA PEDIATRIC GROUP
Agreement Type: CON - CONTRACT
Agreement Dates: 01 Jan 1995 - 31 Dec 1995
Group PCM: YES

Maximum Patient Capacity: 100
Total Assigned: 82
Age Range to Apply Overall: -

PCM Beneficiary Category	Age Range	Capacity	Total Assigned	Pat out of Age Range
ACTIVE DUTY		0		
ACTIVE DUTY FAMILY MEMBER	0 - 18	75	82*	Y
RETIREE		0		
RETIREE FAMILY MEMBER	0 - 16	25		
OTHER		0		

(*) indicates # if beneficiaries Assigned is greated than Capacity

PCM Beneficiary Category: ACTIVE DUTY FAMILY MEMBER

DMIS ID	Spon SNN FMP	Beneficiary Name	Pat Cat	Spon Rank	Case Mgmt	Home Age	Duty Zip	Zip	Home Phone	Date Assigned	Reason
1384	213-76-4345/02	JACKSON,ADRIANNE	K84	AO3	N	13	92029	92121	619-567-9876	15 Dec 1994	EX
1384	213-76-4345/03	JACKSON,THOMAS	K84	A03	N	8	92029	92121	619-567-9876	16 Feb 1995	EX
1384	213-76-4345/04	JACKSON,WINDSOR	K84	A03	N	4	92029	92121	619-567-9876	16 Feb 1995	EX
1384	213-76-4345/05	JACKSON,ZELDA	K84	A03	N	03M	92029	92121	619-567-9876	22 May 1995	EX
3002	111-75-9620/02	ABLE,JOHN	K84	NE5	N	17	92134	92122	619-345-2534	8 Apr 1995	EX
3002	138-83-6549/02	SMITH,ALEXIA	K84	AO5	Y	19	92211	92121	619-999-3353	3 Jan 1995	EX/AX
6214	111-57-8533/04	MIDLER,NANCY	K84	FE5	N	5	92117	92121	619-863-5545	30 May 1995	EX
6214	140-57-8533/02	RODRIQUEZ,HECTOR	K84	FE5	N	18	92117	92121	619-863-5545	4 Oct 1994	EX
6214	140-57-8533/03	RODRIQUEZ,TERRANCE	K84	FE5	N	15	92117	92121	619-863-5545	4 Oct 1994	EX
6214	164-75-9620/02	GEARY,CONNIE	K84	AE2	N	3	92323	92121	619-567-4343	17 Mar 1995	EX

... [etc. There would be 82 names altogether, if the list were completed.]

Active Duty Family Members assigned to this PCM= 82
Active Duty Family Members assigned to this PCM in excess of capacity (EX)= 7
Active Duty Family Members assigend to this PCM who are out-of-age-range (AX)= 14
Total beneficiaries assigned to this PCM= 82
Total beneficiaries assigned to this PCM in excess of capacity (EX) = 3
Total beneficiaries assigned to this PCM who are out-of-age range (AX) = 14

Figure 2-94. PCM Enrollment Mix Discrepancy Report

2.2.4.2 Agreement Reports Menu (AMRM)

2.2.4.2.1 #1 Provider Alphabetic Agreement Roster

Menu Path: PAS Menu → MAN → PMCP → ONET → AMRM → #1

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Provider Alphabetic Agreement Roster option allows you to print reports alphabetically listing current provider agreement data. The listed agreement data includes provider, specialty, provider group, effective date, stop date, discount, and exceptions indicator.

You can select One, Multiple, or All provider types for the roster. The agreements are sorted by provider type, provider name, and provider group. Specialties are listed for each provider. Agreements are totaled by provider type.

If you select Network, the report is sorted by three Provider Types that imply network membership: Network Individual Provider, Network Institution/Service, and Network Provider Group. Report data is the same as if selected by one, multiple, or all provider types.

Use/Frequency:

As needed

Report Sample:

```
WALTER REED AMC                                                                    21 Jun 2001@1802    Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)

                                              PROVIDER ALPHABETIC AGREEMENT ROSTER

Provider Type: NETWORK PROVIDER GROUP
=================================================================================================================================
Group Name                                    Specialty
          Agreement Type                                          Effective Date   Stop Date         Disc %     Except
=================================================================================================================================
ACUTE CR BC                                   FAMILY PRACTICE PHYSICIAN
                                              FAMILY PRACTICE/PRIMARY CARE
                                              PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                          01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                         01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                  01 Jan 2001      01 Jan 2005       CA-40%

ACUTE CR MTF                                  FAMILY PRACTICE PHYSICIAN
                                              FAMILY PRACTICE/PRIMARY CARE
                                              PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                          01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                         01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                  01 Jan 2001      01 Jan 2005       CA-40%

ADULT PR CR BC                                FAMILY PRACTICE PHYSICIAN
                                              FAMILY PRACTICE/PRIMARY CARE
                                              PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                          01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                         01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                  01 Jan 2001      01 Jan 2005       CA-40%

ADULT PR CR MTF                               FAMILY PRACTICE PHYSICIAN
                                              FAMILY PRACTICE/PRIMARY CARE
                                              PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                          01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                         01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                  01 Jan 2001      01 Jan 2005       CA-40%

ALLERGY                                       ALLERGIST
          MTF - MTF STAFF                                         01 Jan 2001      01 Jan 2005       MTF

AMB CARE MTF                                  FAMILY PRACTICE PHYSICIAN
                                              FAMILY PRACTICE/PRIMARY CARE
                                              PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                          01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                         01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                  01 Jan 2001      01 Jan 2005       CA-40%
```

Figure 2-95. Provider Alphabetic Roster

```
WALTER REED AMC                                                                                                    21 Jun 2001@1802    Page 2
                                                Personal Data - Privacy Act of 1974 (PL 93-579)

                                                     PROVIDER ALPHABETIC AGREEMENT ROSTER

Provider Type: NETWORK PROVIDER GROUP  (continued)
=================================================================================================================================
Group Name                                      Specialty
          Agreement Type                                                    Effective Date   Stop Date         Disc %     Except
=================================================================================================================================
AMB CR BC                                       FAMILY PRACTICE PHYSICIAN
                                                FAMILY PRACTICE/PRIMARY CARE
                                                PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                                    01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                                   01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                            01 Jan 2001      01 Jan 2005       CA-40%

BETHESDA DERM                                   DERMATOLOGIST
          NET - CIVILIAN NETWORK PROVIDER                                   01 Jan 2001      01 Jan 2005       CA-10%
          NON - NON-NETWORK/EXCEPTION                                       01 Jan 2001      01 Jan 2005       CA

CARDIOLOGY                                      CARDIOLOGIST
          MTF - MTF STAFF                                                   01 Jan 2001      31 Dec 2004       MTF

CAST                                            ORTHOPEDIC SURGEON
          MTF - MTF STAFF                                                   01 Jan 2001      31 Dec 2004       MTF

DERM CARE MTF                                   DERMATOLOGIST
          MTF - MTF STAFF                                                   01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                            01 Jan 2001      01 Jan 2005       CA-20%

ENT CLINIC                                      FAMILY PRACTICE/PRIMARY CARE
                                                OTORHINOLARYNGOLOGIST
          MTF - MTF STAFF                                                   01 Jan 2001      01 Jan 2005       MTF

FAM MED MTF                                     FAMILY PRACTICE PHYSICIAN
          MTF - MTF STAFF                                                   01 Jan 2001      01 Jan 2005       MTF

FAM PRAC ASSOC                                  FAMILY PRACTICE PHYSICIAN
                                                FAMILY PRACTICE/PRIMARY CARE
                                                PRIMARY CARE NURSE PRACTITIONER QUALIFIED

          NET - CIVILIAN NETWORK PROVIDER                                   01 Jan 2001      01 Jan 2005       CA-15%

FAM PRAC BC                                     FAMILY PRACTICE PHYSICIAN
                                                FAMILY PRACTICE/PRIMARY CARE

                                                PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                                    01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                                   01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                            01 Jan 2001      01 Jan 2005       CA-40%
```

Figure 2-95. Provider Alphabetic Roster (continued)

```
WALTER REED AMC                                                                                                  21 Jun 2001@1802    Page 3
                                                Personal Data - Privacy Act of 1974 (PL 93-579)

                                                      PROVIDER ALPHABETIC AGREEMENT ROSTER

Provider Type: NETWORK PROVIDER GROUP  (continued)
=================================================================================================================================
==
Group Name                                            Specialty
          Agreement Type                                                   Effective Date   Stop Date         Disc %     Except
=================================================================================================================================
==
FAM PRAC MTF                                          FAMILY PRACTICE PHYSICIAN
                                                      FAMILY PRACTICE/PRIMARY CARE
                                                      PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                                   01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                                  01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                           01 Jan 2001      01 Jan 2005       CA-40%

FARRAGUT CENTER                                       GASTROENTEROLOGIST
                                                      INTERNIST
          NET - CIVILIAN NETWORK PROVIDER                                 01 Jan 2001      01 Jan 2005       CA-12%     E
          NON - NON-NETWORK/EXCEPTION                                      01 Jan 2001      01 Jan 2005       CA

FOXHALL MEDICAL                                       PULMONARY DISEASES PHYSICIAN
          NET - CIVILIAN NETWORK PROVIDER                                  01 Jan 2001      01 Jan 2005       CA-12%

GEN MED BC                                            FAMILY PRACTICE PHYSICIAN
                                                      FAMILY PRACTICE/PRIMARY CARE
                                                      PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                                   01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                                  01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                           01 Jan 2001      01 Jan 2005       CA-40%
GEORGETOWN MED                                        CARDIOLOGIST
          NET - CIVILIAN NETWORK PROVIDER                                  01 Jan 2001      01 Jan 2005       CA-12%

HAND SURGERY GROUP                                    HAND SURGEON
          MTF - MTF STAFF                                                  01 Jan 2001      01 Jan 2005       MTF

INT MED BC                                            FAMILY PRACTICE PHYSICIAN
                                                      FAMILY PRACTICE/PRIMARY CARE
                                                      PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                                   01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                                  01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                           01 Jan 2001      01 Jan 2005       CA-40%

INT MED MTF                                           FAMILY PRACTICE PHYSICIAN
                                                      FAMILY PRACTICE/PRIMARY CARE
                                                      PRIMARY CARE NURSE PRACTITIONER QUALIFIED
          CON - CONTRACT                                                   01 Jan 2001      01 Jan 2005       CA-60%
          MTF - MTF STAFF                                                  01 Jan 2001      01 Jan 2005       MTF
          PIC - PARTNER INTERNAL                                           01 Jan 2001      01 Jan 2005       CA-40%


                                                                   Total agreements NETWORK PROVIDER GROUP Type: 56
```

Figure 2-95. Provider Alphabetic Roster (continued)

2.2.4.2.2 #2 Specialty Provider Agreement Roster

Menu Path: PAS Menu → MAN → PMCP → ONET → AMRM → #2

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Specialty Provider Agreement Roster option allows you to print agreement rosters for all active network providers for one, multiple, or all provider types by One, Multiple, or All specialties. Totals are provided for specialty for provider type.

For provider types that imply individuals, the roster lists the provider's group agreements and the associated effective dates, stop dates, discounts, and exception indicators. For providers types that imply groups, for each specialty, the roster lists the agreement, group, effective stop date, discount rate and exceptions.

Use/Frequency:

As needed

Report Sample:

```
WALTER REED AMC                                                                                    21 Jun 2001@1846    Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                             PROVIDER AGREEMENT ROSTER BY SPECIALTY

Provider Type: NETWORK INDIVIDUAL PROVIDER
=================================================================================================================================
Specialty    Agreement  Provider   Group                                        Effective Date     Stop Date         Disc %    Except
=================================================================================================================================
CARDIOLOGIST
             MTF - MTF STAFF
                        CALDWELL,LORRAINE C
                                   CARDIOLOGY                                     01 Jan 2001        31 Dec 2004          MTF
             NET - CIVILIAN NETWORK PROVIDER
                        PARNELL,DOUGLASS C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PEPYS,ANN C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PERRON,CAROL C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PHIDIAS,ELISA C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PLEASANCE,FRANK C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        POMPEY,JOSEPH C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        POST,HENRY C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PROUDFOOT,GEORGETTE C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PSKOV,IVANA C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PUSHKIN,ZELDA C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%
                        PYRAMUS,BASIL C
                                   GEORGETOWN MED                                 01 Jan 2001        01 Jan 2005       CA-12%

                                                                                                CARDIOLOGIST Provider Totals:   12
                                                                                             Total providers all specialties:   12


---------------------------------------------------------------------------------------------------------------------------------
* To see Group Providers, select a Group-level Provider Type.
```

Figure 2-96. Specialty Provider Agreement Roster

2.2.4.2.3 #3 Specialty Provider Agreement Summary

Menu Path: PAS Menu → MAN → PMCP → ONET → AMRM → #3

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Specialty Provider Agreement Summary option allows you to print a summary report giving the number of agreements by provider type, provider specialty, and agreement type. Totals are given for agreements pertaining to a provider type. Grand totals are provided for the entire facility.

Use/Frequency:

As needed. This report should be run when there is a need to determine the volume of agreements in effect on the report run date and the specialties and agreement types supported.

Report Sample:

```
WALTER REED AMC                                 21 Jun 2001@1903   Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)
                     PROVIDER AGREEMENT ROSTER BY SPECIALTY

Provider Type: NETWORK INDIVIDUAL PROVIDER
=====================================================================
Specialty
   Agreement                                            Number Agreements
=====================================================================
CARDIOLOGIST
-----------
   MTF - MTF STAFF                                                    1
   NET - CIVILIAN NETWORK PROVIDER                                   11

                     TOTAL AGREEMENTS FOR SPECIALTY CARDIOLOGIST:    12

     TOTAL AGREEMENTS PROVIDER TYPE NETWORK INDIVIDUAL PROVIDER:     12
```

Figure 2-97. Specialty Provider Agreement Summary

2.2.4.2.4 #4 Discount Provider Agreement Roster

Menu Path: PAS Menu → MAN → PMCP → ONET → AMRM → #4

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Discount Provider Agreement Roster option allows you to print reports showing all active provider agreements by discount. Totals are provided showing the total number of providers for each discount rate. The report is sorted by agreement type, provider type, provider specialty, and discount rate.

Use/Frequency:

As needed

Report Sample:

```
WALTER REED AMC                                        21 Jun 2001@1907    Page 1
                Personal Data - Privacy Act of 1974 (PL 93-579)

                     PROVIDER AGREEMENT ROSTER by DISCOUNT
                            Agreement Type: CONTRACT

==============================================================================
Provider Type: NETWORK INDIVIDUAL PROVIDER
==============================================================================
Specialty: FAMILY PRACTICE PHYSICIAN
  Discount: CA-60%
                  PEBBLE,HENRY O
                       INT MED BC
                  PEPPER,CORBEN O
                       AMB CARE MTF
                  PEREGRINE,DEAN O
                       ADULT PR CR MTF
                  PEWTER,FORMAN O
                       ACUTE CR BC
                  PHILL,JEROME O
                       ADULT PR CR BC
                  PINSKY,ZACH O
                       FAM PRAC MTF
                  POKORNY,BRANDON O
                       INT MED MTF
                  POLLMAN,EARL O
                       FAM PRAC BC
                  PONY,ALAN O
                       ACUTE CR MTF
                  POTOMAC,IAN O
                       AMB CR BC
                  PRISCO,GRANT O
                       GEN MED BC

                                                 TOTAL PROVIDERS AT CA-60%: 11
```

Figure 2-98. Discount Provider Agreement Roster

```
WALTER REED AMC                                        21 Jun 2001@1907    Page 2
                Personal Data - Privacy Act of 1974 (PL 93-579)

                     PROVIDER AGREEMENT ROSTER by DISCOUNT
                     Agreement Type: CONTRACT  (continued)

==============================================================================
Provider Type: NETWORK PROVIDER GROUP
==============================================================================
Specialty: FAMILY PRACTICE PHYSICIAN
  Discount: CA-60%
                  ACUTE CR BC
                  ACUTE CR MTF
                  ADULT PR CR BC
                  ADULT PR CR MTF
                  AMB CARE MTF
                  AMB CR BC
                  FAM PRAC BC
                  FAM PRAC MTF
                  GEN MED BC
                  INT MED BC
                  INT MED MTF

                                                   TOTAL GROUPS AT CA-60%: 11
```

FigureFigure 2-98. Discount Provider Agreement Roster (continued)

2.2.4.2.5 #5 Expiration Date Provider Agreement Roster

Menu Path: PAS Menu → MAN → PMCP → ONET → AMRM → #5

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Expiration Date Provider Agreement Roster option allows you to print reports of TRICARE provider agreements which expire within a specified date range for One, Multiple, or All agreement types. It is sorted alphabetically by provider, and within provider, by provider group. The report displays provider agreement and specialty data. Subtotals are shown at the end of the report for the agreement types with an overall total for all agreements shown on the report.

Use/Frequency:

Monthly or as needed

Report Sample:

```
TIDEWATER                                                                                    01 Oct 1993@1242    Page 1
                                   Personal Data - Privacy Act 1974 (PL-93-579)
                                   Provider Agreement Roster By Expiration Date
                                      Period from 16 Sep 1993 to 01 Dec 1993

==================================================================================================================
Provider                                          Specialty
    Provider Group                                                                   Zip Code        Phone Number
        Payment Address                                                                          Disc %        Except
        Agreement Type                                          Effective Dates
==================================================================================================================
ABBOTT,JAMES                                      GENERAL SURGEON
                                                  INTERNAL MEDICINE
                                                  INTERNAL MEDICINE CONSULTANT

    SALISBURY TRAINING GROUP
        6275 RANCHO MISSION ROAD                  PORTSMOUTH, VA                         23667           (804) 780-0520
        SUP - SUPPLEMENTAL CARE/DIAGNOSTIC SERVICES                18Oct92-17Oct93                   CA-10%        E

    RIVERSIDE MEDICAL
        P O BOX 5436                              HAMPTON, VA                            23669           (804) 890-5432
        822 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                            01Oct92-01Oct93                   CA-12%

ACEVES,ALICIA                                     GENERAL SURGEON
    RIVERSIDE MEDICAL
        P O BOX 5436                              HAMPTON, VA                            23669           (804) 890-5432
        822 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                            05Sep92-05Sep93                   CA-17%
        PEX - PARTNER EXTERNAL                                     01Oct92-01Oct93                   CA-12%

BALLANTINE,ELAINE G                               OPHTHALMOLOGIST
    RIVERSIDE MEDICAL
        P O BOX 5436                              HAMPTON, VA                            23669           (804) 890-5432
        822 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                            01Oct92-01Oct93                   CA-12%

BOOKER,DONALD T                                   OPHTHALMOLOGIST
    RIVERSIDE MEDICAL
        P O BOX 5436                              HAMPTON, VA                            23669           (804) 890-5432
        822 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                            01Oct92-01Oct93                   CA-12%

CALLENDER,OTHELLO                                 PODIATRIST
    RIVERSIDE MEDICAL
        P O BOX 5436                              HAMPTON, VA                            23669           (804) 890-5432
        822 OLD HAMPTON PARKWAY
        NET - CIVILIAN NETWORK PROVIDER                            01Oct92-01Oct93                   CA-12%
```

Figure 2-99. Expiration Date Provider Agreement Roster

TIDEWATER 01 Oct 1993@1242 Page 7

Personal Data - Privacy Act 1974 (PL-93-579)
Provider Agreement Roster By Expiration Date
Period from 16 Sep 1993 to 01 Dec 1993

Agreement Type	Total
CON - CONTRACT	1
MTF - MTF STAFF	2
NET - CIVILIAN NETWORK PROVIDER	21
NON - NON-NETWORK/EXCEPTION	2
PEX - PARTNER EXTERNAL	1
PIC - PARTNER INTERNAL	1
SUP - SUPPLEMENTAL CARE/DIAGNOSTIC SERVICES	1
Total Agreements	29

Figure 2-99. Expiration Date Provider Agreemnt Roster (contnued)

2.2.4.2.6 #6 ZIP Code Agreement Roster

Menu Path: PAS Menu → MAN → PMCP → ONET → AMRM → #6

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The ZIP Code Agreement Roster option allows you to print rosters listing and totaling providers by ZIP Code and specialty. You can generate a roster for a single ZIP Code or a ZIP Code combination, for One, Multiple or All specialties. You may do it for all providers or for PCMs.

Use/Frequency:

Monthly or as needed

Report Sample:

```
WALTER REED AMC                                                                                    21 Jun 2001@1922    Page 1
                                    Personal Data - Privacy Act of 1974 (PL 93-579)
                                         Provider Agreement Roster By ZIP Code
                                                   ZIP Code: 20817
                                                     **PCM only**

==================================================================================================================================
Specialty
    Provider
        Provider Group
            Agreement Type                                                  Effective Dates            Disc %        Except
==================================================================================================================================
FAMILY PRACTICE PHYSICIAN
-------------------------
    HARVARD,STANLEY C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-10%        E

    PAWLOW,GEORGE C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PEDRONE,HARRY C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PETITO,FRED C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PHEE,LONI C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PIES,BERNICE C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PLUTO,ARMAND C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PUGLIA,MARGARET C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%
                                                                  Total providers for FAMILY PRACTICE PHYSICIAN:    8
FAMILY PRACTICE/PRIMARY CARE
----------------------------
    PADFIELD,GRACE C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%

    PROVOST,PHILLIP C
        FAM PRAC ASSOC
            NET - CIVILIAN NETWORK PROVIDER                                 01Jan01-01Jan05            CA-15%
                                                                 Total providers for FAMILY PRACTICE/PRIMARY CARE:    2
```

Figure 2-100. ZIP Code Agreement Roster

```
WALTER REED AMC                                                                                    21 Jun 2001@1922    Page 2
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                             Provider Agreement Roster By ZIP Code
                                                        ZIP Code: 20817
                                                          **PCM only**

==========================================================================================================================
      Specialty
          Provider
              Provider Group
                  Agreement Type                                                Effective Dates            Disc %        Except

==========================================================================================================================
      PRIMARY CARE NURSE PRACTITIONER QUALIFIED
      -----------------------------------------
          PHILPS,REBECCA C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                               01Jan01-01Jan05            CA-15%

          PYPER,ALBERTO C
              FAM PRAC ASSOC
                  NET - CIVILIAN NETWORK PROVIDER                               01Jan01-01Jan05            CA-15%

                                                   Total providers for PRIMARY CARE NURSE PRACTITIONER QUALIFIED:    2
                                                                    Total providers for ZIP Code 20817:   12
```

Figure 2-100. ZI P Code Agreement Roster (contiinued)

2.2.4.3 Miscellaneous Network Reports Menu

2.2.4.3.1 Provider Batch Address Labels – Build Utility

Menu Path: PAS Menu → MAN → PMCP → ONET → MMRM → #1

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE
CPZ LABEL

Application Description:

The Provider Batch Address Labels - Build Utility option allows you to select providers by provider name, agreement type, specialty, or expiration date to generate provider payment address labels. You can specify One, Multiple, or All providers, One, Multiple, or All agreement types, and One, Multiple, or All specialties.

Note: When selecting providers by agreement type, you must also specify an expiration date. The system only selects providers who participate in a specified agreement that expires on that specified date.

When specifying selection by an expiration date without selecting agreements, the system selects providers who participate in any agreement that expires on the specified date.

When you specify a provider for the search, the system searches the Provider file by the specified provider name for label generation.

Based on the search criteria entered, the system searches the MCP Provider file for all providers that meet the specified search criteria.

The providers that meet the search criteria during the above search and have complete payment address information are placed in a global file which may be used to generate and print labels using the Provider Batch Address Labels - Print Utility option.

The providers that meet the search criteria during the above search but have incomplete (missing) payment address information are placed in a global file which may be generated and printed using the Incomplete Provider Address Report option.

Use/Frequency:

As needed

2.2.4.3.2 Provider Batch Address Labels – Print Utility

Menu Path: PAS Menu → MAN → PMCP → ONET → MMRM → #2

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE
CPZ LABEL

Application Description:

The Provider Batch Address Labels - Print Utility option allows you to print provider address labels which were compiled using the Provider Batch Address Labels - Build Utility option.

The system allows you to display a picklist of all global label batches compiled at various times for a specific user or for all users. After you select a batch from the picklists, you can print the labels, delete the batch, or view the search criteria that were used to compile the labels.

You can print a batch of labels in its entirety or print a subset of the batch. If you elect to print a subset, the system prompts you to indicate the number of labels to print and then prints that number of labels in alphabetical order. After the system prints a label, that label is deleted and cannot be reprinted. If all the labels in the batch are printed, the batch is no longer accessible through this option. Batches of labels remain on the system until all the labels have been printed or until a user deletes the batches through this option.

Use/Frequency:

As needed

Report Sample:

```
User: SLATER,PAMELA
Provider: ESCALERA,FRANK M




TO:
CPT  FRANK M ESCALERA
PO BOX 421683
WASHINGTON DC
20301
```

2.2.4.3.3 Discrepancy Avoidance Report

Menu Path: PAS Menu → MAN → PMCP → ONET → MMRM → #3

Security Keys:

CPZ CCP
CPZ NET
CPZ FILE

Contents:

The Discrepancy Avoidance Report option allows you to generate a report that informs you of the groups, providers, and patients in a given place of care or providers that must be changed before the place of care or provider may be inactivated.

The Inactivate/Reactivate Place of Care or Inactivate Provider action within the Group Profile/Agreements Enter/Edit option enables you to inactivate a place of care from the MCP functionality so that it does not appear in any provider groups, from an individual provider group so that you cannot see the place of care, or from the individual provider in the provider group. **Before any place of care can be inactivated, any booked appointments, booked appointments related to referrals, and/or any patients assigned to the place of care as the PCM need to be resolved.** The system also issues a warning if you try to inactivate the only place of care associated with an individual provider.

If this report is generated for a given **place of care**, you can choose one of three selection criteria:

- All providers in all groups
- A single group
- A single provider in a single group.

The report consists of four sections. Each section is sorted first by groups to which the place of care belongs, and then by providers within the group and place of care. The sections contain the following data:

- Patients assigned to providers as PCMs
- Patients having appointments with and referrals to providers
- Patients having wait list requests for providers
- Providers in each group.

If this report is generated for a given **provider**, you can choose one of two selection criteria:

- All groups
- Selected groups.

The report consists of four sections. Each section is sorted first by groups to which the provider belongs, and then by places of care for the provider within the group. The sections contain the following data:

- Patients assigned to the provider as a PCM
- Patients having appointments with and referrals to the provider
- Patients having wait list requests for the provider
- Places of care in each group.

You can also generate this report from those options which perform inactivations and reactivations:

- The Group Profile/Agreements Enter/Edit option
  - * A place of care can be inactivated from a group
  - * A place of care can be inactivated from a provider
  - * A provider can be inactivated from a group
- The Individual Provider Profile/Agreements Enter/Edit option
  - * A place of care can be inactivated from a provider
  - * A provider can be inactivated from a group
- The Provider Enter/Edit option
  - * A provider can be inactivated from all of MCP.

Use/Frequency:

As needed

Report Sample:

```
TRAINING MEDICAL TREATMENT FACILITY                  21 Jun 2001@1946    Page 1
                           DISCREPANCY AVOIDANCE REPORT
                 Personal Data - Privacy Act of 1974 (PL 93-579)
         *** Patients assigned to Provider as Primary Care Manager ***

Provider: ENRIQUEZ,FRANK M
===============================================================================
Provider Group
   Place of Care
      Patient                            FMP/SSN
===============================================================================
 ACUTE CR MTF
   ACUTE CR MTF
      PICARD,AUGUST E                     20/379-43-6100




===============================================================================
Use the Batch PCM Reassignment Option (BMCP) to transfer assigned patients.









TRAINING MEDICAL TREATMENT FACILITY                  21 Jun 2001@1946    Page 2
                           DISCREPANCY AVOIDANCE REPORT
                 Personal Data - Privacy Act of 1974 (PL 93-579)
                       *** Provider Hospital Locations ***

Provider: ENRIQUEZ,FRANK M
===============================================================================
Provider Group
   Place of Care
===============================================================================
 ACUTE CR MTF
   ACUTE CR MTF
```

Figure 2-101. Discrepancy Avoidance Report

2.3 TaskMan Options

Menu Path: Systems Manager Menu (EVE) ➔TM ➔ STT ➔ Enter name of TaskMan Option to schedule

Security Keys:

ZTMMGR

Application Description:

Options may be setup by TaskMan to automatically run an operation and reschedule it to run at a new time. In MCP, several TaskMan options run processes that generate reports, bulletins, and update enrollment transactions. Scheduling these options is the systems specialist's responsibility. File and Table personnel, should be aware of them also.

Business Rules:

- These TaskMan Options should be scheduled to run after hours when the fewest users are on the system.
- The associated bulletins must have an attached mail group so that someone can generate necessary reports.

Other Important Considerations:

MCP/TRICARE will not work correctly if the TaskMan Options are not scheduled and running.

These options should be scheduled by the systems specialist only.

TASKMAN OPTIONS TO SCHEDULE AND FREQUENCY

CP ENROLLMENT BULLETIN Schedule: Daily

Manages and processes Enrollment transactions. Adjusts an enrollee's MCP status depending on the DEERS response received.

1. Changes PENDING ENROLLMENT MCP status to Enrolled/ Disenrolled or Invalid Enrollment/Disenrollment
2. Disenrolls patients with a status of CONDITIONAL ENROLLMENT 120 days after enrollment date.
3. Identifies expired enrollments, disenrolls the patient and sends a disenrollment transaction to DEERS as appropriate for the Enrollment Mode. Adjusts the PCM counts.
4. Identifies all active duty enrollees whose end enroll date the following month matches the day set in the MCP Parameters (V4.5 only) and

transmits and enrollment transaction to DEERS. If eligible, update the end enrollment date.

5. Identifies all active duty who have been enrolled at your site more than 3 years and send a transaction to DEERS (V4.5). Updates enrollment end date.

CP NAS DAILY CLEANUP Schedule: Daily

1. Purges NAS data temporarily stored in CHCS.

CP NET HCP BULLETIN Schedule: Daily

1. Checks on Inactivated MCP Providers and generates CP HCP Inactivation bulletin.

2. Notifies mail group recipients to generate discrepancy report.

CP NET POC BULLETIN Schedule: Daily

1. Checks on MCP Inactivated places of care and generates the CP POC Inactivation mail bulletin.

2. Notifies mail group recipients to generate a discrepancy report.

CP UIC ENROLLEE MAINTENANCE Schedule: Weekly

1. Checks the Unit ID Code entry in a patient's file anytime it is accessed.

2. Updates a MCP cross reference if the UIC has been changed or if the UIC code does not match a valid entry in the Unit Ship ID file.

3. Generates a bulletin to remind users to print the UIC Maintenance report.

CP UPDATE ENR END DATE Schedule: Daily

1. Updates the end enrollment date for active duty enrollees each time a DEERS eligibility transaction is performed in PAS/MCP.

CP UPDATE CANDIDATE FILE Schedule: Daily

1. Checks any changes and updates the Potential Candidate file for Batch Enrollments.

Data Entry Process:

All data entry must be made by the systems specialist only. Ordinary TRICARE users should not have access to schedule these options.

Functionality Interactions:

These TaskMan options are MCP specific and do not affect other functionalities.

Troubleshooting:

If any of the processes such as enrollment tasks do not appear to be running, perform a FileMan Inquiry into the file OPTION and look for a scheduled time. If no future time displays, the TaskMan option is not running. Call the system specialist

2.4 Mail Bulletins

Menu Path:

MAIL GROUP SETUP

Menu Path: Systems Manager Menu (EVE) → MM → MGE → Enter name of the Mail Group (e.g., MCP ENROLLMENTS)

BULLETIN ATTACHMENT

Menu Path: Systems Manager Menu (EVE) → MM → EBUL → Enter Bulletin name (e.g., CP BATCH PCM)

Application Description:

MCP Mail bulletins are system generated whenever a process occurs or fails to occur (e.g., Batch Enrollments Completed, Batch reassignment unsuccessful). The bulletins can be set up to go to one mail group or to separate mail groups depending on its utility. System personnel should set up the mail groups and attach the bulletins.

Business Rules:

- The bulletins must attach to a mail group.
- The bulletins are not division specific.

Other Important Considerations:

Your MTF must decide whether to create one mail group for all the bulletins or separate mail groups depending on the content of the bulletin.

Bulletins:

CP AD BATCH ENR COMPLETE – States that the Batch enroll AD candidates option has been completed.

CP AD BATCH UPD COMPLETE – Notifies the mail group that the process for updating potential AD enrollment candidate file is complete.

CP AGREEMENT MODIFICATION – Notifies the mail group and the user who changed the agreement start date for an existing agreement.

CP BATCH IDENTIFY AD ENR – Notifies the mail group once the job Identify Potential Active Duty Candidates is completed (IPADC).

CP BATCH PCM – Notifies the group when a batch job reassigning beneficiaries from one PCM to another under the Batch PCM option is completed.

CP BATCH PCM ABORT – Notification that the batch job for reassigning beneficiaries from one PCM to another was unsuccessful.

CP BATCH DISEN COMPLETE – Notifies the user when the Batch Disenrollment is complete.

CP BATCH DISENROLL COMPLETE – Notifies that the process of changing from DEERS enrollment (Full Enrollment) to LOCAL EMPANELMENT has completed.

CP ENR DIV CHANGE – Notifies the user and mail group when the option CHANGE ENROLLING DIVISION is complete. Used with DMIS Realignment.

CP HCP INACTIVATION DATE – Generated daily to show any inactive providers, and serves as a reminder to check the Discrepancy Avoidance report.

CP HCP INACTIVATION – Generated when a provider is inactivated or reactivated from one provider group or from all provider groups.

CP INVAILD ENROLLMENT – Notification that beneficiaries were found to have discrepancies between DEERS and CHCS during an Enrollment/ Disenrollment transaction. This bulletin recommends that the Enrollment/ Disenrollment Discrepancy report be printed to reserve and correct the discrepancies.

CP MULTIPLE BATCH PCM – Notifies a group when a batch job for reassigning beneficiaries from one PCM to multiple PCMs under the Batch PCM option has completed.

CP NEW UIC CODE – Notifies recipients that a new UIC code downloaded from DEERS does not match an entry in the Unit/Ship ID file. It recommends updating the file and editing the patient's mini-registration.

CP PCM REACHED MAX CAPACITY – Generated during Auto Enrollment if the user accepts the defaulted PCM and that PCM has reached Maximum overall capacity or Maximum Active Duty Capacity. A warning displays for the user who may continue with the enrollment by assigning an alternate PCM.

CP POC INACTIVATION – Generated when a place of care is inactivated.

CP POC INACTIVATION DATE – Generated daily to show any discrepancies that exist for Places of care that have been inactivated.

CP RECIPROCAL DISENR COMPLETE – Generated when the Auto Reciprocal Disenrollments have completed and whether discrepancies have been identified. The spool document of discrepancies will be deleted after 14 days. A bulletin is also generated when no discrepancies are noted.

CP RENEW AGREEMENT BATCH PCM – Notifies the group that an Agreement was RENEWED and the listed providers had their PCM patients reassigned.

CP RENEW AGREEMENT NON-PART – Notifies the group that an Agreement was RENEWED and the listed providers are NON-PARTICIPANTS in the renewed agreement with PCM patients assigned.

CP RENEW AGREEMENT W-OUT BATCH – Notifies that an agreement was RENEWED and the listed providers have PCM patients that were not reassigned. They were no reassigned either because the user did not have the key to perform the function or the PCM was not selected to have their patients reassigned.

CP UIC MAINT RPT AVAIL – Notifies the group that the UIC Maintenance report is available for printing. The report identifies those enrolled AD members whose UIC is invalid in CHCS or whose UIC has been changed.

CP UIC WITHOUT PCM – Generated during Auto Enrollment if the UIC matches an entry in the Unit/Ship ID file but has not been linked to a PCM (UIC/ PCM Link). A user may still complete the enrollment by directly assigning a PCM.

CP INACTIVATE UIC IN AUTO ENROLLMENT – Notification that an auto enrollment was performed for a patient whose UIC has been inactivated. It recommends that the patient's mini registration be updated.

CP BATCH RENEW COMPLETE – Notification that the process to Batch Renew Enrollment has completed and to generate the Batch Renewal Disenrollment Roster.

CP BATCH DISEMPANEL COMPLETE – Notification that Non-Active Duty members have been Disempanled after switching from Local Empanelment to the DEERS Enrollment mode.

CP PARAMETERS – Notification that the dates to perform annual and monthly eligibility checks are incomplete in the MCP PARAMETERS option.

Data Entry Process:

All data entry should be completed by a Systems person/DBA.

Functionality Interactions

These bulletins do not interact with any existing functionality.

Troubleshooting:

If mail groups are not receiving the bulletins, contact the system administrator.

If a report is not available that a bulletin indicated was ready, review whether the time frame to print has expired. The bulletin will specify the number of days on some reports within which a spooled report must be printed.

CHCS: MCP DESKTOP USER GUIDE

3. PROVIDER NETWORK MANAGEMENT

Brief Outline

3.1 Group Profile/Agreements Enter/Edit (GNET) 3-4
3.2 Individual Provider Profile/agreements Enter/edit (INET). 3-5
3.3 Modify Group Agreement Effective Date (MNET). 3-6
3.4 Outputs & Network Management Reports (ONET). 3-6
3.4.1 Group Management Reports Menu (GMRM). 3-6
3.4.1.1 Group Member Roster 3-7
3.4.1.2 Provider Group Report. 3-8
3.4.1.3 Provider List by Specialty 3-9
3.4.1.4 PCM Enrollment Mix Discrepancy Statistical Summary 3-10
3.4.1.5 PCM Enrollment Mix Discrepancy Report 3-11
3.4.2 Agreement Reports Menu (AMRM) 3-11
3.4.2.1 Provider Alphabetic Agreement Roster 3-11
3.4.2.2 Specialty Provider Agreement Roster. 3-12
3.4.2.3 Specialty Provider Agreement Summary 3-13
3.4.2.4 Discount Provider Agreement Roster (obsolete under TRICARE) 3-13
3.4.2.5 Expiration Date Provider Agreement Roster 3-14
3.4.2.6 ZIP Code Agreement Roster 3-15
3.4.3 Miscellaneous Network Reports Menu (MMRM) 3-15
3.4.3.1 Provider Batch Address Labels - Build Utility. 3-16
3.4.3.2 Provider Address Labels - Print Utility 3-17
3.4.3.3 Discrepancy Avoidance Report 3-17

Introduction

The MCP functionality of CHCS enables users to perform online searches to find the most cost effective source of care for patients. The MCP network is an area-wide health care delivery system based on enrolled beneficiaries and cooperative agreements between military hospitals and civilian health care providers.

Provider network management is intended to accomplish the following:

- document negotiated agreements with civilian providers that provide accessible and cost-effective health care

- develop an integrated network of primary care and specialty care providers.

The MCP software supports collecting and maintaining information for a comprehensive health care network to augment medical treatment facility (MTF) direct-care capabilities. See Figure 5-1: Types of Provider Networks, and Figure 5-2: Creating the Network.

This network may include:

- PRIMUS/NAVCARE clinics
- civilian providers and group providers/health maintenance organizations (HMOs).

The MCP provider network includes both MTF (internal) and civilian (external) health care providers, in addition to MTF contracted providers.

Designated personnel create the structure for the provider network by entering provider group and individual provider information. This information comprises both group and individual profiles.

Definitions

Internal Providers - Internal providers are both military and civilian. The latter have partnership agreements to provide care within the MTF. Whenever possible, internal providers are used.

External Providers - Civilians with agreements to deliver health care, at discounted rates, to Military Health Service System (MHSS) beneficiaries at the provider's place of care.

External providers are used when military care is unavailable on a timely basis. The agreements with external providers are negotiated to obtain the highest quality services for the lowest rates.

Non-Network Provider - A provider who is not a member of the network; i.e., has not signed a network agreement and does not offer a negotiated discount for services.

Exception Provider - A non-network provider who has been identified to give specialized treatment to an enrolled patient based on one of the following:

- **Only Service Available Provider.** A provider who offers a specialty or service unique to the area. Only service available (OSA) providers can be exception providers. They appear on picklists when searching by specialty and location.

– A provider who has previously provided care for a patient and disruption of that care would be detrimental to the patient.

A non-MTF provider group can be created for the exception provider.

Network - A group of individual providers, provider groups, and institutions or services that have an agreement with the MTF to provide services, at a discounted rate, to TRICARE enrolled beneficiaries. This provider type includes MTF provider groups.

The Preferred Provider Organization (PPO) may also benefit non-enrolled patients. Non-enrolled patients may be booked to an MCP provider who charges a lesser rate than the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) allowable rate.

Valid network provider types

NGP - Network Provider Group (provider group only)

NPR - Network Individual Provider (individual providers)

NIS - Network Institution/Service (provider group only).

Non-Network

These individual providers, groups, and institutions or services do not have agreements to provide services, at a discounted rate, to MCP enrolled patients or as part of the PPO.

Beneficiaries may receive CHAMPUS-reimbursed services from non-network providers, if approved by the MTF.

Exception providers may be non-network providers.

Valid non-network provider types include the following:

XPR - Non-Network Provider (individual providers)

XGP - Non-Network Provider Group (provider group only)

XIS - Non-Network Institution/Service (provider group only).

Only Service Available

These individual providers, provider groups, and institution or services do not have an agreement to provide services at a discounted rate. However, the health care finder (HCF) may make referrals to these providers because they offer specialties or procedures not available within the network or through the Non-network providers.

Note: An exception provider may be an OSA provider or a non-network provider but not both.

Valid OSA provider types include the following:

OPR - Only Service Individual Providers (individual providers)

OGP - Only Service Provider Group (provider group only)

OIS - Only Service Institution/Service (provider group only).

3.1 Group Profile/Agreements Enter/Edit (GNET)

Menu Path: PAS System Menu → MAN → PMCP → GNET

Required Fields:

MCP Provider Group Name

Application Description:

The Group Profile/Agreements Enter/Edit option allows you to associate places of care, agreements, and providers with a provider group. It allows you to edit or view the group profile for a selected provider group, and to enter, edit, or view associated clinic profiles for the places of care.

Note: New MCP provider groups must first be created using the File/ Table for MCP Menu options. A group profile can be created only through the Group Enter/Edit option.

You may also add, edit, terminate, and/or renew group agreements. For any agreement, you may add, edit, and/or delete procedure and specialty exceptions, and add or edit primary care manager (PCM) enrollment mix data.

You may enter, edit, or view provider group member profiles. For a given provider group member, you may enter, edit, or delete data for provider agreements; for a given group agreement, you may indicate whether the member provider participates in it, edit the dates and discount rate for the provider, enter procedure

and specialty exceptions, and add or edit PCM enrollment mix data including PCM assignment limitations, age limitations and comments.

You may also inactivate or reactivate a place of care within the group, a provider member within the group, or a provider member within a place of care, and print a Discrepancy Avoidance Report and/or the Enrollment Mix Discrepancy Report.

Descriptions of the capabilities within this option have been separated into the following actions:

Agreements
Providers
Inactivate/Reactivate

Data Entry Process:

Refer to Section 2.2.1, page 2-127 for data entry details.

3.2 Individual Provider Profile/agreements Enter/edit (INET)

Menu Path: PAS System Menu → MAN → PMCP → INET

Required Fields:

MCP Provider Name
MCP Group Name
Output Device

Application Description:

The Individual Provider Profile/Agreements Enter/Edit option allows you to enter or edit individual provider profile and agreement data for selected MCP providers. In addition, you can inactivate or reactivate MCP providers or the providers' places of care. A provider can also be added as a new member to an existing MCP provider group. During the adding or editing process for Places of Care, you can use the Provider Profile Enter/Edit option to update provider profiles, since no appointments can be booked for the provider until PAS provider profile information is entered.

Data Entry Process:

Refer to Section 2.2.2, page 2-187, for data entry details.

3.3 Modify Group Agreement Effective Date (MNET)

Menu Path: PAS System Menu → MAN → PMCP → GNET → MNET

Required Fields:

MCP Provider Group Name
MCP Agreement Type
New Agreement Effective Date

Application Description:

The Modify Group Agreement Effective Date option allows you to modify the effective date of an agreement for a provider group. Each modification causes the system to produce an agreement history record; these records are numbered and sorted in chronological order. This option also allows you to view the agreement history records.

Data Entry Process:

Refer to Section 2.2.4, page 2-195, for data entry details.

3.4 Outputs & Network Management Reports (ONET)

Menu Path: PAS System Menu → MAN → PMCP → ONET

```
   GMRM   Group Management Reports Menu
   AMRM   Agreement Reports Menu
   MMRM   Miscellaneous Network Reports Menu

Select Outputs & Network Management Reports Menu Option:
```

Figure 3-1. Outputs & Network Management Reports Menu

3.4.1 Group Management Reports Menu (GMRM)

Menu Path: PAS System Menu → MAN → PMCP → ONET → GMRM

```
1    Group Member Roster
2    Provider Group Report
3    Provider List by Specialty
4    PCM Enrollment Mix Discrepancy Statistical Summary
5    PCM Enrollment Mix Discrepancy Report

Select Group Management Reports Menu Option:
```

Figure 3-2. Group Management Reports Menu

3.4.1.1 Group Member Roster

Menu Path: PAS System Menu → MAN → PMCP → ONET → GMRM → 1

Required Fields:

Provider group name
Provider name
Specialty name
Agreement type
Output device
Start time

Application Description:

The Group Member Roster option allows you to print a roster listing MCP provider groups, MCP providers within groups, and specialties and agreements pertaining to the providers. You can selectively generate the roster for One, Multiple, or All provider groups.

Use/Frequency:

This report should be run to verify that all groups have been set up and the correct group members identified. This report should be run when a group is added or updated to verify that a group has the correct members with the correct attributes.

Refer to Figure 3-2. Group Management Reports Menu, page 3-7.

3.4.1.2 Provider Group Report

Menu Path: PAS System Menu → MAN → PMCP → ONET → GMRM → 2

Required Fields:

Group Name
Place of Care
Agreement Type
Provider Name
Patient Type
Specialty/procedure code
Provide Type
Section
Output Device

Application Description:

The Provider Group Report option allows you to print a report by specified or selected MCP provider group(s) and section(s). You can select to print the report for One, Multiple, or All provider groups, and within the selected group(s), you can specify the section(s) to print.This report lists most of the MCP data elements collected for a provider or provider group and should be used to validate the accuracy and completeness of the provider record.

Following the group selection, the following sections are available for selection to be printed: group information, places of care, agreements and providers, PCMs, group level exceptions, and individual provider exceptions. Each section requested is printed on a separate page.

Use/Frequency:

As needed. This report should be run whenever a provider, particularly a PCM, is updated in the File and Table Build functions. The report should be used to validate the completeness and correctness of the total information set up for the provider. This report should be used to verify that:

– all places of care have been set up and are activated

– places of care are not duplicated

– groups and their members are appropriately defined and activated

– all specialties have been indicated for the provider and provider group

– individual provider agreement start and stop dates are within the group agreement start and stop dates

– the group is designated as a PCM if any group member is a PCM

– PCM enrollment mixes/capacities are set up correctly

– PCM capabilities have been entered correctly at the group and group member levels, including definition of the correct places of care and appropriate **specialties** indicated as primary care for the provider

– the maximum PCM capacities are set up consistently for the group and for each group member

– general verification of all provider data as needed.

Refer to Figure 2-88. Provider Group Report - Group Information, page 2-199.

3.4.1.3 Provider List by Specialty

Menu Path: PAS System Menu → MAN → PMCP → ONET → GMRM → 3

Required Fields:

Provider type
Specialty
Provider
Provider group
Agreement type
Output device
Start time

Application Description:

The Provider List by Specialty option allows you to print reports listing providers by provider type and specialty. The report totals MCP providers by provider type and by specialty.

You can select to print reports for network providers, for One, Multiple or All specialties, or to print reports for One, Multiple or All MCP provider types and by One, Multiple or All specialties.

Use/Frequency:

As needed. This report should be run to determine if all specialties are appropriately covered by the network. The report allows you to evaluate the types of agreements in the network and the distribution across specialties, as well as expiration dates and discounts.

Refer to Figure 2-92. Provider List by Speciality, page 2-207.

3.4.1.4 PCM Enrollment Mix Discrepancy Statistical Summary

Menu Paths: PAS System Menu → MAN → PMCP → ONET → GMRM → 4

PAS System Menu → MAN → OMCP → PRPT → 7

PAS System Menu → MAN → EMCP → OENR → PRPM→ 7

Required Fields:

Group name
PCM
Output device

Application Description:

The PCM Enrollment Mix Discrepancy Statistical Summary option allows you to generate and print reports identifying PCMs whose patient loads exceed their PCM capacity for one or more beneficiary categories or who have beneficiaries assigned to them whose ages are outside of the PCMs' assigned age range preferences. The system allows you to sort by PCM or by group. Within each PCM or group, the system sorts by agreement. The report identifies by an asterisk (*) the PCM beneficiary categories that have discrepancies and displays the numeric values of the discrepancies.

The system allows you to sort by group or PCM and to select One, Multiple or All of the selected category. The report sorted by group lists the groups alphabetically and, within each group, lists the providers alphabetically. The report includes a statistical summary of the group's capacity and age range preferences and associated patient load, as well as the statistics for each of the providers within the selected group. The report is sorted by PCM and lists alphabetically all PCMs who have discrepancies and includes a statistical summary of their capacity and age range preferences and associated patient load. The report does not include providers who have no discrepancies or groups whose providers have no discrepancies.

Use/Frequency:

As needed.

Refer to Figure 2-93. PCM Enrollment Mix Discrepancy Statistical Summary, page 2-209.

3.4.1.5 PCM Enrollment Mix Discrepancy Report

Menu Paths: PAS System Menu → MAN → PMCP → ONET → GMRM → 5

PAS System Menu → MAN → EMCP → OENR→ PRPM → 8

PAS System Menu → MAN → EMCP → OENR → PRPM→ 8

Required Fields:

Group name
PCM
Beneficiary category
Output device

Refer to Figure 2-94. PCM Enrollment Mix Discrepancy Report, page 2-211.

3.4.2 Agreement Reports Menu (AMRM)

3.4.2.1 Provider Alphabetic Agreement Roster

Menu Path: PAS System Menu → MAN → PMCP → ONET → AMRM → 1

Required Fields:

Provider type
Provider name
Provider group
Agreement type
Output device
Start time

Application Description:

The Provider Alphabetic Agreement Roster option allows you to print reports alphabetically listing current provider agreements. The listed agreement data includes provider, specialty, provider group, effective date, stop date, discount, and exceptions indicator.

You can select One, Multiple or All provider types for the roster. The agreements are sorted by provider type, provider name, and provider group. Specialties are listed for each provider. Agreements are totaled by provider type.

If you select Network, the report is sorted by the three Provider Types that imply network membership - Network Individual Provider, Network Institution/Service, and Network Provider Group. Report data is the same as if selected by One, Multiple or All provider types.

Use/Frequency:

Run this report as needed, to evaluate the scope of the contracts available to support care in the network.

Refer to Figure 2-95. Provider Alphabetic Roster, page 2-213.

3.4.2.2 Specialty Provider Agreement Roster

Menu Path: PAS System Menu → MAN → PMCP → ONET → AMRM → 2

Required Fields:

Provider type
Specialty type
Agreement type
Provider name
Group name
Output device
Start time

Application Description:

The Specialty Provider Agreement Roster option allows you to print agreement rosters for all active network providers for One, Multiple, or All provider types by One, Multiple, or All specialties. Totals are provided for specialty for provider type.

For provider types that imply individuals, the roster lists the provider's group agreements and the associated effective dates, stop dates, discounts, and exceptions indicators. For provider types that imply groups, for each specialty, the roster lists the agreement, group, effective stop date, discount rate and exceptions.

Use/Frequency:

This report should be run as needed to determine the total support available for a specialty and the projected agreement expiration dates of the providers supporting the specialty. Agreement expirations are listed by type of agreement.

Refer to Figure 2-96. Specialty Provider Agreement Roster, page 2-217.

3.4.2.3 Specialty Provider Agreement Summary

Menu Path: PAS System Menu → MAN → PMCP → ONET → AMRM → 3

Required Fields:

Provider type
Specialty
Output device
Start time

Application Description:

The Specialty Provider Agreement Summary option allows the you to print a summary report giving the number of agreements by provider type, provider specialty, and agreement type. Totals are given for agreements pertaining to a specialty and total agreements pertaining to a provider type. Grand totals are provided for the entire facility.

Use/Frequency:

This report should be run as needed, to determine the volume of agreements in effect on the report run date and the specialties and agreement types supported.

Refer to Figure 2-97. Specialty Provider Agreement Summary, page 2-218.

3.4.2.4 Discount Provider Agreement Roster (obsolete under TRICARE)

Menu Path: PAS System Menu → MAN → PMCP → ONET → AMRM → 4

Required Fields:

Provider type
Specialty
Discount
Provider name
Provider group
Output device
Start time

Application Description:

The Discount Provider Agreement Roster option allows you to print reports showing all active provider agreements by discount. Totals are provided showing the total number of providers for each discount rate. The report is sorted by agreement type, provider type, provider specialty, and discount rate.

Use/Frequency:

Run this report to evaluate the savings realized by the provider network and the trends in discounting among network providers.

Refer to Figure 2-98. Discount Provider Agreement Roster, page 2-220.

3.4.2.5 Expiration Date Provider Agreement Roster

Menu Path: PAS System Menu → MAN → PMCP → ONET → AMRM → 5

Required Fields:

Agreement type
Date range
Output device
Start time

Application Description:

The Expiration Date Provider Agreement Roster option allows you to print reports of MCP provider agreements which expire within a specified date range for One, Multiple, or All agreement types, sorted alphabetically by provider, and within provider, by provider group. The report displays provider agreement and specialty data. Subtotals are shown at the end of the report for the agreement types with an overall total for all the agreements shown on the report.

Use/Frequency:

Monthly or as needed to determine when agreements are about to expire.

Refer to Figure 2-100. ZIP Code Agreement Roster, page 2-226.

3.4.2.6 ZIP Code Agreement Roster

Menu Path: PAS System Menu → MAN → PMCP → ONET → AMRM → 6

Required Fields:

ZIP code
Specialty
Provider group
Provider
Agreement type
Output device
Start time

Application Description:

The ZIP Code Agreement Roster option allows you to print rosters listing and totaling providers by ZIP Code and specialty. You can generate a roster for a single ZIP Code or a ZIP Code combination, for One, Multiple or All specialties, and either for all providers or for PCMs only.

The roster is sorted by ZIP Code, provider specialty, provider name, provider group, agreement type, and agreement effective date.

Use/Frequency:

Monthly or as required to identify the geographic distribution of network providers and specialties.

Refer to Figure 2-100. ZIP Code Agreement Roster, page 2-226.

3.4.3 Miscellaneous Network Reports Menu (MMRM)

```
1    Provider Batch Address Labels - Build Utility
2    Provider Batch Address Labels - Print Utility
3    Discrepancy Avoidance Report

Select Miscellaneous Network Reports Menu Option:
```

Figure 3-3. Miscellaneous Network Reports Menu (MMRM)

3.4.3.1 Provider Batch Address Labels - Build Utility

Menu Path: PAS System Menu → MAN → PMCP → ONET → MMRM → 1

Required Fields:

Provider name
Agreement type
Specialty
Expiration
Output device

Application Description:

The Provider Batch Address Labels - Build Utility option allows you to select providers by provider name, agreement type, specialty, or expiration date to generate provider payment address labels. You can specify One, Multiple, or All providers, One, Multiple, or All agreement types, and One, Multiple, or All specialties.

Note: When selecting providers by agreement type, you must also specify an expiration date. The system only selects providers who participate in a specified agreement that expires on that specified date.

When specifying selection by an expiration date without selecting agreements, the system selects providers who participate in any agreement that expires on the specified date.

When you specify a provider for the search, the system searches the Provider file by the specified provider name to generate labels.

Based on the search criteria entered, the system searches the MCP Provider file for all providers that meet the specified search criteria.

Providers who meet the search criteria during the above search and have complete payment address information are placed in a global file which may be used to generate and print labels using the Provider Batch Address Labels - Print Utility option.

Providers who meet the search criteria during the above search but have incomplete (missing) payment address information are placed in a global file which may be generated and printed using the Incomplete Provider Address Report option.

Refer to Figure 3-3. Miscellaneous Network Reports Menu (MMRM), page 3-15.

3.4.3.2 Provider Address Labels - Print Utility

Menu Path: PAS System Menu → MAN → PMCP → ONET → MMRM → 2

Required Fields:

User name
Output device

Application Description:

The Provider Batch Address Labels - Print Utility option allows you to print provider address labels which were compiled using the Provider Batch Address Labels - Build Utility option.

The system allows you to display a picklist of all global label batches compiled at various times for a specific user or for all users. After you select a batch from the picklists, you can print the labels, delete the batch, or view the search criteria that were used to compile the labels.

You can print a batch of labels in its entirety or print a subset of the batch. If you elect to print a subset, the system prompts you to indicate the number of labels to print and then prints that number of labels in alphabetical order. After the system prints a label, that label is deleted and cannot be reprinted unless the provider batch address labels are rerun. If all the labels in the batch are printed, the batch is no longer accessible through this option. Batches of labels remain on the system until all the labels have been printed or until a user deletes the batches through this option.

3.4.3.3 Discrepancy Avoidance Report

Menu Path: PAS System Menu → MAN → PMCP → ONET → MMRM → 3

Required Fields:

Place of care
Provider group name
Provider name

Application Description:

The Discrepancy Avoidance Report option allows you to generate a report that informs you of the groups, providers, and patients in a given place of care or a provider that need to be changed before the place of care or provider may be inactivated.

Before any place of care can be inactivated, any booked appointments, booked appointments related to referrals, and/or any patients assigned to the place of care as the PCM need to be resolved. The system also issues a warning if you try to inactivate the only place of care associated with an individual provider.

If you generate this report for a **place of care**, you can choose one of three selection criteria:

1. All providers in all groups
2. A single group
3. A single provider in a single group.

The report consists of four sections. Each section is sorted first by groups to which the place of care belongs, and then by providers within the group and place of care. The sections contain the following data:

1. Patients assigned to providers as PCMs
2. Patients having appointments with and referrals to providers
3. Patients having wait list requests for providers
4. Providers in each group.

If you generate this report for a **provider**, you can choose one of two selection criteria:

1. All groups
2. Selected groups.

The report consists of four sections. Each section is sorted first by groups to which the provider belongs, and then by places of care for the provider within the group. The sections contain the following data:

1. Patients assigned to the provider as a PCM
2. Patients having appointments with and referrals to the provider
3. Patients having wait list requests for the provider
4. Places of care in each group.

You can also generate this report from those options which perform inactivations and reactivations:

1. The Group Profile/Agreements Enter/Edit option
   a. A place of care can be inactivated from a group
   b. A place of care can be inactivated from a provider
   c. A provider can be inactivated from a group
2. The Individual Provider Profile/Agreements Enter/Edit option
   a. A place of care can be inactivated from a provider
   b. A provider can be inactivated from a group
3. The Provider Enter/Edit option
   a. A provider can be inactivated from all of MCP.

Use/Frequency:

Run this report as required to identify the following in order to inactivate a provider or place of care:

- beneficiaries whose referrals or appointments may need to be rescheduled
- enrollees who may need to be reassigned to another PCM
- wait list requests that may need to be assigned to another provider or place of care
- places of care that may need to be inactivated
- provider members of the group.

Refer to Figure 2-101. Discrepancy Avoidance Report, page 2-233.

CHCS: MCP DESKTOP USER GUIDE

4. DEERS FUNCTIONS AND PROCESSES

Brief Outline

4.1 DEERS Check (Enrollment/Family Member Screens) 4-1
4.2 DEERS Check (Non-Enrollment/Individual Screens) 4-8
4.3 Current DEERS Eligibility Display 4-13
4.4 Enrollees of USTF Managed Care Program 4-17
4.5 CHCS/DEERS Discrepant Data Check 4-19
4.6 Interactive DEERS Eligibility Request 4-24
4.7 DEERS Purge Parameter 4-27
4.8 PAS DEERS Ineligibility Report 4-30
4.9 MCP DEERS Ineligibility Report 4-32

Introduction

The Defense Eligibility Enrollment Reporting System (DEERS) interface is available to CHCS functionality upon demand.

4.1 DEERS Check (Enrollment/Family Member Screens)

Menu Paths:

PAS System Menu → MAN → EMCP → EENR
PAS System Menu → MAN → EMCP → RENR

Application Description:

The DEERS Eligibility Check (Enrollment/Family Member Screens) is invoked for patients being processed through Enrollment functionality only (Enrollment Enter/Edit option or the Reciprocal Disenrollment Processing option). The DEERS Eligibility check is required to determine a selected patient's eligibility for direct care, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Medicare in addition to informing you of the patient's enrollment status and participation in other programs, such as CHAMPUS Dental and Uniformed Services Treatment Facilities (USTF) enrollees.

During enrollment processing, it is likely that not only will the initially selected patient be enrolled but it will most likely be desirable that other members of the family be enrolled as well. The family screen method of processing the DEERS check allows you to rapidly process all selected family members through DEERS

and determine the eligibility for each. The family member connection is determined by the comparison of sponsor social security number (SSN).

After entering the patient's name and confirmation of the name entered, the system performs a DEERS check on the patient. If the patient is not found in DEERS, the system allows you to print the DEERS Eligibility Data Report and then exits the option (refer to Figure 4-7. DEERS Eligibility Data, page 4-11). If the system has performed a DEERS check on the patient within the past five days, the system displays the Current DEERS Eligibility Display screen (refer to Figure 4-10. Current DEERS Eligibility, page 4-15), then displays the Discrepancy screen (refer to Figure 4-13. CHCS/DEERS Discrepancy Data Screen, page 4-21), if appropriate. If you request today's eligibility and enrollment information from DEERS, CHCS displays the DEERS Eligibility Data screen with today's eligibility data directly from DEERS.

After the DEERS check, the system displays to the Demographics Display screen for continuing processing function selection. If the DEERS link is down, the system displays a warning/information message and continues to the Demographics Display screen. Enrollment status is set to "PENDING" if the DEERS link is down and no DEERS check has been made within the past five days.

If a selected patient is determined to be ineligible as a result of the DEERS check, and you have sufficient information to continue an enrollment process, you can enter an override reason and continue processing the enrollment. However, an override is not recommended since DEERS will reject an enrollment on an ineligible beneficiary.

During each DEERS check, CHCS data is compared to DEERS data through the interface linking these two systems, and discrepancies display (refer to Figure 4-13. CHCS/DEERS Discrepancy Data Screen, page 4-21).

Required fields:

Patient name
Sponsor name

Data Entry Process:

<u>Checking DEERS Eligibility During Enrollment or Reciprocal Disenrollment</u>

Select patient

View family members

Select other family members to process

Select patient

Upon entering the DEERS Check (Enrollment/Family Member screen) either from the Enrollment Enter/Edit option or the Reciprocal Disenrollment Processing option, the system displays the name of the patient that it has identified and requests confirmation of the patient name and sponsor name prior to continuing with the DEERS check (refer to Figure 4-1. Select Patient Name Prompts, page 4-3). You are allowed either to confirm and continue or to enter a negative response and return to the *Select PATIENT NAME* prompt to specify another patient name. If the patient is not registered in CHCS, enter patient identification data into CHCS.

```
Select PATIENT NAME: MOREHOUSE,JERALD     20/477-23-3789 01 Apr 1970 M
         OK? YES//   (YES)
SPONSOR NAME: MOREHOUSE,JERALD//
```

Figure 4-1. Select Patient Name Prompts

CHCS uses the sponsor SSN to request a family member response from DEERS. The Family Member Screen (refer to Figure 4-2. Family Member Screen, page 4-4) displays today's DEERS eligibility data for each member in the family. Then the system automatically performs a DEERS Check and if the patient has been determined to be ineligible for this enrollment, the system then allows you to enter an override code and continue with the enrollment or to abort from the enrollment process and return to the *Select PATIENT NAME* prompt. (Refer to Figure 4-7. DEERS Eligibility Data, page 4-11.) Entering an override is not recommended since DEERS will reject enrollments for ineligible beneficiaries. The usual procedure is to require the beneficiaries to correct their data in DEERS before they can be enrolled. DEERS sends data for up to 23 family members.

```
                              FAMILY MEMBER SCREEN
        Patient Name: MOREHOUSE,JERALD                 FMP/SSN: 20/577-23-3789
                 DOB: 01 Apr 1970
        Sponsor Name: MOREHOUSE,JERALD              Sponsor SSN: 577-23-3789
     Elig Start Date: 09 Feb 1992                 Elig End Date: INDEFINITE
   ---------------------------------------------------------------------------
      Name                        Sex     DOB       DDS  ACV  Dir  Med  DMIS ID
   ___________________________________________________________________________
      MOREHOUSE,JERALD            M    01 Apr 1970  20    A     E    N  1000
      MOREHOUSE,MARYANNE          F    01 Aug 1993   1    N     E    N
      MOREHOUSE,IRVING            M    01 Jul 1996   2    E     E    N  1000
      MOREHOUSE,KATHRYN           F    09 Apr 1969  30    N     E    N


   MOREHOUSE,JERALD is this the patient you are enrolling? Yes//
```

Figure 4-2. Family Member Screen

1. Press <Return> to accept the "Yes" default.

View family members

At this point, you are offered an opportunity to select other family members, one at a time, to process from the list of family members displayed. Prior to selecting a family member for enrollment, you can view family members currently registered in CHCS. (Refer to Figure 4-3. Family Member Screen, page 4-4.)

```
                              FAMILY MEMBER SCREEN
     Patient Name: MOREHOUSE,MARYANNE                 FMP/SSN: 01/577-23-3789
              DOB: 01 AUG 1993
     Sponsor Name: MOREHOUSE,JERALD               Sponsor SSN: 577-23-3789
  Elig Start Date: 09 Feb 1992                  Elig End Date: INDEFINITE
---------------------------------------------------------------------------
    Name                        Sex     DOB       DDS  ACV  Dir  Med  Status
 ___________________________________________________________________________
    MOREHOUSE,JERALD            M    01 Apr 1970  20    A     E    N   E
    MOREHOUSE,MARYANNE          F    01 Aug 1993   1    N     E    N   C
    MOREHOUSE,IRVING            M    01 Jul 1996   2    E     E    N   E
    MOREHOUSE,KATHRYN           F    09 Apr 1969  30    N     E    N   E


 ___________________________________________________________________________
 Use SELECT key to select Other Family Member(s) to process, or use F9 key
to view family members currently registered in CHCS
```

Figure 4-3. Family Member Screen

1. Position the cursor next to a family member name that you want to view before processing and press <F9>.

   The system displays the CHCS Family Member Screen (refer to Figure 4-4. CHCS Family Member Screen, page 4-5).

```
                              CHCS FAMILY MEMBER SCREEN
     Patient Name: MOREHOUSE,MARYANNE                 FMP/SSN: 01/577-23-3789
               DOB: 01 AUG 1993
     Sponsor Name: MOREHOUSE,JERALD               Sponsor SSN: 577-23-3789
  Elig Start Date: 09 Feb 1992                  Elig End Date: INDEFINITE
-------------------------------------------------------------------------------
    Name                          Sex     DOB       DDS  ACV  Dir  Med  Status
 ____________________________________________________________________________
    MOREHOUSE,JERALD              M    01 Apr 1970  20    A     E    N   E
    MOREHOUSE,MARYANNE            F    01 Aug 1993   1    N     E    N   C
    MOREHOUSE,IRVING              M    01 Jul 1996   2    E     E    N   E
    MOREHOUSE,KATHRYN             F    09 Apr 1969  30    N     E    N   E


 ____________________________________________________________________________
 Use Prev Screen/Next Screen keys to view family members currently registered
 in CHCS, or Press <RETURN> to continue
```

Figure 4-4. CHCS Family Member Screen

1. Press <Return> to continue.

   The system redisplays the Family Member Screen where you can select the family member you want to process next. (Refer to Figure 4-5. Family Member Screen (Second Family Member), page 4-6.)

Select other family members to process:

```
                                FAMILY MEMBER SCREEN
    Patient Name: MOREHOUSE,MARYANNE                 FMP/SSN: 01/577-23-3789
             DOB: 01 Aug 1993
    Sponsor Name: MOREHOUSE,JERALD               Sponsor SSN: 577-23-3789
 Elig Start Date: 09 FEB 1992                  Elig End Date: INDEFINITE
-------------------------------------------------------------------------------
    Name                          Sex     DOB       DDS ACV  Dir  Med  DMIS ID
 ____________________________________________________________________________
 +* MOREHOUSE,MARYANNE            F    01 Aug 1993   1    N     E    N
    MOREHOUSE,IRVING              M    01 Jul 1996   2    E     E    N   1000
    MOREHOUSE,KATHRYN             F    09 Apr 1969  30    N     E    N


 ____________________________________________________________________________

  MOREHOUSE,MARYANNE  01/577-23-3789  01 Aug 1993  F
Family member match found in CHCS, is this the correct family member?
```

Figure 4-5. Family Member Screen (Second Family Member)

1. Position the cursor next to the family member(s) you want to process next then press <Select>.

2. Enter "Y" at the *Family member match found in CHCS, is this the correct family member?* question.

3. If "N" is entered, the system asks, *Are you adding 'BLITON,MARK' as a new PATIENT?* If you enter "Y," the system displays the mini registration screen and allows you to register this family member in CHCS.

Note: If a discrepancy exists between CHCS and DEERS for the beneficiary, the CHCS/DEERS DISCREPANCY DATA screens display (refer to Figure 4-13. CHCS/DEERS Discrepancy Data Screen, page 4-21).

The system then processes each family member selected as it did the first family member. Each member is processed for registration, in turn, but not for enrollment. To enroll family members, select F(a)mily on the action bar.

Completion of DEERS Check (Enrollment/Family Member Screens)

An individual DEERS check is performed on the family members only if this is a new registration.

Following the DEERS Check, if the results determine that a selected family member has data discrepancies between the CHCS and DEERS files, the CHCS/DEERS Discrepant Data Check is invoked (refer to 4.5 CHCS/DEERS Discrepant Data Check, page 4-19).

Additionally, if the system determines that the selected family member is currently enrolled in USTF, a warning message displays and the beneficiary cannot be enrolled (refer to 4.4 Enrollees of USTF Managed Care Program, page 4-17).

Note: DEERS and CHCS communicate with one another not only interactively, but also through batch transactions such as eligibility, registration, address updates, and enrollment transactions. After the enrollment data is filed in CHCS, CHCS computes the alternate care value (ACV) from the CHCS patient category and sends an enrollment transaction to DEERS (depending on enrollment mode for non-active duty enrollees). The enrollment status is usually set to enrolled, pending enrollment, or conditional enrollment. DEERS in turn sends an acceptance transaction back to CHCS containing the enrollment data sent from CHCS.

If DEERS returns a discrepancy response to CHCS, the MCP Status of the enrollment is changed from Enrolled, Conditional Enrollment, or Pending Enrollment to Invalid Enrollment by a nightly job. Conversely, if DEERS returns a successful response to CHCS, an enrollment with an MCP Status of Invalid Enrollment remains as originally initialized.

A Pending Enrollment is an enrollment with a future enrollment date; an enrollment with status Pending Enrollment acquires a status of Enrolled on that date.The Pending status also results when a DEERS check is batched.

After completing an enrollment or disenrollment transaction in CHCS, the system sends an enrollment or disenrollment transaction to DEERS as a background process for active duty patients while in local empanelment mode and for all patients when in DEERS enrollment mode. The enrollment mode has no effect on active duty enrollments.

After completing all DEERS checks and registration for all selected family members, the system returns to the Demographics Display screen of the option in process (Enrollment Enter/Edit or Reciprocal Disenrollment Processing option). In order to enroll the family members you must select F(a)mily from this action bar.

4.2 DEERS Check (Non-Enrollment/Individual Screens)

Menu Paths:

PAS System Menu → MAN → HMCP → PHCF
PAS System Menu → MAN → HMCP → AHCF
PAS System Menu → MAN → HMCP → NHCF
PAS System Menu → MAN → NMCP
PAS System Menu → MAN → IMCP → NNAS
PAD System Menu → ROM → DER
PAS System Menu → MAN → RMCP → RREG → DRDM
PAS System Menu → MAN → EMCP → IENR
PAS System Menu → CLERK → ROM → DRDM
PAS System Menu → EMER → RER → 2
(and any other menu where you must register a new patient)

Application Description:

The DEERS Eligibility Check (Non-Enrollment/Individual Screens) may be invoked automatically by CHCS or requested for individual patients. The DEERS check determines the patient's eligibility for Direct Care, CHAMPUS, and Medicare. It also informs you of the patient's enrollment status and participation in other programs, such as CHAMPUS Dental and USTF.

After performing a DEERS Eligibility check, you may access up to 10 segments of the patient's historical DEERS eligibility information, and may view and correct existing discrepancies between DEERS data stored in CHCS and the data currently residing in the DEERS database (refer to 4.5 CHCS/DEERS Discrepant Data Check, page 4-19).

Note: From the individual eligibility request options, a "Family Member" screen response results, as the first screen in the Individual DEERS Check, under the following conditions:

1. By user requested Interactive DEERS Check (FMP equals 99 on a sponsor request)

2. If the DEERS database does not contain a direct match to a patient (the DOB does not match and no corresponding DDS is available on CHCS)

3. Individuals within the family having the same dates of birth (as in the case of twins)

4. Automatically performed in Enrollment Processing.

The Family Member screen allows you to view the family members and select the family member to process. CHCS then requests an individual eligibility check that includes the historical eligibility data for the selected family member.

Required fields:

Patient name
Sponsor name

To request a DEERS Check

Data Entry Process:

Select patient
Display Family Member screen from DEERS
Ineligibility Override
View more DEERS data

Select patient

Refer to Select patient, page 4-3.

Display Family Member screen from DEERS

If the DEERS request was initiated by an family member prefix (FMP)=99 code, or if the DEERS database does not contain a direct match to the patient specified date of birth (DOB) does not match and no corresponding DEERS Dependent Suffix (DDS) is available on CHCS), or if two individuals within the same family have the same date of birth (as in the case of twins), the system then displays the Family Member screen from DEERS and allows you to select the correct patient to process for the DEERS eligibility check. (Refer to Figure 4-6. Family Member Screen, page 4-10.)

```
                              FAMILY MEMBER SCREEN
    Patient Name: PEARL,ALAN N                       FMP/SSN: 20/469-69-4415
             DOB: 25 Sep 1973
    Sponsor Name: PEARL,ALAN N                   Sponsor SSN: 469-69-4415
 Elig Start Date:                              Elig End Date:
-------------------------------------------------------------------------------
   Name                          Sex     DOB       DDS  ACV  Dir Med DMIS ID
_______________________________________________________________________________
   PEARL,ALAN N                  M    25 Sep 1973  20    N     E   N
   PEARL,ALICE N                 F    20 Nov 1974  30    C     E   N
   PEARL,ARNOLD N                M    03 Jan 1994   1    C     E   N
   PEARL,ALEXANDER E             M    12 Mar 1996   4    E     E   N
   PEARL,ANTHONY E               M    11 Feb 1992   2    E     E   N
   PEARL,AMANDA E                F    11 Mar 1995   3    E     E   N


_______________________________________________________________________________
Use SELECT key to select Patient for an individual eligibility check.
Use F9 key to view current patient eligibility or
Press RETURN to continue.
```

Figure 4-6. Family Member Screen

1. Position the cursor beside the patient name you want to process and press <Select>.

   The system displays the DEERS Eligibility Data Screen (refer to Figure 4-7. DEERS Eligibility Data, page 4-11).

Ineligibility Override

If the patient is ineligible, the system allows you to enter an override code and continue or abort the process and return to the *Select PATIENT NAME* prompt. (Refer to Appendix A, DEERS ELIGIBILITY OVERRIDE CODE PICKLIST on page A-22, for a list of possible override codes.)

```
                              DEERS ELIGIBILITY DATA
                 Name: PEARL,ERIC                  FMP/SSN: 05/469-69-4415
     Patient Category: USN ACTIVE DUTY                   DDS:
               DOB/Age: 15 Jun 2001/                      Sex: MALE
_____________________________________________________________________________
                     NAME:
                      SEX:                                     DOB: 25 Sep 1973
                      DDS:                             Sponsor SSN: 469-69-4415
                      ACV:
          ACV Start Date:                              Region Code:
                 DMIS ID:
  Care Authorization PH#:                             PCM Location:
            Sponsor Rank:
             Sponsor UIC:
             Direct Care: NOT ELIGIBLE                    Medicare:
Dir Care Elig Start Date:                                  CHAMPUS:
  Dir Care Elig End Date:
  Eligibility End Reason:

                                       BRAC Pharmacy Eligibility:
______________Patient Ineligible. Enter Override to continue_______________
Select to (V)iew more DEERS data,(H)istorical DEERS(O)verride Ineligibility,
       (P)rint, or (Q)uit: O//

Do you want to Override the DEERS Ineligibility and continue? No//

Select DEERS ELIGIBILITY OVERRIDE CODE:
```

Figure 4-7. DEERS Eligibility Data

1. Press <Return> to accept the default (O)verride Ineligibility action.

2. Enter "Y" at the *Do you want to Override the DEERS Ineligibility and continue? No//* prompt.

3. Enter the appropriate DEERS Eligibility Override Code at the *Select DEERS ELIGIBILITY OVERRIDE CODE* prompt.

Note: The data displayed in Figure 4-7. DEERS Eligibility Data, page 4-11 is from the DEERS database.

It is not recommended that you override an ineligibility since DEERS rejects enrollments on an ineligible beneficiary. The customary procedure is to notify the beneficiary to correct their eligibility in DEERS.

View more DEERS data

The action bar on the DEERS Eligibility Data screen also allows you to (V)iew more DEERS data, view (H)istorical DEERS data, or (P)rint DEERS data (refer to the action bar shown in Figure 4-7. DEERS Eligibility Data, page 4-11). If you choose (V)iew more DEERS data the system displays the screen shown in Figure 4-8. DEERS Eligibility Data (View Action), page 4-12. If you choose (H)istorical DEERS, you can view up to 10 segments of historical DEERS eligibility. If you choose (P)rint DEERS data, you can print the DEERS Check information and the historical data. (Refer to Figure 4-9. Historical DEERS Eligibility Data Screen, page 4-13.)

```
                              DEERS ELIGIBILITY DATA
                    Name: PEARL,ERIC              FMP/SSN: 05/469-69-4415
       Patient Category: USA FAM MBR AD              DDS: 20
                 DOB/Age: 01 Apr 1970/26Y             Sex: MALE
_____________________________________________________________________________
   CHAMPUS Dental Flag:
     Dental Start Date:                              Dental End Date:
     Date Last Updated:                               Panograph Date:
              NAS Flag:                                  Organ Donor: YES
  Reportable Disease                                             DNA:
  Database (RDDB) Date:
       Date of Request: 21 Jun 2001@152350
_________________Patient Ineligible. Enter Override to continue_______
  Press <RETURN> to continue
```

Figure 4-8. DEERS Eligibility Data (View Action)

1. Press <Return> to continue.

Historical DEERS data

The system redisplays the DEERS Eligibility Data screen and action bar (refer to Figure 4-7. DEERS Eligibility Data, page 4-11). Choose the (H)istorical DEERS action to display the Historical DEERS Eligibility Data. The sample screen shown in Figure 4-9. Historical DEERS Eligibility Data Screen, page 4-13, is for an active duty patient with extensive historical DEERS data. The plus (+) at the bottom of the middle screen indicates that there is additional data that can be displayed by pressing <Prev Screen> or <Next Screen>.

```
                    HISTORICAL DEERS ELIGIBILITY DATA
                 Name: MOREHOUSE,JERALD            FMP/SSN: 20/577-23-3789
       Patient Category: USA ACTIVE DUTY OFFICER           DDS: 20
                DOB/Age: 01 Apr 1970/26Y                   Sex: MALE
_____________________________________________________________________________
   Period                Direct Care      CHAMPUS          Medicare        ACV
_____________________________________________________________________________
   Date of Request:   04 Dec 1996@113836
   01 Jan 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     N
   01 Mar 95

   02 Mar 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     A
   05 Apr 95

   06 Apr 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     N
   14 Nov 95

   15 Nov 95             ELIGIBLE        NOT ELIGIBLE     NOT ELIGIBLE     A
+  29 Nov 95
_____________________________________________________________________________
Use the PrevScreen and Next Screen to view more data or
Press <RETURN> to continue
```

Figure 4-9. Historical DEERS Eligibility Data Screen

After completing the individual DEERS eligibility/enrollment, the system automatically returns to the point of entry of the option in process (normally the Demographics Display screen).

4.3 Current DEERS Eligibility Display

Menu Paths:

PAS System Menu → MAN → HMCP → PHCF
PAS System Menu → MAN → HMCP → AHCF
PAS System Menu → MAN → HMCP → NHCF
PAS System Menu → MAN → NMCP
PAS System Menu → MAN → EMCP → EENR
PAS System Menu → MAN → EMCP → RENR
PAS System Menu → MAN → IMCP → NNAS
PAD System Menu → ROM → FRG*
PAD System Menu → ROM → MRG*
PAD System Menu → ADT → ADM*

* Only when processing a new patient.

Application Description:

The Current DEERS Eligibility Display screen displays when the patient being processed through any of the menu paths listed above has had a DEERS check performed within the last five days. Data displayed on the Current DEERS Eligibility Display screen is from data stored in the CHCS database from the latest eligibility check and may not reflect the patient's most current DEERS eligibility data. Following enrollment, the system does not request the newest eligibility data from DEERS. Thus, the five-day eligibility reflects the patient's pre-enrollment status. Sites should initiate a new eligibility check after enrollment on all enrollees to verify that DEERS processed the enrollment and to store that information for the five-day check.

Required Data:

Patient name
Sponsor name

Data Entry Process:

To Access the Current DEERS Eligibility Screen

Access the *Select PATIENT* prompt through one of the above-listed menu paths
Select patient
Display five-day eligibility information
Display Current DEERS Eligibility second screen

Access the *Select PATIENT* prompt through one of the above-listed menu paths

Select patient

Refer to Select patient, page 4-3.

Display five-day eligibility information

If a DEERS check has been performed on the selected patient within the past five days, the system displays the Current DEERS Eligibility screen showing the data from that transaction. An action bar allows you to:

– (V)iew additional DEERS data

– (P)rint a copy of the DEERS data for the selected patient

– (R)epeat/initiate another DEERS check for the current date, or

– (C)ontinue accepting the information as shown and continue the process begun when this DEERS check was invoked (refer to Figure 4-10. Current DEERS Eligibility, page 4-15). The date of request on this screen indicates the date the eligibility check was received from DEERS. Consult this date to determine whether the DEERS check should be repeated to obtain more recent information.

```
                              CURRENT DEERS ELIGIBILITY
                Name: MOREHOUSE,KATHRYN             FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                      DDS: 30
               DOB/Age: 09 Apr 1969/26Y                     Sex: FEMALE
_____________________________________________________________________________
            Sponsor Rank: CAPTAIN
             Sponsor UIC: 31127-NAVCRUSERVDET HONOLULU
                 DMIS ID: 6501-TRICARE
                     ACV: E-MCP ENROLLED/DIR.  CARE CHAMPUS ELIGIBLE
          ACV Start Date: 01 Jul 1995            Region Code: 02
  Care Authorization PH#: 619-555-7526          PCM Location: CONTRACT
             Direct Care: ELIGIBLE                  Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 09 Feb 1992                CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: INDEFINITE
  Eligibility End Reason: U-Not Predictable

                                     BRAC Pharmacy Eligibility: NOT ELIGIBLE
           Override Code:
         Date of Request: 04 Dec 1996@1307
_____________________________________________________________________________
Select to (V)iew more DEERS data, (P)rint, (R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 4-10. Current DEERS Eligibility

Actions on the Current DEERS Eligibility action bar:

(V)iew more DEERS: When you select this action, a second screen displays containing the remainder of the DEERS data for the selected patient (refer to Figure 4-11. Current DEERS Eligibility, Second Screen, page 4-16). After viewing, press <Return> to return to the screen and action bar shown in Figure 4-10. Current DEERS Eligibility, page 4-15.

(P)rint: When you select this action, enter a printer name and press <Return> at the *RIGHT MARGIN: 80//* prompt. The system prints a copy of the data on both the initial Current DEERS Eligibility screen and the second Current DEERS Eligibility screen to the printer you selected (refer to Figure 4-12. Current DEERS Eligibility Hard Copy Printout, page 4-17. If you press <Return> at the *Select DEVICE* prompt, the first screen displays on your terminal screen. After viewing the first screen, press <Return> to view the second screen.

Following printing, the system returns to the initial Current DEERS Eligibility screen and action bar.

(R)epeat DEERS check: When you select this action, the system invokes a new online DEERS check for the patient. DEERS must be online to perform this action. After the DEERS check the system proceeds to the next action in the option process being performed when this DEERS check was invoked.This action displays only for a new enrollment, not for an existing enrollment.

(C)ontinue: When you select the default action, the system proceeds to the next action within the option being processed.

(Q)uit: This action allows you to exit the option without further processing.

Display Current DEERS Eligibility second screen

```
                              CURRENT DEERS ELIGIBILITY
                Name: MOREHOUSE,KATHRYN             FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                      DDS: 30
               DOB/Age: 09 Apr 1969/26Y                     Sex: FEMALE
_____________________________________________________________________________
 CHAMPUS Dental Flag: 0-NO COVERAGE
   Dental Start Date:                               Dental End Date:
   Date Last Updated: 14 Aug 1995                    Panograph Date:
             NAS Flag: YES                              Organ Donor: YES
Reportable Disease                                             DNA: YES
Database (RDDB) Date:
     Date of Request:
_____________________________________________________________________________
Press <RETURN> to continue
```

Figure 4-11. Current DEERS Eligibility, Second Screen

1. Press <Return> after viewing this screen. You return to the original DEERS Eligibility screen (refer to Figure 4-10. Current DEERS Eligibility, page 4-15).

```
CURRENT DEERS ELIGIBILITY
                  Personal Data - Privacy Act 1974 (PL-93-579)

                Name: MOREHOUSE,KATHRYN            FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                    DDS: 30
              DOB/Age: 09 Apr 1969/26Y                    Sex: FEMALE
_____________________________________________________________________________
            Sponsor Rank: CAPTAIN
             Sponsor UIC: 31127-NAVCRUSERVDET HONOLULU
                 DMIS ID: 6501-TRICARE
                     ACV: E-MCP ENROLLED/DIR. CARE CHAMPUS ELIGIBLE
          ACV Start Date: 01 Jul 1995                Region Code: 02
  Care Authorization PH#: 619-555-7526             PCM Location: CONTRACT
             Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 01 Jul 1992                   CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: INDEFINITE
  Eligibility End Reason: U-Not Predicatable

                                     BRAC Pharmacy Eligibility: NOT ELIGIBLE
           Override Code:

      CHAMPUS Dental Flag: 0-NO COVERAGE
        Dental Start Date:                        Dental End Date:
                 NAS Flag: YES                     Panograph Date:
     Reportable Disease                                      DNA: YES
     Database (RDDB) Date:
         Date of Request: 04 Dec 1996@1307
```

Figure 4-12. Current DEERS Eligibility Hard Copy Printout

4.4 Enrollees of USTF Managed Care Program

Menu Paths:

PAS System Menu → MAN → HMCP → PHCF
PAS System Menu → MAN → HMCP → AHCF
PAS System Menu → MAN → HMCP → NHCF
PAS System Menu → MAN → NMCP
PAS System Menu → MAN → EMCP → EENR
PAS System Menu → MAN → EMCP → RENR
PAS System Menu → MAN → IMCP → NNAS
PAS System Menu → Clerk → USV
PAS System Menu → Clerk → BOK
PAS System Menu → Clerk → AOP

Application Description:

Following a DEERS Check, the system searches stored DEERS eligibility information to determine if the patient being processed is assigned an ACV code of "U" (Enrolled in USTF Managed Care).

The USTF Managed Care Program is a network of Department of Defense (DOD) owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries (active duty patients are ineligible) as an alternative to other DOD managed care programs including direct care from the MTF.

If the specified patient is not assigned an ACV code of “U,” the system allows you to continue the enrollment process without restriction. If the patient is assigned an ACV code of “U,” the system displays the DEERS Eligibility Data screen with the message:

```
This patient is a Uniformed Services Treatment Facility (USTF) enrollee
who elected, in writing, to receive all non-emergency care from a USTF.
Your facility will not be reimbursed for care provided to this patient
unless the USTF agrees to pay your facility prior to you rendering services
to the patient.
```

The system then allows you to choose either to proceed with the enrollment process or to abort it for this patient. If you elect to proceed in the enrollment function, the enrollment will be rejected by DEERS.

Note: Following the DEERS check when the Family Member screen initially displays, and as a part of the DEERS interface, CHCS checks the ACV and Defense Medical Information Systems Identification (DMIS ID) fields. If the ACV field contains a value indicating enrollment in a program other than TRICARE, or if the DMIS ID field contains a code not matching one or more of the codes of the requesting CHCS host, reciprocal enrollment/disenrollment will be initiated pending user authorization.

If the DMIS/ID Code of the facility where the beneficiary is currently enrolled does not match any of the DMIS/ID Codes on the local CHCS; and if the beneficiary's ACV from DEERS is either Active Duty Enrolled (A), Enrolled/Not CHAMPUS Eligible (D), or CHAMPUS Eligible/Enrolled (E), the system displays the prompt:

```
[FAMILY MEMBER NAME] IS CURRENTLY ENROLLED AT [FACILITY]. DO YOU WISH TO
DISENROLL [FAMILY MEMBER NAME] FROM [FACILITY] (EFFECTIVE ONE DAY PRIOR
TO THE ENROLLMENT DATE) AND ENROLL [NAME] AT THIS FACILITY (Y/N)?
```

You can then choose whether to perform a Reciprocal Enroll/Disenrollment of the selected beneficiary.

4.5 CHCS/DEERS Discrepant Data Check

Menu Paths:

PAS System Menu → MAN → HMCP → PHCF
PAS System Menu → MAN → HMCP → AHCF
PAS System Menu → MAN → HMCP → NHCF
PAS System Menu → MAN → NMCP
PAS System Menu → MAN → EMCP → EENR
PAS System Menu → MAN → EMCP → RENR
PAS System Menu → MAN → IMCP → NNAS
PAD System Menu → ROM → FRG*
PAD System Menu → ROM → MRG*
PAD System Menu → ADT → ADM*

*New patients only.

Application Description:

The CHCS/DEERS Discrepant Data Check action is automatically invoked following a normal DEERS eligibility check for all MCP patients, all non-availability statement (NAS) requests, all first time registered Patient appointment and scheduling (PAS) patients, and all admissions processing of patients. This action is also automatically invoked after an interactive DEERS eligibility check is requested.

After completing the CHCS/DEERS discrepancy data check, the system displays the results of the check and highlights the data elements where a discrepancy exists between the CHCS data on file and the DEERS data just received.The system then allows you to selectively update the CHCS file with the data shown in DEERS and/or print the discrepancy screen showing the DEERS and CHCS entries.

An entitlement discrepancy occurs when a beneficiary's eligibility changes after they are enrolled; e.g., enrollee separates from service.You may clear an entitlement discrepancy indicator with this screen. However, if the entitlement discrepancy is not corrected, the indicator will redisplay the next time an eligibility check is performed. Clearing the enrollment discrepancy does not change the MCP patient status if the patient's status is INVALID ENROLLMENT or INVALID DISENROLLMENT, nor does it correct the patient's ACV on DEERS. These changes can only be performed through enrollment and disenrollment options. Entitlement discrepancies may be viewed on the Enrollee Entitlement

Discrepancy Report (Menu path: PAS System Menu → MAN → OMCP → ERME → ROST → 10).

To correct CHCS/DEERS data discrepancies

Clear entitlement discrepancy
Select CHCS data to correct
Confirm correction of CHCS data to match DEERs
Correct UIC in DEERS

Data Entry Process:

CHCS DEERS Discrepancy Data screen

The system automatically initiates the CHCS/DEERS Discrepant Data Check following the Interactive DEERS Eligibility Check within MCP options for first time registered patients and for all patients being processed for admissions. It is not initiated for existing patients.

The system begins by displaying the patient data found in CHCS and the patient data found in DEERS and highlighting the elements that have a discrepancy. The system then displays an action bar allowing you to update CHCS data from DEERS, print discrepancies, clear entitlement discrepancies, continue, or quit processing (refer to Figure 4-13. CHCS/DEERS Discrepancy Data Screen, page 4-21).

```
                      CHCS/DEERS DISCREPANCY DATA
              Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
  Patient Category: USA FAM MBR AD                     DDS: 30
        MCP Status: ENROLLED                       DOB/Age: 09 Apr 1969/26Y
               ACV: E-MCP ENROLLED/DIR.CAR CHAM    DMIS ID: 6501
      Direct Care: ELIGIBLE                       Medicare: NOT ELIGIBLE
-----------------------------------------------------------------------------
                     CHCS Data                   DEERS Data
_____________________________________________________________________________
   Name           : MOREHOUSE,KATHRYN            MOREHOUSE,KATHRYN
   DOB            : 09 Apr 1969                  09 Apr 1969
   Sex            : FEMALE                       FEMALE
   Patient SSN    : 577-23-3789                  577-23-3789
   Sponsor Rank   : CAPTAIN                      MAJOR
   Station/Unit   : 1912 COMMUNICATIONS          0001 MEDICAL       GP
   UIC Code       : 21810                        LE1CF602
   ID Issue Date  : 08 Dec 1992                  08 Dec 1992
   ID Expire Date : INDEFINITE                   INDEFINITE
   ID Card Number :
   Send patient to Enrollment Office to update Enrollment Entitlement
_____________________ BENEFICIARY ENROLLED IN ANOTHER AREA _________________
Select (U)pdate CHCS, (P)rint Discrepancies, c(L)ear Entitlement Discrepancy,
       (C)ontinue, or (Q)uit: U//L
```

Figure 4-13. CHCS/DEERS Discrepancy Data Screen

Actions on the CHCS/DEERS Discrepancy Data action bar:

(U)pdate CHCS: When you select this action, the system prompts you to select the data elements to be updated and steps through the update process with each element selected (refer to Figure 4-15. CHCS/DEERS Discrepancy Data (Station/ Unit Selected), page 4-23, Figure 4-16. CHCS/DEERS Discrepancy Data (shows discrepancies in Station Unit data), page 4-23, and Figure 4-17. CHCS/DEERS Discrepancy Data, page 4-24).

(P)rint Discrepancies: When you select this action, the system prompts for the output device, prints the discrepancy listing, and returns to the action bar.

c(L)ear Entitlement Discrepancy: If an entitlement discrepancy exists (i.e., beneficiary eligibility has changed since enrollment), the system requires that you either clear the discrepancy before being allowed to continue or exit the function in process (refer to Figure 4-14. CHCS/DEERS Discrepancy Data Continued, page 4-22). You should correct the discrepancy if the DOB in CHCS does not match the DOB in DEERS, hold enrollment until corrected in the appropriate system.

(C)ontinue: When you select this action, the system proceeds to the next step in the option being processed (normally the Demographics Display screen displays next).

(Q)uit: This action allows you to exit the option in process.

Clear entitlement discrepancy

If the patient category is inconsistent with the ACV, the beneficiary may need to be disenrolled or the patient category could be incorrect. Appropriate corrections need to be made.

```
                        CHCS/DEERS DISCREPANCY DATA
              Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
   Patient Category: USA FAM MBR AD                    DDS: 30
         MCP Status: ENROLLED                      DOB/Age: 09 Apr 1969/26Y
                ACV: E-MCP ENROLLED/DIR.CAR CHAM    DMIS ID: 6501
        Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE
-----------------------------------------------------------------------------

This action will clear the Entitlement Discrepancy for this patient. Depending
upon the exact nature of the Entitlement Discrepancy, it may re-appear the next
time an eligibility check is performed. In such a case, it will be necessary
to disenroll and then re-enroll the patient. Also, clearing the enrollment
discrepancy will not change the MCP Patient Status if the patient's status is
INVALID ENROLLMENT or INVALID DISENROLLMENT nor will it change the patient's ACV
on DEERS. These changes can only be done through the enrollment and
disenrollment options.
_____________________________________________________________________________
 Are you sure you wish to proceed? No//YES
```

Figure 4-14. CHCS/DEERS Discrepancy Data Continued

Select CHCS data to correct

After selecting the CHCS data to correct, CHCS automatically replaces the CHCS data with the DEERS data.

```
                        CHCS/DEERS DISCREPANCY DATA
               Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
   Patient Category: USA FAM MBR AD                     DDS: 30
         MCP Status: ENROLLED                      DOB/Age: 09 Apr 1969/26Y
                ACV: E-MCP ENROLLED/DIR.CAR CHAM    DMIS ID: 6501
        Direct Care: ELIGIBLE                      Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------
                     CHCS Data                    DEERS Data
 ___________________________________________________________________________
    Name           : MOREHOUSE,KATHRYN            MOREHOUSE,KATHRYN
    DOB            : 09 Apr 1969                  09 Apr 1969
    Sex            : FEMALE                       FEMALE
    Patient SSN    : 577-23-3789                  577-23-3789
    Sponsor Rank   : CAPTAIN                      MAJOR
  * Station/Unit   : 1912 COMMUNICATIONS          0001 MEDICAL       GP
    UIC Code       : 21810                        LE1CF602
    ID Issue Date  : 08 Dec 1992                  08 Dec 1992
    ID Expire Date : INDEFINITE                   INDEFINITE
    ID Card Number :
 ___________________________________________________________________________
 Use SELECT key to select CHCS data to update.
```

Figure 4-15. CHCS/DEERS Discrepancy Data (Station/Unit Selected)

1. Press <Select> by each data element to be updated.

Confirm correction of CHCS data to match DEERS

```
                        CHCS/DEERS DISCREPANCY DATA
               Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
   Patient Category: USA FAM MBR AD                     DDS: 30
         MCP Status: ENROLLED                      DOB/Age: 09 Apr 1969/26Y
                ACV: E-MCP ENROLLED/DIR.CAR CHAM    DMIS ID: 6501
        Direct Care: ELIGIBLE                      Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------
                     CHCS DATA                    DEERS DATA
 ___________________________________________________________________________
    Station/Unit   : 1912 COMMUNICATIONS          0001 MEDICAL           GP
    UIC Code       : 21810                        LE1CF602


_____________ CAUTION: Data selected will be changed in CHCS files _______
 Are you sure you want to update the CHCS data with the DEERS data? NO// Y
```

Figure 4-16. CHCS/DEERS Discrepancy Data (shows discrepancies in Station Unit data)

1. Enter "Y" to overlay the CHCS data with the DEERS data.

Correct UIC in CHCS

```
                        CHCS/DEERS DISCREPANCY DATA
              Name: MOREHOUSE,KATHRYN              FMP/SSN: 30/577-23-3789
  Patient Category: USA FAM MBR AD                     DDS: 30
        MCP Status: ENROLLED                       DOB/Age: 09 Apr 1969/26Y
               ACV: E-MCP ENROLLED/DIR.CAR CHAM    DMIS ID: 6501
       Direct Care: ELIGIBLE                      Medicare: NOT ELIGIBLE
-------------------------------------------------------------------------------
                    CHCS DATA                    DEERS DATA
_______________________________________________________________________________
   Station/Unit   : 1912 COMMUNICATIONS          0001 MEDICAL           GP
   UIC Code       : 21810                        LE1CF602

UNIT SHIP ID: 1912 COMMUNICATIONS// LE1CF602


_____________ CAUTION: Data selected will be changed in CHCS files _____________
```

Figure 4-17. CHCS/DEERS Discrepancy Data

1. Enter sponsor's correct UIC and press <Return>.

4.6 Interactive DEERS Eligibility Request

Menu Paths:

PAS System Menu →MAN →EMCP →IENR
PAS System Menu →MAN →RMCP →RREG →DRDM
PAS System Menu →MAN →IMCP →NNAS*
PAS System Menu →Clerk →ROM →DRDM
PAS System Menu →EMER →RER →2
PAD System Menu →ROM →DER
* The NNAS option does not allow you to enter a specific date range.

Application Description:

The Interactive DEERS Eligibility Request option enables you to directly query DEERS to perform a DEERS eligibility check on a selected patient. To uniquely identify the patient, you must enter the patient name, DOB, sponsor SSN, and FMP. The system allows you to specify eligibility start and end dates to determine whether a patient who is currently ineligible in DEERS is eligible at an earlier or later date.The patient is not required to be registered in CHCS to perform this check.

This option, unlike other options that perform DEERS checks, always queries DEERS directly. It does not use DEERS data stored in the CHCS Patient file by

DEERS checks performed by other options within the past five days. It does not store the DEERS data from this check in the Patient file for the benefit of other options that check DEERS eligibility.

Required Fields:

Patient name
FMP/SSN
DOB
Eligibility start date
Eligibility end date
Output device

Data Entry Process:

Select the Interactive DEERS Eligibility Request (IENR) option on the Enrollment Processing Menu

Select patient

Complete DEERS Interactive Request screen

Print DEERS Eligibility data

Select the Interactive DEERS Eligibility Request (IENR) option on the Enrollment Processing Menu

Select patient

The system prompts you to begin by entering and confirming the name of a patient (refer to Figure 4-18. DEERS Post Eligibility Request, page 4-25). If the patient is not registered in CHCS, the system prompts you to indicate whether to continue with the DEERS search or to quit the option.

```
MCP-DEERS Post Eligibility Request

Select PATIENT NAME: MITCHELL,ANDREA   30/567-56-5678 09 Aug 1961 F
          OK? YES
```

Figure 4-18. DEERS Post Eligibility Request

Complete DEERS Interactive Request screen

If the patient is registered or you continue even though the patient is not registered, the system displays the DEERS Interactive Request screen, and prompts you to enter data essential for a DEER query (refer to Figure 4-19. DEERS Interactive Request Screen, page 4-26). If the patient is registered, the default values for patient name, DOB, and FMP/SSN are taken from CHCS.

```
                    Patient Name: MITCHELL,ANDREA
                    Date of Birth: 09 Aug 1961
                      Sponsor SSN: 567565678
            Family Member Prefix: 30
          Eligibility Start Date: 25 Jul 1994
            Eligibility End Date: 01 Jan 2001

       When requesting information for a sponsor, enter 99 for the
         family member prefix to return all of the family members.



 File/exit    Abort    Edit File changes and exit.
```

Figure 4-19. DEERS Interactive Request Screen

1. Press <Return> at the *Patient Name* field to accept the patient name you just entered at the *Select PATIENT NAME* prompt.

2. Press <Return> at the *Date of Birth* field to accept the DOB entered in this field from CHCS data previously entered for this patient. Enter the DOB if the patient is not registered.

3. Press <Return> at the *Sponsor SSN* field to accept the Sponsor SSN entered in this field from CHCS data previously entered for this patient. Enter the sponsor SSN if the patient is not registered.

4. Press <Return> at the Family Member Prefix field to accept the FMP entered in this field from CHCS data previously entered for this patient. Enter the FMP or 99 if the patient is not registered.

   Note: When requesting information for a sponsor, you can enter 99 in the family member prefix field to see a list of all the family members.

5. Enter desired Eligibility Start and Eligibility end dates of eligibility.

6. If the system fails to find a record with the specified sponsor SSN and DOB, the system displays the search criteria data you entered on the DEERS Eligibility Data screen, and permits you to print that data.

7. If the system finds records with the specified sponsor SSN but not the specified DOB, the system displays a picklist from DEERS of all family members with the same sponsor SSN, and prompts you to select the desired family member. After you select the family member, the system displays the DEERS data for that family member on the DEERS Eligibility Data screen, and permits you to print the eligibility data. If the DOB on that family member does not match DEERS, you are prompted to accept the DEERS DOB. If you answer "Yes," CHCS is updated with the DEERS DOB.

8. The system then exits the option.

Print DEERS Eligibility data

As soon as you file data on the DEERS Interactive Request screen, the system requests a DEERS search. If a record is found with the specified sponsor SSN and DOB, then CHCS displays the DEERS data on the DEERS Eligibility Data screen (refer to Figure 4-7. DEERS Eligibility Data, page 4-11, for a sample), and permits you to print the eligibility data.

Note: Following the DEERS check, the system searches the DEERS eligibility information to determine if the patient is assigned an ACV code of “U” (Enrolled in USTF Managed Care). (Refer to 4.4 Enrollees of USTF Managed Care Program, page 4-17 for an explanation of this processing.)

4.7 DEERS Purge Parameter

Menu Path: SYSTEMS MANAGER Menu → SM → INT → DEER → EDP

Application Description:

The MCP DEERS Enrollment Responses purge parameter tells CHCS how long to store the DEERS Discrepancy Code in the MCP Patient file. The system default is set for two days. It is recommended that this be changed to at least five days or discrepancies may be purged before you can print them.

The DEERS Discrepancy Code flags an MCP PATIENT with an MCP status of Invalid Enrollment or Invalid Disenrollment to appear on the Enrollment/ Disenrollment Discrepancy report. The reason code and reason code description printed on this report helps you to resolve the discrepancy. Once the code is purged

```
TRAINING MEDICAL TREATMENT FACILITY                                                    21 Jun 2001@1615    Page 1
                                        PAS DEERS INELIGIBILITY REPORT by CLINIC
                                     Personal Data - Privacy Act of 1974 (PL 93-579)
                                              Appointments for  22 Jun 2001
                                                      Part 1 of 2
Clinic: CARDIOLOGY CLINIC
=================================================================================================================
  Patient Name          FMP/SSN         DOB          Last DEERS Check  Next Appt.        Home Phone/           Work Phone
  DEERS Status                                                                                          Clerk
=================================================================================================================
  SUMMERS,ALLAN A       20/600-60-6510  20 Oct 1975  18 Jun 2001       22 Jun 2001@1300  918-555-6712          202-555-3067
  No response on latest DEERS check. Previous check: ELIGIBLE                                           TRAINING,MANAGER

  SUMMERS,ALLAN A       20/600-60-6510  20 Oct 1975  18 Jun 2001       22 Jun 2001@1400  918-555-6712          202-555-3067
  No response on latest DEERS check. Previous check: ELIGIBLE                                           TRAINING,MANAGER

=================================================================================================================
NOTE: Patients, whose names appear on this report, should be reminded to bring proof of their eligibility at the time of their
      appointment.
```

Figure 4-20. PAS DEERS Ineligibility Report

TRAINING MEDICAL TREATMENT FACILITY 21 Jun 2001@1459 Page 2

PAS DEERS INELIGIBILITY REPORT by CLINIC
Personal Data - Privacy Act of 1974 (PL 93-579)
Appointments for 22 Jun 2001
Part 2 of 2

Clinic: CARDIOLOGY CLINIC

Patient Name Alternate Care Value	FMP/SSN	DOB DEERS Direct Care Eligibility	Last DEERS Check	Next Appt.	Home Phone/ Clerk	Work Phone
SUMMERS,ALLAN A U/ENROLLED in USF MANAGED CARE	20/600-60-6510	20 Oct 1975 ELIGIBLE	18 Jun 2001	22 Jun 2001@1300	918-555-6712 TRAINING,MANAGER	202-555-3067
SUMMERS,ALLAN A U/ENROLLED in USF MANAGED CARE	20/600-60-6510	20 Oct 1975 ELIGIBLE	18 Jun 2001	22 Jun 2001@1400	918-555-6712 TRAINING,MANAGER	202-555-3067

NOTE: Patients, whose names appear on this report section are currently in a Uniformed Services Treatment Facilities (USTF) Managed Care Plan. This facility will not be reimbursed for non-emergency care provided to these patients unless their USTF agrees to pay this facility prior to rendering services to the patient.

Figure 4-20. FPAS DEERS Ineligibility Report (continued)

from the system, that patient longer appears on the Enrollment/Disenrollment Discrepancy Report, and the patient's invalid status is not reported to the user.

Data Entry Process:

To change the DEERS Purge Parameter

Access the Edit Purge Parameters (EDP) option on the DEERS Menu:
SM → INT → DEER → EDP
Enter file name and purge parameter

Access the Edit Purge Parameters (EDP) option on the DEERS Menu

Menu Path:

SM → INT → DEER → EDP

Enter file name and purge parameter

1. At the *Select DEERS PURGE LIST FILE NAME* prompt, enter:
   DEERS MCP ENROLLMENT RESPONSES

2. At the *Enter the number of days a DEERS response can remain in this file* prompt, enter the number of days to save the responses.

   The default for the number of days is set initially to two.

3. Exit the option

4.8 PAS DEERS Ineligibility Report

Menu Paths:

PAS System Menu → SCH → ORDM → 4
PAS System Menu → MAN → OMCP → DEMR → 4
PAS System Menu → MAN → EMCP → OENR → DRPM → 4

Contents: The PAS DEERS Ineligibility Report option allows you to generate a report listing those patients who have had a DEERS check performed by the PAS subsystem, and who have been returned as DEERS ineligible.

The report is generated in association with the nightly process (batch job) SD DINQ, which automatically sends DEERS eligibility requests for those patients with scheduled appointments on a future date equal to today plus the number of days specified in the DEERS Batch Pull field in the Facility Profile.

Based on the results of the eligibility requests, the PAS DEERS Ineligibility Report lists those patients with appointments scheduled who either are ineligible for direct care or were not included in responses from DEERS eligibility requests.

The system generates Page 2 of this report only when there are DOD-sponsored patients who have been designated direct care and CHAMPUS ineligible because they have elected to obtain medical treatment through a USTF.

Note: The USTF Managed Care Program is a network of DOD-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries (active duty patients are ineligible) as an alternative to MTF direct care and other DOD managed care programs. A USTF enrollee is direct care ineligible and CHAMPUS ineligible.

The report may be requested by clinic, division, or group. The report is sorted by Patient Identification (PTID) and shows the patient demographics data (patient's name, FMP/SSN, date of birth), current DEERS status, date of the last DEERS check, next appointment, home phone and work phone.

1. The system prompts you to print the report for a selected clinic, division, or group.

2. Following this selection the system displays a warning that this is a 132-column report and will be available tomorrow morning. You may then either elect to proceed or exit the option.

3. If you elect to proceed the system prompts for the desired output device, queues the requested report for processing and printing and exits the option.

Use/Frequency:

Run this report, as needed, to see a list of patients who have applied for care that are not eligible.

4.9 MCP DEERS Ineligibility Report

Menu Paths:

PAS System Menu → MAN → OMCP → DEMR → 3
PAS System Menu → MAN → EMCP → OENR → DRPM → 3

Contents: The MCP DEERS Ineligibility Report option allows you to generate a report, within a specified date range, showing all patients who have had a DEERS check performed by a Managed Care Program (MCP) option and who were found to be ineligible. For each patient, the report lists patient demographics, date of last DEERS check, and pending appointments.

Use/Frequency:

Run this report, as needed, to see a list of patients who have applied for care that are not eligible.

TRAINING MEDICAL TREATMENT FACILITY 21 Jun 2001@1618 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)
MCP DEERS INELIGIBILITY REPORT
From: 20 Jun 2001 To: 21 Jun 2001

Patient / Sponsor	FMP/SSN / Sponsor Unit	Sex	DOB	Date of Trans / Duty Phone	Home Phone / Override	Work Phone / MCP Status	Pending Appts / Process Type
INGRAM,JACKIE J	20/711907401	F	19 Apr 1966	10 Jan 2000	H:918-555-7864	W:918-555-9081	Appts:
INGRAM,JACKIE J	0121 FIGHTER SQ			D:918-555-9081			INTERACTIVE
NAPOLI,FLORENCE	20/100107144	F	06 May 1971	18 Jun 2001	H:619-555-9838	W:	Appts:
NAPOLI,FLORENCE	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NAPOLI,HOLLEY	20/100107146	F	12 Aug 1971	18 Jun 2001	H:619-555-9878	W:	Appts:
NAPOLI,HOLLEY	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NAPOLI,JACKIE	20/100107148	F	21 Jun 1971	18 Jun 2001	H:619-555-7893	W:	Appts:
NAPOLI,JACKIE	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NAPOLI,LINDA	20/100107149	F	27 Jun 1971	18 Jun 2001	H:619-555-8383	W:	Appts:
NAPOLI,LINDA	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,ALLAN	20/100107150	M	08 Jul 1971	18 Jun 2001	H:619-555-8896	W:	Appts:
NATWICK,ALLAN	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,BARBARA	20/100107151	F	21 May 1971	18 Jun 2001	H:619-555-8382	W:	Appts:
NATWICK,BARBARA	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,CHARLES	20/100107152	M	09 Aug 1971	18 Jun 2001	H:619-555-8381	W:	Appts:
NATWICK,CHARLES	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,DONNA	20/100107153	F	25 Feb 1971	18 Jun 2001	H:619-555-8385	W:	Appts:
NATWICK,DONNA	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,EARL	20/100107154	M	07 Jul 1971	18 Jun 2001	H:619-555-8906	W:	Appts:
NATWICK,EARL	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,FLORENCE	20/100107155	F	12 Aug 1971	18 Jun 2001	H:619-555-3784	W:	Appts:
NATWICK,FLORENCE	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,GEORGE	20/100107156	M	10 Oct 1971	18 Jun 2001	H:619-555-2346	W:	Appts:
NATWICK,GEORGE	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE
NATWICK,HOLLEY	20/100107157	F	13 Nov 1971	18 Jun 2001	H:619-555-9125	W:	Appts:
NATWICK,HOLLEY	USS JOHN F KENNEDY CV 67			D:			INTERACTIVE

Figure 4-21. MCP DEERS Ineligibility Report

CHCS: MCP DESKTOP USER GUIDE

5. ENROLLMENT PROCESSING

Brief Outline

5.1 Enrollment Enter/Edit (EENR) 5-4
5.1.1 Enroll a Patient. 5-6
5.1.2 Assign a PCM 5-43
5.1.3 Enroll Family Members 5-54
5.1.4 Enter OHI Information 5-64
5.1.5 Enroll Family Members Into the MCP Using the Family Action 5-71
5.1.6 Assign an Exception Provider to an MCP Patient. 5-80
5.1.7 Renew a Patient's Enrollment 5-86
5.1.8 Cancel an Enrollment 5-89
5.2 Disenrollment (DENR). 5-92
5.3 Reciprocal Disenrollment Processing (RENR) 5-96
5.3.1 Reciprocal Enrollment/Disenrollment 5-96
5.3.2 Reciprocal Disenrollment 5-103
5.4 Conditional Enrollment Processing (CENR) 5-105
5.5 Print/Display Enrollment History (PENR). 5-110
5.6 Interactive Deers Eligibility Request (IENR). 5-113
5.7 Batch Enroll Active Duty (BENR). 5-120
5.7.1 Identify Potential Active Duty Candidates (IBER) 5-120
5.7.2 Update/Print/Enroll Potential AD Candidates (UBER). 5-123
5.7.3 Print Batch Enrollment Report (PBER). 5-126
5.7.4 Delete Potential Candidate List (DBER) 5-127
5.8 Multiple Batch Renewal and Disenrollment Functions (MENR) 5-129
5.8.1 Identify Candidates For Renewal Letter (IMER) 5-129
5.8.2 Batch Renewal and Disenrollment Processing (BMER) 5-133
5.8.2.1 Batch Renew MCP Enrollments 5-133
5.8.2.2 Batch Disenroll Candidates. 5-137
5.8.3 Print Batch Renewal & Disenrollment Products (PMER). 5-142
5.8.3.1 Batch Renew & Disenroll Letter 5-143
5.8.3.2 Batch Renew & Disenroll Labels 5-146
5.8.3.3 Batch Renew & Disenroll Roster. 5-149
5.8.4 Generate Individual Notification Letter & Label (GMER). 5-150

5.9 Outputs and Enrollment Maintenance Reports Menu (OENR) 5-152
5.9.1 DEERS/Enrollment Maintenance Reports Menu (DRPM) . . 5-153
5.9.1.1 MCP Conditional Enrollment Roster 5-153
5.9.1.2 Enrollment/Disenrollment Discrepancy Report 5-156
5.9.1.3 MCP DEERS Ineligibility Report 5-159
5.9.1.4 PAS DEERS Ineligibility Report 5-161
5.9.2 Enrollment Reports Menu (ERPM) 5-164
5.9.2.1 Family Batch Enrollment Labels Menu (LABL) 5-164
5.9.2.1.1 Family Batch Enrollment Labels Build Utility 5-165
5.9.2.1.2 Family Batch Enrollment Labels Print Utility 5-167
5.9.2.1.3 Incomplete Patient Address Report 5-168
5.9.2.2 Enrollment Rosters Menu (ROST) 5-171
5.9.2.2.1 AD Family Members by Unit Enrollment Roster . . . 5-172
5.9.2.2.2 Alphabetic Enrollment Roster by Service 5-173
5.9.2.2.3 Case Management Program Enrollment Roster 5-175
5.9.2.2.4 Change in Eligibility Enrollment Roster 5-175
5.9.2.2.5 Disenrollees for Period by Reason Code 5-177
5.9.2.2.6 Enrollment Roster Exception Conditions 5-178
5.9.2.2.7 Reciprocal Disenrollment by Reason Roster 5-180
5.9.2.2.8 Reciprocal Disenrollment Discrepancy Report 5-181
5.9.2.2.9 Track User Report 5-183
5.9.2.2.10 Enrollee Entitlement Discrepancy Report by Family 5-186
5.9.2.3 Enrollment Summaries Menu (SUMM) 5-189
5.9.2.3.1 Disenrollment Summary by Reason 5-189
5.9.2.3.2 Enrollment Summary Report (SUMM) 5-190
5.9.2.3.3 OHI Enrollment Summary (SUMM) 5-195
5.9.2.3.4 Patient Category Enrollment Summary 5-196
5.9.3 PCM Reports Menu 5-198
5.9.3.1 Available PCM Capacity by Provider Group 5-198
5.9.3.2 Enrollment Roster by PCM 5-201
5.9.3.3 PCM Activity Report 5-203
5.9.3.4 PCM Assignment Change Roster by Reason 5-203
5.9.3.5 PCM Assignment Change Summary 5-205
5.9.3.6 Default PCM/UIC Report 5-207
5.9.3.7 PCM Enrollment Mix Discrepancy Statistical Summary 5-209
5.9.3.8 PCM Enrollment Mix Discrepancy Report 5-212
5.9.4 MCP Enrollment Form (MEFM) 5-214
5.9.5 Address Label for Patient (APAL) 5-214

5.10 Batch PCM Assignment/Reassignment of Enrollees 5-214
5.10.1 Batch PCM Reassignment (BPCM) 5-216
5.10.2 Family PCM Reassignment 5-223
5.10.3 Active Duty Enrollee UIC Maintenance Report 5-229

LOCAL EMPANELMENT AND DEERS ENROLLMENT MODES

Introduction

Each site can use either local empanelment or DEERS enrollment modes. Whether the site uses the local empanelment or DEERS enrollment mode is determined by an entry in the Enrollment Mode field on the MCP Parameters Profile screen. This field controls processing for non-active duty beneficiaries only; active duty beneficiaries are not affected in any way. All sites in a region should be set to the same mode consistent with the conditions of the TRICARE contract.

Local Empanelment Mode

This mode allows a site to conduct managed care activities on a local level without changing the non-active duty beneficiaries' alternate care value (ACV) on the Defense Enrollment Eligibility System (DEERS) database. Using local empanelment, non-active duty beneficiaries would receive the standard Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, but would have the enhancement of a primary care manager (PCM) and other managed care activities. The MCP enrollment beneficiary information is not sent to DEERS, although standard CHAMPUS eligibility information is available from DEERS.

While in the local empanelment mode, DEERS enrollment information does not match information in CHCS. CHCS will show the beneficiary as enrolled, but in DEERS the beneficiary may or may not be enrolled if the beneficiary was or was not enrolled by the TRICARE contractor system.

Note: While in local empanelment mode, enrollment and disenrollment transactions are still sent to DEERS for active duty beneficiaries. Active duty enrollments are not affected by this mode switch.

Note: A one-time quick fix is available that aligns CHCS enrollment information with DEERS enrollment information. Contact your site specialist for additional information. This quick fix will impact system performance; therefore, it must be scheduled carefully.

DEERS Enrollment Mode

This mode allows a site to formally conduct managed care activities; enrollment and disenrollment transactions are sent to DEERS for non-active duty beneficiaries, changing the beneficiaries' ACV. The Fiscal Intermediary (FI) can view the ACV, and thereby the enrollment status, for a given beneficiary when processing TRICARE claims. Full enrollment supports the TRICARE benefit.

If the beneficiary is enrolled in TRICARE by another system, on another CHCS platform, or in another program, check the DEERS Eligibility screen for this enrollment information. The ACV will be other than “A”, “D”, or “E” or the Defense Medical Information Systems Identification (DMIS ID) will be 6901 - 6912 or 6512.

All sites and divisions sharing a CHCS platform must operate using the same enrollment mode, which is set in the MCP Parameters Profile. Active duty are always processed in enrollment mode regardless of the setting of this switch. For non-active duty local enrollments, all transactions for all sites are sent to DEERS if the enrollment mode is set to “enrollment”, and they are not if the enrollment mode is set to “empanelment”.

Refer to PAS: MCP File Maintenance Functions, SAIC/CHCS Doc. TC-4.5-0565, for more information.

5.1 Enrollment Enter/Edit (EENR)

Menu Path: PAS System Menu → MCP → EMCP → EENR

Security Keys:

CPZ CCP

Note: Be aware that the Track User Report indicates the users who are creating and updating enrollments. Take proper security measures such as halting your CHCS session prior to leaving your terminal so no one else can enter data attributed to you.

Required Fields:

Patient Name
Sponsor Name
PCM Name
OHI Name
Policy Holder Name

Application Description:

The Enrollment Enter/Edit option allows you to enroll a patient in MCP and assign a PCM. Once you enter the patient name, register the patient, you can enter, view, and edit the current MCP enrollment for the patient. To complete an enrollment, you must assign a PCM or the enrollment is deleted.

Just as you can register patients in the facility when you book appointments for them or check them in for an appointment, you can also register patients as you enroll them in MCP. The functionality to register patients is embedded in the enrollment option; that is, you do not need to change menu options to complete a patient's registration.

Reciprocal Enrollments/Disenrollments – You may enroll a beneficiary at your site who is currently enrolled at another CHCS site without exiting this option.You can perform a "Reciprocal Enroll/Disenrollment" – that is, you may disenroll the beneficiary from the losing facility one day prior to your facility enrollment start date, and enroll the beneficiary at your site. In order to do this, the following conditions must be present: You enter a beneficiary's name; the DEERS eligibility check shows that the DMIS ID Code of the facility where the beneficiary is currently enrolled does not match any of the local facilities DMIS ID Codes on your CHCS System and the ACV from DEERS is Active Duty Enrolled (“A”), Enrolled/Not CHAMPUS Eligible (“D”), or CHAMPUS Eligible/ Medicare Ineligible (“E”).

Note: If a beneficiary does not wish to be enrolled, but must disenroll from a prior facility, refer to Section 5.2 Disenrollments for further information on Reciprocal Disenrollments.

Renew Enrollments – This option allows you to renew enrollments for non-active duty beneficiaries in the enrolling catchment area prior to expiration of the current term of enrollment (same DMIS ID). The Renew Enrollment action is located on the Demographics Display action bar. The Renew action only displays for those beneficiaries who are currently enrolled and that have not had their current enrollment episode renewed or have not been disenrolled. Those beneficiaries with a status of Conditionally Enrolled, Pending Enrollment, Invalid Enrollment or Ineligible Beneficiaries will not have the Renew Enrollment action displayed. Renewals can also be batch entered in another menu option.

When you elect to exercise the Renew action, the system extends the enrollment end date one year from the current end date, and allows you to enter a free text comment regarding the renew action. No other field is editable other than the comment field. Upon completion of this process the system returns to the Demographics Display action bar. Once a beneficiary's enrollment episode has

been renewed for the coming year, the Renew action is no longer displayed. Only when today's date falls within the renewed enrollment episode will the Renew Enrollment action again be displayed.

Other Options

You can print primary care manager (PCM) place of care and assignment preferences. Additionally, you can add/edit/view or copy other health insurance (OHI) information, or print an enrollment form and/or patient address label.

You can also disenroll an enrolled patient and re-enroll a disenrolled patient, so a patient may have more than one enrollment record. You can display/print any enrollment record in the patient's enrollment history. The system also tracks family relationships of enrolled patients and permits you to enroll other eligible family members of enrolled patients. You can copy the same PCM to several family members.

After completion of an enrollment or disenrollment, the system sends an enrollment transaction or disenrollment transaction to DEERS as a background process for non-active duty patients (if in enrollment mode) and always for active duty.

The MCP status is updated at night when the CP Enrollment Bulletin is run.

Note: The CP Enrollment Bulletin must be run in order to validate the patient's current status and the success of the enrollment. The Bulletin is responsible for setting the invalid enrollments to an invalid status. Otherwise, the enrollments will appear valid in error.

5.1.1 Enroll a Patient.

Menu Path: PAS System Menu - MCP - EMCP - EENR

Data Entry Process:

Enroll a Patient:

Access the Enrollment Enter/Edit (EENR) option on the Enrollment Processing Menu

Identify Patient

Patient Already Registered

Register Patient if not Registered

Enter Sponsor Name

Complete Patient Initial Information

DEERS Processing

Select Patients for Enrollment Processing

Reciprocal Enrollment/Disenrollment

Mini Registration

Allergy Screening

Enrollment

Access the Enrollment Enter/Edit (EENR) option on the Enrollment Processing Menu

Identify Patient

Enter the patient identifier and the sponsor identifier. The patient identifier is usually the same name.

Patient Already Registered

If the patient, whose name has just been entered, is already registered at this facility, a current DEERS eligibility screen will be displayed.

The Demographics Display screen is displayed. Refer to Figure 5-1. Demographics Display Screen, page 5-8. The patient's registration data can then be edited, if necessary, before continuing with the enrollment process.

```
                          DEMOGRAPHICS DISPLAY
                   Name: PEARL,ZACHARY N.      FMP/SSN: 20/569-69-4415
      Patient Category: USN ACTIVE DUTY           DDS:
          Patient Type:                           Sex: MALE
            MCP Status:                       DOB/Age: 12 Jun 1975/26Y
                   ACV:                       DMIS ID:
           Direct Care:                      Medicare:

          Sponsor Name: PEARL,ZACHARY N.         Rank: CHIEF PETTY OFFICE
          Station/Unit: W. R. MED HOLD PP          DSN: 331
          Home Address: 1020 NEWPORT DRIVE
                  City: HAMPTON                  State: VIRGINIA
              ZIP Code: 23665              Home Phone: 974-2333
            Duty Phone: 804-555-4993       Work Phone: 804-555-4993
  Registration Comment: new patient
Last Registration Date: 21 Jun 2001@152316
Outpatient Record Room: MEDICAL RECORDS FILE ROOM
       MCP Enroll Date:                End Enroll Date:
  Primary Care Manager:                      PCM Phone:
           Primary OHI: NOT ASSIGNED        Case Mgmt:

Select (F)ull, (M)ini, (E)nrollment, (N)ew Patient, or (Q)uit
DEMOGRAPHICS: Q//
```

Figure 5-1. Demographics Display Screen

Register Patient if not Registered

If the patient is not registered at this facility, the system allows registration of the patient at this time using the Mini Registration functionality. The only data that CHCS can update in DEERS is the address, phone number, and organ donor response.

Enter Sponsor Name

If the patient is his or her own sponsor, you must still enter the patient's name as the sponsor name. If the sponsor is new to the facility, you must register the sponsor first, even if the sponsor does not live in the local area. Sponsors do not have to be enrolled for you to enroll a family member. In this example, the patient is the sponsor.

Instead of retyping the patient name at this prompt, you can press the spacebar, then <Return>. This causes the system to reenter the patient name you most recently processed in CHCS MCP.

Complete Patient Initial Information

The Patient - Initial Information screen displays. Refer to Figure 5-2. Patient - Initial Information Screen, page 5-9. If the patient is not currently registered in CHCS, the system displays an Initial Information screen.

```
                                        Patient - Initial Information


                Patient Name: PEARL,ZACHARY N
                         FMP: 20
                         DOB: 12 Jun 1975
                         SSN: 569-69-4415
                      PATCAT: N11





 Help = HELP     Exit = F10    File/Exit = DO                  INSERT OFF
```

Figure 5-2. Patient - Initial Information Screen

1. Enter FMP.

   The family member prefix (FMP) for the sponsor is 20. The FMP is used to signify the relationship between the sponsor and the patient.

   If the sponsor and the patient are the same, the cursor displays in the Sponsor FMP field, and you must enter 20 as the sponsor FMP.

   If the sponsor is not the same as the patient, the FMP field is blank. You must enter the patient's FMP

2. Enter DOB.

   Enter the patient date of birth (DOB). Check the DEERS Eligibility Data Screen for the DOB to ensure the correct date. If the correct DOB is not available, you may choose not to enroll the patient until the correct DOB is known. DEERS does not enroll the patient if the CHCS DOB does not match the DEERS DOB. Usually these patients are not enrolled until they correct their DOB in DEERS.

3. Enter SSN.

   Enter the nine-digit patient Social Security number (SSN) for this patient in the format nnn-nn-nnnn. (You need not enter the dashes.)

4. Verify SSN.

   As soon as the SSN entry is completed, the system erases the SSN from view and asks you to verify the patient's SSN entry.

   The necessity to enter the patient's SSN twice is a system device to reduce duplicate patient entries.

   The two SSN entries must match exactly before the system allows you to continue with the registration.

   If the two SSN entries do not match, you are forced to reenter the SSN.

5. Enter the PATCAT.

   The patient category (PATCAT) indicates the patient's service affiliation and entitlement.

   If the patient category is unknown, enter a double question mark (??) to display a list of valid patient category codes. For enrollment, only patient categories ending in 11 (active duty), 31 (retired), 41 (active duty family member), or 43 (retiree family member) are valid, because CHCS calculates ACV values based on PATCAT. CHCS determines the patient ACV, not DEERS. DEERS will reject the enrollment if the ACV is inconsistent with the patient's beneficiary category on DEERS so it is important to correct the patient category in CHCS if inconsistent with the DEERS patient status.

6. File the data.

DEERS Processing

After the initial information screens have been filed, a DEERS eligibility check is automatically processed.

CHCS interfaces with DEERS. DEERS determines eligibility for health care. Enrollment begins with a request for family member eligibility from DEERS.

The system requests a family list from the DEERS database, then displays the resulting Family Member screen from the DEERS data. The family member screen in figure 5-3 is requested using the sponsor SSN, so correct identification of the sponsor is required.

DEERS Check (Enrollment/Family Member Screens)

1. The DEERS Check (Enrollment/Family Member Screens) action is invoked for patients being processed through the Enrollment Enter/Edit option or the Reciprocal Disenrollment Processing option only. The DEERS check downloads patient eligibility and enrollment data directly from the DEERS database and displays the data on the DEERS Eligibility screens. The DEERS check is invoked to determine a selected patient's eligibility for Direct Care, CHAMPUS, and Medicare in addition to informing you of enrollment status and participation in other programs, such as CHAMPUS Dental. The family member screen may display up to 23 members per family.

   During enrollment processing, it is likely that not only will the initially selected patient be enrolled, but it will, most likely, be desirable that other members of the family be enrolled as well. The family screen method of processing the DEERS check will allow you to rapidly process all selected family members through DEERS and determine the eligibility for each. The family member connection is determined by the comparison of Sponsor SSN.

2. If a selected patient is determined to be ineligible as a result of the DEERS check, and you have sufficient information to continue an enrollment process, the system allow you the capability to enter an override reason and continue processing the enrollment for a newborn only. CHCS will set up a conditional enrollment with DEERS until eligibility can be confirmed. DEERS will not accept enrollment on an ineligible patient except in the case of a newborn.

DEERS and Uniformed Services Treatment Facility (USTF) Enrollment

Enrollees of USTF Managed Care Program – Following the DEERS check, the system searches DEERS eligibility information stored locally in CHCS to determine whether the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care).

Note: The USTF Managed Care Program is a network of DOD-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries (active duty patients are ineligible) as an alternative to other DOD managed care programs and direct care from the MTF. USTF enrollees are neither direct care nor CHAMPUS eligible.

If the specified patient is not assigned an ACV code of "U," the system allows you to continue the enrollment process without restriction. If the patient is assigned an ACV code of "U," the system displays the DEERS Eligibility Data screen with the message “This patient is a Uniformed Services Treatment Facility (USTF) enrollee who elected, in writing, to receive all non-emergency care from a USTF. Your facility is not reimbursed for care provided to this patient unless the USTF agrees to pay your facility prior to you rendering services to the patient.” The system does not allow the user to proceed with the enrollment as the beneficiary is currently enrolled in another program. DEERS will reject the enrollment.

If the DEERS link is down or unavailable, or if you or the system batch the DEERS eligibility check, the system bypasses the on-line DEERS eligibility check. You may enter enrollment data without the eligibility data but the enrollment may and often is rejected by DEERS for ineligibility or incorrect data. It is recommended that enrollments be entered only when the DEERS link is active.

```
                              FAMILY MEMBER SCREEN
    Patient Name: PEARL,ZACHARY N.             FMP/SSN: 20/569-69-4415
             DOB: 12 Jun 1975
    Sponsor Name: PEARL,ZACHARY N          Sponsor SSN: 569-69-4415
 Elig Start Date: 25 Sep 1998            Elig End Date: 1999
-----------------------------------------------------------------------
Name            Sex    DOB       DDS      ACV   Dir   Med   DMIS ID

PEARL,ZACHARY N M 12 Jun 1975    20       N           E        N
PEARL,ZELDA N   F 02 Jan 1976    30       C           E        N




   PEARL,ZACHARY N is this the patient you are enrolling? Yes//
```

Figure 5-3. Family Member Screen

Confirm the patient for enrollment

1. Upon entering the DEERS Check (Enrollment/Family Member screen) action, the system first displays the name of the patient that it has identified and will request confirmation prior to continuing with the DEERS check functionality in this action. You will be allowed either to confirm and continue or to enter a negative response and return to the *Select PATIENT NAME* prompt to specify another patient name. Press <Select> to select the family member you are enrolling.

2. If the patient has been determined to be ineligible for this enrollment, the system then allows you to enter an override code and continue with the enrollment or to abort from the enrollment process and return to the *Select PATIENT NAME* prompt. Please note that though CHCS will permit a user to collect and store enrollment information for an ineligible beneficiary, DEERS will reject the enrollment and it becomes invalid in CHCS. The beneficiary data must be corrected in DEERS in order for the beneficiary to be enrolled.

3. If the patient is eligible for enrollment or has had an override reason stipulated, the system then allows you to select other family members to process from the list of family members displayed. The system then processes each family member selected as it did the first family member. For example, registration data will be input on the Mini Registration screen for each family member to be enrolled, then the user may select and enroll those family members from the family member list.

   F9 View of family members – Prior to selection of a family member for enrollment, the system allows you to view which family members are currently registered in CHCS by positioning the cursor next to the family member name and pressing <F9>.

Select Patients for Enrollment Processing

Reciprocal Enrollment/Disenrollment

If eligibility checks are batched during enrollment, CHCS will not determine that a reciprocal disenrollment is needed. In this case, the enrollment is not recommended unless absolutely necessary.

Following the DEERS check when a family member is selected, CHCS checks the ACV and DMIS ID fields. If the ACV field contains a value indicating TRICARE enrollment (“A”, “D”, or “E”) and if the DMIS ID field contains a code not matching one or more of the codes of the requesting site, reciprocal enrollment/disenrollment processing is initiated.

1. If the DMIS ID Code of the facility where the beneficiary is currently enrolled does not match any of the local CHCS facilities DMIS ID Codes; and if the beneficiary's ACV from DEERS is either (A) Active Duty Enrolled, Enrolled/Not CHAMPUS Eligible (D), or CHAMPUS Eligible/Enrolled (E), the system displays the prompt: *FAMILY MEMBER [NAME] IS CURRENTLY ENROLLED AT [FACILITY]. DO YOU WISH TO DISENROLL FAMILY MEMBER [NAME] FROM [FACILITY] (EFFECTIVE ONE DAY PRIOR TO THE ENROLLMENT DATE) AND ENROLL [NAME] AT THIS FACILITY (Y/N)?*. You can then perform a Reciprocal Enroll/Disenrollment of the selected beneficiary. If the user answers “N”, then the application exits without enrolling the beneficiary.

Note: You may also disenroll a beneficiary from a remote facility without enrolling the beneficiary locally by using the Reciprocal Disenroll option on the Enrollment Menu.

CHCS/DEERS Discrepant Data

The system then displays the CHCS/DEERS Discrepant Data Screen which displays a comparison of patient data from CHCS and DEERS, highlighting any discrepancies between the two systems. If you wish, you can print the MCP CHCS/DEERS Discrepancy Data Report. If discrepancies exist, you can update CHCS from DEERS to eliminate one or more of the discrepancies and proceed to the Demographics Display screen. You may not update the DEERS data.

Note: It is extremely important to print and review the MCP CHCS/DEERS Discrepancy Data Report to ensure that all patients enrolled in CHCS are enrolled in DEERS. This report is time-sensitive; therefore if the buffer gets filled or reports are purged, it is impossible to go back and check the discrepancies.

The system also performs a DEERS eligibility check on each beneficiary to determine whether the beneficiary is enrolled in a USTF plan. USTF enrollees are listed in the PAS DEERS Ineligibility Report. The system performs the DEERS eligibility check immediately after the beneficiary has been entered at the *Patient Name* prompt.

If the system recognizes the patient as a USTF enrollee and you accept the default to Continue to enroll the patient, the system checks the ACV of the patient.

If the ACV is defined as U (Enrolled in USTF Managed Care), a message displays explaining that the patient is enrolled in a USTF and your facility will not be reimbursed for the care provided. A USTF enrollee may not be reciprocally disenrolled or enrolled in TRICARE Prime.

If a DEERS check has been performed on the patient within the past five days, the system displays the Current DEERS Eligibility screen and then the CHCS/ DEERS Discrepancy screen (if appropriate). If there are no discrepancies, the system bypasses the CHCS/DEERS Discrepancy screen and displays the Demographics Display screen. If the DEERS interface is down, CHCS displays a warning/information message, and then displays the Demographics Display screen.

Enrollments are stored with an MCP status of "pending enrollment" if the DEERS link is down and no DEERS check has been made within the past five days. The eligibility check and the enrollment date are stored. Once the interface is returned to an operational status, the eligibility check is processed.

If the eligibility checks are batched for active duty enrollees, the end enrollment date will be set to one year from the enrollment start date.

When the eligibility response is returned to CHCS for an active duty enrollee with an eligibility end date of "indefinite," the enrollment end date will automatically be updated to indefinite.

Note: It is important to note that even though an enrollment looks valid in CHCS, it is not actually valid until it is valid in DEERS, even if an override is used for an eligible patient because the DEERS link is down. Batch enrollment capability is available in CHCS, but it is not recommended for routine use.

Current DEERS Eligibility Display

The Current DEERS Eligibility Display action is also invoked from the PCM Booking, Appointment Referral Booking, Non-Enrolled Booking, Enrollment Enter/Edit, Reciprocal Disenrollment Processing, or Non-Availability Statement Processing options. This action only occurs when the patient being processed has had a DEERS check performed with the last five days. Enrollment data from the DEERS system is displayed.

Data Entry Process:

The system proceeds to the Current DEERS Eligibility Display screen when the patient being processed has had a DEERS Check previously performed within the last five days. If an eligibility check has not been performed in the last five days, a new DEERS eligibility check is performed, which includes today's eligibility data.

The system prompts you to begin this functionality by displaying the first Current DEERS Eligibility screen and an action bar allowing you either to view

additional DEERS data, print a copy of the DEERS data for the selected patient, initiate/repeat a new DEERS check for today, or accept the information as shown and continue with the option process being performed when this DEERS check was invoked.

The user may only create a current enrollment for the patient. If the patient is already enrolled, the patient may not be disenrolled in the future and re-enrolled under a new future status. For example, a patient is enrolled currently as active duty, is retiring in the future, and wants to enroll as a retiree today. The future enrollment may be entered after the current enrollment terminates.

Access the *Select PATIENT* prompt through one of the above-listed menu paths

Select patient

Display five-day eligibility information

Display Current DEERS Eligibility second screen

Access the *Select PATIENT* prompt through one of the above-listed menu paths

Select patient

Display five-day eligibility information

If a DEERS check has been performed on the selected patient within the past five days, the system displays the Current DEERS Eligibility screen showing the data from that transaction. An action bar allows you either to:

- view additional DEERS data
- print a copy of the DEERS data for the selected patient
- initiate/repeat another DEERS check for the current date, or
- accept the information as shown and continue with the option process being performed when this DEERS check was invoked (refer to Figure 5-4. Current DEERS Eligibility, page 5-17.The date of request on this screen indicates the date the eligibility check was received from DEERS. The user should consult this date to determine whether the DEERS check should be repeated to obtain more recent information.

Actions on the Current DEERS Eligibility action bar:

(V)iew more DEERS: When you select this action, a second screen is shown containing the remainder of the DEERS data for the selected patient (refer to Figure 5-5. Current DEERS Eligibility, Second Screen, page 5-18). Upon completion of viewing, press <Return> and the system returns to the screen and action bar shown in Figure 5-4. Current DEERS Eligibility, page 5-17.

(P)rint: When you select this action, enter a printer name and press <Return> at the *RIGHT MARGIN: 80//* prompt. The system prints a hard copy of the data on both the initial Current DEERS Eligibility screen and the second Current DEERS Eligibility screen to the printer you selected (refer to Figure 5-6. Current DEERS Eligibility Hard Copy Printout, page 5-19. If you press <Return> at the *Select DEVICE* prompt, the first screen is displayed on your terminal screen. When you've finished viewing the first screen, press <Return> to view the second screen.

Following printing, the system returns to the initial Current DEERS Eligibility screen and action bar.

```
                              CURRENT DEERS ELIGIBILITY
                Name: MOREHOUSE,KATHRYN             FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                      DDS: 30
               DOB/Age: 09 Apr 1969/26Y                     Sex: FEMALE
_____________________________________________________________________________
             Sponsor Rank: CAPTAIN
              Sponsor UIC: 31127-NAVCRUSERVDET HONOLULU
                  DMIS ID: 6501-TRICARE
                      ACV: E-MCP ENROLLED/DIR.  CARE CHAMPUS ELIGIBLE
          ACV Start Date: 01 Jul 1995            Region Code: 02
  Care Authorization PH#: 619-555-7526          PCM Location: CONTRACT
             Direct Care: ELIGIBLE                  Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 09 Feb 1992                CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: INDEFINITE
  Eligibility End Reason: U-Not Predictable

                                   BRAC Pharmacy Eligibility: NOT ELIGIBLE
           Override Code:
         Date of Request: 04 Dec 1996@1307
_____________________________________________________________________________
Select to (V)iew more DEERS data, (P)rint, (R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 5-4. Current DEERS Eligibility

(R)epeat DEERS check: When you select this action, the system invokes a new on-line DEERS check for the patient. DEERS must be on-line to perform this action. At the conclusion of the DEERS check the system proceeds to the next action in the option process being performed when this DEERS check was invoked.This action is displayed only for a new enrollment, not for an existing enrollment.

(C)ontinue: When you select the default action, the system proceeds to the next action within the option being processed.

(Q)uit: This action allows you to exit the option without further processing.

Display Current DEERS Eligibility second screen

```
                              CURRENT DEERS ELIGIBILITY
                Name: MOREHOUSE,KATHRYN             FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                     DDS: 30
              DOB/Age: 09 Apr 1969/26Y                     Sex: FEMALE
_____________________________________________________________________________
 CHAMPUS Dental Flag: 0-NO COVERAGE
   Dental Start Date:                               Dental End Date:
   Date Last Updated: 14 Aug 1995                    Panograph Date:
            NAS Flag: YES                               Organ Donor: YES
Reportable Disease                                             DNA: YES
Database (RDDB) Date:
     Date of Request:
_____________________________________________________________________________
Press <RETURN> to continue
```

Figure 5-5. Current DEERS Eligibility, Second Screen

1. Press <Return> after viewing this screen. You will return to the original DEERS Eligibility screen (refer to Figure 5-4. Current DEERS Eligibility, page 5-17).

```
CURRENT DEERS ELIGIBILITY
                  Personal Data - Privacy Act 1974 (PL-93-579)

                Name: MOREHOUSE,KATHRYN            FMP/SSN: 30/577-23-3789
     Patient Category: USA FAM MBR AD                    DDS: 30
               DOB/Age: 09 Apr 1969/26Y                  Sex: FEMALE
_____________________________________________________________________________
            Sponsor Rank: CAPTAIN
             Sponsor UIC: 31127-NAVCRUSERVDET HONOLULU
                 DMIS ID: 6501-TRICARE
                     ACV: E-MCP ENROLLED/DIR. CARE CHAMPUS ELIGIBLE
          ACV Start Date: 01 Jul 1995               Region Code: 02
  Care Authorization PH#: 619-555-7526             PCM Location: CONTRACT
             Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 01 Jul 1992                   CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: INDEFINITE
  Eligibility End Reason: U-Not Predicatable

                                     BRAC Pharmacy Eligibility: NOT ELIGIBLE
           Override Code:

      CHAMPUS Dental Flag: 0-NO COVERAGE
        Dental Start Date:                        Dental End Date:
                 NAS Flag: YES                     Panograph Date:
     Reportable Disease                                     DNA: YES
     Database (RDDB) Date:
         Date of Request: 04 Dec 1996@1307
```

Figure 5-6. Current DEERS Eligibility Hard Copy Printout

```
                              DEMOGRAPHICS DISPLAY
                 Name:  MCDOUGALL,ADELAIDE             FMP/SSN:  30/566-57-9823
     Patient Category:  USA FAM MBR AD                     DDS:  30
         Patient Type:  MCP/CHAMPUS ELIGIBLE                Sex:  FEMALE
           MCP Status:  ENROLLED                       DOB/Age:  17 Aug 1961/31Y
                  ACV:  E-MCP ENROLLED/DIR. CARE CHA   DMIS ID:  6501
           Direct Care:  ELIGIBLE                       Medicare:  NOT ELIGIBLE
_____________________________________________________________________________
          Sponsor Name:  MCDOUGALL,WILLIAM                  Rank:  COLONEL
          Station/Unit:  CAMP MICHAEL                        DSN:
          Home Address:  500 ORTH NEWTON WAY
                  City:  SAN DIEGO                          State:  CALIFORNIA
              ZIP Code:  92121                         Home Phone:  443-7801
            Duty Phone:  442-0561                      Work Phone:  442-0561
   Registation Comment:
Last Registration Date:  08 Dec 1992@@0831
Outpatient Record Room:  MAIN FILE ROOM (A)
       MCP Enroll Date:  08 Dec 1992               End Enroll Date:  31 Dec 1997
  Primary Care Manager:  SMITH,EARNEST                PCM Phone:  (619)377-7551
           Primary OHI:  ACACIA MUTUAL LIFE INS         Case Mgmt:  NO
_____________________________________________________________________________
Select (F)ull,  (M)ini,  (E)nrollment,  (O)HI,  (P)CM,  Ca(S)e,  F(a)mily,
        (D)isenrollment,  Rene(w),  (H)istory,  (N)ew Patient, (C)ontinue,
        or  (Q)uit DEMOGRAPHICS:  C//

                     Personal Data - Privacy Act 1974  (PL-93-579)
```

Figure 5-7. Demographics Display Screen

Demographics Display Screen

The Demographic Display screen displays.You will see an action bar containing the following choices:

1. Choose one of the following actions:

   Edit the patient's registration

   – with the Mini Registration option

   – with the Full Registration option

   Enter or edit the current enrollment of the current patient

   Enter or edit the OHI policies of the patient

   Enter or edit the PCM data of the patient

   Enter or edit exception or CASE providers for the patient

   Enroll members of the patient's family

   Disenroll the patient and/or the patient's family members

   Renew enrollment (option available only if the patient is not active duty)

   Display or print the history of the patient's enrollments

2. Select a new patient

3. Quit and exit the option

Data Entry Process:

Register the Patient

You begin the enrollment process by performing a DEERS verification for a patient who is not registered in CHCS.

CHCS/DEERS Discrepant Data Check

The CHCS/DEERS Discrepant Data Check action is automatically invoked following a normal DEERS eligibility check action for all MCP patients, all non-availability statement (NAS) requests, all first time registered Patient Appointment and Scheduling (PAS) patients, and all admissions processing of

patients. This action is also automatically invoked after an interactive DEERS eligibility check is requested by the user.

Upon completion of the CHCS/DEERS discrepancy data checking, the system displays the results of the check and highlights the data elements where a discrepancy exists between the CHCS data on file and the DEERS data just received.The system then allows you to selectively update the CHCS file with the data shown in DEERS and/or print the discrepancy screen showing the DEERS and CHCS entries.

An entitlement discrepancy will occur when a beneficiary's eligibility changes after they are enrolled; e.g., enrollee separates from service.You may clear an entitlement discrepancy indicator with this screen. However, if the entitlement discrepancy is not corrected, the indicator will re-appear the next time an eligibility check is performed. Clearing the enrollment discrepancy will not change the MCP patient status if the patient's status is INVALID ENROLLMENT or INVALID DISENROLLMENT, nor will it correct the patient's ACV on DEERS. These changes can only be performed through enrollment and disenrollment options. Entitlement discrepancies may be viewed on the Enrollee Entitlement Discrepancy Report (Menu path: PAS System Menu → MAN → OMCP → ERME → ROST → 10).

To correct CHCS/DEERS data discrepancies

Clear entitlement discrepancy

Select CHCS data to correct

Confirm correction of CHCS data to match DEERs

Correct UIC in DEERS

Data Entry Process:

CHCS DEERS Discrepancy Data screen

The system automatically initiates the CHCS/DEERS Discrepant Data Check action following the Interactive DEERS Eligibility Check within MCP options for first time registered patients and for all patients being processed for admissions. It is not initiated for existing patients.

The system begins by displaying the patient data found in CHCS and the patient data found in DEERS and highlighting the elements that have a discrepancy. The system then displays an action bar allowing you to update CHCS data from

DEERS, print discrepancies, clear entitlement discrepancies, continue, or quit processing (refer to Figure 5-8. CHCS/DEERS Discrepancy Data Screen, page 5-22).

If you elect to continue processing, the system proceeds to the next step in the option being processed (normally the Demographics Display screen). If you elect to quit, the system exists the option in process.

Note: The CHCS/DEERS Discrepancy Data screen also displays in PAS and NAS processing if eligibility data discrepancies are detected during the initial patient registration.

```
                        CHCS/DEERS DISCREPANCY DATA
            Name: PEARL,ZACHARY N.           FMP/SSN: 20/569-69-4415
Patient Category: USN ACTIVE DUTY                DDS:
      MCP Status:                            DOB/Age: 12 Jun 1975/26Y
             ACV:                            DMIS ID:
     Direct Care:                           Medicare:
-----------------------------------------------------------------------
                     CHCS Data                  DEERS Data

   Name           : PEARL,ZACHARY N.           PEARL,ZACHARY N
   DOB            : 12 Jun 1975                12 Jun 1975
   Sex            : MALE                       MALE
   Patient SSN    : 569-69-4415                569-69-4415
   Sponsor Rank   : CHIEF PETTY OFFICER
   Station/Unit   : WALTER REED MED HOLD PP    WALTER REED MED HOLD PP
   UIC Code       : W2DH05                     W2DH05
   ID Issue Date  :
   ID Expire Date :
   ID Card Number :


Select (U)pdate CHCS, (P)rint Discrepancies, (C)ontinue, or (Q)uit: U//
```

Figure 5-8. CHCS/DEERS Discrepancy Data Screen

1. Discrepancy data elements are highlighted and selectable. If you select the Update CHCS action, the cursor is placed next to the first highlighted and selectable data element. You may then select the data elements to update, make the correction(s), and file the data. The system then updates the selected CHCS patient data to match the DEERS data. You may not update DEERS data in the discrepancy processing.

Note: If there are discrepancies between DEERS data and CHCS data, the enrollment may be rejected.

Updating patient data in CHCS is subject to the following rules:

– Only discrepant data is considered for change. If no data discrepancies are detected, the discrepancy screen does not display.

– You cannot update the patient's SSN if the patient is a sponsor. You can only make such an update using the Mini Registration or Full Registration options.

– The UIC sent from DEERS must exist as a standard entry in the CHCS Unit Ship ID file.

– The sponsor rank sent from DEERS does not match the ranks used by CHCS and must be resolved by the user on this screen.

– The UIC and sponsor rank are changed interactively in the sponsor record via the discrepancy screen.

– If the patient is currently an inpatient, the DOB, Sex, and Sponsor Rank fields cannot be changed at the discrepancy screen. These fields are for display only. You can only make these changes using the Mini Registration or Full Registration options.

– If the patient has ever been an inpatient, the DOB and Sex fields cannot be changed at the discrepancy screen. These fields are for display only. You can make these changes using only the Patient Administration (PAD) Corrections Management functionality.

– All changes must pass standard checks for format consistency.

Sponsor Rank - If the selected data element is the Sponsor Rank, the CHCS-stored rank is displayed and you can enter a new rank from the CHCS Rank Table.

UIC Code - If the selected data element is the UIC code, the cursor is positioned directly after the *Station/Unit [Current Station/Unit]* prompt. When you enter a UIC code, refer to the standard UIC tables. Do not enter a new code. If you do not know the UIC, you can enter the ZIP Code to display a help list of the UICs in that ZIP Code area.

Enrollee Entitlement Changes Resulting in Discrepancies

When a beneficiary's eligibility changes after enrollment, the change is detected after the DEERS eligibility check has been performed. The patient record is marked with one of the following entitlement discrepancy flags:

1 Sponsor No Longer Active Duty
2 No Longer CHAMPUS Eligible

3 Sponsor Retired
4 No Longer Medicare Eligible
5 Became Medicare Eligible
6 Became CHAMPUS Eligible
7 Possible Active Duty PCS

In order to clear the discrepancy, the patient must be disenrolled from MCP. The disenrollment and reciprocal disenrollment processes clear the Entitlement Discrepancy field at the time the disenrollment is filed. If the patient is re-enrolled, the enrollment start date is compared to the ACV End Date from the previous enrollment episode to prevent overlapping enrollment episodes. The Enrollment Entitlement Discrepancy Report lists all enrollees with entitlement discrepancies.

The DEERS Eligibility Data Screen

The DEERS Eligibility Data screen displays immediately after an individual eligibility check and contains the actual data from the DEERS database which is current as of that day.

```
                          DEERS ELIGIBILITY DATA
            Name:PEARL,ZACHARY N              FMP/SSN: 20/569-59-4415
 Patient Category:USN ACTIVE DUTY                 DDS:
          DOB/Age:12 Jun 1975/26Y                  Sex:
-----------------------------------------------------------------------
                       NAME:  PEARL,ZACHARY N
                        SEX:  MALE                  DOB: 12 Jun 1975
                        DDS:  20            Sponsor SSN: 569-69-4415
                        ACV:  N-NOT ENROLLED/CHAMPUS INELIGIBLE
            ACV Start Date:  30 Oct 1999         Region Code:
                   DMIS ID:  0037-Walter Reed AMC
    Care Authorization PH#:                      PCM Location:
              Sponsor Rank:
               Sponsor UIC:
               Direct Care:  ELIGIBLE        Medicare: NOT ELIGIBLE
  Dir Care Elig Start Date:  25 Sep 1998     CHAMPUS:
    Dir Care Elig End Date:   17 Mar 2004
    Eligibility End Reason:

                                       BRAC Pharmacy Eligibility:
-----------------------------------------------------------------------
Select to (V)iew more DEERS data, (H)istorical DEERS, (P)rint, (C)ontinue,
       or (Q)uit: C//
```

Figure 5-9. Sample DEERS Eligibility Data Screen for an Eligible Patient

Recent changes/additions to the DEERS Eligibility Data screen fields include:

Care Authorization PH# has been added. This is the 24-hour phone number to reach a PCM.

Elig Start Date is now 'Dir Care Elig Start Date.'

Elig End Date is now 'Dir Care Elig End Date.'

Eligibility Comment is now 'Eligibility End Reason.'

SSN is now 'Sponsor SSN.'

Region Code has been added. This is the region where the beneficiary is enrolled, if enrolled.

PCM Location has been added. This indicates whether the PCM is a direct care PCM (00) or a contractor PCM (01).

BRAC Pharmacy Eligibility has been added.

Access the (C)ontinue action on the DEERS Eligibility Data Screen action bar

The system displays an action bar that contains the following actions:

(V)iew More DEERS Data. Review additional data received from DEERS. If you select this option, an additional DEERS data screen displays. Information on this screen includes whether the patient has CHAMPUS Dental care, the date this eligibility information was last updated, a Panograph date, whether the patient is an organ donor, whether the patient has reportable diseases (yes or no), and the date of the request.

Press <Return> at this screen to redisplay the first DEERS Eligibility Data screen with the action bar.

(H)istorical DEERS. View historical DEERS eligibility data. If you select this option, the Historical DEERS Eligibility Data screen displays each eligibility segment for the individual. The eligibility segments cover two years prior to and six months into the future as the default.

(O)verride Ineligibility. Enter an override code if the patient's Direct Care eligibility is Not Eligible. This only allows an enrollment to be recorded in CHCS; it will not be recorded in DEERS as it will be rejected.This option appears on the action bar only if the Direct Care Eligibility code indicates Not Eligible, with a message stating "Patient Ineligible."

If you elect to override, you are required to enter an override code to continue. Enter a question mark to list valid override codes. If you elect not to override, you must quit the option.

(P)rint. Print all eligibility information, including the historical data, if available.

If you select this option, the system prompts for a Device and then prints the report. The report includes information from the DEERS Eligibility Data screen, the additional DEERS Eligibility data screen, as well as the Historical DEERS Eligibility Data screen.

(C)ontinue. Continue with the process from which the user entered the DEERS eligibility check.

(Q)uit. Exit the screen and the enrollment process.

DEERS Link Unavailable

When eligibility data is not available and the site is operating in the DEERS Enrollment Mode, the site interprets eligibility based on the enrollment transaction response.

When the site is operating in local empanelment mode and eligibility is batch processed, the system later evaluates the MCP status based on the eligibility response when received.

The ACV field identifies a non-enrolled patient as N - NOT ENROLLED/ CHAMPUS INELIGIBLE (active duty or non-CHAMPUS) or C-CHAMPUS eligibles (CHAMPUS eligible and direct care eligible).

CHCS generates the ACV based on the beneficiary's patient category, age and other factors.The ACV field reflects the type of eligibility for the patient. A complete list of ACV codes is provided where the MCP Enrollment – Continuation Screen is discussed. This field cannot be changed by the user. The patient category must be correct, or the enrollment may be rejected by DEERS. The ACV may be corrected by changing the patient category or by changing the patient type value. Refer to page 5-36 for a listing of valid ACV codes.

The Mini Registration screen displays (refer to Figure 5-10. Mini Registration Screen, page 5-27).

Data Entry Process:

Full Registration - If you elect to enter the Full Registration option, the system prompts you to modify the registration of the current patient. Then the system returns to the action bar.

Mini Registration – If you elect to enter the Mini Registration option, the system prompts you to modify the registration of the current patient. The system then returns to the action bar. When entering a new registration, the following fields on the screen have the same data from the DEERS eligibility check already filled in (i.e., sex, patient address, DOB and sponsor SSN.) This is the only time DEERS addresses and other data may be viewed in CHCS.

```
Patient: PEARL,ZACHARY N.                                Mini Registration
FMP/SSN: 20/569-69-4415       DOB: 12Jun75       PATCAT: N11    Sex: M
                 Personal Data - Privacy Act of 1974 (PL 93-579)
      Patient: PEARL,ZACHARY N.                        DOB: 12 Jun 1975
       PATCAT: N11 (USN ACTIVE DUTY)                   FMP: 20
   Home Phone: 974-2333        W:                      SSN: 569-69-4415
 Patient Addr: 1020 NEWPORT DRIVE                      Sex: MALE
         City: HAMPTON               St/Cntry: VA      Zip: 23665

      Sponsor: PEARL,ZACHARY N.                   Service: NAVY
          FMP: 20                              Sponsor SSN: 569-69-4415
       PATCAT: N11 (USN ACTIVE DUTY)                   DOB: 12 Jun 1975
  Command Sec:                                        Rank:
 Station/Unit:
 Duty Address:
         City:                        St/Cntry:         Zip:
   Duty Phone:                                          DSN:

  O/P Rec Loc:
  O/S Rec Loc:
  Primary Phy:
  Reg Comment:
```

Figure 5-10. Mini Registration Screen

Much of the information displayed on this screen is automatically entered from previous screens, and the demographic data is transferred from the selected family member. For a new registration, the displayed data is defaulted from DEERS data in the eligibility information.

This screen contains both patient information (top and bottom portions) and sponsor information (middle portion).

1. Enter the Home Phone.

   This field is automatically entered with the patient's home phone number from DEERS on a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

2. Enter the Work Phone.

   Press <Return> to leave the patient's work phone number blank. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

3. Enter the Patient Address.

   This field is automatically entered with the patient's address from DEERS for a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

4. Enter the Sex.

   This field is automatically entered with the patient's sex from DEERS for a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data.

5. Enter the ZIP.

   This field is automatically entered with the patient's zip code from DEERS for a new registration and from CHCS for an existing registration. Press <Return> to accept the data, or enter new data. Changes to this data updates DEERS.

   The following fields are automatically entered with the sponsor's information (if the sponsor's registration in CHCS contains this information):

   – Sponsor

   – FMP

   – Sponsor SSN

   – PATCAT

- DOB
- Command Security
- Rank
- Station/Unit
- Duty Address
- City
- St/Cntry
- Zip
- Duty Phone
- DSN

6. Enter the Service.

   This field is automatically entered with the sponsor's service.

7. Enter the Sponsor SSN.

   This field is automatically entered with the sponsor's Social Security number.

8. Enter the Command Security.

   This is not a required field; however, you should complete this field if the sponsor is designated as a member of one of the following security programs:

   - Personnel Reliability Program (PRP)
   - Presidential Support Program (PSP)
   - Sensitive Compartmented Information (SCI).

   The information contained in this field flags the system to list this patient on the daily Command Security Report. The Command Security Report lists any designated active-duty patient who had an appointment on the previous day. More information on completing this field may be obtained by entering a double question mark (??).

9. Enter the Sponsor Rank.

10. Enter the Station/Unit.

    If the system cannot locate within the UIC table, the name of the station/ unit that you have just entered, CHCS prompts you if you want to use it as is. You can enter YES to use the station/unit as is, or enter NO to reject it.

    You can also enter the ZIP code to get a pick list of UICs located in the ZIP code.

11. Confirm Station/Unit.

12. Enter the Duty Address.

13. Enter the ZIP.

    The City and State fields are automatically entered based on the ZIP code entered.

14. Enter the Duty Phone.

15. Enter the DSN.

    Enter the sponsor's Defense Switching Network (DSN) number or prefix.

16. Enter the O/P Rec Location.

    You must enter an outpatient record (O/P) location for the patient's records.

    If the O/P Rec Loc field is left blank, the prompt *Patient Record Room Missing* displays at the bottom of the Demographics Display screen. You must either enter a record room in the O/P Rec Loc field or create a medical record for this patient before continuing with the enrollment process.

17. Enter the O/S Record Location.

    O/S stands for off-site. If the outpatient record has not been created using the Medical Record Tracking software, you may enter information regarding the actual whereabouts of the records in the O/S Rec LOC field, using 3 to 65 characters. This information helps complete the paperwork in the record file and account for records not found in any of the hospital record locations.

18. Enter the Primary Physician.

19. Enter the Registration Comment.

20. Does [patient] want to be an organ donor?

    This is an optional field and can be left blank. Check your site policy regarding this field.

Note: If you answer Y or N, an address update/organ donor transaction is sent in the background to DEERS to record the patient's wishes vis-a-vis organ donation.

If a patient is already registered and enrolled in CHCS, a second screen displays showing enrollment PCM information.

If the patient is already enrolled in MCP, the Enrollment/Empanelment Information screen displays with additional information about the patient.

```
Patient: BARBOSA, SALVADOR E       Enrollment/Empanelment Information
FMP/SSN: 20/027-52-5196      DOB 10sEP62       PATCAT: F11   Sex: M
---------------------------------------------------------------------

            ACV:  A-ACTIVE DUTY/MCP ENROLLED
        DMIS ID:  0125-MADIGAN AMC
       PCM Name:  RFJ GROUP                     PCM Phone: 301 999 8888
   PCM Location:  01-CONTRACTOR PCM
       Medicare:  NOT ELIGIBLE









    Press <Return>:

---------------------------------------------------------------------
File/exit       Abort       Edit
File changes and exit.
```

Figure 5-11. Enrollment/Empanelment Information

PCM Name

PCM Location: (CHCS sets a PCM location code in the enrollment transaction based on the type of PCM assigned to the enrollee. The code “00” indicates a direct care PCM and “01” indicates a contractor PCM. Contractor systems that enroll also create this data and send it to DEERS.

PCM Phone: The phone number of the 24-hour line to reach the PCM.

Medicare eligibility status - Indicates whether patient is medicare eligible - yes or no.

File the data.

21. Enter/Edit Allergy Information?

    You may press <Return> to accept the default or enter Y(ES) to edit the patient's allergy data. If you enter Y(ES) the system displays the patient's Allergy Enter/Edit screen (refer to Figure 5-12. Allergy Enter/Edit Screen, page 5-32).

    The complete list of allergies and allergy comments entered for this patient displays whenever a health care provider (HCP) enters RX or MED as an order type through order entry. The HCP can proceed to order the desired medication, but receives a warning that must be overridden and a reason for overriding the warning must be entered.

```
PEARL,ZACHARY N                 20/569-69-4415  26y M   CPO   Allergy Enter/Edit
===============================================================================
Allergy:
BARBITURATES

Comment:
HIVES




 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 5-12. Allergy Enter/Edit Screen

Complete the Allergy Screen

Repeat Steps 1 and 2 for each allergy entered.

1. Enter Allergy.

   A patient's allergy can be an allergy class, a brand name, a generic name, or an ingredient not marketed separately; e.g., Imipenem.

If help is needed, enter ?? to display a picklist of allergies.This allergy picklist is the First Data Bank (FDB) list, which is updated at each site quarterly. Press <Next Screen> several times to scroll through the list or quit to exit the picklist.

If the patient's allergy is not on the FDB list, enter OTHER and specify the allergy in the comments field.

2. Enter Allergy Comment.

   The comment filed is usually used to document the severity of the allergy or the symptoms the patient describes.

   You can enter additional allergies, if required.

3. File the data.

4. Press <Return> to continue.

Active Duty Auto Enrollment

The option to automatically enroll a patient into MCP is only available when entering or editing a mini-registration for an active-duty patient who has never been enrolled in MCP. The user must also hold the CPZ ENROLL security key to automatically enroll active duty.

1. Enroll in Managed Care?

   For this example, complete MCP enrollment is performed rather than automatic enrollment.

Select the Enrollment action on the Demographics Display action bar

The first MCP Enrollment – Continuation screen displays (refer to Figure 5-14. MCP Enrollment Screen, page 5-41).

Note: If enrollment is restricted by residential address, and the patient you are enrolling is not within the catchment area, the following message displays "-Invalid Patient ZIP CODE, location is not within Catchment Area". The following message is also displayed to holders of the CPZ ZIP security key - "Do you want to override? No//." Authorized users may select to override the restriction and continue with the enrollment. Otherwise, you should request that the system administrator add the ZIP code to the Catchment Area Table.

Enrolling the Beneficiary

The MCP Enrollment - - Continuation Screen is the primary enrollment screen.

The fields in the top portion of the screen are filled in with data from the patient's previously entered MCP demographics information in CHCS. This information is for display only and cannot be edited. If the patient's enrollment is not recorded in CHCS, the data does not show enrollment information from DEERS.

The fields in the bottom portion of the screen can be edited.

MCP Status Field

In the top portion of the screen, the MCP Status field is blank for those patients that have not been enrolled. This field is for display only and cannot be edited for those patients already enrolled. The following are valid MCP statuses and status codes and are explained below:

Code	Status
C	Conditional Enrollment
D	Disenrolled
E	Enrolled
IE	Invalid Enrollment
ID	Invalid Disenrollment
PE	Pending Enrollment

The system uses the following conditions and rules to derive the specific status to assign to each patient:

– **Conditional Enrollment** - If the patient is a newborn (less than 1 year old, FMP 01-19) or a new spouse (FMP 30-39) and is not registered in DEERS and you choose to override the ineligibility, the MCP status displays as Conditional Enrollment. All other ineligible beneficiaries cannot be enrolled and are rejected by DEERS. Conditional enrollments are stored in a suspense file in DEERS and are set up as an enrollment when eligibility is confirmed.

– **Pending Enrollment** - If the response from DEERS is delayed (for example, if the DEERS line is busy and the inquiry must be batched), or if the MCP enrollment date is a future date, the MCP status displays as Pending Enrollment.

– **Disenrolled** - If a patient has been formerly enrolled in CHCS and is now disenrolled, the MCP status displays as Disenrolled. However, the enrollment ACV and DMIS ID still display on enrollment screens to indicate the previous enrollment status.

– **Enrolled** - Four conditions must be met for a patient to be assigned the Enrolled status.

  * A response of eligible must be received from DEERS (indicates eligibility on the enrollment start date)

  * The MCP Enrollment screens must be completed and filed

  * A PCM must be assigned to the patient

  * MCP enroll date must be a past or current date

  * Status until the CP Enrollment Bulletin determines the enrollment was not accepted by DEERS.

– **Invalid Enrollment** - If a discrepancy or ineligibility response is received from DEERS as a result of filing a patient's enrollment, the MCP status is changed that night by the CP Enrollment Bulletin to Invalid Enrollment. You may correct the patient data, then reenter the enrollment screen for this patient to retransmit data to DEERS and file the data. This action retransmits the enrollment transaction to DEERS with the corrections. Only invalid enrollments may be retransmitted to DEERS. This status remains until the discrepancies are corrected, then the MCP status is changed to Enrolled.

– **Invalid Disenrollment** - If the system receives a discrepancy response from DEERS after sending the Disenrollment transaction, the MCP status displays as Invalid Disenrollment. This status remains until the discrepancies are corrected; then the MCP status is changed to Disenrolled. You may correct this record and file the data. This action retransmits the Disenrollment to DEERS with the corrections. If patient ID data is changed in CHCS after enrollment, the Disenrollment is rejected as DEERS no longer recognizes the enrollee. Return the data temporarily to the enrollment ID and retransmit.

ACV Field

The ACV defines the type of eligibility for the patient (refer to Appendix A, ACV Codes, on page A-19). CHCS derives an ACV based on the Patient Category, CHAMPUS eligibility from DEERS, and age and then sends the derived value to DEERS as part of the enrollment transaction.

If DEERS disagrees with the CHCS-derived ACV, the enrollment is rejected and the MCP status is updated at night to “Invalid Enrollment.” Enrollment status is updated at night when the CP Enrollment Bulletin is run. The beneficiary appears on the Enrollment Discrepancy Report with the DEERS reason for the rejection. The discrepancy can then be resolved (based on the reason provided on the report) and the enrollment transaction can be retransmitted to DEERS.

The ACV field, located on the top portion of the screen, is for display only and cannot be edited directly.

The MCP patient type may be changed in certain circumstances to correct the ACV assigned; e.g., from MCP DIRECT CARE to MCP CHAMPUS to change the ACV to "E" for TRICARE enrollment provided the patient is CHAMPUS eligible.

Note: The CP Enrollment Bulletin must be run each night in order to validate the patient's current status and the success of the enrollment.

Note: CHCS only uses codes A, E, C, D, and N (described below). Additional codes identify other DOD benefit programs.

The following ACV codes can be generated in the ACV field by CHCS during the enrollment process (you cannot enter data in this field):

A – Indicates the specified patient is active duty and is currently enrolled in MCP.

E – Indicates the specified CHAMPUS eligible patient is enrolled in TRICARE and is an active duty family member, retired family member, or retiree under the age of 65. Patients can have dual eligibility, that is, they can be CHAMPUS eligible, an active duty dependent (spouse), and also be Medicare eligible. CHAMPUS eligibility has priority and they should be assigned an "E".

C – Indicates the specified CHAMPUS eligible patient is covered under TRICARE Standard and is an active duty family member, retired family member, or retiree under the age of 65 who is not enrolled in MCP. The ACV code is changed to "E" by the system after the patient is enrolled in TRICARE Prime.

D – Indicates the specified patient is over 65 and Medicare eligible.

N – Indicates the patient (if active duty, Medicare eligible or CHAMPUS Ineligible) is direct care eligible only. The code includes active duty not yet

enrolled.The system assigns the ACV code of “D” or “A” (whichever is applicable) after the patient has been enrolled.

Note: After the enrollment data is filed and a PCM has been assigned to the patient, the enrollment transaction is sent to DEERS. DEERS then sends a response back to CHCS. If a discrepancy response is received by CHCS, an Enrollment/Disenrollment Discrepancy Bulletin is generated for this patient. Local empanelment mode does not control active duty enrollment processing; all active duty enrollments are sent to DEERS and recorded there, regardless of the value of the mode.

```
ENROLLMENT HISTORY: 21 Jun 2001                  MCP Enrollment -- CONTINUATION


                 Name: PEARL,ZACHARY N               FMP/SSN: 20/569-69-4415
     Patient Category: USN ACTIVE DUTY                   DDS:
         Patient Type: MCP/ACTIVE DUTY                    Sex: MALE
           MCP Status:                               DOB/Age: 12 Jun 1975/26Y
 Primary Care Manager:                             PCM Phone:
          Primary OHI: NOT ASSIGNED                Case Mgmt: NO
                  ACV: A-ACTIVE DUTY/MCP ENROLLED
          Direct Care:                              Medicare:
 ==============================================================================

   Enrolling Division: DIV A - TRAINING HOSPITAL

         Patient Type: MCP/ACTIVE DUTY

      MCP Enroll Date: 21 Jun 2001
      End Enroll Date: 20 Jun 2002

   Enrollment Comment:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-13. MCP Enrollment - - Continuation Screen

Complete the first MCP Enrollment - - Continuation Screen

1. Enter Enrolling Division.

   The Enrolling Division field is automatically entered with the name of the current user's division. Press <Return> to accept this default or enter another valid division. Because the default enrolling division displayed may not be correct, be sure before you press <Return> that this is the correct division. A division has a Medical Expense and Performance Reporting System (MEPRS) code and unique DMIS ID assigned to it for workload

reporting. The DMIS ID is stored in DEERS to indicate where the beneficiary is enrolled.

For a list of valid divisions, enter a double question mark (??).

The PCM should provide care at the enrolling division so be sure to check these two data elements for consistency.

2. Enter Patient Type.

   The patient type is derived by the system based on the patient's PATCAT, ACV code, and age, if no DEERS response is received.

   The patient type cannot be edited for an active duty patient. Only the patient type for a non-active duty patient can be changed.

   Following is a list of patient types and descriptions used in MCP.

   These types are only used during the enrollment process if the CHCS derived patient type is overridden by the user. Refer to the ACV section for more information.

Code	**Patient Type**
AD*	Active Duty
MCA	MCP/Active Duty
MCD	MCP/Non-CHAMPUS Eligible
MCP	MCP/CHAMPUS Eligible CH *CHAMPUS
MED	Medicare
OTH*	Other
SUP*	Supplement Care

   The system uses the following conditions and rules to derive the specific patient type for each eligible patient:

   – All active duty patients enrolled in MCP are designated as MCA. (You cannot change the patient type for active duty patients.)

   – All patients over the age of 64 are designated as MEDICARE (MED), provided they are not also CHAMPUS eligible. If they are CHAMPUS eligible, they can be enrolled in TRICARE Prime by changing the patient type to MCP/CHAMPUS eligible. Otherwise, they are assigned an ACV of “D” and enrolled in Medicare simulation.

– All active duty family members, retired family members, and retirees under the age of 65 are designated as MCP if they are CHAMPUS eligible. If they are not CHAMPUS eligible, they are space available only and may not enroll.

Press <Return> to accept this type, or enter MCP to enroll dual eligible patients in TRICARE or MCD.

3. Enter MCP Enroll Date.

You can edit the field with a date in the past or future, if desired, but it may not overlap another enrollment period in DEERS.

DEERS sends the ACV disenrollment dates in the eligibility transaction to prevent CHCS from creating a new enrollment episode that will overlap a prior episode.

The MCP Enrollment Start date is determined differently for active duty and non-active duty beneficiaries and reciprocal disenrollments.

Active Duty - For active duty beneficiaries, the Enrollment Start Date defaults to today's date. You can press <Return> to accept the default date or edit this date to any date using the following criteria:

– Must be on or after October 1, 1992

– Must be on or after the patient's date of birth

– Must not overlap a previous enrollment episode in DEERS or CHCS.

Non-Active Duty - For non-active duty beneficiaries, the Enrollment Start Date defaults to the first day of the next month (e.g., 1 May 2001). The user may enter any first of the month date, past or future that meets the above three criteria.

4. Enter End Enroll Date.

Active Duty - If a date exists in the End Eligibility Date field for the active duty beneficiary, this date is entered in the End Enroll Date field. The Enrollment End Date defaults to 'Indefinite' when the End Eligibility Date from DEERS is either all 9s or null in CHCS. You may press <Return> to accept this date or enter any date.

For active duty beneficiaries, the system updates the CHCS Enrollment End Date with the DEERS Eligibility End Date each time a DEERS eligibility transaction is performed in PAS/MCP. CHCS also updates the End Enrollment Date with the ending date on the last day of the month

prior to the eligibility expiration date via a nightly batch job. Sites must review the MCP End of Eligibility Report regularly to catch active duty that may be disenrolled prematurely. DEERS end eligibility dates are not always current.

Note: This process is automatic and does not require user interface.

Non-Active Duty - The Enrollment End Date defaults to one year from the Enrollment Start Date, and is always on the last day of the given month (e.g., 30 April 2002). You can edit this date to be any end-of-month date as long as it is less than the system-defaulted Enrollment End Date and later than the Start Enroll Date.

5. Enter Enrollment Comment.

   Press <Return> to exit this field without making an entry, or enter an enrollment comment, using from 1 to 50 characters.

Enrollment - Second Screen

As with the first screen, the fields in the top portion of the screen are filled in with data form the patient's previously entered MCP demographics information from CHCS. This information is for display only and cannot be edited.

The fields in the bottom portion of the screen can be edited.

.

```
PATIENT: PEARL,ZACHARY N                                          MCP ENROLLMENT


                 Name: PEARL,ZACHARY N                FMP/SSN: 20/569-69-4415
     Patient Category: USN ACTIVE DUTY                    DDS:
         Patient Type: MCP/ACTIVE DUTY                    Sex: MALE
           MCP Status:                               DOB/Age: 12 Jun 1975/26Y
 Primary Care Manager:                             PCM Phone:
          Primary OHI: NOT ASSIGNED                Case Mgmt: NO
                  ACV: A-ACTIVE DUTY/MCP ENROLLED
          Direct Care:                              Medicare:
 ==============================================================================

          Patient SSN: 569-69-4415

             Language:

       ID Card Number:                              Date Issued:
       Effective Date:                          Expiration Date:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-14. MCP Enrollment Screen

1. If the patient is not the sponsor, the cursor is placed in the SSN field and you must enter the patient's SSN. The patient can be enrolled as a family member, or active duty, and can be looked up on DEERS under either SSN. You may enter the number as nine continuous digits (e.g., 445125847) or in the form nnn-nn-nnnn (e.g., 445-12-5847).

   If the patient is the sponsor, the system automatically enters the SSN number in the SSN field from previously entered data. The cursor is positioned in the Language field.

2. Enter Language.

   Enter the primary language spoken by the patient if other than English. For a complete list of valid languages, enter a double question mark (??).

   Press <Return> to leave this field blank. The system automatically assumes that all patients can communicate in English.

These following fields default from the DEERS Eligibility information on a new enrollment only and are optional.

3. Enter the ID card number.

4. Enter Date Issued.

   Enter the date of issue on the ID card.

5. Enter Effective Date.

   Enter the effective date of the ID card, or enter INDEFINITE.

6. Enter Expiration Date.

   Enter the expiration date of the ID card, or enter INDEFINITE.

7. File the data.

Select a PCM

The PCM Search Criteria displays (refer to Figure 5-15. PCM Search Criteria Screen, page 5-44).

5.1.2 Assign a PCM

You must assign a PCM to a new enrollee to complete the enrollment process. If a PCM is not assigned, the enrollment for this patient is deleted. A PCM may be either an individual provider or a group provider. This option may be accessed on a new enrollment following the Enrollment screens or from the Demographic Display screen to change a PCM.

You enter this action from the Demographics Display screen action bar by selecting (P)CM on the action bar. The system then displays an action bar permitting you to change the search criteria for a PCM search, directly assign a user specified PCM, search for a PCM who meets search criteria, modify PCM history, print PCM data, view family PCM assignments, or quit this action and return to the Demographics Display screen action bar for continued processing in the Enrollment Enter/Edit options.

Data Entry Process:

Assign a PCM:

Access the PCM Search Criteria Screen
Select the (D)irect PCM Assignment action
Complete the PCM Search Criteria Screen
Print Enrollment Form
Print Patient Address Label
Select Quit to exit the Demographics Display Screen

Access the PCM Search Criteria Screen

```
                                PCM SEARCH CRITERIA
   Patient: PEARL,ZACHARY N                      FMP/SSN: 20/569-69-4415
  Language:                                             DDS:
 Specialty:                                     DOB/Age: 12 Jun 1975/26Y
       PCM:                                      PCM Gender:
  Location:                                            Date: 21 Jun 2001
-------------------------------------------------------------------------




-------------------------------------------------------------------------
Select (C)hange Search Criteria, (D)irect PCM Assignment,
       (V)iew Family Assignments, or (Q)uit PCM: C//
```

Figure 5-15. PCM Search Criteria Screen

The system displays the following actions on the action bar:

(C)hange Search Criteria – The system displays five search criteria: specialty, location, PCM gender, patient language, and default search criteria. The system prompts you to enter values for each of the criteria that you have selected. The system then returns to the PCM Search Criteria Action Bar.

(D)irect PCM Assignment – The system prompts you to enter the name of a specific PCM.

(S)earch PCM – The system permits you to enter this action only if search criteria have been set using the action described in the "Change Search Criteria" section above. The system displays all PCMs who meet the selection criteria and prompt you to select one. (Using <F9>, you can view location (place of care) data and assignment preferences, for a particular PCM prior to selecting the PCM for assignment to the patient.) If you are changing the PCM of the patient, the system prompts you to enter the change assignment reason. The system then prompts you to indicate whether to print the PCM report. The system then returns to the PCM Search Criteria Action Bar.

(M)odify PCM History – The system permits you to enter this action only if the patient has formerly had a PCM different from the current one. The system displays an action bar requesting that you select to modify data for a PCM, view data of past and present PCMs, or quit this action and return to the PCM Search Criteria Action Bar.

Modify PCM History, Modify – The system displays the list of all PCMs who were formerly assigned to the patient and prompts you to select the PCM whose data is to be modified. The system then prompts you to modify the date of change and the date when the PCM was de-assigned from the patient. The system then prompts you to enter the change assignment reason and then returns to the PCM Search Criteria Action Bar.

Modify PCM History, View – The system displays the list of all PCMs who were formerly assigned to the patient. When you press <Return>, the system returns to the PCM Search Criteria Action Bar.

(P)rint PCM – The system displays or prints the PCM report, containing a listing of data pertaining to the current PCM as specified by you, and then returns to the PCM Search Criteria Action Bar.

(V)iew Family Assignments – The system displays the list of all the family members together with the PCMs (if any) assigned to them. When you press <Return>, the system returns to the PCM Search Criteria Action Bar.

(Q)uit – When you select (Q)uit from the PCM Search Criteria Action Bar, the system returns to the Demographics Display screen and the Demographics Display Action Bar.

The PCM Search Criteria screen has three windows:

Display

The Display window at the top of the screen displays the following active search parameters:

Patient Name (left side of window)

Language - Languages other than English

Specialty - PCM's specialty

PCM - Provider name

Location - Zip codes or location name

FMP/SSN - Patient FMP/SSN

DDS - DEERS Dependent suffix for patient

DOB/Age - Patient's DOB and age

PCM Gender - Patient preference for gender of PCM

Date - Date PCM assigned

Select

The Select window in the middle section of the screen displays PCM picklists. At this point, the Select window is blank.

Interact

The Interact window in the bottom section of the screen displays messages, prompts, and action bars.

An action bar displays a list of options. Type one of the character(s) within the parentheses, for the desired option, then press <Return>. The selected function is performed, then control is returned to the action bar. An action bar is not case sensitive.

Default values appear at the end of the action bar prompt followed by a double slash (//). They may be selected by pressing <Return>. If no default is present, you must make a selection or quit this action bar by entering either <Q> or <^>, then pressing <Return>.

Select the Direct PCM Assignment action to select default PCM.

1. Accept the default PCM displayed.

2. File the PCM.

3. Display/Print PCM and place of care?NO//

   Enter YES to display or print the PCM place of care information.

   To accept the default not to display or print the PCM place of care, press <Return>. You return to the PCM Search Criteria screen.

4. Select Device.

   Press <Return> to print to the screen.

5. Enter Right Margin.

   The screen displays the provider's address, phone number, directions to the place of care, hours of service, and any additional comments.

6. Press <Return><Return> to continue (to return to the PCM Search Criteria screen).

Select the Direct PCM Assignment action to assign a specific PCM.

The Direct PCM Assignment action allows you to assign a specific PCM to a patient.

1. The system displays all the records pertaining to the chosen PCM and prompts you to select one.

2. Using <F9>, you can view location data and assignment preferences for the PCM before selecting the PCM for assignment to the patient.

3. If you are changing the PCM of the patient, the system prompts you to enter the change assignment reason.

4. The system prompts you to indicate whether to print the PCM report.

5. The system then returns to the PCM Search Criteria Action Bar.

Note: A default PCM may display at the *Select PCM* prompt. This displays only for active duty. Whenever an active duty patient with that UIC is enrolled and a Direct PCM assignment is performed, the default PCM displays. This default PCM has been entered previously in the MCP files. A specific UIC was assigned a specific default PCM.

---

6. You may accept the default PCM, or enter a new PCM name.

7. Select the Quit action (to quit the PCM Search Criteria screen)

   The enrollment transaction is batched for later transmission to DEERS.

Select the (C)hange Search Criteria action on the PCM Search Criteria Screen

Press <Return> to accept the Change Search Criteria default.

The PCM Search Criteria screen is redisplayed. The search parameters are listed in the Select window.

```
                                PCM SEARCH CRITERIA
   Patient: PEARL,ZELDA N                            FMP/SSN: 30/569-69-4415
  Language:                                              DDS:
 Specialty:                                          DOB/Age: 02 Jan 1976/25Y
       PCM:                                        PCM Gender:
  Location:                                             Date: 21 Jun 2001
--------------------------------------------------------------------------------
   Specialty
   Location
   PCM Gender
   Patient Language
   Default Search Criteria


-
---------------------Specialty and Location are required------------------------
Use SELECT key to select SEARCH CRITERIA to be changed.
```

Figure 5-16. PCM Search Criteria (Change Search Criteria)

Complete the PCM Search Criteria Screen

1. **Specialty**

   A specialty and location are required.

   Position the cursor next to the desired search criteria, then press <Select>.

   The specialty you enter is used when searching for a PCM.

   The specialty you enter appears at the top of the screen in the Display window.

2. Confirm the specialty selected.

   You can deselect a category by pressing <Select> again.

   When all selections have been marked, activate the selections by pressing <Return>.

   Selecting the Default Search Criteria parameter commands the system to automatically use the currently selected search criteria parameters for your user ID during each subsequent search action until you change them, even if you log off the system.

The prompt to enter the specialty displays in the Interact window. A picklist of specialties and speciality combinations is available by entering ?? at the specialty prompts.

3. Location

This search criteria specifies the location by ZIP code(s) in which to search for a PCM.

The prompt accepts three possible formats:

ZIP Code(s)

Enter one to five-digit ZIP codes or enter partial ZIP codes, for 5-digit ZIP codes, Nine-digit ZIP codes are not allowed. If you enter more than one ZIP code, separate each ZIP code by a comma.

EXAMPLES:

Select Location: 23707

Select Location: 23707,23708,23665

If you enter more than one ZIP code, the *This ZIP Code Combination does not currently exist. Do you wish to generate cross-references for this ZIP Code Combination? No//* message and prompt might display if that combination has never been entered before.

If you enter NO at this prompt, the system does not generate cross-references for the combination of ZIP codes you entered. Providers are displayed in ZIP code order. Within each ZIP code, each provider is sorted from highest to lowest discount rate.

If you enter YES at this prompt, the system generates cross-references for the combination of ZIP codes entered. Providers display from highest to lowest discount rate, regardless of the ZIP code.

You should accept the default of YES, unless otherwise instructed by your site policy and procedures. If you enter YES, the system becomes more efficient when this particular combination is used again.

Wild Card(s)

Enter from one to five wild cards. A wild card is represented by the first three or four characters of a ZIP code. It allows you to search on a range of

ZIP codes. If you enter more than one wild card, separate each wild card by a comma.

EXAMPLES:

Select Location: 237

The system searches on the range of ZIP codes from 23700 to 23799.

Select Location: 2370

The system searches on the range of ZIP codes from 23700 to 23709.

Select Location: 2370,236,2355

The system searches for the range of ZIP codes including 23700 to 23709, 23600 to 23699, and 23550 to 23559.

Providers display according to ZIP codes. Within each ZIP code, the providers are sorted from highest to lowest discount rate.

ZIP Code Combination

Enter one ZIP code combination. This is a text identifier (defined by the site) representing a range of ZIP codes. ZIP code combinations that cross over TRICARE regional service areas may still be within the same catchment area.

EXAMPLES:

Select Location: NEW YORK CATCHMENT AREA

Select Location: NEW YORK CITY

Select Location: MANHATTAN

To display existing ZIP code combinations, enter a double question mark (??).

If you enter a ZIP code combination that does not current exits, the *This ZIP Code Combination does not currently exist. Do you wish to generate Cross References for this ZIP Code Combination now? No//* message and prompt displays.

Create a Cross Reference?

Creating a cross-reference helps the system become more efficient for later searches using this same ZIP code combination.

The locations you entered appear in the Display window.

4. PCM Gender

   Indicates the PCM's gender. If this is selected as part of the search criteria, only PCMs of the specified gender display on the PCM Assignment screen.

5. Patient Language.

   If this is selected as part of the search criteria, each PCM who speaks the patient's preferred language is indicated by a tilde (') next to the name.

6. Confirm the language entry.

   If this is selected as part of the search criteria, each PCM who speaks the patient's preferred language is indicated by a tilde (~) next to the name.

7. Default Search Criteria.

If this is selected, the *Do you want the current criteria selections to be saved as your Default Selection Criteria? YES//* prompt displays. If you accept the YES default, the selected search criteria remain selected for all beneficiaries until it is deselected for your user ID.

After all the selected search criteria have been entered, the PCM Search Criteria screen is redisplayed. The Search PCM action has been added to the PCM action bar.

After entering the search criteria, CHCS displays a list of PCMs that meet the search criteria and have agreements to treat this type (category) of patient.

Complete the PCM Assignment Screen

```
                                PCM ASSIGNMENT
   Patient: PEARL,ZELDA N                          FMP/SSN: 30/569-69-4415
  Language: SPANISH                                    DDS:
 Specialty: FAMILY PRACTICE/PRIMARY CARE           DOB/Age: 02 Jan 1976/25Y
       PCM:                                      PCM Gender:
  Location: 20307,20817                                Date: 21 Jun 2001
-------------------------------------------------------------------------------
   Provider                CS Cat   Specialty        Agr Locat Sex Disc   Avail

    ALBERT,CHARLES D       B   MD   FANILY PRACTICE  MTF 20307   M  MTF     468
    ALTON,PATRICIA M       E   MD   FAMILY PRACTICE  MTF 20307   F  MTF     500
    AUSTIN, GILBERT, M     E   MD   FAMILY PRACTICE  MTF 20307   M  MTF     485

Use SELECT key to select PCM to be assigned.
Press F9 key to view Assignment Preferences, Place of Care of Watch Codes
```

Figure 5-17. PCM Assignment Screen

The Select window in the middle of the PCM Assignment screen displays a list of the PCMs who meet the search criteria specified. A PCM may appear on this list multiple times, once for each place of care and specialty and agreement combination. The system displays the list of PCMs in random order to avoid preferential provider choices. For example, the PCMs will not appear on the list in alphabetical order. (Refer to Figure 5-17. PCM Assignment Screen, page 5-52.) For each provider, the list also displays the following information:

Certification Specialty (CS) - Indicates the level of Board Certification the provider holds for this specialty. Valid codes are:

Blank	Not Certified, or Does Not Exist in the Specialty File
E	Board Eligible
BO	Board Certified
NA	National Certification

Provider Category (CAT) - Indicates the professional level of the provider; e.g., MD=Physician, NP=Nurse, PA=Physician Assistant.

Agreement Type (Agr) - The following are valid agreement types:

CON	Contract
MTF	MTF Staff
NET	Civilian Network Provider
NON	Non-Network/Exception
PEX	Partner External

PIC	Partner Internal
SUP	Supplemental Care/Diagnostic Services

Location (Locat) - ZIP code of the provider's place of care.

Provider Gender (Sex) - The valid specifications for provider gender are:

M	Male
F	Female
Blank	None specified

Overall Discount Rate (Disc) - The valid overall discount rates are:

CA - Group the CHAMPUS allowable rate for services rendered.

CA-x% - Group accepts the CHAMPUS allowable rate minus an established percentage for services rendered.

MTF - Group members are military providers with no direct charge for services rendered to eligible beneficiaries.

UC - Group accepts the usual and customary rate for services rendered.

UC-x% - Group accepts the usual and customary rate minus an established percentage for services rendered.

Total Available PCM Capacity (Avail) - Indicates the total available patient capacity for the provider. The system ensures that each PCM has a capacity of at least 1 before listing them on the screen.

Note: The tilde (~) next to a provider's name indicates that the provider speaks the preferred language of the patient.

MTF providers display first, followed by providers based on their overall discount rate (providers with the largest discount first). Civilian providers are listed in random order each time a new list is displayed.

The Other Health Insurance screen displays only for non-active duty patients. *Do you want to print enrollment form? No//* displays.

Print Enrollment Form

Enter “Yes” if the enrollment form is to be printed.

Refer to Figure 6-78. Managed Care Enrollment Form, page 6-134.

Print patient address label? NO//

Enter "Yes" to print a single mailing label for the patient.

The Demographics Display screen displays.

1. Quit to exit the Demographics Display screen and return to the Enrollment Processing Menu

5.1.3 Enroll Family Members

Menu Path: PAS System Menu → MAN → **EMCP** → EENR

Data Entry Process:

Enroll Family Members:

Select Patient
Complete the Patient - Initial Information Screen
View the Family Member Screen
Select family member to register and move demographic data from
Perform Mini-Registration
Enter Allergies
Enroll Beneficiary
Assign a PCM

Select Patient

1. Enter the patient identifier.

   For this example, the patient would not be registered at your facility and you would perform a Mini Registration for the patient.

2. The prompt, *Are you adding [patient name]' as a new PATIENT (the nth)?* displays.

Confirm that you are adding a new patient.

3. Enter Sponsor Name.

4. Confirm the Sponsor Name.

Patient Initial Information

The Patient - Initial Information screen displays (refer to Figure 5-18. Patient - Initial Information Screen, page 5-55). The Sponsor Name, Sponsor SSN, and Patient Name fields are automatically entered. You cannot edit data in these 3 fields.

Complete the Patient - Initial Information Screen

```
Sponsor Name: PEARL,ZACHARY N                      Patient - Initial Information
 Sponsor SSN: 569-69-4415



                Patient Name: PEARL,ZELDA N
                         FMP:
                         DOB:
                         SSN:
                      PATCAT:


 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 5-18. Patient - Initial Information Screen

1. Enter FMP.

   The FMP for the sponsor is 20. The FMP is used to signify the relationship between the sponsor and the patient.

   If the sponsor and the patient are the same, the cursor displays in the Sponsor FMP field, and you must enter 20 as the sponsor FMP.

   If the sponsor is not the same as the patient, the FMP is blank. You must enter the patient's FMP.

2. Enter DOB.

   Enter the DOB. Check the DEERS Eligibility Data Screen for the DOB to ensure the correct date. If the correct DOB is not available, you may choose not to enroll the patient until the correct DOB is known. DEERS does not enroll the patient if the CHCS DOB does not match the DEERS DOB. Usually these patients are not enrolled until they correct their DOB in DEERS.

3. Enter SSN.

   Enter the nine-digit patient SSN for this patient in the format nnn-nn-nnnn. (You need not enter the dashes.)

4. Verify SSN.

   As soon as the SSN entry is completed, the system erases the SSN from view and asks you to verify the patient's SSN entry.

   The necessity to enter the patient's SSN twice is a system device to reduce duplicate patient entries.

   The two SSN entries must match exactly before the system allows you to continue with the registration.

   If the two SSN entries do not match, you are forced to reenter the SSN.

5. Enter the PATCAT.

   The PATCAT indicates the patient's service affiliation and entitlement.

   If the patient category is unknown, enter a double question mark (??) to display a list of valid patient category codes. For enrollment, only patient categories ending in 11 (active duty), 31 (retired), 41 (active duty family member), or 43 (retiree family member) are valid, because CHCS calculates ACV values based on PATCAT. CHCS determines the patient ACV, not DEERS. DEERS will reject the enrollment if the ACV is inconsistent with the patient's beneficiary category on DEERS so it is important to correct the patient category in CHCS if inconsistent with the DEERS patient status.

6. File the data.

   A DEERS Eligibility check is performed.

   The Family Member screen displays with all family members listed (refer to Figure 5-19. Family Member Screen, page 5-57).

```
                              FAMILY MEMBER SCREEN
   Patient Name: PEARL,ZELDA N                    FMP/SSN: 30/569-69-4415
             DOB: 02 Jan 1976
   Sponsor Name: PEARL,ZACHARY N                 Sponsor SSN: 569-69-4415
 Elig Start Date: 25 Sep 1998                   Elig End Date: 1999
-------------------------------------------------------------------------
   Name                        Sex    DOB      DDS  ACV  Dir  Med  DMIS ID

   PEARL,ZACHARY N                 M   12 Jun 1975  20    N    E    N
   PEARL,ZELDA N                   F   02 Jan 1976  30    C    E    N




PEARL,ZELDA N is this the patient you are enrolling? Yes//
```

Figure 5-19. Family Member Screen

Complete the Family Member Screen

1. Upon entering the DEERS Check (Enrollment/Family Member screen) action, the system first displays the name of the patient that it has identified and will request confirmation prior to continuing with the DEERS check functionality in this action. You will be allowed either to confirm and continue or to enter a negative response and return to the *Select PATIENT NAME* prompt to specify another patient name.

2. If the patient has been determined to be ineligible for this enrollment, the system then allows you to enter an override code and continue with the enrollment or to abort from the enrollment process and return to the *Select PATIENT NAME* prompt. Please note that though CHCS will permit a user to collect and store enrollment information for an ineligible beneficiary, DEERS will reject the enrollment and it becomes invalid in CHCS. The beneficiary data must be corrected in DEERS in order for the beneficiary to be enrolled.

3. If the patient is eligible for enrollment or has had an override reason stipulated, the system then allows you to select other family members to process from the list of family members displayed. The system then processes each family member selected as it did the first family member. For example, registration data will be input on the Mini Registration screen for each family member to be enrolled, then the user may select and enroll those family members from the family member list.

F9 View of family members – Prior to selection of a family member for enrollment, the system allows you to view which family members are currently registered in CHCS by positioning the cursor next to the family member name and pressing <F9>.

Select patients for enrollment processing

Confirm the patient for enrollment

The DEERS Eligibility Screen displays (refer to Figure 4-10. Current DEERS Eligibility, 4-15).

Select the (C)ontinue action on the DEERS Eligibility Screen

Select family member to move demographic data from

If a Mini Registration (new or an edit) is performed for a patient who already has one or more family members registered in CHCS, the system allows you to copy demographic information such as addresses and telephone numbers. Use caution when copying demographic information from the sponsor to the dependent. If the sponsor is remotely located, the dependent's address will be incorrect. It is recommended that dependent information be copied from another family member or entered independently.

```
Select Family Member to Move Demographic Data FROM:



PEARL,ZACHARY N                    20/569-69-4415
```

Figure 5-20. Family Member Demographics Move Screen

1. The *Select Family Member to Move Demographic Data From* prompt displays along with a selection list of registered family members. Select the family member whose demographic data you want to copy.

2. Use the down-arrow key to position the cursor next to the desired family member. When the cursor is positioned, press <Select>.

   An asterisk (*) appears next to the selected family member.

3. You can deselect a family member by pressing <Select> again.

4. Press <Return> to activate the selection.

Complete the Mini Registration Screen

```
Patient: PEARL,ZELDA N                                          Mini Registration
FMP/SSN: 30/569-69-4415       DOB: 02Jan76       PATCAT: N41    Sex: F
                 Personal Data - Privacy Act of 1974 (PL 93-579)
      Patient: PEARL,ZELDA N                          DOB: 02 Jan 1976
       PATCAT: N41 (USN FAM MBR AD)                   FMP: 30
   Home Phone: 974-2333        W:                     SSN: 100-20-0068
 Patient Addr: 1020 NEWPORT DRIVE                     Sex: FEMALE
         City: HAMPTON               St/Cntry: VA     Zip: 23665

      Sponsor: PEARL,ZACHARY N                    Service: NAVY
          FMP: 20                             Sponsor SSN: 569-69-4415
       PATCAT: N11 (USN ACTIVE DUTY)                  DOB: 12 Jun 1975
  Command Sec: PERSONNEL RELIABILITY PROGRAM         Rank: CHIEF PETTY OFFICER
 Station/Unit: WALTER REED MED HOLD PP
 Duty Address: 3939 CONSTITUTION AVE
         City: WASHINGTON            St/Cntry: DC     Zip: 20307
   Duty Phone:                                        DSN: 331

  O/P Rec Loc:
  O/S Rec Loc:
  Primary Phy:
  Reg Comment:
 Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 5-21. Mini Registration Screen

Refer to Section 5.1.1 for an explanation of the Mini Registration fields.

Select the (E)nrollment action on the Demographics Display Screen

Complete the MCP Enrollment – Continuation screen

```
ENROLLMENT HISTORY: 01 Jul 2001                  MCP Enrollment -- CONTINUATION


                 Name: PEARL,ZELDA N                 FMP/SSN: 30/569-69-4415
     Patient Category: USN FAM MBR AD                    DDS:
         Patient Type: MCP/CHAMPUS ELIGIBLE              Sex: FEMALE
           MCP Status:                               DOB/Age: 02 Jan 1976/25Y
 Primary Care Manager:                             PCM Phone:
          Primary OHI: NOT ASSIGNED                Case Mgmt: NO
                  ACV: E-MCP ENROLLED/DIR. CARE CHA
          Direct Care:                              Medicare:
 ==============================================================================

   Enrolling Division: DIV A - TRAINING HOSPITAL

         Patient Type: MCP/CHAMPUS ELIGIBLE

      MCP Enroll Date: 01 Jul 2001
      End Enroll Date: 30 Jun 2002

   Enrollment Comment:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-22. MCP Enrollment - - Continuation Screen

Refer to Section 5.5.1 for an explanation of the MCP Enrollment - - Continuation screen fields.

Complete the second MCP Enrollment screen

```
PATIENT: PEARL,ZELDA N                                          MCP ENROLLMENT


                 Name: PEARL,ZELDA N                 FMP/SSN: 30/569-69-4415
     Patient Category: USN FAM MBR AD                    DDS:
         Patient Type: MCP/CHAMPUS ELIGIBLE              Sex: FEMALE
           MCP Status:                             DOB/Age: 02 Jan 1976/25Y
 Primary Care Manager:                            PCM Phone:
          Primary OHI: NOT ASSIGNED               Case Mgmt: NO
                  ACV: E-MCP ENROLLED/DIR. CARE CHA
          Direct Care:                             Medicare:
 ==============================================================================

          Patient SSN: 100-20-0068

             Language: SPANISH

       ID Card Number: 19945                     Date Issued: 01 Jan 2001
       Effective Date: 01 Jan 2001           Expiration Date: 17 Nov 2004



File/exit    Abort    Edit
File changes and exit.
```

Figure 5-23. MCP Enrollment Screen

Assign a PCM

Refer to Section 5.1.2. for an explanation of how to assign a PCM.

```
                                PCM SEARCH CRITERIA
   Patient: PEARL,ZELDA N                            FMP/SSN: 30/569-69-4415
  Language:                                              DDS:
 Specialty:                                          DOB/Age: 02 Jan 1976/25Y
       PCM:                                        PCM Gender:
  Location:                                             Date: 21 Jun 2001
--------------------------------------------------------------------------------
   Specialty
   Location
   PCM Gender
   Patient Language
   Default Search Criteria


-
---------------------Specialty and Location are required------------------------
Use SELECT key to select SEARCH CRITERIA to be changed.
```

Figure 5-24. PCM Search Criteria (Change Search Criteria)

Complete the PCM Search Criteria Screen

Select the (S)earch PCM action

Expand the Provider Record

1. View expanded data for the provider: [provider name] then <F9>.

   Place the cursor next to the provider record you wish to view, then press <F9>. The PCM Assignment screen displays for the selected provider (refer to Figure 5-25. PCM Direct Assignment Screen (Expanded Provider Record), page 5-63).

```
                              PCM DIRECT ASSIGNMENT
   Patient: PEARL,ZELDA N                          FMP/SSN: 30/569-69-4415
  Language: SPANISH                                    DDS:
 Specialty: FAMILY PRACTICE/PRIMARY CARE          DOB/Age: 02 Jan 1976/25Y
       PCM:                                     PCM Gender:
  Location:                                          Date: 21 Jun 2001
-------------------------------------------------------------------------------
   Provider                CS Cat   Specialty        Agr Locat Sex Disc   Avail

   ~AUSTIN,GILBERT M       E  MD    FAMILY PRACTICE  MTF 20307  M  MTF      485




Select (A)ssignment Preferences, (P)lace of Care, or (Q)uit: P//
```

Figure 5-25. PCM Direct Assignment Screen (Expanded Provider Record)

Select (P)lace of Care

1. Enter P to display provider place of care information.

2. The PCM Assignment screen displays showing the provider's address and directions to the place of care (refer to Figure 5-26. PCM Direct Assignment Screen (Place of Care), page 5-64).

```
                              PCM DIRECT ASSIGNMENT
   Patient: PEARL,ZELDA N                           FMP/SSN: 30/569-69-4415
  Language: SPANISH                                     DDS:
 Specialty: FAMILY PRACTICE/PRIMARY CARE            DOB/Age: 02 Jan 1976/25Y
       PCM:                                       PCM Gender:
  Location:                                            Date: 21 Jun 2001
-------------------------------------------------------------------------------
   Provider                CS Cat   Specialty        Agr Locat Sex Disc   Avail

   ~AUSTIN,GILBERT M       E  MD    FAMILY PRACTICE  MTF 20307  M  MTF      485

   ACUTE CR MTF
   ACUTE CR MTF
   6885 16TH STREET
   WASHINGTON, DC 0
   Phone:  202 271-5851

+                      Directions to Place of Care

Use NEXT SCREEN/PREV SCREEN keys to view text or Press <RETURN> to continue
```

Figure 5-26. PCM Direct Assignment Screen (Place of Care)

1. Press <Return> to view the hours of service.

2. Quit and exit the PCM Assignment screens.

   The PCM Assignment screen displays again.

The enrollment transaction is sent to DEERS after the PCM has been assigned to the new patient.

5.1.4 Enter OHI Information

Introduction

The Standard Insurance Company Table

The DOD has developed a standard insurance company table to be used in CHCS. Each site stores a subset of this file locally in the Insurance Company file to support third party collections. Security for the Insurance Company file is controlled via FileMan access codes and there is an audit trail of changes made to this file.

The purpose of this table is to ensure consistent identification of insurance data, minimize data entry requirements, and minimize duplicate company

identification. To accomplish these goals, the patient health insurance data input screens have been modified to provide uniform collection of data across subsystems (because data elements are required from PAS/MCP, PAD and Medical Services Accounting (MSA)/Third Party Collection (TPC), the input screens contain all requirements and are identical for all functionalities).

When you update OHI policy data for a registered outpatient who qualifies for TPC billing, the system automatically performs CHCS table lookups.

You may optionally enter an unlimited number of OHI policies for any patient who is non-active duty.

If no OHI policies exist for this patient, the message - No Policies Found - displays at the bottom of the Select window.

Data Entry Process:

Enter OHI Information:

Access the Other Health Insurance - Enter/Edit screen

Add an OHI policy

```
                              OTHER HEALTH INSURANCE

         Patient: PEARL,ZELDA N                       FMP/SSN: 30/569-69-4415
Patient Category: USN FAM MBR AD                          DDS: NOT ENTERED
MCP Patient Type: MCP/CHAMPUS ELIGIBLE                    Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                  DOB/Age: 02 Jan 1976/25Y
             PCM: FAM MED MTF                            Date: 21 Jun 2001
--------------------------------------------------------------------------------
     Insurance Co Name    Eff Date   Policy Holder            Billing Status
       Policy Number      Exp Date     Relationship
--------------------------------------------------------------------------------









---------------------------------No Policies Found------------------------------
Select (A)dd OHI, (I)nsurance Company Enter/Edit, (V)iew Expired Policies Also,
       or (Q)uit OHI: Q//
```

Figure 5-27. Other Health Insurance Screen

Access the Other Health Insurance - Enter/Edit screen

The first Other Health Insurance - Enter/Edit - screen is divided into two parts (refer to Figure 5-28. Other Health Insurance Enter/Edit Screen, page 5-67). The top half displays the patient demographic data entered from previous screens. The bottom half displays fields to be edited with OHI information.

Select the (A)dd OHI action on the Other Health Insurance Screen

The following actions are displayed on the action bar:

(**A**)dd OHI - Enter a new OHI policy from the standard insurance table listing. The number of possible entries is unlimited.

(**E**)dit - Edit an existing OHI policy.

Note: This action only displays if OHI information has already been entered.

(**I**)nsurance Company Enter/Edit - Enter or edit insurance company information.

(**V**)iew Expired Policies Also - View information for expired insurance policies, in addition to active policies that the patient holds.

(**C**)opy OHI - Copy existing OHI information from other family members to the specified patient.

Note: This action displays only if the patient is non-active duty, is currently registered in CHCS, and other family members have existing insurance policies.

(Q)uit - Allows you to exit the Other Health Insurance screen.

```
POLICY:               {}                    OTHER HEALTH INSURANCE - ENTER/EDIT

                Patient: PEARL,ZELDA N                FMP/SSN: 30/569-69-4415
       Patient Category: USN FAM MBR AD                   DDS:
       MCP Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
              MCP Status: PENDING ENROLLMENT           DOB/Age: 02 Jan 1976/25Y
                     PCM: FAM MED MTF                   Date: 21 Jun 2001
==============================================================================
          Policy number:
 Insurance Company Name:                                Phone:
         Effective Date:                       Expiration Date:



         Primary Policy:
            Policy Type:                        Billing Status:
             Group Name:                          Group Number:

    Precertification/UR:


   PreCert/UR on Report:        PreCert/UR Authorization Code:

Help = HELP      Exit = F10     File/Exit = DO                       INSERT OFF
```

Figure 5-28. Other Health Insurance Enter/Edit Screen

Complete the Other Health Insurance - Enter/Edit Screen

1. Enter the Policy Number.

   Enter the alphanumeric number of this patient's insurance policy, using from 3 to 17 characters.

2. Enter the Insurance Company Name.

   Enter the name of the patient's insurance company from the standard table.

3. Confirm the Insurance Company Name.

4. Enter Phone.

   The Phone field is defaulted from the information maintained in the system OHI file for this insurance company. The cursor automatically moves to the Effective Date field.

5. Enter Effective Date of policy.

   Press <Return> to accept the default of today's date or enter another date.

6. Enter Expiration Date of policy.

7. Enter Policy Type.

   Enter the appropriate policy type for this patient's selected insurance. The following policy types can be entered in this field:

Code	**Policy Type**
CS	CHAMPUS Supplement
CH	CHAMPUS/CHAMPVA
CO	Commercial
GR	Employer Group
MS	MEDICARE/MEDICAID Supplement
SD	Student

8. Enter Billing Status.

   Press <Return> to accept the Billable Status default of Billable.

   Policies may be Billable (inpatient and outpatient), Billable (inpatient only), Billable (outpatient only) or Non-billable.

   The Primary Policy must be Billable. All secondary policies can be either Billable or Non-Billable. The Billing Status does not change after the policy has expired.

9. If the patient is covered under a group policy, enter the insured group name and the Group Number. These are free-text fields.

   For this example, the policy is not a group policy.

10. Enter Precertification/UR.

    Enter an optional Precertification and Utilization Requirement (UR) free-text comment.

    Medical conditions, restrictions, or requirements imposed by the insurance company on this policy should be entered in this field. Examples of information that would be entered include: “Pre-admission approval is required,” or “Second opinion authorized.”

11. Enter PreCert/UR on Report.

    The Precertification and Utilization Requirement on Report field has a Yes or No choice. If you select Yes, the text entered in the Precertification and Utilization Requirement field are displayed on the Insurance Precertification/Utilization Requirement Roster (URR) report.

12. Enter PreCert/UR Authorization Code.

    The Precertification and Utilization Requirement Authorization Code is a free text field containing the authorization code received from the insurance company which verifies that the insurance company authorized the procedure.

    This screen collects policy holder and employer data for the policy.

```
POLICY: AETNAFL       {3377}              OTHER HEALTH INSURANCE - ENTER/EDIT

                 Patient: PEARL,ZELDA N                FMP/SSN: 30/569-69-4415
        Patient Category: USN FAM MBR AD                   DDS:
        MCP Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
              MCP Status: PENDING ENROLLMENT           DOB/Age: 02 Jan 1976/25Y
                     PCM: FAM MED MTF                     Date: 21 Jun 2001
==============================================================================
     Policy Holder Name:
      Policy Holder SSN:
Relationship to Insured:
         Street Address:
                   City:
                  State:
                    Zip:

  Insured Employer Name:                                 Phone:
         Street Address:
                   City:
                  State:
                    Zip:

Help = HELP      Exit = F10     File/Exit = DO                      INSERT OFF
```

Figure 5-29. Other Health Insurance - Enter/Edit Screen

1. Enter Policy Holder Name.

2. Confirm the Policy Holder.

3. Enter Policy Holder SSN.

   The policy holder's SSN displays if the policy holder is registered in CHCS. Press <Return> to accept the SSN of the policy holder. If the policy holder is not registered in CHCS, enter the policy holder SSN.

4. Enter Relationship to Insured.

   Enter the relationship of this patient to the policy holder. To list valid relationships, enter a double question mark (??). If the address is defaulted, you may press <Return> to bypass the defaulted field.

5. Enter Insured Employer Name.

   If this is a group insurance policy maintained by an insured employer, enter the name of the employer. The cursor moves to the Phone field.

If this is not a group insurance policy for an employer, press <Return> to exit this field without an entry. You are prompted to file the data.

6. Enter the address or press <Return> to bypass the remaining fields.

7. File the data.

   The Other Health Insurance - screen displays with policies listed. Note that a new action, (E)dit OHI, has been added to the action bar. You may now enter another insurance company name or edit the existing insurance policy information.

```
                              OTHER HEALTH INSURANCE

         Patient: PEARL,ZELDA N                        FMP/SSN: 30/569-69-4415
Patient Category: USN FAM MBR AD                           DDS: NOT ENTERED
MCP Patient Type: MCP/CHAMPUS ELIGIBLE                     Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                   DOB/Age: 02 Jan 1976/25Y
             PCM: FAM MED MTF                             Date: 21 Jun 2001
-------------------------------------------------------------------------------
     Insurance Co Name    Eff Date   Policy Holder            Billing Status
       Policy Number      Exp Date     Relationship

  P) AETNA LIAE AND CASU  21 Jun 01  PEARL,ZELDA N            BOTH
       3377               01 Jun 02    SELF.....................

Select (A)dd OHI, (E)dit OHI, (I)nsurance Company Enter/Edit,
       (V)iew Expired Policies Also, or (Q)uit OHI: Q//
Do you want to print enrollment form? No//
```

Figure 5-30. Other Health Insurance Screen

5.1.5 Enroll Family Members Into the MCP Using the Family Action

Menu Path: PAS System Menu → MAN → **EMCP** → EENR

Application Description:

Family Enrollment – You can access this action only if the patient is already registered. The system displays an action bar prompting you to enroll all family members, enroll selected individual family members, or quit the family enrollment action and return to the Demographics Display action bar.

Family Enrollment - All Family Members – The system displays all family members. All the nonenrolled family members are marked as selected, and the system prompts you to deselect those family members who are not to be enrolled. The system then prompts you to enroll each selected family member. For each family member, you are asked whether to copy the patient's OHI data to the family member's.

For each family member, the system prompts you for the following: you must indicate whether or not to copy the patient's OHI data to the current family member. If so, you must indicate the relationship of the current family member to the insured, who is not necessarily the same as the patient. Additionally, you need to indicate whether to copy the patient's PCM data to the current family member. The system then prompts you to enter the family member's enrollment data as described in the "Enrollment" section above, except that you are prompted to enter PCM and OHI data only if the patient's PCM or OHI data were not copied to the current family member as described above.

After you have enrolled all the patients, the system returns you to the Demographics Display Action Bar.

Family Enrollment - Individual Family Members – The system displays all family members. All unenrolled family members are marked as unselected, and the system prompts you to select those family members who are to be enrolled. Then the system prompts you to enroll each selected family member as described above in the Family Enrollment section. The system then returns to the Demographics Display Screen.

Data Entry Process:

Enroll Family Members Into the MCP Using the Family Action.

Enter the Patient Name

Confirm Patient Name

Display Current DEERS Eligibility Screen for Family member

Display Demographics Display Screen

Select Family Member(s) to enroll

Copy OHI information

Do you want to copy PCM to [patient name]?

Enroll Family Member

Print the enrollment form? NO//

Print the patient address label? NO//

Enter Patient Name

Confirm the patient name

This prompt refers to the family member who is already enrolled in MCP. It does not necessarily refer to the sponsor of the family member who is about to be enrolled.

Press <Return> to accept the current sponsor.

Display Current DEERS Eligibility for Family Member

Because a DEERS check was processed for this patient within the last five days, the Current DEERS Eligibility screen displays.

```
                            CURRENT DEERS ELIGIBILITY
                  Name: PATRICK,ZELDA E                FMP/SSN: 30/637-24-9618
     Patient Category: USN FAM MBR AD                     DDS: 30
              DOB/Age: 07 May 1971/30Y                    Sex: FEMALE

            Sponsor Rank: CHIEF PETTY OFFICER
             Sponsor UIC: N47673-DIA
                 DMIS ID: 0037-WALTER REED AMC
                     ACV: E-MCP ENROLLED/DIR. CARE CHAMPUS ELIGIBLE
          ACV Start Date: 11 Mar 1999               Region Code: 02
  Care Authorization PH#: 555-2349                 PCM Location: DIRECT CARE PC
             Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 12 Mar 2001                   CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 10 Feb 2003
  Eligibility End Reason:

                                       BRAC Pharmacy Eligibility: NO
           Override Code:
         Date of Request: 17 Jun 2001

Select to (V)iew more DEERS data, (P)rint, (R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 5-31. Current DEERS Eligibility Screen

1. Select the (C)ontinue action at the Current DEERS Eligibility Screen

Display Demographics Display Screen

The Demographics Display screen displays with the specified patient's information.

```
                              DEMOGRAPHICS DISPLAY
                  Name: PATRICK,ZELDA E              FMP/SSN: 30/637-24-9618
      Patient Category: USN FAM MBR AD                   DDS: 30
          Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
            MCP Status: ENROLLED                     DOB/Age: 07 May 1971/30Y
                   ACV: E-MCP ENROLLED/DIR. CARE CHA DMIS ID: 0037
           Direct Care: ELIGIBLE                    Medicare:

          Sponsor Name: PATRICK,ZIGGY E                 Rank: CHIEF PETTY OFFICE
          Station/Unit: DEFENSE INTEL AGENCY SEA D       DSN:
          Home Address: 962 MOORE DR
                  City: BALTIMORE                      State: MARYLAND
              ZIP Code: 21210                     Home Phone: 410-555-1212
            Duty Phone: 202-555-7010              Work Phone:
  Registration Comment:
Last Registration Date: 09 Sep 1999@1011
Outpatient Record Room: OUTPATIENT RECORDS
       MCP Enroll Date: 01 Jul 2001          End Enroll Date: 30 Jun 2002
  Primary Care Manager: PEKNY,JAMES M              PCM Phone: 202 456-9878
           Primary OHI: BLUE CROSS/BLUE SHIELD, NC Case Mgmt: NO

Select (F)ull, (M)ini, (E)nrollment, (O)HI, (P)CM, Ca(s)e, F(a)mily,
       (D)isenroll, (H)istory, (N)ew Patient, or (Q)uit DEMOGRAPHICS: E//
```

Figure 5-32. Demographics Display Screen

1. Select the F(a)mily action on the Demographics Display Screen.

   Using this action, the Family Enrollment screen displays. The action bar at the bottom of the screen allows you to select from the following actions:

   – (A)ll Family Members - Enroll one or more specified family members at one time.

   – (I)ndividual Members - Enroll only one specified individual family member.

   – (Q)uit Family - Exit the screen.

Select Family Member(s) to Enroll

A list of family members registered in CHCS displays in the Select window. For each family member, the following information is also displayed: FMP/SSN, Sex,

DOB, and Enrollment Status. Selectable family members with an unenrolled status are highlighted.

Note: If no additional family members exist, the message - There are no other family members - displays at the bottom of the Select window.

```
                                FAMILY ENROLLMENT
         Patient: PATRICK,ZELDA E                     FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                          DDS: 30
             PCM: PEKNY,JAMES M                     PCM Phone: 202 456-9878
     Primary OHI: BLUE CROSS/BLUE SHIELD, NC             Date: 21 Jun 2001
-------------------------------------------------------------------------------
   FMP/SSN         Family Member                     Sex     DOB       Status
-------------------------------------------------------------------------------
   01/637-24-9618  PATRICK,ZACH N                     M   09 Jan 1995
   20/637-24-9618  PATRICK,ZIGGY E                    M   07 Oct 1969     E
   30/637-24-9618  PATRICK,ZELDA E                    F   07 May 1971     E





-------------------------------------------------------------------------------
Select (A)ll Family Members, (I)ndividual Members, or (Q)uit FAMILY: A// I
```

Figure 5-33. Family Enrollment Screen

1. Select the (I)ndividual Members action on the Family Enrollment Screen.

   Use <Select> to select the family member to be enrolled and press <Return> to activate the selection.

2. If the patient who is enrolling the family member is active duty, the *Relationship to Insured* prompt displays.

3. Copy OHI information.

   The prompt *Do you want to copy OHI to [family member]? No//* displays. Only non-active duty family members have OHI information. Enter YES to copy the specified patient's insurance information to the family member you are enrolling.

   Be careful when copying active duty sponsor data to a family member as the sponsor may not reside with the family. Addresses can be changed in DEERS incorrectly causing problems with mailings to the family.

Do you want to copy PCM to [patient name]?

Enroll Family Member

The MCP Enrollment -- Continuation screen displays. The cursor is positioned at the Enrolling Division field.

```
ENROLLMENT HISTORY: 01 Jul 2001                  MCP Enrollment -- CONTINUATION


                Name: PATRICK,ZACH N                FMP/SSN: 01/637-24-9618
     Patient Category: USN FAM MBR AD                   DDS: 30
         Patient Type: MCP/CHAMPUS ELIGIBLE              Sex: MALE
           MCP Status:                              DOB/Age: 09 Jan 1995/06Y
 Primary Care Manager:                            PCM Phone:
          Primary OHI: NOT ASSIGNED               Case Mgmt: NO
                  ACV: E-MCP ENROLLED/DIR. CARE CHA
          Direct Care: ELIGIBLE                     Medicare:
 ==============================================================================

   Enrolling Division: DIV A - TRAINING HOSPITAL

         Patient Type: MCP/CHAMPUS ELIGIBLE

      MCP Enroll Date: 01 Jul 2001
      End Enroll Date: 30 Jun 2002

   Enrollment Comment:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-34. MCP Enrollment - - Continuation Screen

1. Enter Enrolling Division.

   The Enrolling Division field is automatically entered with the name of the current user's division. Press <Return> to accept this default or enter another valid division. Enter ?? to list the divisions the user may enroll to.

2. Enter Patient Type.

   The patient type is derived by the system based on the patient's PATCAT, ACV code, and age. For this example, press <Return> to accept the system-derived data in the field.

3. Enter MCP Enroll Date.

   Press <Return> to accept the displayed default of the first day of the coming month as start of the enrollment date. You may edit the field with a date in the past or future, if desired.

4. Enter End Enroll Date.

   Press <Return> to accept the system-defaulted end enrollment date. This will be one year from the Enroll date for non-active duty or the DEERS end of eligibility for active duty.

5. Enter Enrollment Comment.

   Press <Return> to exit this field without making an entry, or enter an enrollment comment, using from 1 to 50 characters. The second MCP Enrollment screen displays.

Complete the second MCP Enrollment screen

```
PATIENT: PATRICK,ZACH N                                          MCP ENROLLMENT


                 Name: PATRICK,ZACH N                FMP/SSN: 01/637-24-9618
     Patient Category: USN FAM MBR AD                    DDS: 30
         Patient Type: MCP/CHAMPUS ELIGIBLE              Sex: MALE
           MCP Status:                               DOB/Age: 09 Jan 1995/06Y
 Primary Care Manager:                            PCM Phone:
          Primary OHI: NOT ASSIGNED               Case Mgmt: NO
                  ACV: E-MCP ENROLLED/DIR. CARE CHA
          Direct Care: ELIGIBLE                     Medicare:
 ==============================================================================

          Patient SSN:

             Language:

       ID Card Number:                            Date Issued:
       Effective Date: 12 Mar 2001           Expiration Date: 10 Feb 2003




Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-35. MCP Enrollment Screen

1. Enter Language.

   Enter the primary language spoken by the patient or press <Return> to leave this field blank. You do not need to enter English, because the system automatically assumes that all patients can communicate in English, unless otherwise specified.

2. Enter ID Card Number of beneficiary.

3. Enter Date Issued of ID card.

4. Enter Effective Date of ID card.

5. Enter Expiration Date of ID card.

6. File the data.

   A message displays that the PCM is being copied.

Print the enrollment form?NO//

Enter “Yes” to print the enrollment form and select the output device.

Print the patient address label?NO//

1. Enter “Yes” to print a single label for the patient and select the output device.

2. (Q)uit the Family Enrollment screen

3. The system displays the Demographics Display Screen. (Q)uit the Demographics Display Screen

5.1.6 Assign an Exception Provider to an MCP Patient

Menu Path: PAS System Menu → MAN → EMCP → EENR

Application Description

Case Management –

You can only access this action if the patient is enrolled in CHCS. You are prompted either to enter/edit an exception provider or to quit this action and return to the action bar. Case Management providers must be HCPs in the Provider file.

The system permits you to access this action only if the patient has already been enrolled. The Case Management selection appears on the option's action bar in instances where it is applicable. If the specified patient has a case management provider, the system automatically defaults the name of the case management provider at the *Select PROVIDER* prompt. The health care finder (HCF) can accept the default or enter the name of a different provider. However, the provider whose name is entered must have an agreement type that accepts the patient's specified patient type. The provider must be entered in the Provider files in CHCS. For this reason, if the case manager provider is not a provider, then it might be better not to enter that enrollee here.

The system prompts you either to enter/edit an exception provider or to quit this action and return to the action bar of the option from which you entered this action.

Case Management (Enter/Edit Exception Provider) –

The system displays existing exception providers, if any, and then prompts you to enter a new exception provider or select an existing one to edit. (Using <F9>, you may query the history of an existing provider before selecting the provider record.) In either case, the system prompts you to enter or edit the exception provider data, including provider phone, provider specialty, start date, stop date, and condition.

After the above process is complete, the system permits you either to enter or edit another exception provider or quit this action and return to the action bar of the option where case management was selected.

Data Entry Process:

Assign an Exception Provider to an MCP Patient:

Enter Patient Name

Confirm the Sponsor Name

Display Current DEERS Eligibility Screen

Enter an exception provider name

Complete the MCP Exception Information - - Continuation Screen

View the patient's exception provider history on the Case Management - - Enter/Edit Screen

Enter Patient Name

Confirm the Patient Name

Confirm the Sponsor Name

Press <Return> to accept the patient's current sponsor.

Display Current DEERS Eligibility Screen

The Current DEERS Eligibility screen displays.

The Demographics Display screen displays.

Select the Ca(s)e action on the Demographics Display Screen

Select Update Action

The Case Management screen displays. You may enter a new exception provider or edit the information for an existing exception provider. The patient must be an enrollee.

The Select window displays any exception providers currently assigned to the patient. For each provider, the specialty start date (to begin authorized care) and stop date (to end authorized care) also display.

If the patient currently does not have any exception providers, the message. No Exception Providers Assigned - displays at the bottom of the Select window.

```
                                CASE MANAGEMENT
         Patient: PATRICK,ZELDA E                      FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                           DDS: 30
    Patient Type: MCP/CHAMPUS ELIGIBLE                     Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                   DOB/AGE: 07 May 1971/30Y
             PCM: PEKNY,JAMES M                           Date: 21 Jun 2001
-------------------------------------------------------------------------------
    Exception Provider       Specialty                Start Date    Stop Date









                         No Exception Providers Assigned
Select (E)nter/edit Exception Provider, or (Q)uit Case: E//
```

Figure 5-36. Case Management Screen

1. Select the Enter/edit Exception Provider action on the Case Management Screen.

2. Enter Exception Provider.

The Case Management - Enter/Edit screen displays. The cursor is positioned in the Select window preceding the prompt <--- *Enter Exception Provider*.

```
                          CASE MANAGEMENT - ENTER/EDIT
         Patient: PATRICK,ZELDA E                     FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                          DDS: 30
    Patient Type: MCP/CHAMPUS ELIGIBLE                    Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                  DOB/AGE: 07 May 1971/30Y
             PCM: PEKNY,JAMES M                          Date: 21 Jun 2001
-------------------------------------------------------------------------------
    Exception Provider       Specialty                Start Date    Stop Date

                             <--- Enter Exception Provider









Enter a new Exception Provider or Press <RETURN> to continue
```

Figure 5-37. Case Management Enter/Edit Screen

1. Enter an exception provider name.

Note: You may only enter a non-network provider from the MCP Provider Group Profile.

---

2. Confirm the provider name.

3. Confirm the addition of the exception provider.

   Enter NO if you want to reject the exception provider name and return to the Case Management - Enter/Edit screen. For this example, enter YES to confirm the provider. The MCP Exception Information -- Continuation screen displays.

The MCP Exception Information -- Continuation screen is divided into two parts. The top half displays the patient demographic data entered previously. The bottom half displays fields to be edited with case management information. The Exception Provider field is defaulted with information entered in the previous screen.

```
EXCEPTION PROVIDER: PHARIS,DARNELL C   MCP EXCEPTION INFORMATION -- CONTINUATION


                 Patient: PATRICK,ZELDA E              FMP/SSN: 30/637-24-9618
        Patient Category: USN FAM MBR AD                   DDS: 30
            Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: FEMALE
              MCP Status: PENDING ENROLLMENT           DOB/AGE: 07 May 1971/30Y
                     PCM: PEKNY,JAMES M                   Date: 21 Jun 2001
 ==============================================================================
      Exception Provider: PHARIS,DARNELL C               Phone: 301 644-1232
      Provider Specialty:
              Start Date: T
               Stop Date:

               Condition:


Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-38. MCP Exception Information - - Continuation Screen

1. Exception Provider.

   This field is automatically entered from a previous screen. You cannot edit this field.

2. Enter the Phone.

   The Phone field is defaulted from the information maintained in the system provider file for this provider. Press <Return> to accept this information.

3. Enter Provider Specialty.

   Enter the specialty for this provider. Only specialties that are currently defined in the Provider file for this provider can be entered. To display a complete list of specialties, enter a double question mark (??).

4. Enter Start Date.

   Enter the date for which the patient is authorized to begin receiving care from this exception provider, or press <Return> to accept the default of today's date. For this example, press <Return>.

5. Enter Stop Date.

   Enter the date for which the patient is no longer authorized to receive care from this exception provider.

6. Enter the Condition.

   Enter an optional comment explaining the patient's medical condition requiring the specialized care from this exception provider.

7. File the data.

   The Case Management - Enter/Edit screen with the exception providers assigned displays. At this point, you may enter another exception provider name, edit the existing exception provider information, or view the patient's exception provider history.

View the patient’s exception provider history on the Case Management - Enter/ Edit Screen

For the specified exception provider, the screen displays the Exception Provider Name, Specialty, Start Date, Stop Date, Phone Number, and Condition.

```
                          CASE MANAGEMENT - ENTER/EDIT
         Patient: PATRICK,ZELDA E                     FMP/SSN: 30/637-24-9618
Patient Category: USN FAM MBR AD                          DDS: 30
    Patient Type: MCP/CHAMPUS ELIGIBLE                    Sex: FEMALE
      MCP Status: PENDING ENROLLMENT                  DOB/AGE: 07 May 1971/30Y
             PCM: PEKNY,JAMES M                          Date: 21 Jun 2001
-------------------------------------------------------------------------------
    Exception Provider       Specialty                Start Date    Stop Date

    PHARIS,DARNELL C         NEPHROLOGIST             21 Jun 01     19 Sep 01
                             <--- Enter Exception Provider






Use SELECT Key to select Exception Provider to edit.
Use F9 Key to View History or Press <RETURN> to continue
```

Figure 5-39. Case Management Enter/Edit Screen - View Provider Information

Move the cursor to the exception provider desired and press <F9> to display the Case Management Condition screen.

1. (Q)uit the Case Management Condition screen.
2. (Q)uit the Case Management - Enter/Edit screen.
3. (Q)uit the Case Management screen.
4. (Q)uit to exit the Demographics Display screen.

The Enrollment Processing Menu displays.

5.1.7 Renew a Patient's Enrollment

Application Description:

Enrollment Renewal Policies and Procedures

Before renewing a patient's MCP enrollment episode, be sure to check the specific policies and procedures with the Benefits Office at your site. Enrollment renewal may have associated fees or other patient and site requirements. Access the Enrollment Enter/Edit (EENR) option on the Enrollment Processing Menu. The HA policy dictates that each renewal be entered for each individual. A

renewal simply extends the end enrollment date out one year. No transaction goes to DEERS.

Renewing a Patient's Enrollment

You can renew enrollments for non-active duty beneficiaries (CHAMPUS eligibles only) at your facility who have a current enrollment episode that expires within a year from today.

The Renew action displays on the Demographics Display action bar when you attempt to enroll a patient who is currently enrolled as of today and has not had their current enrollment episode renewed. The Renew action does not display for those beneficiaries with a status of Conditionally Enrolled, Pending Enrollment, Invalid Enrollment, or Ineligible. The renew action displays for 20 days after expiration to allow a grace period to receive and process enrollments. If not received, CHCS disenrolls the patient after 20 days.

When you renew a patient's enrollment, the system automatically extends the enrollment end date one year from the current enrollment end date, to a last day of the month. Once you renew a patient's enrollment episode, the Renew action no longer displays for that patient until their enrollment once again needs to be renewed. This prevents you from renewing a patient's enrollment years into the future without collection of the necessary fees.

Menu Path: PAS System Menu → MAN → EMCP → EENR

Data Entry Process:

Renew a Patient's Enrollment

Enter the patient name
Renew the Enrollment

Enter the patient name

1. Enter the patient's name and select the correct patient.
2. Confirm the patient name.
3. Confirm the sponsor name.

   The system displays the Family Member Screen.

4. Confirm that you are renewing the patient enrollment.

The system displays the Demographics Display Screen.

View Renewal Dates and Enter Comment

The MCP Renewal -- Continuation screen displays.

```
ENROLLMENT HISTORY: 01 Mar 2001                     MCP Renewal -- CONTINUATION


                 Name: PEARL,ALEXANDER E             FMP/SSN: 04/469-69-4415
     Patient Category: USN FAM MBR AD                    DDS: 4
         Patient Type: MCP/CHAMPUS ELIGIBLE              Sex: MALE
           MCP Status: ENROLLED                      DOB/Age: 12 Mar 1996/05Y
 Primary Care Manager: PELLES,LOUIS M              PCM Phone: 202 456-9878
          Primary OHI: NOT ASSIGNED                Case Mgmt: NO
                  ACV: MCP ENROLLED/DIR. CARE CHAMP
          Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE
 ==============================================================================

   Enrolling Division: DIV A - TRAINING HOSPITAL

         Patient Type: MCP/CHAMPUS ELIGIBLE

      MCP Enroll Date: 01 Mar 2001
      End Enroll Date: 30 Jun 2002

   Enrollment Comment:
Ask for Help = HELP   Screen Exit = F18   File/Exit = DO
```

Figure 5-40. MCP Renewal - - Continuation Screen

1. The end enroll date is already extended one year to an end of month date and is not enterable.

2. Enter an Enrollment Comment.

   You can enter an enrollment comment but you cannot edit the enrollment dates.

3. File the data.

   The system displays the Demographics Display Screen.

4. (Q)uit to exit the Demographics Display Screen.

5.1.8 Cancel an Enrollment

Menu Path: PAS System Menu → MCP → EMCP → DENR

Security Keys:

None required.

Application Description:

Cancellation of an enrollment is performed in the Disenrollment function using the "EC" disenrollment reason and setting the end date to the same date as the start enroll date. For example, beneficiary will have no enrollment period.

Data Entry Process.

Cancel an Enrollment:

Enter Patient Name
Display Demographics Display Screen
Select the family member whose enrollment is to be cancelled.
Cancel Enrollment in Disenrollment Function

Enter Patient Name

1. Enter the name of the patient whose enrollment is to be cancelled.

2. Confirm the patient name.

3. The system displays the Demographics Display Screen.

```
                                DISENROLLMENT
         Patient: PEARL,ZACHARY N                     FMP/SSN: 20/569-69-4415
Patient Category: USN ACTIVE DUTY                         DDS: 20
      MCP Status: ENROLLED                               Date: 21 Jun 2001
-------------------------------------------------------------------------------
   FMP/SSN         Family Member                Sex    DOB     ENR Date  Status

   20/569-69-4415  PEARL,ZACHARY N               M  12 Jun 75  21 Jun 01    E
   30/569-69-4415  PEARL,ZELDA N                 F  02 Jan 76  01 Jul 01    PE









Select (A)ll Family Members, (I)ndividual Family Members,
       or (Q)uit Family Disenroll: A//
```

Figure 5-41. Disenrollment Screen

1. Select the (I)ndividual Family Members action on the Disenrollment Screen.

2. Select the family member whose enrollment is to be cancelled.

3. Confirm patient whose enrollment is to be cancelled.

Cancel Enrollment

The system displays the Disenrollment Screen.

The enrollment is canceled using disenrollment functionality; i.e., creating a null enrollment period.

```
                                DISENROLLMENT
        Patient: PEARL,ZACHARY N                  FMP/SSN: 20/569-69-4415
Patient Category: USN ACTIVE DUTY                          DDS: 20
      MCP Status: DISENROLLED                           Date: 21 Jun 2001
-----------------------------------------------------------------------
   FMP/SSN        Family Member              Sex    DOB     ENR Date  Status

+* 30/569-69-4415  PEARL,ZELDA N              F  02 Jan 76  01 Jul 01   PE




OK TO DISENROLL PEARL,ZELDA N? Yes//
Disenrollment Date: 01 Jul 2001//   (01 Jul 2001)
Enter Disenrollment Reason: EC
```

Figure 5-42. Disenrollment Screen

1. Enter Disenrollment Date: [default date]//

   The Disenrollment date must be the same as the Enrollment Start Date or the enrollment will not be truly canceled in CHCS or DEERS.

2. Enter Disenrollment Reason.

   The following reasons are for disenrollment. Those reasons with an asterisk (*) are not enterable.

DE	Disenrollment/Expiration
EC	Enrollment Cancelled
EE	Enrolled in Error
GA	Griev/Complain - Accessibility
GB	Griev/Complaint - Benefits
GO	Griev/Complaint - Other
GP	Griev/Complaint - Providers
JO	Joined HMO/New OHI Coverage
*LE	Loss of Entitlement
MCS	Moving (to CRI Site)
MMM	Moving (to Non MCP Site)
MOM	Moving (to other MCP Site)
MV	Moving (Other)
PN	Provider Pref Not in Plan
*RD	Reciprocally Disenrolled
*RED	Reciprocally Enrolled/Disenrolled
*RM	Remotely Disenrolled
*TD	Termination of DEERS Enrollment Mode

*TL Termination of Local Empanelment Mode.

3. (Q)uit the Disenrollment Screen

5.2 Disenrollment (DENR)

Menu Path: PAS System Menu → MAN → EMCP → DENR

Security Key(s):

None identified.

Required Fields:

Patient name.

Application Description:

The Disenrollment option allows you to disenroll MCP patients; e.g., when a patient leaves a catchment area. The system prompts you to enter the name of a patient registered in CHCS, and you can then disenroll any or all enrolled member(s) of the patient's family. For correct disenrollment, the start and end dates must be different.

When a patient is disenrolled through this option, the system clears that patient's Entitlement Discrepancy code, if present, which resolves any Entitlement Discrepancy condition. If you subsequently re-enroll the patient, the enrollment start date is then compared to the ACV End Date from the previous enrollment. The dates are automatically adjusted, when necessary, to prevent overlapping enrollment episodes.

Note: CHCS does NOT allow the disenrollment to be corrected or to be canceled once it has been filed in CHCS. In the case of input errors, this can affect a beneficiary's claim for payment and services. DEERS maintains an enrollment history for all enrollments. The only way to correct this error is to contact Customer Support to have the beneficiary record corrected in CHCS. A letter must be forwarded by the site to DEERS requesting that the data be corrected. Be certain that the patient you are disenrolling is the correct patient prior to filing and exiting the disenrollment screen and that you enter the correct date.

Data Entry Process:

Disenroll a Patient:

Access the Disenrollment option on the Enrollment Processing Menu
Select the Patient Name
Display Demographics Display Screen
Disenroll family members
Select the family member for disenrollment
Enter disenrollment

Access the Disenrollment option on the Enrollment Processing Menu

Select the Patient Name

1. Enter name of patient to be disenrolled.
2. Confirm the patient name.
3. When the patient name is selected and confirmed, no DEERS check is performed. The system displays the Demographics Display screen with the Demographics Display action bar.

This action bar is used to either access the Full Registration option in PAD, access the Mini Registration option in PAD, enter or edit the OHI policies of the patient with the Enrollment Enter/Edit option in PAS, select a New patient, exit this phase of the option and continue to the Disenrollment Screen.

Disenrollment – You may access this action only if the patient is already enrolled in CHCS. The system displays an action bar prompting you to disenroll

All family members, disenroll Individual family members, or Quit the disenrollment action and return to the Demographics Display action bar.

Note: Before disenrollment, be sure to check the family member response screen or the DEERS Eligibility Data screen in the Enrollment module to verify the patient ID in DEERS and if necessary, modify the patient ID in CHCS to match it. If the patient identification has changed since enrollment, DEERS may not recognize the patient and rejects the disenrollment. The patient must be disenrolled with the same sponsor, SSN, DOB, and DDS that they were enrolled under. Be aware that DEERS does not store an "end enrollment date", only a "disenrollment date". The patient is enrolled in DEERS until CHCS sends a disenrollment to DEERS.

Disenroll Family Members

```
                              DISENROLLMENT
          Patient: PEARL,ZACHARY N.         FMP/SSN: 20/569-69-4415
 Patient Category: USN ACTIVE DUTY              DDS:
       MCP Status:                             Date: 21 Jun 2001
-----------------------------------------------------------------------
   FMP/SSN        Family Member         Sex    DOB     ENR Date     Status

20/569-69-4415 PEARL,ZACHARY N.         M 12 Jun 75 ***********************
*************************************************************************
*************************************************************************
*************************************************************
```

to be disenrolled. Then the system prompts you to disenroll each selected family member.

For both the **(A)ll Family Members** and **(I)ndividual Family Members** actions, if at least one family member is selected to be disenrolled, the system continues the process. For each family member (if any) who has pending appointments and/or wait list requests, the system prompts you to indicate whether to print the Display Patient Appointments report. Then you are prompted to indicate whether to disenroll the selected family member(s).

Note: The disenrollment reason of "EC" must be used only to cancel enrollments and the disenroll date must be set to the enrollment start date. Otherwise DEERS does not cancel the enrollment and leaves the patient enrolled during the period from the start to the disenroll date.

Select the family member for disenrollment

The Disenrollment screen displays a family picklist in the Select window. For each member, the list displays the following information:

- FMP/SSN
- Sex
- DOB
- Enrollment Date
- Enrollment Status

Those selectable family members with a current status of Enrolled, Pending Enrollment, Conditional Enrollment, or Invalid Disenrollment are highlighted.

Note: If no additional family members exist, the message - There are no other family members - displays at the bottom of the Select window.

Confirm patient to be disenrolled

Use <Select> to select the patient to be disenrolled and press <Return>.

Note: If the specified patient has pending appointments, you are notified by a message at the bottom of the Select window. You are also prompted whether to display or print the patient's appointments.

---

1. Enter Disenrollment Date: [default date]//

   You must enter a disenrollment date. For an enrollment cancellation, enter the enrollment start date as the disenrollment date. This is a required field.

2. Enter Disenrollment Reason.

   Enter a valid disenrollment reason. For a list of valid reasons, enter a double question mark (??).

   The system automatically sends an MCP disenrollment transaction to DEERS. The Disenrollment screen displays. Use "EC-Enrollment Cancellation" only to cancel an enrollment in CHCS and DEERS.

   The following disenrollment reasons are valid. Reasons marked with an asterisk (*) cannot be entered.

DE	Disenrollment/Expiration
EC	Enrollment Cancelled
EE	Enrolled in Error
GA	Griev/Complain - Accessibility
GB	Griev/Complaint - Benefits
GO	Griev/Complaint - Other
GP	Griev/Complaint - Providers
JO	Joined HMO/New OHI Coverage
*LE	Loss of Entitlement
MCS	Moving (to CRI Site)
MMM	Moving (to Non MCP Site)
MOM	Moving (to other MCP Site)
MV	Moving (Other)
PN	Provider Pref Not in Plan
*RD	Reciprocally Disenrolled
*RED	Reciprocally Enrolled/Disenrolled
*RM	Remotely Disenrolled
*TD	Termination of DEERS Enrollment Mode
*TL	Termination of Local Empanelment Mode.

3. (Q)uit to exit the Disenrollment Screen

5.3 Reciprocal Disenrollment Processing (RENR)

5.3.1 Reciprocal Enrollment/Disenrollment

Introduction

The Reciprocal Enrollment/Disenrollment functionalities allow you to reciprocally disenroll beneficiaries from a losing facility and optionally enroll them in MCP at your site.

– Reciprocal Disenrollment allows you to reciprocally disenroll a beneficiary from the losing facility without enrolling the beneficiary at your facility.

– Reciprocal Enrollment/Disenrollment allows you to enroll a patient at your facility while at the same time disenrolling the beneficiary from the losing facility. This is described in more detail in the next objective.

The Reciprocal Enrollment/Disenrollment functionality is accessible in the Enrollment option ONLY when a DEERS eligibility check is performed real-time, not batched.

Reciprocal Disenrollment at the Losing Facility (Batch Process at Night)

DEERS maintains a separate file of all beneficiaries reciprocally disenrolled for each losing facility. DEERS automatically processes all of the beneficiaries who have been reciprocally disenrolled from any of their DMIS ID codes.

Once DEERS receives this request, it sends blocks (up to 55 records) of data to the requesting CHCS site. CHCS then begins automatically disenrolling those beneficiaries and removing them from their assigned PCMs. Once a block of data has been successfully processed, CHCS requests the next block, and so on until all data has been processed. CHCS then processes the data and verifies that the number of blocks received was correct. If correct, those blocks are purged from the DEERS database.

Examples of discrepancy responses for reciprocal disenrollments generated by CHCS and/or DEERS are:

– data is not ready to be sent

– the transmission was not received

– there is no more data

– CHCS received more/fewer blocks than DEERS had sent

– the disenrollment was successful, but the enrollment was not.

A new cross-reference in the Patient file is used to locate the beneficiaries for auto disenrollment at the losing site. Auto Reciprocal Disenrollment does not send a disenrollment transaction to DEERS as the beneficiary is already disenrolled in DEERS.

If CHCS receives more/fewer blocks than DEERS has sent, Auto Disenrollment automatically starts over and requests the data again. If some blocks of data were already successfully processed, CHCS ignores the record if it encounters a beneficiary already disenrolled with the Remotely Disenrolled reason.

Those beneficiaries that CHCS has auto reciprocally disenrolled display on the Disenrollees for Period by Reason Report under the reason RD - Remotely Disenrolled. In the event any discrepancies are detected during the auto reciprocal disenrollment process, those beneficiaries display on the new Reciprocal Disenrollment Discrepancy Report. If a beneficiary CHCS identification has changed since enrollment, they are not disenrolled in CHCS. These discrepancies must be corrected by changing the patient back to the enrolling ID and disenrolling them.

When the automatically generated task is completed, it generates a bulletin informing the mail group that Auto Reciprocal Disenrollment has completed and it has encountered discrepancies to be resolved. If no discrepancies were encountered, the bulletin informs the user which report to print for a list of all beneficiaries remotely disenrolled from the losing facility.

Reciprocal Disenrollment by Reason Roster

The Reciprocal Disenrollment by Reason Roster option is accessed from the Enrollment Rosters Menu (ROST). This report shows only reciprocal disenrollments with the Disenrollment Reason Code of Reciprocally Enrolled/ Disenrolled (RED) or Reciprocally Disenrolled (RD). You can select either one or both of the reciprocal disenrollment reasons that you wish to see on the report for a specified date range. This is a wide (132 column) report and may be output to line printers.These are disenrollments initiated by your facility to release enrollees from other facilities.

Note: The Disenrollees for Period by Reason Report allows you to print all of the other disenrollment reasons, including Remotely Disenrolled (RM).

Patients reciprocally disenrolled from your facility by another facility appear under “Remotely Disenrolled” (RM).

Reciprocal Disenrollment Discrepancy Report

The Reciprocal Disenrollment Discrepancy Report identifies the following discrepancies:

– Patient Not Enrolled at Losing Facility (usually occurs when patient identification information has changed)

– Patient Not Registered/Not Found at Losing Facility (usually occurs when patient identification information has changed).

This report must be printed within 14 days or it is automatically deleted. You should print the report so that the discrepancies can be resolved. If

discrepancies are not corrected, your site enrollment totals will not match DEERS totals.

Note: You should print the Disenrollees for Period by Reason Report to list the beneficiaries that were remotely disenrolled. You can identify the disenrolling facility by doing a DEERS check and looking at the eligibility segments.

Reciprocal Enrollment/Disenrollment

Reciprocal Enrollment/Disenrollment processing is accessed through the Enrollment Enter/Edit option on the Enrollment Processing Menu. The user must request a real-time DEERS eligibility check to initiate the function. Otherwise, CHCS will not know the beneficiary is enrolled elsewhere. When you begin an enrollment and DEERS indicates the beneficiary is already enrolled at another site, you can use this option to remotely disenroll the beneficiary from MCP at the losing facility and then enroll the beneficiary in MCP at your facility. The disenrollment is sent to DEERS and forwarded to the losing facility.

You may reciprocally enroll/disenroll an individual and/or family members.

Eligibility Requirements

Eligibility for the Reciprocal Enrollment/Disenrollment action requires the following:

- DEERS is running
- ACV from DEERS for the selected beneficiary is either Active Duty Enrolled (A), Enrolled/Not CHAMPUS Eligible (D), or Enrolled/CHAMPUS Eligible (E)
- The beneficiary's DMIS ID code does not match any of the local facility's DMIS ID Codes
- The current date of this enrollment is after the ACV start date recorded on DEERS. DEERS does not store an end enrollment date, only a disenrollment date when posted.

Family Member Screen

If a beneficiary is eligible for reciprocal enrollment/disenrollment, and you elect to proceed, you are taken through the existing enrollment functionality. After you file the enrollment, CHCS sends a reciprocal enrollment/disenrollment transaction to DEERS. If you abort during the enrollment process prior to filing, the reciprocal enrollment/disenrollment transaction is not sent and no changes are made. A reciprocal disenrollment can be entered on any CHCS host.

Family Members - If there is more than one family member enrolled at the losing facility, the system displays all the family members currently enrolled at that facility on the Family Member screen. You may then select those family members you wish to process.

Currently Registered Family Members – If the family member is currently registered at the gaining facility, the system displays the name of the matching patient in CHCS and prompts you to confirm that this is the correct patient to process.

Family Members Not Registered – If the family member is not currently registered at the gaining facility, you may register the family member immediately following the reciprocal enrollment/disenrollment prompt.

Note: You enroll the initial beneficiary and then use the Family Enrollment option on the Demographics Display screen action bar to enroll the remaining family members. The system reciprocally enrolls/disenrolls those family members whom you had previously confirmed with a YES when the reciprocal enrollment/disenrollment prompt displayed on the Family Member screen.

You must confirm for each individual beneficiary/family member that you wish to proceed with disenrollment from the losing facility and proceed to enroll the beneficiary/family member in the gaining facility.

Processing New Enrollment after Reciprocal Disenrollment

1. **Enrollment Start Date –** The system defaults 'today' in the Enrollment Start Date field for the gaining facility, however, you can edit this date using the following criteria:

   – must be on or after October 1, 1992

   – must be on or after the patient's date of birth

   – must not overlap a previous enrollment episode

   – must be at least one day after the Enrollment Start Date from the losing facility.

Note: The disenrollment date for the losing facility is the gaining facility enrollment start date minus one day.

---

2. **Enrollment End Date –** The enrollment end date will be computed for the type of patient as follows:

Active Duty – For active duty, the gaining facility Enrollment End Date becomes the Eligibility End Date from the registration/eligibility transaction received from DEERS. The user may override this date and enter any date.

Non-Active Duty – For non-active duty, the Enrollment End Date defaults to one year from the Enrollment Start Date and is the last day of that month. The date can be edited to be any end-of-month date that is less than the system-defaulted Enrollment End Date.

Once you have filed the enrollment at the gaining facility and the enrollment/ disenrollment transaction is sent to DEERS, you cannot edit the Enrollment Start Date. Ensure that the correct date has been entered. This prevents gaps in coverage and overlapping enrollment episodes that would result in invalid enrollments. You may only renew, disenroll, edit the Enrollment End Date, or cancel the new enrollment.

For those patients that have been successfully reciprocally disenrolled and enrolled, the system automatically inserts the following standard reciprocal enrollment comment into the Enrollment Comment field for the beneficiary at the gaining facility:

Transferred from [DMIS ID code description].

This flags the beneficiary as a transfer from another catchment area. If the DMIS ID code description is blank, then the DMIS ID code is printed.

Note: When you cancel the reciprocal enrollment/disenrollment, the beneficiary/family member remains disenrolled at the losing site with the same effective date. You are only canceling the new enrollment at the gaining facility.

Batched DEERS Eligibility Requests

You must perform an online DEERS check, using the Enrollment option, to invoke the Reciprocal Enrollment/Disenrollment option in order to correct the discrepancy.

When the DEERS eligibility request is batched or if the DEERS link isn't active when the enrollment action was performed, and the beneficiary is currently enrolled at another catchment area, DEERS issues a discrepancy when it receives the enrollment transaction. This results in the beneficiary's enrollment becoming an Invalid Enrollment (DEERS Discrepancy Code 56: Invalid Enrollment - Patient Already Enrolled) at the gaining facility. It is recommended that all enrollments be entered when the DEERS link is available

to avoid discrepancies. Many beneficiaries and most active duty are currently enrolled in TRICARE at another site so the probability is high that batched enrollments will be rejected.

If the DEERS link is down and enrollments cannot be processed, use the native DEERS (NDEERS) function to check on the eligibility. Often, the DEERS link is up but the connection through CHCS is down. Return to the user sign-on and put NDEERS in as the username. This access requires special privileges. Contact the system administrator for assistance. If you connect to DEERS, then DEERS is up and the problem is on the link.

Once the discrepancy is encountered, the system generates the CP Enrollment Bulletin that identifies the beneficiaries with discrepancies and alerts you to print the Enrollment/Disenrollment Discrepancy Report to correct these beneficiaries. The CP Bulletin must be scheduled through TaskMan. If the Bulletin is not run, discrepancies are not identified for correction and CHCS will not have the same data as DEERS.

New Disenrollment Reasons

The following disenrollment reasons are automatically inserted by CHCS in the Reciprocal Disenrollment History section of the MCP Patient file for the beneficiary at the losing and gaining facility:

- RED (Reciprocally Enrolled/Disenrolled) - Used when the gaining facility enrolls the beneficiary into their facility and disenrolls the beneficiary from the losing facility.

- RD (Reciprocally Disenrolled) - Used when the gaining facility disenrolls the beneficiary from the losing facility and then does not enroll the beneficiary at their facility.

- RM (Remotely Disenrolled) - Used at the losing facility when another facility not on their own CHCS host disenrolls the beneficiary.

The reasons RED and RD appear on the Reciprocal Disenrollment by Reason Roster.

The reason RM appears on screens and reports and is counted like any other type of disenrollment.

5.3.2 Reciprocal Disenrollment

Data Entry Process:

Disenroll a Patient from Another Facility and do not enroll the patient in your facility:

Menu Path: PAS System Menu → MAN → EMCP → RENR

Security Key(s):

None identified.

Required Fields:

Patient name
Sponsor name
Output device
Disenrollment date

Application Description:

The Reciprocal Disenrollment Processing option allows you to reciprocally disenroll a beneficiary from MCP at the losing facility without enrolling this beneficiary in MCP at the gaining (local) facility.

In order to perform a reciprocal disenrollment using this option, DEERS must be up and running. To be a candidate for reciprocal disenrollment, the beneficiary must be DEERS eligible, currently enrolled in MCP at another facility, registered in CHCS at the gaining facility, and associated with a DMIS ID code that does not match any of the local facility's DMIS ID codes. The beneficiary must also be assigned a TRICARE ACV in DEERS of Active Duty Enrolled (A), Enrolled/Not CHAMPUS Eligible (D), or CHAMPUS Eligible/ Enrolled (E).

Select Patient Name

Confirm the location

Confirm the disenrollment date

Select Patient Name

1. The patient name must already be registered at this facility to enable reciprocal disenrollment.

2. Confirm the patient name.

3. Confirm the sponsor name.

The system queries DEERS and then displays the Family Member screen. The screen displays the DMIS ID Code of the facility where each beneficiary is currently enrolled in MCP.

You may select one or more family members for reciprocal disenrollment.

Note: DEERS must be running to enable reciprocal disenrollment. If DEERS is down, the message displays - 'DEERS must be running to process a Reciprocal Disenrollment. Please try again later.'

```
                                FAMILY MEMBER SCREEN
    Patient Name: POET,ZOE E                          FMP/SSN: 30/100-20-1601
             DOB: 16 May 1967
    Sponsor Name: POET,ZANE E                     Sponsor SSN: 100-20-1601
 Elig Start Date: 15 Mar 2001                   Elig End Date: 19 Mar 1993
-------------------------------------------------------------------------------
   Name                            Sex     DOB       DDS  ACV  Dir  Med  DMIS ID

   POET,ZANE E                      M   12 Sep 1965  20    A    E    N   0124
   POET,ZOE E                       F   16 May 1967  30    A    E    N   0124




POET,ZOE E is currently enrolled at NH PORTSMOUTH.
Do you wish to disenroll POET,ZOE E from NH PORTSMOUTH (Y/N)? Y

Disenrollment Date: 21 Jun 2001//
```

Figure 5-44. Family Member Screen

1. Confirm the patient you are disenrolling and the location.

   Enter Y to reciprocally disenroll the patient from the losing facility.

2. Confirm the disenrollment date.

   Press <Return> to accept the default of today's date, or enter another date. The disenrollment date must be at least one day after the current enrollment episode start date at the losing facility.

The system enters REMOTELY DISENROLLED as the disenrollment reason for the patient at the losing facility.

You return to the Enrollment Processing Menu.

5.4 Conditional Enrollment Processing (CENR)

Menu Path: PAS System Menu → MAN → EMCP → CENR

Security Key(s):

None required.

Required Fields:

Patient Name
Division

Application Description:

The Conditional Enrollment Processing option enables you to check the eligibility of conditionally enrolled patients in DEERS, and to cancel their enrollments if they are not eligible. After conditional enrollments are filed, positive eligibility responses in any CHCS function automatically changes the status to “Enrolled”. You can select individual patients, or all conditionally enrolled patients in one division, multiple divisions, or all divisions to initiate an eligibility check to DEERS to determine whether the newborn has been enrolled and, if so, to correct the CHCS status to “Enrolled”.

If the patient enrollment status is not updated in CHCS before 120 days after enrollment, CHCS automatically cancels the enrollment even if the patient was enrolled by DEERS. The user must perform regular eligibility checks on these beneficiaries.

Data Entry Process:

<u>Process a Conditional Enrollment Patient:</u>

Select (I)ndividual Patient at the Conditional Enrollment Processing Screen

Select Patient Name

(R)epeat eligibility transaction

Select the desired patient

Select Patient Name

Complete the DEERS Interactive Request Screen

```
                        CONDITIONAL ENROLLMENT PROCESSING

--------------------------------------------------------------------------------



-----------------------------------------------------------------------------------------------
Select (I)ndividual Patient, (A)ll Patients, or (Q)uit: A//
```

Figure 5-45. Conditional Enrollment Processing

Select (I)ndividual Patient at the Conditional Enrollment Processing Screen

(I)ndividual Patient – Allows you to repeat an eligibility transaction for an individual patient with a conditional enrollment status. You may also cancel an individual's conditional enrollment. You may not cancel the real enrollment here if the beneficiary has been enrolled in DEERS. The system prompts you to begin by entering and confirming the name of a patient. The patient must be registered in CHCS and conditionally enrolled in MCP. The system performs a MCP CHCS/DEERS Discrepant Data Check Function, and you proceed to the action bar described in the “Process Patients” section below.

(A)ll Patients – Allows you to search for all patients with a conditional enrollment status. You may search for all such patients from one, multiple, or all divisions. After the list of conditional enrollment patients displays, you may select one, several, or all patients to process. The system displays an action bar prompting you to select one, multiple, or all divisions, or to quit the action bar and return to the main action bar. If you enter a single division, the system prompts you to enter the name of a division, and then continue to the action bar described in the section below. If you choose to select multiple divisions, the system displays a picklist of divisions, and you can select the desired divisions

(or all divisions) from the list. The system then continues to the action bar to initiate conditional enrollment processing.

Select patient name

1. Enter the name of the patient.
2. Confirm the patient name.

Conditional Enrollment Options

The Conditional Enrollment Processing screen displays. The patient name displays in the Select window, with his/her FMP/SSN, Enrollment Date, Number of Days Since Enrollment Initiated (#Days), and Previous Transaction Date (Prev Trans).

The system displays all the conditional enrollments and an action bar to allow you to repeat eligibility checks on patients you select.

```
                        CONDITIONAL ENROLLMENT PROCESSING

Division: DIV A - TRAINING HOSPITAL
-------------------------------------------------------------------------------
   Name                           FMP/SSN         Enroll Date  #Days  Prev Trans
-------------------------------------------------------------------------------
   PRICE,DANA E                   30/572-69-4710   19 Jun 01     2









-------------------------------------------------------------------------------
Select (R)epeat eligibility transaction, (C)ancel enrollment, or (Q)uit: Q//
```

Figure 5-46. Conditional Enrollment Processing Screen

1. Repeat the DEERS eligibility transaction on the patients.
2. Cancel the conditional enrollment of the patients.
3. Quit the action bar and return to the main action bar for individual patient or all patients, whichever was originally selected.

***(*R)epeat Eligibility Transaction –** The system displays a picklist and prompts you to select the patients for whom to perform a DEERS check.

Note: If you position the cursor by a patient and press <F9>, the system displays the conditional enrollment data on the patient, and then returns you to the patient selection process. For each selected patient, the system performs a DEERS check and prompts you to indicate whether to cancel the patient enrollment. As soon as the system has processed the last patient, it returns to the action bar. If the patient is enrolled in DEERS, the MCP status in CHCS is updated to “ENROLLED.”

Enrollees of USTF Managed Care Program – Following the DEERS check, the system will search stored DEERS eligibility information to determine whether the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care). Please refer to the “DEERS and Uniformed Services Treatment Facility (USTF) Enrollment” section on page 11 of Section 3.1, Enrollment Processing for further information.

(C)ancel Enrollment – The system displays a picklist and prompts you to select the patients for whom to cancel the conditional enrollment. Indicate whether to cancel all the selected patients. If you choose yes, the system cancels enrollments in CHCS for all selected patients. In either case, the system then returns you to the action bar described in the "Process Patients" section described above.

1. Select the desired patient.

   Press <Select> at the patient's name, then press <Return>.The MCP - DEERS Post Eligibility Request screen displays.

2. Select Patient Name.

3. Confirm the patient name.

   The DEERS Interactive Request screen displays.

```
DEERS ELIG/REG RESPONSES:                                DEERS INTERACTIVE REQUEST


                     Patient Name: PRICE,DANA E
                    Date of Birth: 28 Dec 1962
                      Sponsor SSN: 572694710
            Family Member Prefix: 30
          Eligibility Start Date:
            Eligibility End Date:


       When requesting information for a sponsor, enter 99 for the
         family member prefix to return all of the family members.

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO         INSERT OFF
```

Figure 5-47. DEERS Interactive Request Screen

Complete the Conditional Enrollment DEERS Interactive Request screen

1. Enter Patient Name.

2. Enter Date of Birth.

3. Enter Sponsor.

4. Enter Family Member Prefix.

5. Enter Eligibility Start Date.

   Enter the beginning date for which to check the patient's eligibility. This may be a past date if you want to perform a DEERS check to retrieve past eligibility data for this patient.

6. Enter Eligibility End Date.

   Enter the ending date for which to check the patient's eligibility. You may also enter a past date in this field.

7. File the data.

   A DEERS check is automatically processed. You may enter B to batch the DEERS check, or Q to stop the DEERS request. If you enter Q, you may not continue with the conditional enrollment processing. When the DEERS response is received, the DEERS Eligibility Data screen displays with the patient eligibility fields updated.

   If the patient receives an ineligible status again, the *Do you want to CANCEL enrollment?* prompt displays. You can select to cancel this patient's enrollment at this time. For this example, the patient receives an eligible status.

8. Press <Return> until the Enrollment Processing Menu displays.

9. Exit the Enrollment Processing Menu.

   The Managed Care Program Menu displays.

5.5 Print/Display Enrollment History (PENR)

Menu Path: PAS System Menu → MAN → EMCP → PENR

Security Keys:

None required.

Required Fields:

Patient name
Output device

Application Description:

The Print/Display Enrollment History option allows you to generate a list of the local enrollments on CHCS for a selected patient and display/print the enrollment history for any of those enrollments.

Data Entry Process:

Print/Display an Enrollment History:

Select Patient Name
Select (C)ontinue at the Demographics Display Screen
Select (D)isplay/Print Enrollment History at the Enrollment History Screen
Select the most recent episode
Select Device
Enter the Right Margin
Quit the Enrollment History Screen

Select Patient Name

1. Enter the patient name.

   No DEERS check is performed. The patient must be registered in CHCS, but need not have a current or previous enrollment in MCP.

2. Confirm the patient name.

   The Demographics Display screen displays.

Select (C)ontinue at the Demographics Display Screen

The system displays the Enrollment History Screen. All enrollment episodes for the patient display in the Select window. You may select one, several, or all episodes to print or display.

Print/Display Enrollment History – The system displays all the enrollments on CHCS for the current patient, past and present, and an action bar prompting you either to display or print the enrollment history of the patient, or to quit and exit the option.

If you display or print an enrollment history, the system prompts you to choose the enrollment(s) to display or print from a picklist. The system then displays or prints the enrollment report, and returns you to the action bar, where you can display/print another enrollment history, or quit and exit the option.

```
                                ENROLLMENT HISTORY
         Patient: PFEIFER,ALLISON E                    FMP/SSN: 20/572-69-4717
Patient Category: USAF ACTIVE DUTY                         DDS:
    Patient Type: MCP/ACTIVE DUTY                          Sex: FEMALE
      MCP Status: ENROLLED                            DOB/AGE: 25 Dec 1966/34Y
-------------------------------------------------------------------------------
   Enroll Date   Disenroll Date   Disenrollment Reason
-------------------------------------------------------------------------------
   16 Mar 01     10 Feb 03
   10 Jan 01     15 Mar 01        MOVING (OTHER)





-------------------------------------------------------------------------------
Select (D)isplay/Print Enrollment History, or (Q)uit: D//
```

Figure 5-48. Enrollment History Screen

Select (D)isplay/Print Enrollment History at the Enrollment History Screen

The Display Enrollment History screen is divided into two parts. The top half displays the patient demographic data entered previously. The bottom half displays information about the patient's enrollment episode. The fields on this screen cannot be edited.

1. Select any enrollment episode.

   The *Select DEVICE* prompt displays.

2. Select Device.

   If you press <Return>, the enrollment history displays on your screen. If you enter the name of a printer, the history prints on that printer.

3. Enter Right Margin.

   The Enrollment History displays or prints as shown below.

```
                 Personal Data - Privacy Act of 1974 (PL 93-579)
                            DISPLAY ENROLLMENT HISTORY
            Patient: PFEIFER,ALLISON E            FMP/SSN: 20/572-69-4717
     Patient Category: USAF ACTIVE DUTY                     DDS:
         Patient Type: MCP/ACTIVE DUTY                      Sex: FEMALE
         MCP Status: ENROLLED                    DOB/Age: 25 Dec 1966/34Y
=========================================================================
   Enrolling Division: DIV A - TRAINING HOS
        Patient Type: MCP/ACTIVE DUTY           Patient SSN: 572-69-4717
      MCP Enroll Date: 16 Mar 2001
 End Elig/Enroll Date: 10 Feb 2003
   Enrollment Comment:
                  ACV: ACTIVE DUTY/MCP ENROLLED
              DMIS ID:
             Language:
       ID Card Number: 4953430                   Date Issued: 20 Jun 2001
      Effective Date: 20 Jun 2001           Expiration Date: 10 Feb 2003

 Primary Care Manager: GREENE,JOHN M              PCM Phone: 202 271-5850
            Case Mgmt: YES
          Primary OHI:
      Enrolled Date:
          Enrolled By:

   Last Modified Date:
     Last Modified By:

   PCM Date of Change:    PCM Name:                PCM Changed By:

Press <RETURN> to continue
```

Figure 5-49. Display Enrollment History Screen

1. Press <Return> to exit the Display Enrollment History screen.

2. Exit the Enrollment History screen.

   The Enrollment Processing Menu displays.

5.6 Interactive Deers Eligibility Request (IENR)

Menu Path: PAS System Menu → MAN → EMCP → IENR

Security Keys:

None required.

Required Fields:

Patient name
FMP/SSN
DOB
Eligibility start date
Eligibility end date
Output device

Application Description:

The Interactive DEERS Eligibility Request option enables you to directly query DEERS to perform an eligibility check on a patient. To uniquely identify the patient, you must enter the patient name, DOB, sponsor SSN, and FMP. The system enables you to specify eligibility start and end dates to determine whether a patient who is currently ineligible in DEERS was eligible at an earlier date or will be eligible in the future.

A patient does not have to be registered in CHCS to perform this option. If the patient is not registered in CHCS, the system prompts you to indicate whether to continue with the DEERS search or to quit the option. Note that the PCM does not display.

This option, unlike other options that perform DEERS checks, always queries DEERS directly. It does not use DEERS data stored in the Patient file by DEERS checks performed by other options within the past five days.

The system displays the DEERS Interactive Request screen, and prompts you to enter data essential for a DEERS query. If the patient is registered, the default values for patient name, DOB, FMP/SSN, and eligibility start and end dates are taken from CHCS.

Data Entry Process:

Perform a DEERS check on a patient:

Select Patient Name
Complete the DEERS Interactive Request Screen
(V)iew more DEERS data on the DEERS Eligibility Data Screen
View (H)istorical DEERS on the DEERS Eligibility Data Screen

Select Patient Name

1. Enter the name of the patient whose eligibility is to be requested from DEERS.

2. Confirm the patient name.

If the patient is not currently registered in CHCS, the *PATIENT NOT CURRENTLY REGISTERED. PROCEED WITH DEERS REQUEST?* prompt displays. You may enter “Yes” to continue with the DEERS request, if desired.

For this example, the patient is already registered in CHCS, and the DEERS Interactive Request screen displays.

Complete the DEERS Interactive Request Screen

```
DEERS ELIG/REG RESPONSES:                          DEERS INTERACTIVE REQUEST


                    Patient Name: PETERS,KENNETH K
                   Date of Birth: 22 Jan 1966
                     Sponsor SSN: 400407503
            Family Member Prefix: 20
          Eligibility Start Date:
            Eligibility End Date:


       When requests information for a sponsor, enter 99 for the
         family member prefix to return all of the family members.









Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 5-50. DEERS Interactive Request Screen

1. Patient Name
2. Date of Birth
3. Sponsor SSN
4. Family Member Prefix
5. Eligibility Start Date

   Enter the beginning date for which to check the patient's eligibility. This may be a past date if you want to perform a DEERS check to retrieve past eligibility data for this patient.

6. Eligibility End Date

   Enter the ending date for which to check the patient's eligibility. For this example, enter T for today's date. You may also enter a past or future date in this field.

File the data

A DEERS check is automatically processed. When the DEERS response is received, the DEERS Eligibility Data screen displays and the patient eligibility fields are updated.

Display DEERS Eligibility Data

As soon as you finish entering data into this screen, the system performs the DEERS search. If the specified sponsor SSN and DOB are found in DEERS, then CHCS displays the DEERS data on the DEERS Eligibility Data screen (figure 5-51) and permits you to print the eligibility data.

Enrollees of USTF Managed Care Program: Following the DEERS check, the system searches stored DEERS eligibility information to determine if the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care). Please refer to the “DEERS and Uniformed Services Treatment Facility (USTF) Enrollment” section on page 11 of Section 3.1, Enrollment Processing for further information.

If the system fails to find a record with the specified sponsor SSN and DOB, it displays your search criteria on the DEERS Eligibility Data screen, and permits you to print the eligibility data.

If the system finds records with the specified sponsor SSN but not the specified DOB, then it displays a picklist of all family members with the same sponsor SSN, and prompts you to select the desired family member. Then the system displays the DEERS data for that family member on the DEERS Eligibility Data screen, and permits you to print the eligibility data. The system then quits and exits the option.

```
                              DEERS ELIGIBILITY DATA
                 Name: PETERS,KENNETH K              FMP/SSN: 20/400-40-7503
     Patient Category: USN ACTIVE DUTY                   DDS: 20
              DOB/Age: 22 Jan 1966/35Y                    Sex: MALE

                    NAME: PETERS,KENNETH K
                     SEX: MALE                                DOB: 22 Jan 1965
                     DDS: 20                          Sponsor SSN: 400-40-7503
                     ACV: A-ACTIVE DUTY/MCP ENROLLED
          ACV Start Date: 02 Oct 1992               Region Code: 02
                 DMIS ID: 0037-WALTER REED ARMY MEDICAL CENTER
  Care Authorization PH#:                           PCM Location: DIRECT CARE PC
            Sponsor Rank: LIEUTENANT JUNIOR GRADE
             Sponsor UIC: N31471-NAVPHIBASE
             Direct Care: ELIGIBLE                     Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 25 Sep 1998                   CHAMPUS: NOT ELIGIBLE
  Dir Care Elig End Date: 16 Mar 2004
  Eligibility End Reason: U-Not Predictable

                                       BRAC Pharmacy Eligibility:
                                 DOB Does NOT Match
Select to (V)iew more DEERS data, (H)istorical DEERS, (P)rint, or (Q)uit: Q//
```

Figure 5-51. DEERS Eligibility Data Screen

Note: The *DOB Does NOT Match* prompt displays in the middle of the screen when the patient's date of birth in CHCS and DEERS do not match. You should try to correct the inconsistency. Ask the patient for the correct date. If the CHCS data is incorrect, correct the DOB field on the Mini Registration screen. If the error is in the DEERS system, instruct the patient to go to the nearest DEERS office and ask that this be corrected.

At the bottom of the DEERS Eligibility Data screen, available options on the action bar include:

(V)iew More DEERS Data – View additional data received from DEERS.If you select this option, an additional DEERS data screen displays for this patient. Information on this screen includes whether the patient is an organ donor, has any reportable diseases, and has CHAMPUS Dental care, the date this eligibility information was last updated, a Panograph date, and the date of the request.

(H)istorical DEERS – View historical DEERS eligibility data. If you select this option, the Historical DEERS Eligibility Data screen displays, listing up to 10 eligibility segments on file in DEERS for the selected date range.

(O)verride Ineligibility – This option appears on the action bar only if the Direct Care Eligibility code indicates Not Eligible, with a message stating

“Patient Ineligible.”Enter an override code if the patient's Direct Care eligibility is Not Eligible. If you elect to override, you are then required to enter an override code to continue. Enter a question mark (?), to display a list of valid override codes.

(P)rint – Print all eligibility information, including the historical data, if available. If you select this option, the system prompts for a Device and then prints the report. The report includes information from the DEERS Eligibility Data screen, the additional DEERS Eligibility Data screen, as well as the Historical DEERS Eligibility Data screen. If you press <Return> in the Device field, the eligibility data will display on the screen rather than print.

(Q)uit – Exit the screen.

When eligibility data is not available and the site is operating in the DEERS Enrollment Mode, the site interprets eligibility based on the most recent enrollment transaction response from DEERS stored in CHCS. It is recommended that this function be executed with DEERS access to avoid confusion.

When the site is operating in local empanelment mode and eligibility is batch processed, the system will evaluate MCP status based on the eligibility response from DEERS. The time for the response from DEERS depends upon the number of eligibility requests in the queue and the system load.

Select the Historical DEERS action

The Historical DEERS Eligibility Data screen displays a listing of all previous eligibility segments and/or the last ten enrollment segments for the patient. You can request the default, which covers two years in the past and up to six months in the future. You can also enter a date range.

1. Press <Return> to continue.

   The DEERS Eligibility Data Screen redisplays.

2. Quit the DEERS Eligibility Data Screen.

5.7 Batch Enroll Active Duty (BENR)

5.7.1 Identify Potential Active Duty Candidates (IBER)

Menu Path: PAS System Menu → MAN → EMCP → BENR → IBER

Security Keys:

CPZ IDENTIFY AD

Required Fields:

Medical activity date

Application Description:

The Identify Potential Active Duty Candidates option allows you to identify all active duty records in the Patient file that have no MCP enrollment history. Based on the date of medical activity, records have flags to denote those active duty candidates with medical activity since that requested date. When running this "identify" option, the system creates a potential active duty enrollment candidate file that can then be used to update, print, and/or enroll the active duty candidates.

At any time there is only one candidate file containing records of potential active duty enrollment candidates. Rerunning this option deletes any previously created potential candidate file. The user should update those active duty who are gone, separated, or ineligible with a permanent block flag so they are never selected again by this process. CHCS will remove the permanent block flag if the active duty record is modified after the block flag is set.

Running this option will affect system performance, so schedule this option carefully. Eligibility checks will be put in the batch queue at night and daytime batched eligibility checks will not be performed until the Batch Enroll Active Duty Checks are completed.

Data Entry Process:

Identify Potential Active Duty Candidates:

The user may select active duty with medical activity after a selected date or may process all active duty ever registered in CHCS.

```
                POTENTIAL ACTIVE DUTY CANDIDATE UPDATE/REPORT

Medical Activity Date: 22 Jun 1999
 Potential Candidates: 2858
-------------------------------------------------------------------------------




-------------------------------------------------------------------------------
Select candidates (W)ith Medical Activity, (A)ll Candidates, or (Q)uit: W//
```

Figure 5-52. Potential Active Duty Candidate Update/Report

The system prompts you to begin by issuing a warning message if a Potential Candidate file already exists, and requesting confirmation to purge the old file in order to create a new one.

```
                IDENTIFY POTENTIAL ACTIVE DUTY CANDIDATES

Medical Activity Date: 22 Jun 1999



                              WARNING !!!
    The Potential Candidates file already exists from 21 Jun 2001.
    If you continue with this action, the prior information will be
      deleted, along with any data updates that have been entered.


Are you sure you want to delete the Potential Candidate file? No//
```

Figure 5-53. Identify Potential Active Duty Candidates Warning Message

If you answer “No” and do not purge the old file, the system exits the option at this point.

```
                    IDENTIFY POTENTIAL ACTIVE DUTY CANDIDATES


Medical Activity Date:
-----------------------------------------------------------------------



          Enter a Medical Activity Date.  The system will identify all
          active duty potential candidates who have not been enrolled
         previously.  The user will have the option to select only those
          records with medical activity since the activity date.


-------------------------------------------------------------------------------------------
Enter Date of Last Medical Activity: 22 Jun 1999//
```

If you confirm to purge the old file, or if a previous file did not exist, enter a medical activity date (date of last medical activity). The system will again request confirmation to continue or to exit the option.

1. If a YES (to continue) is entered, the system prompts you to enter the date of last medical activity and tasks the job to build a Potential Active Duty Candidate file.

Since the job is system intensive, it is processed at the hours designated in the File/Table Menu through the MCP Parameters Profile Enter/Edit option. This job may take several days to complete, and resumes building the file, where it left off the day before, at the designated task time each evening. This process continues until the file is completed. You receive a mail bulletin when the job has completed.

Refer to Section 2.4, File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

5.7.2 Update/Print/Enroll Potential AD Candidates (UBER)

Menu Path: PAS System Menu → MAN → **EMCP** → BENR → UBER

Security Keys:

None Required.

Required Fields:

UIC
Patient category
Alpha range
SSN
Enrollment date
Output device
Start/stop time

Application Description:

The Update/Print/Enroll Potential AD Candidates option allows you to update, print lists, or enroll potential active duty candidates resulting from your previous use of the Identify Potential Active Duty Candidates option. You can select to process all candidates, or just candidates with medical activity. Processing should be performed in manageable subsets, and you can sort by UIC, patient category, alphabetically, or by SSN; and then select a subset of the resulting selected data for processing convenience and manageability.

Data Entry Process:

Update/Print/Enroll Potential AD Candidates:

Process only candidates with medical activity or process all candidates?

The system displays the Potential Active Duty Candidate Update/Report Screen.

```
                  POTENTIAL ACTIVE DUTY CANDIDATE UPDATE/REPORT

Medical Activity Date: 22 Jun 1999
 Potential Candidates: 2858




                                    WARNING!

          The Potential Active Duty Candidate List contains 2858
          entries.  You are strongly urged to update, display, or
          print subsets of the data.  Use the action bar below to
          create a subset appropriate to your needs.




Select to sort subset by (U)IC, (P)atient Category, (A)lphabet, (S)SN,
       or (Q)uit:U//
```

Figure 5-54. Potential Active Duty Candidate Update/Report

The action bar allows you to sort a subset of candidates by UIC, Patient Category, Alphabetically, or by SSN, or to quit and exit the option.

UIC Code Processing: When you elect to process by UIC, the system displays an action bar allowing you to process one, multiple, or unknown UICs ("unknown" being a recognized category). If one is selected, the system prompts for the UIC code to process. If multiple is selected, the system prompts for a valid UIC code or partial description. This process is repeated until you press <Return> without making another entry. When that process is complete, or when "unknown" is selected, the system prompts for an alphabetic range of patient names to process (start and stop range). The system then continues with the Update/View, Print, and Enroll action.

Patient Category Processing: When you elect to process by patient category, the system prompts for the patient category code and then for an alphabetic start and stop range for the candidates within that patient category code.

Alphabet or SSN Processing: When you elect to process either alphabetically by candidate name or by social security number, the system then prompts for the start and stop range, which allows you to create a workable subset of the candidate file.

After establishing a working file, you can update, view, print lists, and/or enroll candidates from the working file. Press <F9> to view complete data about a candidate, and <F7> to search for a candidate. During the updating process you can select the Agreement Type for PCM assignment. Press <F9> to view location/preferences during this process, update the UIC and to assign the PCM and an alternate PCM when required. Refer to the Updating Section listed below for more information.

Upon completion of individual record updates, the system then redisplays the candidate list with all the individual records that have been updated low-lit and all remaining records hi-lighted.

Updating:

The system allows you to select the data elements to be updated for the selected batch of candidates. These elements are UIC, PCM, Alternate PCM, Enrolling Division, and Enrollment Block Flag. You are also allowed to specify that the elements selected are used for all subsequent batches generated within the current session by selecting "Default Data Elements."

```
                 POTENTIAL ACTIVE DUTY CANDIDATE UPDATE/REPORT

Medical Activity Date: 22 Jun 1999 by Patient Category
     Patient Category: USA ACTIVE DUTY ENLISTED
          Alpha Range: A,K
                   To: K,L
-----------------------------------------------------------------------
   UIC
   PCM
   Alternate PCM
   Enrolling Division
   Enrollment Block Flag
   Default Data Elements





-----------------------------------------------------------------------
Use SELECT key to select Data Elements to be updated
```

Figure 5-55. Potential Active Duty Candidate Update/Report Data Elements Updates

After selecting the data elements for update, the system prompts sequentially for UIC, PCM, Alternate PCM, Enrolling Division, and Enrollment Block Flag, depending upon the items selected.

Print Report:

When a report is desired, the system prompts for the sections of the report to print. You may print a list of candidates eligible for enrollment, and/or a list of candidates not eligible for enrollment. Possible sorts for the report are: UIC, Patient Category, Alphabetical or by SSN. Section 2 (Candidates not eligible) is sorted by Enrollment Block Reason. Entries on the report are limited to those Potential Candidates selected as part of the subset.

Enrollment:

Enrolling Division: The system enrolls candidates with the Enrolling Division set as either the division attributed to the PCM's place of care or the Enrolling Division entered via the Update process. The Enrolling Division entered via the Update process has precedence over that of the PCM's place of care.

Enrollment Date: You can specify the date of enrollment for the batch of candidates being enrolled. The system establishes a default date of "tomorrow's date" which may be accepted by you as the enrollment date for the batch.

End Enrollment Date: The End Enrollment Date is the End Eligibility Date received from DEERS. Candidates without DEERS eligibility responses are not enrolled and are treated the same as candidates with any other Enrollment Block Reason.

The system tasks the enrollment process for the batch depending upon the values entered in the Hours for Running Batch Enrollment field and exits from the option. The system generates a notification bulletin to you when the task is completed.

Refer to Section 2.4, File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

5.7.3 Print Batch Enrollment Report (PBER)

Menu Path: PAS System Menu → MAN → EMCP → BENR → PBER

Security Keys:

None required.

Required Fields:

Spool document name
Output device

Application Description:

The Print Batch Enrollment Report option allows you to print a two-part report showing successful enrollments and candidates unable to be enrolled. This report is printed from the document file previously created, edited, and processed through the Batch Enroll Active Duty options (Identify Potential Active Duty Candidates option and Update/Print/Enroll Potential AD Candidates option).

The site prints this report to determine those enrollees who were selected during Active Duty Enrollment to be enrolled and the final status of their enrollment. Beneficiaries whose enrollments were rejected may be corrected and resubmitted.

Data Entry Process:

Proceed through the Managed Care Program Menu and Enrollment Processing Menu to the Batch Enroll Active Duty Menu and select the Print Batch Enrollment Report option.

```
Select SPOOL DOCUMENT NAME:CP BATCH UPD-21Jun01-1459-1
Number of Copies: 1//
Output to:
```

Figure 5-56. Print Batch Enrollment Report Screen

The system prompts for the spool document name, the number of copies desired, and the output device. The system then generates the two-part output report and exit the option.

5.7.4 Delete Potential Candidate List (DBER)

Menu Path: PAS System Menu → MAN → EMCP → BENR → DBER

Security Keys:

CPZ IDENTIFY AD

Required Fields:

None

Application Description:

The Delete Potential Candidate List option allows an authorized user to delete the Candidate file after all updating/enrolling actions have been completed. Once deleted, no further actions for the Active Duty Batch Enrollment process can be taken until a new Candidate file is created via the Identify Potential Active Duty Candidates option.

Data Entry Process:

Proceed through the Managed Care Program Menu and Enrollment Processing Menu to the Batch Enroll Active Duty Menu and select the Delete Potential Candidate List option (DBER).

```
Delete Potential Active Duty Candidates
---------------------------------------



There are currently 2858 potential candidates remaining in the
Candidate file. This option will delete all candidates for all
users. All batch enrollment jobs previously tasked but not yet
complete will also be deleted. Following deletion, the Identify
option must be re-run to re-initiate Batch Active Duty Enrollment.


Do you want to delete all candidates? No//
```

Figure 5-57. Delete Potential Candidate List Screen

The system prompts you to begin by requesting confirmation that all candidates should be deleted. The system then prompts again for confirmation to proceed with the file deletion. After receiving two confirmations, the system deletes the Candidate file and exits the option.

5.8 Multiple Batch Renewal and Disenrollment Functions (MENR)

Introduction:

This menu allows you to identify candidates for renewal notification, perform Batch Renewal and Disenrollment processing, print batch renewal and disenrollment letters, print batch renewal/disenroll rosters, and generate individual notification letters and labels.

The Batch Renewal Process

DEERS currently transmits eligibility data to CHCS. The batch renewal action requires that a DEERS eligibility request transaction be batched to verify eligibility.

MCP sites notify beneficiaries that their enrollment eligibility is expected to expire and encourage participants to renew their enrollment prior to the expiration date. Renewal Notification letters are generated one to two months in advance for all beneficiaries expected to lose enrollment coverage if not renewed.

5.8.1 Identify Candidates For Renewal Letter (IMER)

Menu Path: PAS System Menu → MAN → EMCP → MENR → IMER

Security Keys:

CPZ RENEW DIS BATCH

Required Fields:

Division(s)
End enrollment start date
End enrollment stop date
MCP office

Application Description:

This option allows you to generate a list of non-active duty beneficiaries whose enrollments expire within a specified date range and who therefore require a Renewal Notification Letter. This letter serves as a reminder to the recipient of their enrollment expiration date and a chance to respond whether they wish to renew or disenroll. The text of the letter may be edited by the site and will be displayed for all divisions that generate this letter.

The search criteria for the list is based on division(s) and date range. The option prompts you to enter enrolling division(s) and to enter a date range based on the beneficiary's enrollment end date.

The system then creates a processing job to identify beneficiaries who meet the search criteria. An output file is created as a result. A spool file is created to print (and reprint if necessary) renewal notification letters.

The date range (based on enrollment end date) is site defined. Also, the site can limit the identification of beneficiaries based on enrolling division(s). The generation of Renewal Notification Letters applies only to non-active duty beneficiaries.

If beneficiaries renew their enrollment, these patients will not be included in a future process to identify candidates for disenrollment because their enrollment end date will have been extended one year.

Data Entry Process:

Batch enroll candidates who qualify for renewal:

Select Enrolling Division(s)

Enter End Enrollment Start Date

Enter End Enrollment Stop Date

Select MCP Office

Continue processing

Select <Return> to continue

Quit the Renewal Notification Letter Candidates Screen

Select Enrolling Divisions

This screen allows the user to select sets of divisions to search for renewal candidates.

```
                    RENEWAL NOTIFICATION LETTER CANDIDATES

   Enrolling Division:
End Enroll Date Range:
--------------------------------------------------------------------------------



-----------------------------------------------------------------------------------------
Select (O)ne, (M)ultiple, (A)ll Enrolling Divisions or (Q)uit:
```

Figure 5-58. Renewal Notification Letter Candidates Screen

One

If you select One division, you must identify the division to be used in the search criteria. Since One division is the default value for this action bar, the name of the selected division will display in the follow-on screen header. The division you are currently logged into is automatically displayed.

Multiple

When you select Multiple divisions to be used in the search criteria, you can identify one division or all divisions. Because of limited space in the header, the number rather than the names of the divisions selected display.

When multiple divisions are selected, the system displays only those enrolling divisions to which you have access, based on 'allowable divisions' defined in your User file. An enrolling division can be one of the divisions, but not necessarily all of the divisions. The division you are currently logged into is automatically displayed as the default division.

All

If you select All divisions, the system automatically selects all allowable enrolling divisions to be used in the search criteria. If All is selected, 'All Selected' displays in the screen header.

```
                    RENEWAL NOTIFICATION LETTER CANDIDATES

   Enrolling Division: All Selected
End Enroll Date Range:



Enter End Enrollment Start Date: 30 Jun 2001//
```

Figure 5-59. Renewal Notification Letter Candidates Screen

1. Enter End Enrollment Start Date.

   You can enter a question mark (?) to access help text to view other formats for entering the date. Enter the earliest enrollment end date that should be included when selecting enrollments for renewal letters.

   Notice that the default date for the earliest End Enrollment Date is the last day of the current month and the Stop Date is the last day of the following month. These dates will be used to select enrollments that will require renewal.

   You can define a date range of up to six months from the current date to search for expiring enrollments for non-active duty beneficiaries.

2. Enter End Enrollment Stop Date.

   Enter the latest end enrollment date that should be included when selecting enrollment for renewal letters.

3. Select MCP Office.

   This address is used for the Renewal Notification Letters. When the user is an HCF, their associated MCP office is defaulted.

4. Continue processing.

A message displays, indicating when the Renewal Notification Candidates file was last generated. The system also displays a task number and a message that you will receive a bulletin when the task is complete.

Refer to Section 2.4, File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

If you selected the option in error, you can enter No here and exit the option.

If you continue the process, the system informs you of the assigned task number for the letter batch job. Upon completion, the system forwards a mail message with the spool document name for the notification letters.

As a reminder, only non-active duty beneficiaries are identified through this option.

5. Press <Return> to continue.

   The message 'Letters have been tasked.' displays.

6. Quit to exit the Renewal Notification Letter Candidates Screen.

5.8.2 Batch Renewal and Disenrollment Processing (BMER)

Menu Path: PAS System Menu → MAN → EMCP → MENR → BMER

Required Fields:

Division
Enrollment expiration date range
Sponsor SSN

Application Description:

The Batch Renewal and Disenrollment Processing options allow you to identify candidates for renewal notification, perform Batch Renewal and Disenrollment processing, print batch renewal and disenrollment letters, print batch renewal/ disenroll rosters, and generate individual notification letters and labels.

5.8.2.1 Batch Renew MCP Enrollments

Application Description:

The Renewal Batch Processing screen displays a candidate list based on the search criteria entered and the Renew action selected. Candidates for renewal must have a current MCP status of Enrolled.

If the candidate list is too large to be displayed in one screen, the system displays a plus sign (+) on the first and/or the last record in the window.

Beneficiaries displayed within this option are sorted by Sponsor SSN, then by FMP. The beneficiary name, FMP/SSN, PCM, DOB, and End Enrollment Date display.

Data Entry Process:

Batch Renew MCP Enrollments:

Select Enrolling Division(s)

Select Renewal Date Range

Select Sponsor SSN(s)

Select Patients to Renew

Identify PCM

The system prompts you to begin by displaying the initial action bar prompting you to either select One, Multiple, All enrolling divisions or quit and exit the option.

```
                        RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division:
---------------------------------------------------------------------



---------------------------------------------------------------------
Select (O)ne, (M)ultiple, (A)ll Enrolling Divisions or (Q)uit:
```

Figure 5-60. Renewal & Disenrollment Processing Screen and Action Bar

Select Enrolling Division

Press <Select> to select divisions to process.

Select Renewal

Search by Sponsor SSN(s)

You may also search by sponsor SSN. If sponsor SSN is selected, you can enter one or multiple sponsor SSNs from which to search the database for batch renewal or disenrollment processing.

For a sponsor SSN search, you may enter one or multiple complete (9 digit) SSNs. As you enter the SSN, the entry displays in the middle window along with the sponsor name. The system continues to prompt you to enter a sponsor SSN. If multiple SSNs are entered, the header is updated with the count of each one entered.

If you enter the search criteria of sponsor SSN, the (A)ll action is available.

If the (A)ll action is selected, the system automatically selects all patients for processing and you cannot remove or deselect any patients from the list. All records are then processed. All patients selected are renewed with the same Renewal PCM.

1. Enter End Enrollment Start Date

   Enter the earliest end enrollment date that should be included when selecting enrollments for renewal.

2. Enter End Enrollment Stop Date

   Enter the latest end enrollment date that should be included when selecting enrollments for renewal.

3. Select (R)enew Enrollment at the action bar.

When you select the (R)enew Enrollment action, the system displays all records that meet the search criteria and that are non-active duty beneficiaries. Refer to Figure 5-62 on Page 5-138.

If you select Disenroll, the system displays all records that meet the search criteria. The disenrollment action is allowed for both active duty and non-active duty enrollees.

> **Note**: Be careful not to select disenroll for patients you wish to renew. This process cannot be reversed.

If you select Quit, the system returns you to the previous action bar.

Note: The system automatically prevents patients from being assigned to a provider when the enrollment load is greater than the system capacity level.

Select Patients to Renew.

```
                              RENEWAL BATCH PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
 End Enroll Search: 30 Jun 2001 to 31 Jul 2001
-------------------------------------------------------------------------------
   Patient Name           FMP/SSN         PCM                  DOB      End Enr

   PRESCOTT,ALBERT A      20/100-24-0024  FAM MED MTF          11Mar45  15Jul01
   PRESCOTT,BRENT B       20/100-24-0025  FAM MED MTF          05Jan52  15Jul01
   PRESCOTT,CURT C        20/100-24-0026  FAM MED MTF          08Jul56  15Jul01
   PRESCOTT,DONALD D      20/100-24-0027  FAM MED MTF          21Jun45  15Jul01
   PRESCOTT,EDMUND M      20/100-24-0028  FAM MED MTF          21Aug50  15Jul01
   PRESCOTT,FRANCIS F     20/100-24-0029  FAM MED MTF          01Jul55  15Jul01
   PRESCOTT,GERALD G      20/100-24-0030  FAM MED MTF          03May45

-------------------------------------------------------------------------------
Select ONE Renewal PCM for (M)ultiple patients, (I)ndividual patient,
       or (Q)uit:
```

Figure 5-61. Renewal Batch Processing Screen

If the (M)ultiple action is selected, the system positions the cursor in the middle window and allows you to select patients for processing. All selected patients are processed with the same Renewal PCM.

If the (I)ndividual action is selected, the system positions the cursor in the window and allows you to select patients for processing. After each beneficiary has been selected, the system prompts you to enter a Renewal PCM for that patient. After you have entered the Renewal PCM, the cursor returns to the patient list and allows you to continue to select another patient to individually process. This function does not change the enrolling division.

1. Select the candidates to be updated.

   Position the cursor next to each of the specified names and press <Select>. Press <Return> to activate your selections.

2. Once you have selected a candidate, you may press <F9> to view current enrollment information.

3. In addition to viewing beneficiary information within the candidate list, you may press <F7> to search for a particular record within the list. This feature lets you navigate quickly through the candidate list. Using this key, you can enter a string of numeric characters (three to nine digits) to search for a sponsor SSN.

4. Select Prior PCM?

The beneficiary has the option to continue with their current PCM. If the user answers “No”, a new PCM may be selected.

5. The list of candidates displays again. This allows you to select additional candidates, if you need to do so.

   Do not select additional candidates.

6. Select (P)rocess batch on the action bar.

7. Continue and (R)enew the batch.

   A message displays that the Batch Renewal process has been tasked. Also, the task number is identified, and the notice displays that you will receive a bulletin when the process is complete.

Refer to Section 2.4, File Table and Building and Maintenance, for information concerning mail bulletins. This section describes the menu path, business rules and specific bulletins associated with mail bulletins.

8. Quit to exit the Renewal Batch Processing Screen.

5.8.2.2 Batch Disenroll Candidates

Application Description:

The Batch Disenrollment Process

Batch disenrollment requires that a disenrollment transaction be sent to DEERS when the site is operating in DEERS enrollment mode for non-active duty enrollees and for active duty enrollees. In empanelment mode, transactions go to DEERS for active duty only.

Once candidates who have pending enrollment expiration dates have been identified, they are informed and given the opportunity to renew or disenroll.

If a beneficiary has responded that they wish to disenroll, they are batch disenrolled and a Disenrollment Notification Letter is generated and sent to the family. Multiple family members are included on the family letter.

Enrollees are selected by division and by SSN or expiration date. The disenrollment date and reason are entered and can be applied either on an individual basis or to all candidates collectively.

The Disenroll Batch Processing screen displays a list of all records which meet the search criteria. The disenrollment action is allowed for both active duty and non-active duty enrollees.

Beneficiaries displayed within this option are sorted by sponsor SSN and then by FMP. The beneficiary name, FMP/SSN, DOB, End Enrollment Date, and PCM display.

If the candidate list is large, the screen displays a plus sign (+) to indicate that additional names are available on continuing screens.

Data Entry Process:

Batch Disenroll Candidates:

Select Division(s)

Select Sponsor SSN(s) or enrollment date range

Select Candidates to Disenroll

Enter Disenrollment Data

Disenroll Selected Beneficiaries

Select Division(s)

The user may select any enrolling divisions to search provided the user is authorized access to the division.

```
                        RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division:
---------------------------------------------------------------------------




---------------------------------------------------------------------------
Select (O)ne, (M)ultiple, (A)ll Enrolling Divisions or (Q)uit:
```

Figure 5-62. Renewal & Disenrollment Processing Screen

Refer to figure 5-60 on Page 5-134 for a description of this screen's functions.

Select End Enrollment Date Range or (S)ponsor SSN

Enter selection criteria that will be used to select enrollees to disenroll.

```
                        RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
------------------------------------------------------------------------
-----------------------------------------------------------------------
Select (E)nd Enrollment Date Range, (S)ponsor SSN, or (Q)uit:
```

Figure 5-63. Renewal & Disenrollment Processing Screen

Enter End Enrollment Date Range

```
                       RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
 End Enroll Search:



Enter End Enrollment Start Date: 30 Jun 2001//
```

Figure 5-64. Renewal & Disenrollment Processing Screen

Select Candidates to Disenroll

Candidates may be selected according to the date their enrollment will expire. Their expiration dates must be future dates. Candidates may also be selected by one or multiple SSNs.

```
                        RENEWAL & DISENROLLMENT PROCESSING

Enrolling Division: DIV A - TRAINING HOSPITAL
Sponsor SSN Search:
-----------------------------------------------------------------------
Sponsor SSN     Sponsor Name

  569-69-4415    PEARL,ZACHARY N
               <----- Enter Sponsor SSN




-----------------------------------------------------------------------
Enter a valid Sponsor SSN.
A maximum of 100 is allowed.
```

1. Enter SSNs one at a time.

   When Sponsor SSN is selected, you can enter one or multiple Sponsor SSNs from which to search the database for batch renewal or disenrollment processing.

   You can enter up to 100 complete (9 digit) SSNs for the search.

   The SSN displays in the middle window as you enter it, along with the Sponsor name. If you enter multiple Sponsor SSNs, the header is updated with the number of entries.

2. Press <Return> to exit the prompt.

3. Press <Select> to select beneficiaries.

4. Select the (D)isenroll action at the action bar.

Potential candidates for disenrollment must have a current MCP status of Enrolled.

Note that enrollment loads may exceed the acceptable system capacity. However, the patient load is reduced as patients are disenrolled and the loads may be lowered back to capacity level. After reaching capacity, they are no longer permitted to exceed capacity.

```
                          DISENROLL BATCH PROCESSING

Enrolling Division:  All Selected
 End Enroll Search:  05 May 1997 to 13 Jul 1997
-----------------------------------------------------------------------
  Patient Name    FMP/SSN         PCM              DOB      End Enr
-----------------------------------------------------------------------
  ALLEN,GLORIA E  30/239-21-3116  GRAAM,GOSLING    05May55  31May97
  MANUEL,PATRICK  01/450-13-7095  MIAMI LAKES MEDI 11Oct93  31May97
  MANUEL,MARIA    30/450-13-7095  MIAMI LAKES MEDI 07Jun67  31May97
  CLARK,KAREN     30/453-82-7466  JOHNSON,DAVID    31Jan50  31May97
  STEWART,RENATE  30/457-76-9605  ALEXANDER,NICK   22Sep48  31May97
  MORRISEY,DANIEL 20/482-52-3205  HARTFORD,MEDICAL 31Mar44  31May97

-----------------------------------------------------------------------
Select ONE Disenrollment Date/Reason for (M)ultiple patients,
    (I)ndividual patient, or (Q)uit:
```

1. Select Multiple patients or individual patients.

   You can position the cursor at an individual candidate name or multiple candidate names and then press <F9> to view current enrollment information.

2. Enter Disenrollment Reason.

   A list of reasons for disenrollment displays. You must select a reason from the list. This reason will be assigned to all selected disenrollees.

   The list has standard entries but also allows site definable entries.

   If you select Multiple patients, this Disenrollment Reason applies to all patients that were selected be disenrolled. If you select an individual patient, the Disenrollment Reason entered here, applies only to that patient.

3. Accept the default Disenrollment Date.

   If you selected Multiple patients, this Disenrollment Date applies to all patients that were selected to be disenrolled. If you selected an individual patient, the Disenrollment Date applies only to that patient.

   The existing nightly tasked job (CP Enrollment Bulletin) transmits a DEERS disenrollment transaction on the day in which the disenrollment

date occurs if it is a future date. A patient retains the enrollment status of Enrollee in DEERS until the disenrollment date is in the past.

For sites operating in DEERS Enrollment mode, a disenrollment transaction is sent for all beneficiaries. For sites operating in local empanelment mode, a disenrollment transaction is sent only for active duty beneficiaries (who are not affected by the mode indicator).

4. Process this batch.

   The message displays the number of records that will be batch disenrolled.

5. Continue to disenroll this batch.

6. Enter MCP Office.

   After the MCP Office has been entered, the message displays that Batch Disenrollment process has been tasked, along with the task number. You will receive a bulletin when complete.

7. Press <Return> to continue.

   Once the batch disenroll process has been completed, the system returns you to the action bar to repeat the disenroll batch processing for additional patients, if necessary.

8. Select Quit to exit the screen.

   You are returned to the Multiple Batch Renewal and Disenrollment Functions Menu.

5.8.3 Print Batch Renewal & Disenrollment Products (PMER)

Menu Path: PAS System Menu → MAN → EMCP → MENR → PMER

Application Description:

The Print Batch Renewal & Disenrollment Products option has three subsets: Letters, Labels, and Roster. When you select PMER, you will see a screen that allows you to choose one of the three. Each is described separately below.

```
 1      Batch Renew & Disenroll Letter

 2      Batch Renew & Disenroll Labels

 3      Batch Renew & Disenroll Roster

Select Print Batch Renewal & Disenrollment Products Option:
```

5.8.3.1 Batch Renew & Disenroll Letter

Menu Path: PAS System Menu → MAN → EMCP → MENR → PMER - 1

Application Description:

The Batch Renew & Disenroll Letters option allows you to print renewal and disenrollment letters in batch form to be mailed to beneficiaries from spool files previously generated via the following options:

Identify Candidates for Renewal Notification Letter
Batch Renewal & Disenrollment Processing.

This option additionally generates an Incomplete Patient Address Report, listing beneficiaries in the spool file batch who had insufficient address information for generation of the renewal or disenrollment letter.

The Renewal Notification Letter

The Renewal Notification Letter is generated only for non-active duty beneficiaries. Only one Renewal Notification letter is printed for family members who have the same enrollment expiration date, Sponsor SSN, and mailing ZIP code when contained in the same processing batch. The site may change the text of the letter.

For family members who have the same end enrollment date, this date is printed at the bottom of the Notification Letters. The beneficiary's home address is used as the mailing address for the Notification Letter and mailing labels.

Refer to Section 5.8.1 for more information.

The Disenrollment Notification Letter

Disenrollment Notification Letters are generated for non-active-duty and active duty beneficiaries. Only one Disenrollment Letter is printed for family members who have the same disenrollment date, Sponsor SSN, and mailing ZIP code if

contained in the same processing batch. The site may change the text of the letter, though the signature line on the letter is automatically generated based on the user who is logged onto the system and cannot be changed.

For family members who have the same disenrollment date, only one letter is printed and the date is printed at the bottom of the letter. The beneficiary's home address is used as the mailing address for the Notification Letter and mailing labels.

For family members identified in the same renewal job, letters and labels are printed in the following FMP order: 30, 01, 02, 03, 04, etc. Letters and labels are tasked to be printed during off peak hours.

Data Entry Process:

Batch Renew & Disenroll Letters:

Select Spool Document Name.

Specify the number of copies to print.

Enter the output device.

Select Spool Document Name

This name identifies the candidates for renewal or disenrollment.

Specify the number of copies of each letter to print

Enter the output device

The Renewal Notification Letters scroll on the screen.

OFFICE OF HEALTH CARE FINDER

678 DUPONT CIRCLE

WASHINGTON, DC 20308

TRICARE PRIME RENEWAL NOTIFICATION LETTER

June 21, 2001

ALBERT A PRESCOTT

3278 HALL STREET

LANHAM, MD 20703

Dear ALBERT A PRESCOTT,

Your current enrollment and the enrollment of any family members listed below will expire on the end enrollment date indicated. If you wish to renew your enrollment, the appropriate enrollment form and renewal fee (if applicable) must be received at the Tricare Service Center by the 20th of the month before your enrollment expires.

If you do not elect to renew your enrollment, you will be disenrolled effective the first day after your enrollment expires. Your benefit entitlement will revert to prior entitlement. You will no longer be assigned to your current Primary Care Manager and you will receive medical services only on a space available basis in our military treatment facilities.

If you have any questions or concerns, you may call the TRICARE SERVICE CENTER at (307) 555-2933.

Sincerely,

OFFICE OF HEALTH CARE FINDER

WANDA JONES, Health Care Finder

Figure 5-65. Sample Renewal Notification Letter

5.8.3.2 Batch Renew & Disenroll Labels

Menu Path: PAS System Menu → MAN → EMCP → MENR → PMER → 2

Application Description:

The Batch Renew & Disenroll Labels option allows you to print renewal and disenrollment labels in batch form from spool files previously generated via the following options:

Batch Renewal & Disenrollment Processing
Identify Candidates for Renewal Notification Letter.

Data Entry Process:

Batch Renew & Disenroll Labels:

Select User(s) or Label Print Job
Print Labels

Select User(s) or Label Print Job

Search for labels generated by one user, all users, or the print task number at the Batch Renewal & Disenrollment Labels Screen.

```
                    BATCH RENEWAL & DISENROLLMENT LABELS

                                          Total   # Labels
   Task #  User                         Found   To Print    Date Generated
-----------------------------------------------------------------------------




-----------------------------------------------------------------------------
Search for labels generated by (T)ask #, (O)ne user, (A)ll users or (Q)uit:
```

Figure 5-66. Batch Renewal & Disenrollment Labels Screen

1. If you select the (T)ask number action, the system allows you to search for the spool file by task number by entering the task number.

2. If you select the (O)ne user action, the system allows you to search for spool files created by one person by prompting you to enter your name.

3. If you select the (A)ll users action, the system allows you to search for spool files created by any user and presents you with a list of files. The system allows you to select the desired spool file from the list.

Note: If you specify a spool file that does not contain any labels for printing, then the system displays the message **THERE ARE NO LABELS ELIGIBLE FOR PRINTING** and redisplays the Spool File Selection action bar.

---

4. If you select the (Q)uit action, the system exits the option.

Select the User(s) who requested the labels.

```
                    BATCH RENEWAL & DISENROLLMENT LABELS

                                        Total   # Labels
   Task # User                          Found   To Print    Date Generated
-----------------------------------------------------------------------

     1030 TRAINING,MANAGER                10        10    20 Jun 2001@1902


-----------------------------------------------------------------------
Use the SELECT key to select label batch
```

Figure 5-67. Batch Renewal & Disenrollment Labels

1. If you select the (P)rint action, the system displays a warning stating that large print orders may cause a printer jam and the number of labels that are waiting to print.

   The system also displays another action bar containing the following actions: (S)UBSET, (A)LL LABELS, (T)EST PRINTER, and (Q)UIT. (Refer to the Print Action Bar paragraphs later in this section.)

2. If you select the (D)elete batch action, the system prompts you to confirm that you want to delete the spool file. If you respond NO, the system redisplays the Print/Delete/View Action Bar. If you respond YES, the

system deletes the spool file and redisplays the Spool File Selection action bar.

3. If you select (V)iew search criteria action, the system displays data about the spool file such as name of the user who created the file, the date the file was created, the action (renewal or disenrollment), the enrolling divisions, and the end enrollment start and stop date range.

4. If you select the Q)uit action, the system redisplays the Spool File Selection action bar.

```
                      BATCH RENEWAL & DISENROLLMENT LABELS

                                  Total       # Labels
  User                             Found      To Print      Date Generated
-----------------------------------------------------------------------
  TRAINING,MANAGER                   10           10     20 Jun 2001@1902


             CAUTION:  LARGE PRINT ORDERS WILL INCREASE THE RISK
                              OF A PRINTER JAM!

               There are currently 10 labels waiting to print.




-----------------------------------------------------------------------
Select to print a (S)ubset, (A)ll Labels, (T)est printer, or (Q)uit: A//
```

Figure 5-68. Batch Renewal & Disenrollment Labels Screen

Print Labels

1. If you select the (S)ubset action, the system prompts you to enter the number of labels to print. The system allows you to enter a minimum of one and a maximum equal to the number of labels in the spool file. After you specify a number, the system prompts you to specify an output device. The system will then generate the output and redisplay the Spool File Selection action bar.

Note: If there is only one label in the batch, the system will suppress the (S)ubset action.

If you select the (A)ll labels action, the system prompts you to specify the output device. The system will generate the output and redisplay the Spool File Selection action bar.

If you select the (T)est printer action, the system prompts you to specify the output device and will print test labels on that device. The system will then redisplay the Print action bar.

If you select the (Q)uit action, the system will redisplay the Print/Delete/View action bar. (Refer to the "Print/Delete/View Action Bar" paragraphs earlier in this section.)

2. Select Device.

3. Select Quit at the action bar to exit the Batch Renewal & Disenrollment Labels Screen.

5.8.3.3 Batch Renew & Disenroll Roster

Menu Path: PAS System Menu → MAN → EMCP → MENR → PMER → 3

Application Description:

The Batch Renew & Disenroll Roster option allows you to print a roster listing beneficiaries previously identified either for renewal or for disenrollment via the Batch Renewal & Disenrollment Processing option.

Data Entry Process:

Batch Renew & Disenroll Roster:

Print Batch Renew and Disenroll Roster

1. Select Spool Document Name.

   This name identifies the candidates for renewal or disenrollment.

2. Specify the number of copies to print.

3. Enter the output device.

   The Roster scrolls on the screen if you press <Return> at the Device prompt.

5.8.4 Generate Individual Notification Letter & Label (GMER)

Menu Path: PAS System Menu → MCP → EMCP → MENR → GMER

Application Description:

The Generate Individual Notification Letter & Label option allows you to generate individual renewal or disenrollment notification letters and labels for a single beneficiary.

If the patient is active duty, the system prompts you to quit, if renewal letters are requested. If the patient is disenrolled, then the system allows you to print a disenrollment notification or to quit. If the patient is enrolled, you may print a renewal notification or quit. If you choose to quit, the system will remove all patient data from the screen and prompt you to enter a patient name.

If you elect to print a renewal or a disenrollment notification, enter the name of the MCP office that will be printed on the letter as the return address. If you are entered into the database as an HCF, the system enters your associated MCP office as the default. You will then enter the name of the device on which the letters are to be printed.

After you select an output device, the letter will print and the system will allow you to print an address label. If you choose not to print an address label, you will return to the initial Generate Individual Notification Letters/Labels screen and can select another patient or exit the option. If you decide to print an address label, the system prompts you to enter the name of the output device. Once you specify the device, you will return to the initial Generate Individual Notification Letters/Labels screen and be able to either select another patient or exit the option.

Data Entry Process:

Generate an Individual Notification Letter & Label:

Select Patient

Select Disenrollment or Renewal Notice to Print

Select MCP Office

The individual letter will display/print

Print an Address Label for the Letter

Select Patient

1. Enter the name of the patient for whom to print the notice.
2. Confirm the patient name.

The Generate Individual Notification Letters/Labels Screen displays, showing data about the patient. If the patient is disenrolled, the Disenrollment Notification action displays. If the patient's enrollment has been renewed, the Renewal Notification action displays.

```
                GENERATE INDIVIDUAL NOTIFICATION LETTERS/LABELS

       Patient Name: PEARL,JOE N
 Enrolling Division: DIV A - TRAINING HOSPITAL
  Start Enroll Date: 20 Jun 2001
    End Enroll Date: 20 Jun 2001
   Disenroll Reason: ENROLLMENT CANCELLED
Last Renewal Letter:









Print (D)isenrollment Notification, or (Q)uit:
```

Figure 5-69. Generate Individual Notification Letters/Labels Screen

1. Select Print (D)isenrollment Notification on the Print (D)isenrollment Notification.

2. The *Select MCP Office* prompt displays. If you are entered into the database as an HCF, your associated MCP office will display as the default.

3. Press <Return> to select the default MCP office.

4. Select Device.

5. Enter the Right Margin.

   The individual letter will display/print.

6. Press <Return> to print the label.

7. Select Device.

8. Enter the Right Margin.

   The individual address label will display/print.

9. Exit the Generate Individual Notification Letters/Labels screen.

10. Exit the Multiple Batch Renewal and Disenrollment Functions Menu.

    The Enrollment Processing Menu displays.

5.9 Outputs and Enrollment Maintenance Reports Menu (OENR)

Introduction:

The Enrollment Reports Menu contains the Family Batch Enrollment Labels Menu, the Enrollment Rosters Menu, and the Enrollment Summaries Menu. For these reports, you may print the enrollment roster/report for one or more divisions. If you choose (M)ultiple divisions, the system provides a picklist of divisions from which to choose. Once all or multiple divisions are selected, the Division field is filled with the number of divisions selected. When you are asked to select a division and you want to view a list of divisions, enter ??. Once you enter the division, the Division field is filled in with the division name.

If you enter <^> at the *Report Month & Year OR '^' to enter specific date range* prompt, the system asks for a Report Start Date and a Report Stop Date. Once entered, these dates are displayed in the Dates field.

Before printing, the system will warn you that the report may be complex and that you should queue it to print during non-peak hours. Press <Q> at the *Select DEVICE* prompt to send the report to the print queue to be printed later. A device must be selected for printing these reports, as they cannot be printed to the screen or a slaved device.

5.9.1 DEERS/Enrollment Maintenance Reports Menu (DRPM)

Introduction:

The DEERS/Enrollment Maintenance Reports Menu is used to generate information about conditional enrollment, enrollment/disenrollment discrepancies, DEERS ineligible patients from MCP, and DEERS ineligible patients from PAS.

Menu Path: PAS System Menu → MCP → EMCP → OENR → DRPM

5.9.1.1 MCP Conditional Enrollment Roster

Menu Path: PAS System Menu → MCP → EMCP → OENR → DRPM → 1

Contents:

This report lists, by division, all the newborns and spouses who are currently ineligible in DEERS at the time of enrollment. These beneficiaries are conditionally enrolled in CHCS with an assigned PCM until eligibility can be confirmed. DEERS is notified by CHCS of the conditional enrollment. DEERS will automatically enroll the newborn or spouse when their eligibility is established in DEERS, provided it is established within 120 days of receipt of the Conditional Enrollment notification from CHCS. If eligibility is not established within 120 days, the conditional enrollment will be deleted in DEERS and in CHCS. A new enrollment must be re-entered in CHCS if the newborn is to be enrolled after 120 days.

Frequency/Use:

This report should be checked at least weekly. An eligibility check should be requested weekly for each beneficiary on this report. CHCS will automatically correct the “Conditional” status to “Enrolled” whenever a DEERS eligibility transaction indicates that the beneficiary is enrolled in DEERS.

The site should use this report to list those beneficiaries whose conditional enrollments have not become actual enrollments. The user can determine which conditional enrollees need eligibility checks before their enrollments expire and are deleted in CHCS (after 120 days).

Special Instructions:

Discrepancies in DEERS and CHCS enrollments and enrollment counts will result if Conditional Enrollments are not resolved routinely. If DEERS enrolls the beneficiary, but CHCS is not aware of this and deletes the conditional enrollment for the beneficiary after 120 days, discrepancies will occur and will be difficult to identify. DEERS enrollment totals will be greater than CHCS enrollment totals for the site.

Conditional enrollments for spouses are currently not supported by TRICARE policy and spouses should not be enrolled until they are eligible.

NH PORTSMOUTH, VA 22 Jan 1993@1110 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)
MCP CONDITIONAL ENROLLMENT ROSTER

Division: TRIPLER ARMY MEDICAL CENTER

Name Patient Address	FMP/SSN	DDS	DOB OHI	Patient Category PCM	Spons Rank	Home Phone Work Phone	Enrollment Date Auto Disenroll Date
FARRINGTON,JOSEPHINE 9987 SUNSET ST PORTSMOUTH, VA 23701	30/098-00-0001		11 Nov 70	USN FAM MBR RET LIMBAUGH,RUSH	CDR	447-7560	26 May 93 23 Sep 93
GLASS,WHITNEY 1219 HALE DRIVE SAN DIEGO, CA 92101	02/224-13-4285		01 Jul 93	USAF FAM MBR AD WASHINGTON,WAYNE	SSG	8048515119	06 Jul 93 03 Nov 93
KELEMAN,CATHERINE 303 S CHERRY MORRISON, IL 61270	40/359-46-8955		12 JUN 19	USAF FAM MBR AD PARKS,BERNICE	CPT	(805)772-3310	14 Jun 93 12 Oct 93

Division total: 3

Figure 5-70. MCP Conditional Enrollment Roster

5.9.1.2 Enrollment/Disenrollment Discrepancy Report

Menu Path: PAS System Menu → MCP → EMCP → OENR → DRPM → 2

Contents:

This report is an alphabetical listing by enrollee name of those enrollments rejected by DEERS or having invalid/inconsistent data in CHCS. CHCS assigns these rejected enrollments a status of "Invalid Enrollment." The report identifies the reason for rejection and the data that must be corrected in CHCS so that the enrollment will be accepted by DEERS when retransmitted.

Beneficiaries on this report are not currently grouped by division.

Frequency/Use:

The user shall consult this report to identify enrollments and disenrollments that were rejected because the enrollment or demographic data is incorrect or inconsistent. Invalid enrollments should be corrected and retransmitted so they can be accepted by DEERS.

This report MUST be run before CHCS purges the DEERS reject responses (usually every 2 or 3 days.) Run nightly.

Special Instructions:

These discrepancies must be manually corrected through the enrollment or disenrollment process. If you do not correct these invalid enrollments/ disenrollments, they will remain in CHCS as invalid but are counted as an enrollment or disenrollment. They will not be recorded or counted in DEERS. CHCS enrollment counts will not agree with DEERS until these corrections are made.

If not printed before the reject messages are purged, the enrollment and disenrollment discrepancy messages are lost and invalid enrollments will appear to be valid enrollments (status of "Enrolled") in CHCS. In addition, the beneficiary will not be enrolled in DEERS. Once the error messages are purged, the lost enrollments can only be identified through special ad hoc reports that have been developed by MEDSITE. Each enrollment must be corrected manually through FileMan.

Some causes for the discrepancies are:

– beneficiary is ineligible (for batched enrollments)

- already enrolled in another area or program (need to invoke reciprocal disenrollment)
- enrollment start date overlaps a current or former enrollment history segment in DEERS or CHCS
- enrollee ACV not consistent with DEERS patient eligibility
- patient category not consistent with FMP or Sponsor Rank in CHCS
- sponsor SSN not in DEERS (for batched enrollments)
- sponsor in DEERS but family member not in DEERS (for batched enrollments)
- CHCS date of birth does not match DEERS date of birth
- DEERS Dependent Suffix (DDS) mismatch between CHCS and DEERS
- enrollment update or disenrollment rejected by DEERS (usually patient identification has changed in CHCS since enrollment)
- disenrollment or enrollment cancellation not issued by the enrolling division (i.e., DMIS ID does not match because user is in the wrong division when changing the enrollment data).

```
TRIPLER AMC, HI                                                                                                    07 Jul 1993@1517     Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                          ENROLLMENT/DISENROLLMENT DISCREPANCY REPORT
                                              From: 06 Jul 1993    To: 07 Jul 1993
==================================================================================================================================
Patient                      FMP/SSN         Sex DOB          Home Phone         Work Phone         Date of Trans MCP Status
   Sponsor                          Sponsor Unit        Pending Appts  Duty Phone        Discrepancy
==================================================================================================================================
AURELIUS,GERTRUDE            30/808-60-0101  F   04 Jul 1960  H:                 W:                 06 Jul 1993   INVALID ENROLLMENT
                                     CAMP SWAMPY         NON-MTF        D:444-5555        SSN Not Found in DEERS Data Base - Verify S

DELANO,ANNA                  02/368-64-6645  F   16 Dec 1983  H:555 555-5444     W:555-555-0912     06 Jul 1993   INVALID ENROLLMENT
  DELANO,KENNETH EUGENE              A COMPANY                          D:555-8787        Invalid Enrollment Date Change - Patient No

DELANO,WILBUR                04/368-64-6645  M   19 Dec 1989  H:39009290760      W:                 06 Jul 1993   INVALID ENROLLMENT
  DELANO,KENNETH EUGENE              A COMPANY                          D:555-8787        Invalid Enrollment - Not Eligible For Plan

GUILLERO,DANIEL              01/534-48-2466  M   31 Jul 1975  H:                 W:                 07 Jul 1993   INVALID ENROLLMENT
  GUILLERO,DONALD H                  AIR COMBAT COMMAND                 D:                Invalid Enrollment - Patient Already Enroll

----------------------------------------------------------------------------------------------------------------------------------
Beneficiaries with a DEERS Discrepancy Code 56: 'Invalid Enrollment - Patient Already Enrolled' will need to be disenrolled from
their current facility and re-enrolled here.
```

Figure 5-71. Enrollment/Disenrollment Discrepancy Report

5.9.1.3 MCP DEERS Ineligibility Report

Menu Path: PAS System Menu → MC P → EMCP → OENR → DRPM → 3

Contents:

The MCP DEERS Ineligibility Report lists all patients who received an ineligible response from DEERS within the past one to five days. It contains the following data: Patient Name, FMP/SSN, Sex/DOB, Date of Transaction, Home Phone, Work Phone, Pending Appointments, Sponsor Name, Sponsor's Unit, Duty Phone, Override Code, MCP Status, and the Process Type (i.e., batch or interactive).

Frequency/Use:

This report should be generated daily.

```
NH PORTSMOUTH, VA                                                                                                  11 May 1993@0945     Page 1
                                        Personal Data - Privacy Act of 1974 (PL 93-579)
                                                MCP DEERS INELIGIBILITY REPORT
                                             From: 10 May 1993    To: 11 May 1993
=================================================================================================================================
Patient                    FMP/SSN          Sex DOB          Date of Trans    Home Phone        Work Phone      Pending Appts
   Sponsor                        Sponsor Unit                     Duty Phone      Override   MCP Status                Process Type
=================================================================================================================================
GALLOWAY,RAE               20/218480614     F   02 Nov 1946  06 May 1993@0900 H:                W:              Appts:
  GALLOWAY,RAE                   1st Air Cav                       D:                                                        BATCH

OLSON,SVEN                 20/317400514     M   07 Nov 1944  07 May 1993@1503 H:                W:              Appts:
  OLSON,SVEN                     1st Air Cav                       D:                                                        INTERACTIVE

WILSON,FAYE                20/408220678     F   01 Jan 1932  06 May 1993@1305 H:                W:              Appts:
  GALLOWAY,R                     1st Air Cav                       D:                            CONDITIONAL ENROLLMENT BATCH
```

Figure 5-72. MCP DEERS Ineligibility Report

5.9.1.4 PAS DEERS Ineligibility Report

Menu Path: PAS System Menu → MCP → EMCP → OENR → DRPM → 4

Contents:

The PAS DEERS Ineligibility Report alphabetically lists the names of patients with scheduled appointments who have not had a DEERS check performed within a valid time period or whose DEERS check indicated the patient is ineligible for direct care. It contains the following data: Clinic, Patient Name, FMP/SSN, DOB, Date of Last DEERS Check, Next Appt, Home Phone, Work Phone, and DEERS Status.

Beneficiaries who are identified as USTF enrollees, or whose DEERS check indicates the patient is ineligible for direct care are listed in the second section of the PAS DEERS Ineligibility Report.

Frequency/Use:

This report should be generated daily.

```
TRIPLER ARMY MEDICAL CENTER                                                                                    18 Aug 1995@1254    Page 1
                                                PAS DEERS INELIGIBILITY REPORT by DIVISION
                                             Personal Data - Privacy Act 1974 (PL 93-579)
                                                   Appointments for  02 Aug 1995
                                                          Part 1 of 2
Division: A DIVISION
=================================================================================================================================
Clinic/
  Patient Name          FMP/SSN         DOB          Last DEERS Check  Next Appt.        Home Phone/          Work Phone
  DEERS Status                                                                                            Clerk
=================================================================================================================================
ALLERGY (T)
----------
  ABERCROMBE,DOUGLAS    99/800-44-0407  07 Apr 1944  18 Aug 1995@0939  06 Aug 1995@1100
  NOT ELIGIBLE                                                                                            THACKER,DAVID

  SIMPSON,BETTY         01-362-77-6576  07 Sep 1973  30 Sep 1995@1531  10 Oct 1995@0900  446-6644
  NOT ELIGIBLE                                                                                            DE BLASIO,MICHAEL

CARDIOLOGY (A)
--------------
  SMITH,DANIEL          20/457-65-2398  25 Aug 1960  30 Sep 1995@0802  02 Oct 1995@1000  678-0987
  No Response on Latest DEERS Check.  Previous check:  ELIGIBLE                                           THACKER,DAVID

  TUCKER,ELIZABETH      20/161-61-6161  16 AUG 1968  29 Sep 1995@1147  01 Oct 1995@1300  555-2121             977-3450
  No Response on Latest DEERS Check.  Previous check:  NOT ELIGIBLE                                       METCALF,DAVID

=================================================================================================================================
NOTE: Patients, whose names appear on this report, should be reminded to bring proof of their eligibility at the time of their
      appointment.
```

Figure 5-73. PAS DEERS Ineligibility Report

```
TRIPLER ARMY MEDICAL CENTER                                                                    18 Aug 1995@1254    Page 2
                                        PAS DEERS INELIGIBILITY REPORT by DIVISION
                                      Personal Data - Privacy Act 1974 (PL 93-579)
                                            Appointments for  02 Aug 1995
                                                     Part 2 of 2
Division: A DIVISION
=================================================================================================================================
Clinic/
  Patient Name          FMP/SSN         DOB          Last DEERS Check  Next Appt.        Home Phone/           Work Phone
  Alternate Care Value                  DEERS Direct Care Eligibility                    Clerk
=================================================================================================================================
ALLERGY (T)
----------
  ABERCROMBE,DOUGLAS    99/800-44-0407  07 Apr 1944  18 Aug 1995@0939  06 Aug 1995@1100
  U/ENROLLED IN USTF MANAGED CARE       NOT ELIGIBLE                                      THACKER,DAVID

  SIMPSON,BETTY         01-362-77-6576  07 Sep 1973  30 Sep 1995@1531  10 Oct 1995@0900  446-6644
  U/ENROLLED IN USTF MANAGED CARE       NOT ELIGIBLE                                      DE BLASIO,MICHAEL


  (NOTE:  The system shall generate Part 2 only if there are DEERS ineligible patients who are enrolled in a USTF
   Managed Care plan to be included in this report.


=================================================================================================================================
NOTE:  Patients, whose names appear on this report section are currently enrolled in a Uniformed Services Treatment Facilities
       (USTF) Managed Care Plan.  This facility will not be reimbursed for non-emergency care provided to these patients unless
       their USTF agrees to pay this facility prior to rendering services to the patient.
```

Figure 5-73. PAS DEERS Ineligibility Report (continued)

5.9.2 Enrollment Reports Menu (ERPM)

Menu Path: PAS System Menu → MCP → EMCP → OENR → ERPM

The Enrollment Reports Menu options allow you to generate information about active duty dependents by unit, alphabetic enrollment by service, case management program enrollment, change in eligibility enrollment, Disenrollees for period by reason code, disenrollment by reason, enrollment roster, exception conditions, OHI enrollment, and patient category enrollment. These options also allow you to create and print labels for families.

5.9.2.1 Family Batch Enrollment Labels Menu (LABL)

Menu Path: PAS System Menu → MCP → EMCP → OENR → ERPM → LABL

The Family Batch Enrollment Labels Menu options allow you to build and print family batch enrollment labels for enrolled and nonenrolled patients, and to sort them by unit or location. During the build process, you may define selection criteria. Labels are generated only for patients who meet the criteria and who have complete address information. You may then print these labels either in their entirety or in subsets.

You may also print an Incomplete Patient Address Report showing the patients who failed the minimum address requirements. After updating these patients' addresses, you may print their labels.

5.9.2.1.1 Family Batch Enrollment Labels Build Utility

Menu Path: PAS System Menu → MCP → EMCP → OENR → ERPM → LABL → 1

Application Description:

The Family Batch Enrollment Labels Build Utility allows you to build family batch enrollment labels for enrolled and nonenrolled patients, and sort them by unit or location. During the build process, you may define selection criteria. Labels are generated only for patients who meet the criteria and who have complete address information.

Data Entry Process:

Build Family Batch Enrollment Labels

Select (E)nrolled or (N)onenrolled patients
Print labels by (U)nit, (L)ocation
Select (O)ne, (M)ulitple, (A)ll Unit ID Names
Select patients (W)ith or w(I)though OHI
Print labels with (D)uty Address or (H)ome Address

Select (E)nrolled or (N)onenrolled patients or (Q)uit

You may generate labels for enrolled or nonenrolled patients.

Print mailing labels to mail managed care materials to beneficiaries.

```
                          FAMILY BATCH ENROLLMENT LABELS

Enroll Status: ENROLLED
-------------------------------------------------------------------------------




-----------------------------------------------------------------------------------------------
Select to print labels by (U)nit, (L)ocation or (Q)uit:
```

Figure 5-74. Family Batch Enrollment Labels

Print labels by (U)nit, (L)ocation or (Q)uit

If you elect to generate labels by unit, you may select One, Multiple, or All units. If you elect to generate labels by location, you must enter a specific location for which to generate the labels. Location may be one or several ZIP codes or a geographic area, such as Tidewater.

Select (O)ne, (M)ultiple, (A)ll Unit ID Names

Select units with patients receiving labels.

1. You may select from the following search criteria to generate the patient labels:

   – patient category groups - you may select from patient statuses such as Active Duty, Retired, and so on

   – OHI - you may select patients with or without OHI

   – enrollment expiration date range - you may specify the specific date range

   – PCM - you may select one, multiple, or all PCMs.

2. Print labels by (D)uty Address or (H)ome Address or (Q)uit.

   Based on the search criteria entered, the system searches the Patient file and generates the appropriate patient labels. All patients that meet the specified search criteria are candidates to have a label generated. However, labels are generated only for patients who have complete address information.

3. Do you want to proceed with this report?No//

4. Recommended Start Time: NOW//

5.9.2.1.2 Family Batch Enrollment Labels Print Utility

Menu Path: PAS System Menu → MCP → EMCP → OENR → LABL → 2

Application Description:

The Family Batch Enrollment Labels Print Utility allows you to print family batch enrollment labels either in their entirety or in subsets.

Data Entry Process:

Print Family Batch Enrollment Labels:

Access the Family Batch Enrollment Labels Print Utility option on the Family Batch Enrollment Labels Menu **Select (O)ne or (A)ll user** **Select label batch** **(P)rint labels, (D)elete batch or, (V)iew Label Search Criteria** **Print a (S)ubset, (A)ll Labels, (T)est printer**

Access the Family Batch Enrollment Labels Print Utility option on the Family Batch Enrollment Labels Menu

You may search for a list of labels generated by one or all users. The system searches for these label batches and displays them on the Family Batch Enrollment Labels-Print Utility screen.

```
                  FAMILY BATCH ENROLLMENT LABELS - PRINT UTILITY

                                      Total       # Labels
   User                               Found       To Print      Date Generated
-------------------------------------------------------------------------------



---------------------------Print Queue is currently empty-----------------------
Select (O)ne, (A)ll users, or (Q)uit: Q//
```

Figure 5-75. Family Batch Enrollment Labels - Print Utility Screen

1. Search for labels generated by (O)ne, (A)ll users, or (Q)uit.
2. Press <Select> to select label batch.
3. Select (P)rint, (D)elete batch, (V)iew search Criteria, or (Q)uit.

   The system allows you to:

   – print a label batch - prints all labels, or a subset by specifying how many labels to print

   – delete a label batch

   – view search criteria - displays the search criteria used to generate the batch enrollment labels.

4. Select to print a (S)ubset, (A)ll Labels, (T)est printer, or (Q)uit.

   If Print is selected, the system allows you to print subsets for large print jobs in order to avoid printer jams.

5. Select DEVICE.
6. Quit the Family Batch Enrollment Labels Print Utility Screen.

5.9.2.1.3 Incomplete Patient Address Report

Menu Path: PAS System Menu → MCP → EMPC → OENR → LABL → 3

Contents:

The Incomplete Patient Address Report option allows you to print a listing of patients with incomplete address (home or duty) information. This report is generated when you or another user attempt to print MCP patient address labels, and patients with insufficient address information exist. The report lists any patient with an incomplete patient address: sponsor SSN, FMP/DDS, sponsor name, home telephone number, home address (if any), duty telephone number, and duty address (if any).

It is important to remember that more than one user may have been trying to generate patient labels based on different search criteria. As a result, more than one listing of incomplete patient addresses may have been produced.

Frequency/Use:

This report should be run each time patient labels are generated.

This report should be run to identify patients who require mailings in MCP but whose addresses need correction prior to label generation.

Special Instructions:

As addresses are corrected for beneficiaries on the report, the corrected beneficiaries will be removed from the report. The report will list only the remaining invalid or incomplete addresses. CHCS supports the separate printing of labels for the corrected addresses.

```
TIDEWATER MCP                                          27 Apr 1994@1532    Page 1
                  Personal Data - Privacy Act 1974 (PL-93-579)
                     INCOMPLETE PATIENT HOME ADDRESS REPORT

Address: HOME                                        Enroll Status: NONENROLLED
Unit ID: ALL
==============================================================================
Name                    FMP/SSN          DDS  Sponsor            Home Phone
   Patient Home Address                      PATCAT             Work Phone
                                             Rank               Duty Phone
==============================================================================
ANDREWS,JERRY           20/335-89-0112   20   ANDREWS,JERRY      (804) 223-4788
                                              USN ACTIVE DUTY
                                              LT                 (804) 442-2772
BASIL,GEORGE            20/447-09-9844   20   BASIL,GEORGE       (804) 899-6224
                                              USA ACTIVE DUTY
   PORTSMOUTH, VA 23711                       SGT                (804) 899-5176
ELKINS,RONALD           20/448-10-9887   20   ELKINS,RONALD      (804) 223-4788
   232 DROGHEDA ST                            USN ACTIVE DUTY    (804) 337-4778
   PORTSMOUTH, VA                             CAPT               (804) 442-2772
NOBEL,ROXANNE           20/387-22-6554   20   NOBEL,ROXANNE      (804) 224-4133
                                              USAF ACTIVE DUTY
   PORTSMOUTH, VA 23706                       LT                 (804) 442-2998
STANLEY,ROBERT          20/232-56-2776   20   STANLEY,ROBERT     (804) 224-9667
                                              USN ACTIVE DUTY
   PORTSMOUTH, VA 23708                       LT                 (804) 442-3876
WILSON,MICHAEL          20/565-35-2887   20   WILSON,MICHAEL     (804) 898-8995
                                              USA ACTIVE DUTY
   PORTSMOUTH, VA 23706                       CPT                (804) 442-4555

                                        Total Incomplete Home Addresses:      6
```

Figure 5-76. Incomplete Patient Address Report

5.9.2.2 Enrollment Rosters Menu (ROST)

```
                    INCOMPLETE PATIENT ADDRESS REPORT

-------------------------------------------------------------------------------




                         Print Queue is currently empty
Select (Q)uit:
```

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST

```
   1      AD Family Members by Unit Enrollment Roster

   2      Alphabetic Enrollment Roster by Service

   3      Case Management Program Enrollment Roster

   4      Change in Eligibility Enrollment Roster

   5      Disenrollees for Period by Reason Code
```

Figure 5-77. Enrollment Rosters Menu

Introduction

The Enrollment Rosters Menu options enable you to print rosters pertaining to patient enrollment. These rosters include current MCP enrolled dependents of active duty enrollees; active duty enrollees by division and branch of service; active duty enrollees with case management records by division, and exception providers with the division; active duty enrollees with pending change of eligibility status; disenrollees by reason code; and enrollees with defined exception conditions. These rosters are normally generated for a specified date range and for selected divisions.

For complete description of these reports, refer to each report below.

5.9.2.2.1 AD Family Members by Unit Enrollment Roster

Menu Path: PAS → MCP → OMCP → ERME → ROST → 1

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → ROST → 1

Contents:

The AD Family Member by Unit Enrollment Roster option enables you to print a list of all current MCP enrollees with a patient category status of "dependent of active duty." The report includes sponsor name, SSN, rank, family member name, FMP, DDS, DOB, and enrollment date. The report provides subtotals for the number of enrollees by family and Unit ID, and a grand total of all activated family members. The report is sorted by the sponsor's Unit ID and SSN.

This report lists, by unit of assignment, all family member enrollees whose active duty sponsor is assigned to that unit. The report will help identify TRICARE Prime family member enrollees who may move when their active duty sponsor's unit moves and a family member enrollee population profiled by sponsor unit. The user may select specific units for the report.

Frequency/Use:

This report should be run to analyze the enrollee population by sponsor duty stations and/or to determine the affect on family member PCM assignments when a unit is going to change locations. This is a large report and should be run infrequently.

```
WALTER REED AMC                                          21 Jun 2001@1513 Page 3
                  Personal Data - Privacy Act of 1974 (PL 93-579)
             ENROLLMENT ROSTER for ACTIVE DUTY FAMILY MEMBERS by UNIT
Division: DIV A - TRAINING HOSPITAL
Unit:  0121 FIGHTER          SQ
==============================================================================
Sponsor/                   Sponsor                                      Enrolled
  Family Members            FMP/SSN/Rank        FMP  DDS   DOB            Date
==============================================================================
PIGEON,ROBERT E             20/571-69-0000/CPT
---------------------------------------------
  PIGEON,DANA E                                 30         29 Dec 1961 19 Jun 2001

                                                       Family Member Total:      1
PARISH,STEPHEN J            20/571-69-4700/CPT
---------------------------------------------
  PARISH,LISA L                                 30         03 Jan 1960 19 Jun 2001

                                                       Family Member Total:      1
                                                                Unit Total:      2
```

Figure 5-78. Enrollment Roster for Active Duty Family Members by Unit

5.9.2.2.2 Alphabetic Enrollment Roster by Service

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 2

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → ROST → 2

Contents:

The Alphabetic Enrollment Roster by Service option enables you to print, in alphabetical order, a roster of enrollees by branch of service for selected division(s). The roster may be printed for One, Multiple, or All divisions; and within the selected division(s), by One, Multiple, or All branches of service. The user may select multiple UICs or multiple patient categories and may limit enrollments on the report for those whose enrollment start dates fall within a user defined period. Data provided includes name, FMP/SSN, DDS, DOB, PCM, sponsor, rank, home and work phone numbers, address, enrollment effective date, exception condition text, OHI status, patient category, and MCP status. All enrollments are included regardless of status; e.g., invalid, conditional and pending are also listed. Enrollees with an ACV of “D” are also listed.

Frequency/Use:

This report should be run to verify the current enrollees and their enrollment status.

This is a large report and should be run infrequently and only to verify the enrollees.

Special Instructions:

In CHCS version 4.5, the user may run this report daily to list and verify all the enrollments entered that day or for any date range. The report will print the status of each enrollment.

```
TRIPLER AMC, HI

22 Jan 1996@1517 Page 1

Personal Data - Privacy Act 1974 (PL 93-579}
ALPHABETIC ENROLLMENT ROSTER By SERVICE
From 16 Jan 1995 To 19 Jan 1996
Division TRICARE HCP
MARINE CORPS
==========================================================================
Name                FMP/SSN        DDS DOB          PCM                Spon
Home Phone  Effective Dates
Patient Address                OHI          Patient Category   Rank
Work Phone  MCP Status
==========================================================================
PALA,MINDY         31/800-82-0705   05 Jul 70 BANES,JOSEPH   CPL 390-1023
01 Feb 95 - 02 Jun 98
293854 Highway 67                     USMC FAM MBR AD            Enrolled
Escondido,CA 92026
PALA,PAUL       20/800-82-0705  12 Aug 72 ABBOT,JAMES    CPL 390-1023 01
Feb 95 - 02 Jun 98   293B54 Highway 67
Escondido,CA 92026


MARINB CORP Total:     2

                                                     Diviaion Total:    2
```

Figure 5-79. Alphabetic Enrollment Roster by Service Screen

5.9.2.2.3 Case Management Program Enrollment Roster

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 3

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → ROST → 3

Contents:

The Case Management Program Enrollment Roster option enables you to print an alphabetical list of all currently enrolled beneficiaries who have been identified as Case Management patients in the local MCP network. The report provides a subtotal for each exception provider in a specified division. Patient data provided includes name, FMP/SSN, DDS, DOB, sponsor rank, home and work phone numbers, address, enrollment effective date, exception condition text, OHI status, patient category, and MCP status.

Frequency/Use:

This report should be run as needed to obtain a list of all network case managers recorded in MCP who have enrollees assigned to them.

```
TIDEWATER

                                                                    13 Jan 2001@1517 Page 1

                        Peraonal Data - Privacy Act 1974 (PL 93-579}
                             CASE MANAGEMENT PROGRAM ENROLLMENT ROSTER
                               Exception Provider: ADAMSON,GEORGE V
        Division: AIR FORCE MTF DIVISION
==========================================================================================
Name              FMP/SSN      DDS    DOB    PCM            Spon Home Phone  Effective Dates
Patient Address    Condition Text    OHI       Patient Category  Rank Work Phone  MCP Status
==========================================================================================
ROBERTS,HAROLD 20/555-56-6555 09 Feb 50  THOMAS,DAVID   8329749273 23 Aug 00 - 07 Oct 01
  8847 XENIA AVE                              USAF ACTIVE DUTY              Enrolled
  HAMPTON,VA 23665
                     bleeding ulcer
```

Figure 5-80. Case Management Program Enrollment Roster

5.9.2.2.4 Change in Eligibility Enrollment Roster

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 4

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → ROST → 4

Contents:

This report lists, by division and by end of eligibility category, all enrollees projected to be approaching a change to their eligibility status. The end of eligibility criteria include enrollees approaching their 21st, 23rd, or 65th birthday, as well as enrollees approaching their end of eligibility date. Beneficiaries are listed alphabetically within each end of eligibility category. The report includes the total count of enrollees approaching a potential change in eligibility.

Frequency/Use:

This report should be run weekly to identify those beneficiaries whose original eligibility, at the time of enrollment, will soon change and whose enrollment entitlement may, therefore, change.

Special Instructions:

The user should disenroll a beneficiary from TRICARE on their birth date if they meet the end of eligibility criteria for age per the report. The user will use this report as follows:

– In releases prior to 4.5, the user should determine from this report which active duty members will be automatically disenrolled by CHCS because they have reached their end of enrollment date stored in CHCS. At the time of enrollment, the active duty member's end of eligibility date is stored on the CHCS enrollment record as the end of enrollment date. The end of enrollment date in CHCS will not be updated if the end of eligibility for an active duty member changes in DEERS. Until 4.5, the user must access the patient record in MCP and initiate an eligibility check for the beneficiary. This eligibility check will update the end enrollment date to the end of eligibility date from DEERS, preventing the active duty member from being prematurely disenrolled by CHCS on the wrong end enrollment date.

– In 4.5, CHCS will automatically verify the active duty end of eligibility date on the last day of the month prior to expiration and will correct the date to the new end date in DEERS. However, beneficiaries whose end of eligibility date is corrected after the end of the month will not be corrected. The user must still check for these beneficiaries.

– In 4.6, CHCS will verify the active duty end of eligibility date on the night the eligibility expires and will correct the date if a change has occurred. The active duty member will be disenrolled only if eligibility has expired according to the corrected date. The user will also be able to select enrollees by beneficiary category to print.

Please note that end eligibility dates in DEERS may not be current resulting in premature disenrollment of active duty. You should extend their end enrollment date 120 days to prevent inappropriate disenrollments.

```
TIDEWATER

                                                                    13 Apr 2001@1517 Page 1

                        Peraonal Data - Privacy Act 1974 (PL 93-579}
                              CHANGE IN ELIGIBILITY ENROLLMENT ROSTER
                                 FROM: 14 Apr 2000  TO: 14 Apr 2001
Division: A Division                        Eligibility Category: APPROACHING THE AGE OF 21
==========================================================================================
Name             FMP/SSN      DDS DOB        PCM            Spon Home Phone  Enrollment Date
Patient Address     Condition Text     OHI         Patient Category   Rank Work Phone  End
Eligibility Date
                                                Sponsor Name                      MCP Status
==========================================================================================
LONG,CHRISTY      02/654-32-1098    05 NOV 80   THOMAS,DAVID     Cpt  234-2344   02 Jun 00
  12343 LIBERTY RD                              USA FAM MBR AD                    02 Jun 01
  SAN DIEGO, CA 92121
```

Figure 5-81. Change in Eligibility Enrollment Roster

5.9.2.2.5 Disenrollees for Period by Reason Code

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 5

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → ROST → 5

Contents:

The Disenrollees for Period by Reason Code option enables you to print a report which lists by division, the individual enrollees whose disenrollment was entered into CHCS during the user specified date range. Patients are listed under their reason for disenrollment. The user has the option to print some or all of the disenrollment reasons and selected divisions. Reciprocal disenrollments of the local enrollees (by remote sites) are listed under the reason “RM - Remotely Disenrolled.”

Frequency/Use:

The report should be run weekly to select those reasons that indicate dissatisfaction with the program or a PCM. This report should be run as needed when disenrollment trends need to be analyzed by the site.

This report should be used to determine patient dissatisfaction with the program or PCM or to analyze trends and frequency in disenrollment. This report can be used to track the beneficiaries who are disenrolling. The report also identifies the category and numbers of the beneficiary who are disenrolling. Specific reasons may be of special interest to the MTF Commander, Lead Agent, or the Quality Assurance review.

Special Instructions:

Currently sites may define their own disenrollment reasons in addition to the standard values. In a future release, the site defined disenrollment reasons will no longer be accepted and only standard reasons will be used. Therefore, sites are urged to use the standard values initially as much as possible.

```
TIDEWATER

                                                                    13 Apr 2001@1517 Page 1

                        Peraonal Data - Privacy Act 1974 (PL 93-579}
                                 DISENROLLEES For PERIOD BY REASON
                                FROM: 14 Mar 2001  TO: 14 Apr 2001
        Division: A Division                                                Disenrollment
        Reason: EE ENROLLED IN ERROR
==========================================================================================
Name            FMP/SSN        DDS   DOB       PCM           Spon Home Phone   Disenrollment
Patient Address                         OHI        Patient Category  Rank Work Phone   Date
==========================================================================================
BLITON,KATHRYN       30/278-55-5025   30   09 Apr 69    THOMAS,DAVID      CPT  001535-7116
02 Apr 2001
  4376 Governor Drive                        OHI           USA FAM MBR AD
  Hampton,VA 23665

FARMER,FRANCINE      30/333-66-655    30   02 Sep 70    DEL CARMEN,GLEN R  MAJ  939209-3489
26 Mar 2001
  3322 Wynton Ave                                          USA FAM MBR AD
  Scranton,PA 21776

FARMER,FRANKLIN      20/333-66-6555   20   01 Jan 50    MADISON,MICHAEL   MAJ  619555-5555
12 Apr 2001
  1111 MISSION BLVD                                        USA ACTIVE DUTY
  San Diego, CA 92109

JAVENS,LAURIE        30/478-55-5045   30   09 Feb 53    PRIMARY CARE PNH  SGT  804-367-0093
20  Mar 2001
  11345 Sandy Dr                             OHI           US FAM MBR RET
  San Diego, CA 92124

                                                              Selected Reason Total:   4

                                                              Selected Division Total:  4
```

Figure 5-82. Disenrollees for Period By Reason Report

5.9.2.2.6 Enrollment Roster Exception Conditions

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 6

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → ROST → 6

Contents:

The Enrollment Roster Exception Conditions option enables you to print a report alphabetically listing enrollees, by exception provider with defined exception conditions. The report subtotals each provider specialty and exception provider, and totals all exception providers within the specified division.

Frequency/Use:

This report should be used as needed to assess the network case management load by specialty and by individual for enrollees only with MCP providers as case managers.

```
TIDEWATER

                                                                    24 May 2001@1517 Page 1

                       Peraonal Data - Privacy Act 1974 (PL 93-579}
                              ENROLLMENT ROSTER EXCEPTION CONDITIONS
                                FROM: 24 Apr 2000  TO: 24 May 2001
                           Exception Provider: ADAMSON,GEORGE V
        Diviaion: A Division
==========================================================================================
Specialty            FMP/SSN        DDS   DOP       Patient Category        Effective Dates
   Name                Condition Text                                              MCP Status
==========================================================================================
UROLOGIST
---------
  DANNY,PAT            20/111-11-1112        01 Jan 50  USA RET LOS OFFICER
30 Apr 00 - 07 Feb 01
                      Enlarged prostate                                          Enrolled

  LONG,CRISTY          02/64-32-1098         05 Nov 82  USA FAM MBR AD          10
Apr 00 - 08 Nov 01
                      Urinary infection                                          Enrolled

                                                                  Specialty Total:  2

                                                                   Provider Total:  2
```

Figure 5-83. Enrollment Roster Exception Conditions Report

5.9.2.2.7 Reciprocal Disenrollment by Reason Roster

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 7

Contents:

This report lists those beneficiaries who were reciprocally disenrolled from a remote site by a local CHCS user during the user specified date range. The report identifies each beneficiary, the losing site, and the reason for reciprocal disenrollment; i.e., whether the beneficiary was disenrolled because the beneficiary either was enrolling locally or elected TRICARE Standard rather than TRICARE Prime.

The disenrollments are not grouped by division at this time.

Frequency/Use:

This report should be run when reciprocal disenrollment trends and volumes need to be identified or when there is a question about a reciprocal disenrollment issued locally. This is a 132 column report that may be output to a line printer.

Note: The Disenrollees for Period by Reason Report option allows you to print all of the other disenrollment reasons, including Remotely Disenrolled (RM). Remotely Disenrolled are enrollees disenrolled in your system by another site.

```
TIDEWATER

                                                                    01 Apr 2001@1517 Page 1

                       Peraonal Data - Privacy Act 1974 (PL 93-579}
                                RECIPROCAL DISENROLLMENT BY REASON
                                FROM: 01 MAY 2001  TO: 04 May 2001
                            Exception Provider: ADAMSON,GEORGE V
        Division: A Division
==========================================================================================
RECIPROCAL DISENROLLMENT Reason         DOB         Losing       Facility  Gaining Facility
Patient Name          FMP/SSN                 DMIS ID       Enr Start Date   Enr Start Date
                  DDS                     Description    Enr End Date     Enr End Date   User
==========================================================================================
RECIPROCALLY ENROLLED/DISEROLLED
------------------------------------------------------------------------------------------
  ALLEN,JASON         01/555-33-3555  06 Nov 1970   6501          03 May 2000
02 May 2001  LEE,JUDY                          1
                                          TIDEWATER MCP  01 May 2001   31 May 2001

  ALLEN,VICTORIA      30/555-33-3555  11 Sep 1955   6501          02 May 2000
03 May 2001  LEE,JUDY
                  30                       TIDEWATER MCP 01 May 2001    31 May 2001

  BLACKWELL,GERALD D20/150-48-9565   02 Oct 1969  6501           02 May 2000
03 May 2001  FONG,MAY
                  20                       TIDEWTER MCP  01 May 2001    31 May 2001

  CLARK,PATRICK J     20/188-40-1205   03 Sep 1957  6501          26 May 2001
02 May 2001  WARD,JOHN
                  20                       TIDEWATER MCP 01 May 2001    31 May 2001

                                       RECIPROCALLY ENROLLED/DISENROLLED Subtotal:  4
                                                      TRICARE MANAGED CARE Total:   4
```

Figure 5-84. Reciprocal Disenrollment by Reason Roster

5.9.2.2.8 Reciprocal Disenrollment Discrepancy Report

Menu Path: PAS System Menu → MCP → OMCP → ERME → ROST → 8

Contents:

When DEERS notifies CHCS that a local CHCS enrollee has been disenrolled in DEERS by a remote site, CHCS must be able to disenroll this beneficiary to release the PCM and reflect the same enrollment status as DEERS. CHCS may be unable to locally disenroll the beneficiary as a result of some beneficiary data discrepancy, such as a patient identification changing since enrollment. If this happens, the beneficiary is listed on this spooled report with the disenrollment data sent from DEERS and the reason the disenrollment could not be completed.

Beneficiaries on this report are not currently grouped by division.

The Reciprocal Disenrollment Discrepancy Report option enables you to print a report containing the discrepancies "Patient Not Enrolled at Losing Facility" and "Patient Not Registered/Not Found at Losing Facility." A mail message is sent daily to the CPZ MGR mail group indicating whether or not discrepancies exist.

Frequency/Use:

You should consult this report to identify and correct any reciprocal disenrollments initiated by remote sites that have been received and rejected by CHCS. These discrepancies must be corrected to maintain synchronization of the CHCS and DEERS data.

Often you will need to check the patient's identification in DEERS, identify the patient name in CHCS, change the patient identification to its overall value at enrollment and disenroll the patient.

A mail message is sent daily to the CPZ MGR mail group indicating that discrepancies exist or do not exist. The user MUST print the report and make the necessary corrections.

Special Instructions:

This spooled report will be purged after 14 days. If the discrepancies are not corrected, the documentation on the discrepancies is lost. The beneficiary will remain incorrectly enrolled in CHCS even though no longer enrolled at the site according to DEERS. Making the corrections will ensure that the beneficiary PCM slot is freed in the local system and will help ensure that CHCS enrollment counts match those in DEERS.

Note: You should print the Disenrollees for Period by Reason Report to list the beneficiaries who were remotely disenrolled.

```
  Subj: RECIPROCAL DISENROLLMENT HAS COMPLETED
     Thu, 03 Nov 1996 14:50:01 11 Lines
From: POSTMASTER (Sender: GONZALES,MARION} in 'IN' basket.
-----------------------------Expires: 02 Feb 1995-----------------
Reciprocal Diaenrollment haa completed for 03 Nov 1996.

Beneficiaries have been identified as having discrepancies.

The following Reciprocal Disenrollment Discrepancy Report should
be generated so the discrepancies can be corrected: RECIP DISENROLL
03Nov96-1449

Action MUST be taken to update the Reciprocal Disenrollment
Discrepancy information.

This report MUST be Printed Within 14 Days Before Auto-Deletion!!

Select MESSAGE Action: IGNORE (in IN basket)//
```

Figure 5-85. Reciprocal Disenrollment Discrepancy Report (Page 1 of 2)

```
NMC PORTSMOUTH VA

                                                          03 Jun 2001@1517 Page 1

                      Peraonal Data - Privacy Act 1974 (PL 93-579}
                          RECIPROCAL DISENROLLMENT DISCREPANCY REPORT

        Spool Doc: RECIP DISENROLL 03Jun01-1449
==========================================================================================
Disenrollment Descrepancy Reason                    Gaining Facility         Losing Facility
Patient Name         FMP/SSN   DDS    DOB        DMIS ID  Description      DMIS ID  Description
==========================================================================================
PATIENT NOT ENROLLED AT LOSING FACILITY
----------------------------------------
  BIEGLER,EDWRD J      20/534-48-2444   31 Jul 1985   8888    TEST            6501
TIDEWATER MCP
```

Figure 5-86. Reciprocal Disenrollment Discrepancy Report (Page 2 or 2)

5.9.2.2.9 Track User Report

Menu Path: PAS System Menu→MCP→OMCP→ERME→ROST→9

Contents:

The Track User Report option enables you to print a report showing MCP enrollment records that have been originated, modified, or had the PCM

changed within a specified date range. This report displays the users that originated or modified an enrollment record, or changed the PCM for an enrollment record. This report may be printed for One, Multiple, or All divisions, and within divisions by One, Multiple, or All sponsor SSNs, Patient Category Groups, or Users.

```
        TRIPLER ARHY MEDICAL CENTER                                  23 Mar 1995@1306   Page 1
                                              Personal Data - Prlvacy Act 1974 {PL-93-579)
                                         TRACK USER REPORT by Family
                                     From: 01 Feb 1995 To: 28 Feb 1995
        Division: TRIPLER ARMY MEDICAL CENTER
        Sponsor SSN: 279-56-5025
==========================================================================================
Patient Name            FMP/SSN                DOB/AGE         PAT             Spon            DMIS
                                                               CAT             Rank            ID
==========================================================================================
JONES,WILLIAM H        01/279-56-5025          01 Jan 2001/4y    F41             CPT             6501

   Effective Dates: 01 NOv 1994 - 31 Oct 1995                           Date Enrolled: 31 Oct 1994
         MCP Status: ENROLLED                                               Enrolled by: DEB,SANDRA D
               ACV: E-NCP BNROLLED/DIR.CAR CHA                      Date Last Modified: 27 Peb 1995
       Direct Care: ELIGIBLE                                           Last Modified by: HONORS,JEFFREY
          Medicare: NOT ELIGIBLE                                   Date PCM Last Changed: 06 Apr 1995
      Current PCM:DEL CARMEN,RICHARD                                PCM Last Changed by: BEAN,BAR8ARA B

JONES,FREDERICK T      20/279-56-5025          10 Sep 1964/30Y   Fll             CPT             6501

  Effective Dates: 01 Feb 1995 - 31 Jan 1996                             Date Enrolled: 04 Feb 1995
       MCP Status: ENROLLED                                             Enrolled by: HOLLEY,CONSTANCE
              ACV: A-ACTIVE DUTY/MCP ENROLLED                       Date Last Modified: 17 Jan 1995
      Direct Care: ELIGIBLE                                          Last Modified by: THOMAS,JACXIE J
         Medicare: NOT ELIGIBLE                                   Date PCM Last Changed: 12 Jan 1995
      Current PCM: GONZALBZ,ROBERTO A                              PCM Last Changed by: THOMAS,JACKIE J

JONES,SAHANTNA Y       30/279-56-5025           11 Jun 1963/31Y   P31             CPT             6501

  Effective Dates: 01 Nov 1994 - 31 Oct 1995                          Date Enrolled: 31 Oct 1994
       MCP Status: ENROLLED                                                 Enrolled by: DOE,SANDRA D
              ACV: E-MCP ENROLLED/DIR. CARE CHA                     Date Last Modified: 03 Apr 1995
      Direct Care: ELIGIBLE                                           Last Modified by: HONORS,JEFFREY
          Medicare: NOT ELIGIBLE                                   Date PCM Last Changed: 11 Feb 1995
Current PCM: DEL CARMEN,RICHARD R                               PCM Last Changed by: BBAN,BARBARA B
```

Figure 5-87. Track User Report by Family

```
        TRIPLBR ARMY MEDICAL CENTER                                          23 Mar 1995@1306
Page 1
                         Peraonal Data - Prlvacy Act 1974 {PL-93-579)
                          TRACK USER REPORT by Patient Category Group
                               From: 01 Feb 1995 To: 28 Feb 1995
                           Division: TRIPLER ARMY MEDICAL CENTER
Patient Category Group: ACTIVE DUTY
==============================================================================================
Patient Name             FMP/SSN                 DOB/AGE         PAT       Spon         DMIS
                                                                 CAT       Rank
==============================================================================================
ABEL,CHARLES           20/501-84-0317          26 Nov 1981/23y   F11       CPT          6501


         Effective Dates: 01 Feb 1995 - 31 Jan 1996           Date Enrolled: 01 Feb 1995
              MCP Status: ENROLLED                              Enrolled by: DOE,SANDRA
                     ACV: A-ACTIVE DUTY/MCP BNROLLED     Date Last Modified: 03 Feb 1995
             Direct Care: ELIGIBLE                         Last Modified By: GARRISON,DEBORAH G
                Medicare: NOT ELIGIBLE                     Date PCM Changed: 03 Jan 1995
             Current PCM: MERCER,MICHAEL M              PCM Last Changed by: GARRISON,DEBORAH G

BLITON,CHARLES         20/266-32-4025          04 Sep 1960/35y   F11       1LT          6501

         Effective Dates: 01 Jun 1994 - 31 May 1995           Date Enrolled: 31 May 1995
              MCP Status: INVALID DISENROLLMENT                 Enrolled by: HOLLEY,CONSTANCE
                     ACV: A-ACTIVE DUTY/MCP BNROLLED     Date Last Modified: 11 Feb 1995
             Direct Care: ELIGIBLE                         Last Modified By: GARRISON,DEBORAH G
                Medicare: NOT ELIGIBLE                     Date PCM Changed: 19 Jul 1995
             Current PCM: GONZALEZ,ROBERTO A            PCM Last Changed by: HARRIS,KIMBERLEY

BROWN,LESTER L         20/400-87-5879          10 Oct 1965/29y   F11       SSG          6501

         Effective Dates: 01 Mar 1995 - 28 Feb 1996           Date Enrolled: 11 Feb 1995
              MCP Status: INVALID ENROLLMENT                    Enrolled by: HONORS,JEFFREY
                     ACV: A-ACTIVE DUTY/MCP BNROLLED     Date Last Modified: 11 Apr 1995
             Direct Care: ELIGIBLE                         Last Modified By: HONORS,JEFFREY
                Medicare: NOT ELIGIBLE                     Date PCM Changed: 16 Feb 1995
             Current PCM: BARRETT,THERESA A             PCM Last Changed by: GARRISON,DEBORAH G

MARSHALL,DEBBIE A       20/113-45-6726          18 Mar 1960/35y   F11       CPT          6501

         Effective Dates: 01 Mar 1995 - 28 Feb 1996           Date Enrolled: 22 Feb 1995
              MCP Status: ENROLLED                              Enrolled by: LEE,SANDRA
                     ACV: A-ACTIVE DUTY/MCP ENROLLED     Date Last Modified: 03 Apr 1995
             Direct Care: ELIGIBLE                         Last Modified By: HONORS,JEFFREY
                Medicare: NOT ELIGIBLE                     Date PCM Changed: 06 Apr 1995
             Current PCM: DEL CARMEN,RICHARD            PCM Last Changed by: JONES,JACKIE J
```

Figure 5-88. Track User Report by Patient Category Group

5.9.2.2.10 Enrollee Entitlement Discrepancy Report by Family

Menu Path: PAS System Menu→MCP→OMCP→ERME→ROST→10

Contents:

The Enrollee Entitlement Discrepancy Report option enables you to print a list of all enrollees with entitlement discrepancies.

You select the enrolling divisions for the report. You receive a message indicating that this is a complex report and asking if you wish to proceed.The report shows the original eligibility, the current eligibility, and the now invalid ACV frequency/use.

Entitlement discrepancies can occur when a beneficiary's entitlement changes after enrollment; e.g., active duty to retiree or retiree to Medicare. These enrollees should be disenrolled. Entitlement discrepancies are detected by CHCS whenever a beneficiary receives care and a DEERS eligibility check is performed. A potential active duty PCS will be reported for evaluation based on their currently assigned UIC in DEERS.

```
TRICARE SERVICE AREA (PORTSMOUTH)                                                                    20 Oct 1995@0804    Page 1
                                        Personal Data - Privacy Act 1974 (PL-93-579)
                                         ENROLLMENT ENTITLEMENT DISCREPANCY REPORT

Division: A DIVISION
Entitlement Discrepancy: NO LONGER DIRECT CARE ELIGIBLE
=================================================================================================================================
Name                        Sponsor SSN   FMP  DDS    DOB          Home Ph       Street Address          City         State  Zip
  Pat Cat                   DEERS Sponsor Status
                            Original Entitlement:     Direct Care       CHAMPUS            MEDICARE      ACV-Description
                            Current Entitlement:      Direct Care       CHAMPUS            MEDICARE      ACV-Description
=================================================================================================================================
ABBOTT,ALLEN                800-55-0101   20          01 Jan 1955  (619) 535-1234 10260 Campus Drive     San Diego     CA    92121
  USA ACTIVE DUTY OFFICER
                            Original Entitlement:     ELIGIBLE          NOT ELIGIBLE       NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLLED
                            Current Entitlement:      NOT ELIGIBLE

CAMPBELL,JANE               800-59-0210   20          02 Feb 1953  (619) 553-4321 55 Pacific Highway     San Diego     CA    92101
  USAF ACTIVE DUTY
                            Original Entitlement:     ELIGIBLE          NOT ELIGIBLE       NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLLED
                            Current Entitlement:      NOT ELIGIBLE

PROVIDER,DAVID              888-08-0008   20          05 Apr 1967  (619) 287-9876 1 Main Street          San Diego     CA    92117
  USA ACTIVE DUTY ENLISTE
                            Original Entitlement:     ELIGIBLE          NOT ELIGIBLE       NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLLED
                            Current Entitlement:      NOT ELIGIBLE

ROY,RANDY                   613-22-4444   20          15 May 1952  (619) 321-8765 9467 Hi Park Road      San Diego     CA    92037
  USN ACTIVE DUTY
                            Original Entitlement:     ELIGIBLE          NOT ELIGIBLE       NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLLED
                            Current Entitlement:      NOT ELIGIBLE

                                                                  Total for NO LONGER DIRECT CARE ELIGIBLE: 4
```

Figure 5-89. Enrollee Entitlement Discrepancy Report (Page 1 of 2)

```
TRICARE SERVICE AREA (PORTSMOUTH)                                                    20 Oct 1995@0804    Page 2
                                   Personal Data - Privacy Act 1974 (PL-93-579)
                                    ENROLLMENT ENTITLEMENT DISCREPANCY REPORT

Division: A DIVISION (continued)
Entitlement Discrepancy: SPONSOR RETIRED
=================================================================================================================
Name                     Sponsor SSN   FMP  DDS    DOB          Home Ph       Street Address          City         State  Zip
  Pat Cat                DEERS Sponsor Status
                         Original Entitlement:     Direct Care       CHAMPUS            MEDICARE      ACV-Description
                         Current Entitlement:      Direct Care       CHAMPUS            MEDICARE      ACV-Description
=================================================================================================================
ALLEN,THOMAS             359-55-5025   01   1     01 Jan 1945  (619) 522-7293 6745 Clairement Mesa   San Diego     CA    92120
  A41 USA FAM MBR AD     Retired
                         Original Entitlement:     ELIGIBLE          ELIGIBLE           NOT ELIGIBLE  E-ENROLLED/DIR. CARE CHA
                         Current Entitlement:      ELIGIBLE          CHAMPUS ELIGIBLE   NOT ELIGIBLE  E-ENROLLED/DIR. CARE CHA

CARLTON,CHARLENE         098-78-5432   30   20    31 Mar 1962  (619) 734-5748 456 Mercer Avenue      San Diego     CA    92122
  F11 USAF Active Duty   Retired
                         Original Entitlement:     ELIGIBLE          NOT ELIGIBLE       NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLL
                         Current Entitlement:      ELIGIBLE          CHAMPUS ELIGIBLE   NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLL

MILLER,CHARLES L         587-66-3165   20   20    22 Jun 1942  (619) 354-9467 4853 Ruffin Road       San Diego     CA    92123
  F11 USAF Active Duty   Retired
                         Original Entitlement:     ELIGIBLE          NOT ELIGIBLE       NOT ELIGIBLE  A-ACTIVE DUTY/MCP ENROLL
                         Current Entitlement:      ELIGIBLE          CHAMPUS ELIGIBLE   NOT ELIGIBLE  E-MCP ENROLLED/DIR. CARE CHA

                                                                                                  Total for SPONSOR RETIRED: 3
                                                                                                      Total for A DIVISION:  7
                                                                                         Total for Selected Division(s):  7
```

Figure 5-89. Enrollee Entitlement Discrepancy Report (Page 2 of 2)

5.9.2.3 Enrollment Summaries Menu (SUMM)

Menu Path: PAS System Menu → MCP → OMCP→ ERME → SUMM

```
1      Disenrollment Summary by Reason

2      Enrollment Summary Report

3      OHI Enrollment Summary
```

Figure 5-90. Enrollment Summaries Menu Screen

Application Description:

The Enrollment Summaries Menu options enable you to generate summary enrollment and disenrollment reports. The disenrollment report shows totals by disenrollment reason within each selected division. The enrollment summary reports show totals by selected categories, such as OHI, patient category status, and PCM.

5.9.2.3.1 Disenrollment Summary by Reason

Menu Path: PAS System Menu → MCP → OMCP → ERME → SUMM → 1

Alternate Menu Path: PAS → MAN → EMCP → OENR → ERPM → SUMM → 1

Contents:

The Disenrollment Summary by Reason option enables you to print a report summarizing the number of disenrollees for a specified date range. The report contains a subcount of disenrollees for each reason code, a subtotal for each division, and a grand total for all disenrollees within the specified date range and the specified divisions.

Frequency/Use:

This report should be run as needed to select those reasons that indicate dissatisfaction with the TRICARE program or a PCM. In addition, this report should be run when the site needs to determine disenrollment trends on a monthly or quarterly basis for selected reasons.

```
TIDEWATER                                        24 Oct 1996@1146 Page 1
DISENROLLMENT SUMMARY by REASON
From: 24 Sep 1995 To: 24 Oct 1996
Division: A DIVISION
=================================================================
  Reason Code       Disenrollment Reason                       Total
=================================================================
  EC                ENROLLMENT CANCELED                            3
  EE                ENROLLED IN ERROR                              2
  PN               PROVIDER PREF NOT IN PLAN                       1
_________________________________________________________________
                                          Division Total: 6
```

Figure 5-91. Disenrollment Summary By Reason Report

5.9.2.3.2 Enrollment Summary Report (SUMM)

Menu Path: PAS System Menu → MCP → OMCP → ERME → SUMM → 2

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → SUMM → 2

The Enrollment Summary Report option enables you to print a two-part summary report.

Part I: By Patient Category

Contents:

This section shows, by enrolling division and user specified date range, the total enrollments broken out by beneficiary category (active duty, dependent of active duty, retired, dependent of retired, and other). Sub-totals are also provided by rank: E1-E4, E5-E9, W1-W4, O1-O10. Consolidated totals are printed for all divisions selected for the report. The counts include all pending, conditional, and invalid enrollments that fall in the report date range.

The column totals contain counts as follows:

#Enrollments - the total number of first-time enrollments entered in CHCS during the reporting period.

#Re-enrolls - the total number of enrollments for beneficiaries who were previously enrolled then disenrolled then re-enrolled in this CHCS system.

#Families - the number of new families who enrolled during the report period. A family may be a retiree with no dependents, a dependent only, or a single family with several dependents. Reenrollments are not counted in this total.

#Count Appts - primary care and specialty care appointments that are made for enrollees to direct care providers. These appointments are counted as workload.

#Non-Count - primary care and specialty appointments that are made for enrollees to civilian providers. These appointments are not counted as workload.

Total Enrollees - the total number of active duty and non-active duty enrollees in TRICARE Prime as of the last date of the report.

#Disenrolls - the number of disenrollments entered during the reporting period. If a beneficiary is disenrolled twice during the report period, both disenrollments are counted. If the beneficiary was enrolled before the report period then is disenrolled during the report period, that disenrollment is also counted.

#Admissions - the number of admissions for enrollees to a direct care inpatient facility in CHCS during the report period. If an enrollee is admitted twice during the report period with different register numbers, both admissions are counted.

Frequency/Use:

This report should be run whenever enrollment totals need to be reconciled to ensure that all enrollments are being recorded in CHCS and to match totals by beneficiary category in DEERS.

Special Instructions:

Active duty enrollee counts in CHCS should match the active duty enrollee counts in DEERS after conditional, pending, and invalid enrollments are subtracted. The consolidated counts of non-active duty will not match the total

enrollees in DEERS if the contractor is enrolling some of the non-active duty beneficiaries through their system. The totals on this report should be verified, by division, against totals on other reports run for the same date range (i.e., usually with a "To" date of today) as follows:

Compare: Total for Category on the Enrollment Summary Report (Summary by Category).

To: Beneficiary Category Total (active duty, retiree, etc.) on the Patient Category Enrollment Summary (by Patient Category).

Compare: Total for Category (active duty, retiree, etc.) on the Enrollment Summary Report (Summary by Category).

To: Total (by Category) on the Patient Category Enrollment Summary Report (Category by Service).

Compare: #Disenrolls (for the division) on the Enrollment Summary Report.

To: Division Total on the Disenrollment Summary by Reason Report.

Compare: Consolidated totals for active duty (less invalid, pending, and conditional enrollments) on the Enrollment Summary Report.

To: Total enrollments for active duty on the DEERS Enrollment Report.

Compare: Total for Category (for each beneficiary category) on the Enrollment Summary Report (Summary by Category).

To: Number of Enrollees by Patient Type (for each beneficiary category) on the Available PCM Capacity Report (by PCM).

Note: All CHAMPUS eligibles must be added together in order to match.

Compare: Total for Category (for active duty, CHAMPUS, and other) on the Enrollment Summary Report (Summary by Category).

To: Total by ACV (ACV = “A” for active duty; ACV = “E” for CHAMPUS eligible; ACV = “D” for Medicare and direct care only) on the DEERS Enrollment Figures.

Note: On the DEERS report, for a DMIS ID, add all totals for ACV = “E” to get total TRICARE Prime enrollees (CHAMPUS eligibles). DEERS totals do not include conditional, pending, or invalid enrollments. The DEERS report totals enrollees by their ACV while CHCS totals enrollees by their current patient category.

Part II: By PCM

Contents:

The second part of the report contains the same information and selection capabilities as the first part, but totals are reported by PCM. Refer to Section I for a description of the contents of each column on the report. Consolidated totals are also printed for all divisions selected for the report. Pending, conditional, and invalid enrollments are counted.

Frequency/Use:

This report should be run whenever enrollment totals need to be reconciled to ensure that all enrollments are being recorded in CHCS and to verify PCM assignment volumes.

Special Instructions:

Active duty enrollee counts in CHCS should match the active duty counts in DEERS by DMIS ID after invalid, pending and conditional enrollments are subtracted from the CHCS totals. Consolidated totals for non-active duty should also match by DMIS ID after invalid, pending and conditional enrollments are subtracted from the CHCS totals. The totals on this report should be verified, by division, against totals on other reports run for the same date range (i.e., usually with a "To" date of the first of the coming month to capture all pending enrollments) as follows:

Compare: Total Enrollees by Agreement Type (for each PCM) on the Enrollment Summary Report (Summary by PCM).

To: Number of Enrollees by Agreement Type on the Available PCM Capacity Report (for each PCM)

Note: Pending, conditional, and invalid enrollments are counted in the Enrollment Summary reports and in the Available PCM Capacity report. The totals should match if the reports cover the same time period; i.e., with an end date of the first of the coming month (to capture enrollees from next month).

TIDEWATER MCP 26 Mar 1994@1059 Page 3

ENROLLMENT SUMMARY REPORT

*** Section 1: Enrollment Summary by Category ***

From: Feb 1994 To: Feb 1994

Enrolling Division: Consolidated Grand Total for All Divisions

Category/ Sponsor Rank	#Enrollments / Total Enrollees	#Re-Enrolls / #Disenrolls	#Families / #Admissions	#Count Appts / #Non-Count
ACTIVE DUTY				
E1 - E4	2972	324	N/A	1194
	12778	26	24	1058
E5 - E9	1526	0	N/A	2386
	11068	14	112	1527
W1 - W4	21	18	N/A	400
	3604	4	0	157
O1 - O10	1060	44	N/A	4117
	4767	34	226	336
Total for Category:	5579	386	N/A	8097
	32217	78	362	3078
FAM MBR OF ACTIVE DUTY				
E1 - E4	4240	34	703	2168
	19590	82	186	399
E5 - E9	401	4	148	4068
	2030	18	166	206
W1 - W4	12	11	4	412
	850	1	3	86
O1 - O10	794	4	230	3199
	5004	96	196	90
Total for Category:	5447	53	1085	9847
	27474	197	551	781
RETIRED	51	1	8	3570
	152	6	152	796
FAM MBR OF RETIRED	12631	108	238	8101
	29378	374	54	16926
OTHER	180	0	30	705
	446	4	24	43

Figure 5-92. Enrollment Summary Report

5.9.2.3.3 OHI Enrollment Summary (SUMM)

Menu Path: PAS System Menu → MCP → OMCP → ERME → SUMM → 3

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → SUMM → 3

Contents:

The OHI Enrollment Summary option enables you to print a report listing the number of current enrollees who have active policies with other health insurance companies. An enrollee covered by multiple policies is reported for each insurance company. The report sorts alphabetically by insurance company name. Insurance Carriers with the most policies are listed before those with fewer policies.

Frequency/Use:

This report may be run as needed and may be used by TPC or by the TSC contractor to determine the number of enrollees with Other Health Insurance policies as well as the most widely subscribed Insurance Carriers.

```
TIDEWATER                                        20 Sep 199600905 Page 1
      OTHER HEALTH INSURANCE ENROLLMENT SUMMARY
=================================================================
Short Name        Insurance Company Name                       Total
=================================================================

A M LIFE CO.      A M LIFE CO.1
AAA LIFE INS      AAA LIFE INSURANCE CORP.                       2
AARP GROUP INS    AARP GROUP HEALTH INSURANCE PR                 1
ABAG BENEFITS     ABAG BENEFITS TRUST PC HEALTH                  1
ACADIAN LIFE      ACADIAN LIFE INSURANCE CO                      1

-----------------------------------------------------------------
                             Selected OHI Enrollees Total:    6
```

Figure 5-93. OHI Enrollment Summary Report

5.9.2.3.4 Patient Category Enrollment Summary

Menu Path: PAS System Menu → MCP → OMCP → ERME → SUMM → 4

Alternative Menu Path: PAS → MAN → EMCP → OENR → ERPM → SUMM → 4

Contents:

This report shows, by division, the total current enrollees as of the report run date grouped either by patient category, (e.g, A11, A14, N11, A41, A31, F43) or by service affiliation. Sub-totals by beneficiary category are included. The beneficiary categories are active duty, family member of active duty, retired, family member of retired, and other. The counts included pending, conditional, and invalid enrollments.

Frequency/Use:

The site should print this report as needed to determine the distribution of enrollees by service and by beneficiary category/patient category. This report can be used to identify the existence of beneficiaries who were enrolled in error or whose patient categories have changed since enrollment; i.e., who now appear in the Other category or in an invalid patient category such as a civilian category.

Special Instructions:

Refer to the Enrollment Summary Report description for guidance on reconciliation of report totals for this report. All reports must cover the same time period in order to be reconciled.

The DEERS Report computes total enrollees by their ACV while CHCS totals enrollees by their current patient category. This difference in the two systems may account for some of the discrepancies in counts by beneficiary category.

In addition, if a patient category changes in CHCS, the Available PCM Capacity report totals will not match the totals on this report. This occurs because the Available PCM Capacity totals represent the patient category of the beneficiary at enrollment, not the current patient category.

```
TIDEWATER                                        20 Sep 199691312 Page 1
     PATIENT CATEGORY ENROLLMENT SUMMARY
                  **** ENROLLEE TOTALS By PATIENT CATEGORY ****
Division: A DIVISION
=================================================================
Patient Category                                        Enrollee Total
=================================================================
Active Duty
-----------

           All   USA ACTIVE DUTY                          10
           A14   USMA CADET                                1
           B11   NOAA ACTIVE DUTY                          1
           Fll   USAF ACTIVE DUTY                          1
           N11   USN ACTIVE DUTY                           3 3
                                      Active Duty Total: 16

Fam Mbr Of Active Duty
----------------------
 A41  USA FAM MBR AD                                          10
           F41   USAF FAM MBR AD                                 2
           N41   USN FAM MBR AD                                  1
                                  Fam Mbr Of Active Duty Total:    13
Retired
-------
           A31   USA RET Los ENLISTED                            3
                                            Retired Total:    3

Fam Mbr Of Retired
------------------
           F43    USAF FAM MBR RET                               1
                                     Fam Mbr Of Retired Total:

Other
-----
           B48     NOAA UNREMARRIED FORM SPOUSE 2
                                                 Other Total:      2
-----------------------------------------------------------------
                                                 Division Total:35
```

Figure 5-94. Patient Category Enrollment Summary Report (Enrollee Totals by Patient Category)

```
TIDEWATER                                          20 Sep 199601312 Page
PATIENT CATEGORY ENROLLMENT SUMMARY
                     **** PATIENT CATEGORY By SERVICE ****
Division: A DIVISION
==============================================================================
Patient Category Enrollment Summary
==============================================================================

SERVICE   ACTIVE DUTY  FAM MBR AD   RETIREE    RET FAM MBR   OTHER TOTAL

AIR FORCE      1            20         0           0              3
ARMY          11             10         3           10              25
NAVY3          3              1         0            0               4
OTHER1         1              0         0            2               3
TOTAL         16             31         3           12              35
```

Figure 5-95. Patient Category Enrollment Summary Report (Patient Category by Service)

5.9.3 PCM Reports Menu

```
    1   Available PCM Capacity by Provider Group
    2   Enrollment Roster by PCM
    3   PCM Activity Report
    4   PCM Assignment Change Roster by Reason
    5   PCM Assignment Change Summary
    6   Default PCM/UIC Report
    7   PCM Enrollment Mix Discrepancy Statistical Summary
    8   PCM Enrollment Mix Discrepancy Report

Select PCM Report Menu Option:
```

5.9.3.1 Available PCM Capacity by Provider Group

Menu Path: EMCP → OENR → PRPM → 1
OMCP → PRPT → 1

Contents:

This report lists, for each PCM group and PCM group member, the maximum capacity, patient load, and remaining capacity for each of the PCM's agreements and for each type of patient (active duty, active duty family member, retiree, retiree family member, and other) supported by the agreement. The report

counts include conditional, pending, and invalid enrollments. The totals represent the total number of enrollees assigned to the PCM at report run time.

Use:

This report should be run to determine the patient load for a PCM and the distribution of enrollees by beneficiary category. This report can be used to predict when a PCM is approaching capacity or has additional room to receive more enrollees. The report also shows the group capacity and the relationship of the members' capacities to the group.

Frequency:

This report should be printed for each provider added or updated or to verify current PCM capacities.

Special Instructions:

The Enrollment Roster by PCM can be used to verify the totals on this report.

The patient load totals reflect the patient type (active duty, active duty family member, retiree, retiree family member, or other) at the time the patient is enrolled and should be consistent with the DEERS totals by ACV; if the patient's type has changed since enrollment, this report may not agree with the totals on other CHCS reports that total by the patient's current type. The enrollment totals on this report will always differ from the total enrollee counts in DEERS by the total of all the conditional, pending (future), and invalid enrollments in CHCS. DEERS counts only valid current enrollments.

TIDEWATER

29 Sep 1993@1041 Page 1

AVAILABLE PCM CAPACITY By PROVIDER GROUP

Provider Group / PCM / Agreement Type / Patient Type	Agreement Start/End Dates	Maximum Patient Capacity	Number of Enrollees By Agreement Type	Number of Enrollees By Patient Type	Remaining Capacity
CARDIOLOGY PNH					
MTF MTF STAFF	07 May 1993 - 07 May 1996	500	1		499 (a)
MCA MCP/ACTIVE DUTY		200			
MCP MCP/CHAMPUS ELIGIBLE				1	
Group Total:		500	1		499
CARDIOLOGY PNH					
MTF MTF STAFF	07 May 1993 - 07 May 1996	500			499 (b)
Provider Total:		500	0		499

(a) REMAINING CAPACITY can be distributed over ALL Patient Types LINKED/COVERED by that Agreement Type.
(b) Individual Provider Capacity may be LIMITED by the OVERALL Maximum Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned to Other PCMs within the PROVIDER GROUP.
(c) Group/Providers do NOT include UNLIMITED (UNL) capacities.

Figure 5-96. Available PCM Capacity by Provider Group

5.9.3.2 Enrollment Roster by PCM

Menu Path: EMCP → OENR → PRPM → 2
OMCP → PRPT → 2

Contents:

This report lists, by division, all the PCMs that have current TRICARE Prime enrollees assigned to the division. The enrollees assigned to each PCM are listed under the PCM's name. A PCM will appear in each division where their enrollees are assigned. All enrollees are listed including those with a pending (future), conditional, and invalid status. The user may select specific PCMs or divisions to print. The report provides a enrollee subtotal for each PCM.

Use:

This report should be run as follows: (1) when there is a problem with PCM assignments, (2) to verify actual assignments to each PCM at the beneficiary level against the totals printed on the Available PCM Capacity report, (3) to identify the actual enrollees assigned to a PCM. This report should be run specifically to perform the following:

- verify individual enrollee PCM assignments
- verify beneficiary PCM assignments following a Batch PCM Reassignment
- verify that enrollees assigned to a PCM are also assigned to the correct division
- forward a list of enrollees to each PCM
- determine the MCP enrollment status of each enrollee assigned to the PCM
- compare enrollee counts with the Available PCM Capacity Report for a PCM.

Frequency:

As needed.

```
TRIPLER AMC, HI                                                                                    08 Jul 1993@1403     Page 1
                                   Personal Data - Privacy Act 1974 (PL 93-579)
                                              ENROLLMENT ROSTER By PCM
                                         Provider Group: THACKER PROVIDER GROUP
Division: A DIVISION
=================================================================================================================================
PCM
   Name                        FMP/SSN        DDA   DOB                                  Spon   Home Phone         Effective Dates
     Patient Address                                 OHI       Patient Category          Rank   Work Phone         MCP Status
=================================================================================================================================
PIERCE,MATTHEW
--------------
   BRADY,GREG                  01/234-23-4234        01 Jan 82                           CAPT   405-555-3455       26 May 93 - 26 May 98
     2304 Main St.                                             USA FAM MBR AD                    405-555-4321       Enrolled
     Los Angeles, CA 91000

SCOTT,MATTHEW
-------------
   MORRISON,MICHAEL            20/234-23-4117        14 Jul 65                           CAPT                      17 May 93 - 17 May 98
     18 Elm Avenue                                             USA ACTIVE DUTY                   213-555-6677       Enrolled
     St. Louis, MO  43211

                                                                                                                Division Total: 2
```

Figure 5-97. Enrollment Roster by PCM

5.9.3.3 PCM Activity Report

Refer to Section 6.4.3.4., page 141, for description and sample PCM Activity Report.

5.9.3.4 PCM Assignment Change Roster by Reason

Menu Path: EMCP → OENR → PRPM → 4
OMCP → PRPT → 4

Contents:

This report lists, by PCM reassignment reason and by losing PCM, each enrollee who has been reassigned to a new PCM within a user specified date range. Invalid, conditional, and pending enrollments are included. Totals are provided for all beneficiaries and for each change reason.

Use:

The site may use this report to identify those PCMs who are losing patients due to patient dissatisfaction or for reasons that may be an alert to the Quality Assurance review. Trends in reassignment preference and in reassignment volume may also be assessed with this report as well as the patients involved in the reassignment.

Frequency:

This report should be printed whenever PCM performance and reassignment frequency and volumes need to be analyzed at the provider detail level.

TIDEWATER 01 Oct 1993@1606 Page 1

PCM ASSIGNMENT CHANGE ROSTER by REASON
Personal Data - Privacy Act 1974 (PL-93-579)
From: 23 Jun 1993 To: 01 Oct 1993
REASON: DE DATE ASSIGNED IN ERROR

Provider Changed From / Enrollee Name	FMP/SSN	DDS	Spon Rank	Patient Category / MCP Status	Provider Changed To	Assign Date / Change Date
BLONDELL,AMY						
BLITON,KATHRYN	30/278-55-5025	30	COL	USA FAM MBR AD Enrolled	EAKLE,THOMAS K	01 Oct 93 01 Oct 93
JAVENS,KAITLYN	01/478-55-5045	1	SFC	USA FAM MBR RET Enrolled	DOBLES,WILLIAM	01 Oct 93 01 Oct 93
					Losing PCM Total:	2
CRAWFORD NEUROLOGY						
CRAWFORD,JOE	20/554-27-7243		ENS	USN ACTIVE DUTY Enrolled	CRAWFORD NEUROLOGY	14 Jul 93 14 Jul 93
CRAWFORD,JACQUI						
CRAWFORD,JIM	20/551-27-7242		LT	USN ACTIVE DUTY Enrolled	EMERSON,JACK	01 Jul 93 01 Jul 93
EDDY,JESSICA	01/112-27-7242		ENS	USN FAM MBR AD Enrolled	ALEXANDER,STEPHEN	29 Jun 93 29 Jun 93
JAVENS,KAITLYN	01/478-55-5045	1	SFC	USA FAM MBR RET Enrolled	DOBLES,WILLIAM	01 Oct 93 01 Oct 93
					Losing PCM Total:	3
DOBLES,WILLIAM						
JAVENS,KAITLYN	01/478-55-5045	1	SFC	USA FAM MBR RET Enrolled	DOBLES,WILLIAM	01 Oct 93 01 Oct 93
MADISON,MICHAEL						
BLITON,JERALD	20/278-55-5025	20	COL	USA ACTIVE DUTY Enrolled	RICKET,SAM	23 Sep 93 03 Oct 93
BOWKS,AMANDA	03/577-08-7015	3	SGT	USAF FAM MBR AD Disenrolled	BULLINGER,ERIC	21 Sep 93 21 Sep 93
					Losing PCM Total:	2
OLIVER,SAMUEL						
ROBERTS,HAROLD	20/555-66-6555	20	COL	USAF ACTIVE DUTY Enrolled	DEL CARMEN,GLEN R	19 Aug 93 19 Aug 93

Figure 5-98. PCM Assignment Change Roster by Reason

5.9.3.5 PCM Assignment Change Summary

Menu Path: EMCP → OENR → PRPM → 5

Contents:

This report prints, by losing PCM and for a user specified date range, the number of enrollees who have been reassigned to a new PCM and the reason for the change. Invalid, pending, and conditional enrollments are included in the counts. Totals are provided by change reason and by division.

Use:

This report may be used to identify, at a summary level, PCM reassignment activity, the reasons for reassignment, and the PCMs who are losing patients frequently and may present a Quality Assurance issue. Positive and negative trends in reassignment preference and in reassignment volume may also be assessed with this report.

Frequency:

This report should be printed whenever PCM performance and reassignment trends need to be analyzed at a summary level.

Special Instructions:

This report should be analyzed in combination with the Disenrollment Summary by Reason to determine when there is dissatisfaction with the TRICARE program.

```
TIDEWATER                                                  29 Sep 1993@1349    Page 1
                        ASSIGNMENT CHANGE SUMMARY For PCM
                       From: 21 Jun 1993      To: 29 Oct 1993
                           Previous PCM: CARDIOLOGY PNH
=========================================================================
   Assignment Change Reason                                        Enrollees
=========================================================================
   PM     PATIENT MOVED                                                  1
   DI     PROVIDER DIED                                                  2


                                                  Previous PCM Total:    3
```

Figure 5-99. PCM Assignment Change Summary

5.9.3.6 Default PCM/UIC Report

Menu Path: PAS → MAN → EMCP → OENR → PRPM → 6

Contents:

This option produces a report that shows the association between UICs and default PCMs. The report lists UIC, Unit Name, PCM, Provider Group, Agreement, and Start and End Dates. Default PCMs are only valid for active duty enrollments to MCP. The report can be sorted by UIC or by Default PCM.

Use:

Maps PCMs to UICs.

Frequency:

As needed.

```
MCP DIVISION                                          02 Feb 199501506    Page 1
                  Personal Data - Privacy Act 1974 (PL-93-579)
                            Default PCM/UIC Report
                            *** Sorted by UIC ***

================================================================================
  UIC          Unit Name
     PCM                     Provider Group        Agr    Start Date    Stop Date
================================================================================
  11101        1ST MARINES
    ARGENTINIA,ALEXANDER  SAIC INTERNAL          CON    1 Oct 1993    30 Sep 1994

  FF414        USS AQUILA
    BAHAMAS,BARBARA       SAIC INTERNAL          CON    1 Aug 1993    30 Jul 1994

  FF356        USS ARIES
    BAHAMAS,BARBARA       SAIC INTERNAL          CON    1 Aug 1993    30 Jul 1994

  LE1CF602     1912 COMMUNICATIONS GP
    ARGENTINA,ALEXANDER   SAIC INTERNAL          CON    1 Oct 1993    30 Sep 1994

================================================================================
** Indicates UIC code has been inactivated.
```

Figure 5-100. Default PCM/UIC Report

5.9.3.7 PCM Enrollment Mix Discrepancy Statistical Summary

Menu Path: PAS → MAN → EMCP → OENR → PRPM → 7

Contents:

This report lists PCM Beneficiary Categories that have discrepancies. The discrepancies are identified with an asterisk or flag ("Y"). This report identifies patient loads that include beneficiaries whose ages are outside the PCM's age range preferences, or if the PCM Beneficiary Category Capacity is lower than the current assigned patients. The report lists the Provider Group, Agreement Type, Agreement Dates, Maximum Patient Capacity, Age Range to Apply Overall, Total Assigned, and the PCM Beneficiary Category, Age Range, Capacity, and Patients out of Age Range.

Use:

Identifies two potential problems in the way patients are being assigned to PCMs: 1) when enrolled beneficiaries are outside the PCM's accepted age range, and 2) when number of enrollees exceeds the PCM's capacity.

Frequency:

As needed.

TRIPLER ARMY MEDICAL CENTER 24 Oct 1995@1440 Page 1

Personal Data - Privacy Act 1974 (PL-93-579)

PCM ENROLLMENT MIX DISCREPANCY STATISTICAL SUMMARY
by Provider group

Provider Group: WOLLIN GROUP PCM CAPACITY

Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996
Group PCM: YES

Maximum Patient Capacity: 30 Age Range to Apply Overall: 1 - 2
Total Assigned: 17

PCM Beneficiary Category	Age Range	Capacity	Total Assigned	Pat out of Age Range
ACTIVE DUTY	1 - 2			
ACTIVE DUTY FAMILY MEMBER	1 - 2	30	11	8
RETIREE	1 - 2	0		
RETIREE FAMILY MEMBER	1 - 2	0		
OTHER	1 - 2	0	6 *	2

THE FOLLOWING INDIVIDUAL PROVIDERS WITHIN THIS GROUP HAVE EITHER CAPACITY OR AGE RANGE DISCREPANCIES AS INDICATED:

Figure 5-101. PCM Enrollment Mix Discrepancy Statistical Summary Report

```
       Provider: WOLLIN,MAGDALENA
 Agreement Type: NON - NON-NETWORK/EXCEPTION
Agreement Dates: 29 Aug 1995 - 28 Aug 1996

Maximum Patient Capacity:    18        Age Range to Apply Overall: 16 -   '
          Total Assigned:    17
==========================================================================
                                                   Total    Pat out of
PCM Beneficiary Category      Age Range     Capacity     Assigned   Age Range
--------------------------------------------------------------------------
ACTIVE DUTY                     16  -                0
ACTIVE DUTY FAMILY MEMBER       16  -                          11          8
RETIREE                         16  -
RETIREE FAMILY MEMBER           16  -
OTHER                           16  -                0          6 *        2
==========================================================================
```

(*) indicates # of beneficiaries Assigned is greater than Capacity

Figure 5-101. PCM Enrollment Mix Discrepancy Statistical SummaryReport (continued)

5.9.3.8 PCM Enrollment Mix Discrepancy Report

Menu Path: PAS → MAN → EMCP → OENR → PRPM → 8

Contents:

This report includes the statistics from the PCM Enrollment Mix Discrepancy Summary Report and the names of the individual beneficiaries who are currently assigned to PCMs in categories where the number of assigned beneficiaries exceed the PCM's capacity for that category, or whose age is outside the PCM's age range preference. The report lists the DMIS ID, sponsor SSN/FMP, beneficiary name, PATCAT, sponsor rank, age, home and duty zip codes, home phone number, date assigned, and reason, and indicates if there is a case manager. The user may choose to sort the report by PCM, by MCP Provider Group, or by Beneficiary.

Use:

Identifies two potential problems in the way patients are being assigned to PCMs: 1) when enrolled beneficiaries are outside the PCM's accepted age range, and 2) when number of enrollees exceeds the PCM's capacity.

Frequency:

As needed.

PORTSMOUTH NH 15 Jun 1995@1530 Page 1

Personal Data - Privacy Act 1974 (PL-93-579)
PCM ENROLLMENT MIX DISCREPANCY REPORT
by PCM

PCM: BENJAMIN,ARTHUR

Provider Group: DE ANZA PEDIATRIC GROUP
Agreement Type: CON - CONTRACT
Agreement Dates: 01 Jan 1995 - 31 Dec 1995

Maximum Patient Capacity: 100
Total Assigned: 82
Age Range to Apply Overall: -

PCM Beneficiary Category	Age Range	Capacity	Total Assigned	Pat Out of Age Range
ACTIVE DUTY		0		
ACTIVE DUTY FAMILY MEMBER	0 - 18	75	82*	Y
RETIREE		0		
RETIREE FAMILY MEMBER	0 - 16	25		
OTHER		0		

(*) indicates # of beneficiaries Assigned is greater than Capacity

PCM Beneficiary Category: ACTIVE DUTY FAMILY MEMBER

DMIS ID	Spon SSN	FMP	Beneficiary Name	Pat Cat	Spon Rank	Case Mgmt	Age	Home Zip	Duty Zip	Home Phone	Date Assigned	Reason
1384	213-76-4345/02		JACKSON,ADRIANNE	K84	AO3	N	13	92029	92121	619-567-9876	15 Dec 1994	EX
1384	213-76-4345/03		JACKSON,THOMAS	K84	AO3	N	8	92029	92121	619-567-9876	16 Feb 1995	EX
1384	213-76-4345/04		JACKSON,WINDSOR	K84	AO3	N	4	92029	92121	619-567-9876	16 Feb 1995	EX
1384	213-76-4345/05		JACKSON,ZELDA	K84	AO3	N	03M	92029	92121	619-567-9876	22 May 1995	EX
3002	111-75-9620/02		ABLE,JOHN	K84	NE5	N	17	92134	92122	619-345-2534	8 Apr 1995	EX
3002	138-83-6549/02		SMITH,ALEXIA	K84	AO5	Y	19	92211	92121	619-999-3353	3 Jan 1995	EX/AX
6214	111-57-8533/04		MIDLER,NANCY	K84	FE5	N	5	92117	92121	619-863-5545	30 May 1995	EX
6214	140-57-8533/02		RODRIQUEZ,HECTOR	K84	FE5	N	18	92117	92121	619-863-5545	4 Oct 1994	EX
6214	140-57-8533/03		RODRIQUEZ,TERRANCE	K84	FE5	N	15	92117	92121	619-863-5545	4 Oct 1994	EX
6214	164-75-9620/02		GEARY,CONNIE	K84	AE2	N	3	92323	92121	619-567-4343	17 Mar 1995	EX

... [etc. There would be 82 names altogether, if the list were complete.]

Active Duty Family Members assigned to this PCM = 82
Active Duty Family Members assigned to this PCM in excess of capacity (EX) = 7
Active Duty Family Members assigned to this PCM who are out-of-age-range (AX) = 14
Total beneficiaries assigned to this PCM = 82
Total beneficiaries assigned to this PCM in excess of capacity (EX) = 3
Total beneficiaries assigned to this PCM who are out-of-age-range (AX) = 14

Figure 5-102. PCM Enrollment Mix Discrepancy Report

5.9.4 MCP Enrollment Form (MEFM)

Menu Path: PAS System Menu → EMCP → OENR → MEFM

Contents:

The MCP Enrollment Form option allows you to print an MCP enrollment form for a specified MCP patient. This form includes the enrollment date and ending eligibility/enrollment date; patient name, and identifying data; sponsor name and identifying data; PCM and place of care data; insurance company and policy data; and case management involvement.

The form additionally displays a site-definable eligibility, benefits, and responsibility statement for the patient; an area for the patient's signature and date of signing; and an area to indicate the record room for the patient.

Frequency/Use:

Refer to Figure 6-78. Managed Care Enrollment Form, page 6-134.

5.9.5 Address Label for Patient (APAL)

Menu Path: PAS System Menu → MCP → EMCP → OENR → APAL

Application Description:

The Address Label for Patient option allows you to print an address label for one or more patients.

Frequency/Use:

When necessary.

Refer to Figure 6-79. Patient Address Label, page 6-135.

5.10 Batch PCM Assignment/Reassignment of Enrollees

Introduction

Application Description:

The Batch PCM Reassignment options allow you to reassign a group of enrollees to a new PCM without having to do individual reassignments.The Batch PCM Reassignment option allows you to reassign patients using the following methods:

Reassign All - Reassign all the patients assigned to the current PCM to a new gaining PCM.

By Beneficiary Category - Reassign a group of enrollees of the same beneficiary category from the current PCM to a new gaining PCM. You can reassign only one beneficiary category or many beneficiary categories at the same time.

By UIC - Reassign a group of active-duty enrollees with the same Station/Unit from the current PCM to a new gaining PCM. You can reassign only one valid UIC type at a time. You cannot change the UIC with this option.

Family - Reassign a family or selected members of a family to a new PCM

Multiple PCMs - Reassign patients assigned to the current PCM to more than one PCM within the same provider group. Reassignments proceed until the first PCMs capacity is full, then to the second PCM until capacity is full, then to the third PCM, etc.

In addition, a variety of reports are generated as a result of the batch PCM reassignment/process:

> Enrollee/Patient Assignment Notification - Generated for each patient who is reassigned using the Batch PCM Reassignment option. The notice, which can be folded and placed in a window envelope, informs the patient of the reassignment and includes directions and other information about the new PCM's place of care.
>
> Provider Notification Roster - Lists all patients that have been reassigned to a PCM using the Batch PCM Reassignment option since a specified date. A cover letter can also be generated to include the PCM's payment address and the MCP office that generated the roster. This may be mailed to the gaining and losing PCMs as notification of the change.
>
> PCM Reassignment Report - A three-part report that lists the results of a Batch PCM Assignment action:
>
> > Part I lists the patients who have been reassigned.
> >
> > Part II lists any patients who were not successfully reassigned.
> >
> > Part III lists any appointment with the prior PCM that are scheduled for the patients listed in Part I.

5.10.1 Batch PCM Reassignment (BPCM)

Menu Path: PAS System Menu → MAN → BMCP → BPCM

Security Keys:

CPZ PCM BATCH

Required Fields:

Current PCM
PCM Agreement
Specialty
Location
Agreement Type *
Gaining PCM
Assignment Reason

* Required if selected as search criteria.

Application Description:

The Batch PCM Reassignment option allows you to reassign the patients of one PCM to one or more other PCMs. You may enter the name of the current PCM and select the appropriate agreement for that PCM. You may select subsets of patients to reassign by Patient Type, or by UIC for active duty only. The system then prompts you either to assign a gaining PCM who meets certain search criteria, to choose one or more gaining PCMs from a list of all PCMs in the current PCM's provider group, or to transfer patients from one place of care to another for the same provider. During the PCM reassignment process, you may view the gaining PCM's Assignment Preferences and/or Place of Care information.

You may also reassign active duty enrollees from one PCM to another based on the enrollee's UIC. Upon entry of a given UIC code, the system displays the names of all PCMs who have active duty enrollees with that UIC code. You may override the default and specify another gaining PCM. A PCM assignment change reason shall be recorded.

Following a reassignment, the system generates a mail message informing appropriate personnel of the completion of reassignment and then creates and stores a PCM Reassignment Report to be printed at a later time.

Batch PCM Reassignment does not change the enrolling division if the new PCM practices in another location. The user must make this change for each

enrollee in the Enrollment module. The user will select each PCM and reassign their enrollees to a new PCM.

Data Entry Processing:

Reassign a patient's PCM to another PCM:

Access the Batch PCM Reassignment option on the Batch PCM Reassignment Menu

Select (C)urrent PCM or (U)IC

If current PCM, select PCM agreement

Select (B)enficiary Category

Select the desired search criteria for change. (Specialty, Location and Agreement Type)

Select Gaining PCM

Assign New PCM

Access the Batch PCM Reassignment option on the Batch PCM Reassignment Menu.

```
                              BATCH PCM REASSIGNMENT
      Current PCM:                                Gaining PCM:
   Provider Group:                             Provider Group:
    PCM Agreement:                       Gaining PCM Agreement:
 Total Enrollees:                   Total Available Capacity:
      Active Duty:                                  Location:
 AD Family Member:                                Specialty:
          Retiree:                     Beneficiary Categories:
RET Family Member:                                       UIC:
            Other:
-------------------------------------------------------------------------------




-----------------------------------------------------------------------------------------------
Select (C)urrent PCM, (U)IC, or (Q)uit: C//
```

Figure 5-103. Batch PCM Reassignment

1. Select (C)urrent PCM at the action bar.

2. Enter the Current PCM Name.

   If the current PCM belongs to more than one provider group. the system displays a list of the provider groups with the *Select PCM PROVIDER GROUP* prompt. Enter the number identifying the correct provider group and press <Return>.

Select the PCM Agreement

The Select window displays all provider agreements with PCM exceptions. You select which agreement to process. Only one agreement can be processed at a time.

The PCM agreement you select displays in the Display window on the left side. Also displayed is the number of patients (by beneficiary category) currently assigned.

The beneficiary categories are those that define MCP-enrolled status:

Active Duty
Retired
Retiree Family member
Other
Active Duty Family Member

```
                              BATCH PCM REASSIGNMENT
      Current PCM: ALVAREZ,GILBERT M           Gaining PCM:
   Provider Group: FAM PRAC MTF             Provider Group:
    PCM Agreement:                    Gaining PCM Agreement:
  Total Enrollees:                Total Available Capacity:
      Active Duty:                                Location:
 AD Family Member:                               Specialty:
          Retiree:                  Beneficiary Categories:
RET Family Member:                                     UIC:
            Other:
-------------------------------------------------------------------------------
                      Total      ADY       AFM       RET       RFM       OTH
   Agr     Disc        Cur       Cur       Cur       Cur       Cur       Cur

   MTF     MTF           4         3         1


Use SELECT key to select PCM agreement for Reassignment or
Press <RETURN> to continue
```

Figure 5-104. Batch PCM Reassignment Screen

1. Position cursor next to PCM agreement and press <Select>.

Select the Beneficiary Category

The Select window displays all beneficiary categories that apply to the enrollees currently assigned to the current PCM. For example, if patients with the beneficiary categories ADY and AD Family Member are assigned to the current PCM, then only those types display.

The beneficiary categories you select appear in the Display window. Search by beneficiary category to find a valid PCM agreement with a sufficient capacity to accommodate all patients of the beneficiary category selected. You may select one or multiple beneficiary categories for reassignment from the current PCM. Multiple beneficiary categories may limit the resulting PCM picklist.

Select the Change Search Criteria action on the Batch PCM Reassignment screen action bar

```
                          BATCH PCM SEARCH CRITERIA
      Current PCM: ALVAREZ,GILBERT M           Gaining PCM:
   Provider Group: FAM PRAC MTF             Provider Group:
    PCM Agreement: MTF               Gaining PCM Agreement:
  Total Enrollees: 4              Total Available Capacity:
      Active Duty: 3                              Location:
 AD Family Member: 1                             Specialty:
          Retiree:                  Beneficiary Categories: ADY
RET Family Member:                                     UIC:
            Other:

   Specialty
   Location
   Agreement Type
   Default Search Criteria


                      Specialty and Location are Required
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 5-105. Batch PCM Search Criteria Screen

Select the set of desired search criteria for change

1. Specialty

2. Location

   This is the location by ZIP code(s) in which to search for the Gaining PCM. Enter one or more ZIP codes consisting of 3 to 5 digits. The system searches for locations using the 3rd, 4th, or 5th digits. You may enter up to five ZIP codes in this field. Separate each ZIP code by a comma.

   You may also enter the name of a ZIP code combination instead of entering separate ZIP codes. A ZIP code combination is the identifier defined in the ZIP Code Combination file. It lists a logical grouping of ZIP codes. For example, the ZIP code combination DC AREA would include all the ZIP codes for the Washington, D.C. area.

3. Agreement Type

   This searches for a gaining PCM by agreement type. If an agreement type is not specified, the system searches for a gaining PCM with any PCM agreement, regardless of its type.

The message “Searching...” displays while the system searches for the appropriate PCMs.

For each PCM displayed, the system displays if a provider has multiple specialities and multiple places of care. If so, the provider will be listed multiple times, once for each combination.

Certification Specialty (CS) - Indicates the level of Board Certification the provider holds for this specialty. Valid codes are:

Blank	Not Certified
E	Board Eligible
BO	Board Certified
NA	National Certification

Provider Category (Cat) - Indicates the professional level of the provider, for example, MD = Physician, NP = Nurse Practitioner, PA=Physician Assistant, etc.

Provider Specialty (Specialty)

Agreement Type (Agr)

Location (Locat) - Individual ZIP code of the PCM’s Place of Care.

Provider Gender (Sex)

Overall Discount Rate (Disc)

Total Available PCM Capacity (Avail) - Indicates the total available patient capacity for the provider.

Providers are listed in two groups. MTF providers are listed first and external providers next. Within these groups, providers are listed by discount rates, in order of largest to smallest. Finally, within each set of rates, the order is by ZIP code. In the Disc column, MTF providers are designated by “MTF” instead of by an actual discount percentage value.

PCM Screening:

The total available PCM capacity must be sufficient to accommodate the patients being reassigned from the current PCM. The system does not display PCMs with insufficient capacity to accept the patients. They also may not display due to inactive agreements, search criteria, if the other provider’s agreement plan does not accept the patient type, or the other provider is not specified as a PCM.

```
                              BATCH PCM REASSIGNMENT
      Current PCM: ALVAREZ,GILBERT M           Gaining PCM:
   Provider Group: FAM PRAC MTF             Provider Group:
    PCM Agreement: MTF               Gaining PCM Agreement:
  Total Enrollees: 4              Total Available Capacity:
      Active Duty: 3                             Location: ARLINGTON
 AD Family Member: 1                            Specialty: FAMILY PRACTICE/PRIM
          Retiree:                  Beneficiary Categories: ADY
RET Family Member:                                    UIC:
            Other:
-------------------------------------------------------------------------------
   Provider               CS Cat   Specialty        Agr Locat Sex Disc    Avail
-------------------------------------------------------------------------------
   ARRIBA,GILBERT M       E  MD    FAMILY PRACTICE  MTF 20301  M  MTF       496
   BEALE,SHARON M         B  MD    FAMILY PRACTICE  MTF 20301  F  MTF       496
   CRAWFORD,KYLE M           NPC   PRIMARY CARE NUR MTF 20301  M  MTF       497
   DELL,ALICE M              MD    FAMILY PRACTICE  MTF 20301  F  MTF       500
   EDROZO,FRANK M            NPC   PRIMARY CARE NUR MTF 20301  M  MTF       499

-------------------------------------------------------------------------------
Use SELECT key to select gaining PCM to be assigned
Press F9 key to view Assignment Preferences, Place of Care, or Watch Codes
```

Figure 5-106. Batch PCM Reassignment Screen

In some cases, the gaining PCM may have a total available PCM capacity that is less than the current PCM's number of total enrollees. This is acceptable as long as the gaining PCM as sufficient capacity both overall and in the designated beneficiary category to accommodate all patients (by beneficiary category) previously selected for reassignment.

1. Select the Gaining PCM.

   If you select a provider with an agreement type that differs from that of the current PCM, the message - This is a change in Agreement Type. Continue with Reassignment? No// - displays. You may confirm the selection and continue, or choose not to continue and return to the provider list to make another selection.

   Similarly, if you select a provider with an overall discount rate that differs from that of the current PCM, the message - This is a change in Discount Rate. Continue with Reassignment? No// - displays. Confirm the change or exit the reassignment process.

2. Confirm the PCM assignment.

3. Change Assignment Reason.

4. After entering a reason, the reassignment process is sent to TaskMan to be processed as time permits.

5. The request is processed and the system displays the Batch PCM Reassignment Menu.

6. After the reassignment process completes, you receive a bulletin indicating the completed reassignment. The bulletin is also sent to the mail group BATCH PCM.

   Refer to Section 2.4, File Table and Building and Maintenance for information concerning mail bulletins. This section describes the menu path, business rules, and specific bulletins associated with mail bulletins.

Note: You should also run the PCM Reassignment Report to:

– Ensure that no discrepancies were found during the reassignment process.

– Check if any appointments with the prior PCM should be canceled and rescheduled with the gaining PCM.

5.10.2 Family PCM Reassignment

Menu Path: PAS System Menu → MAN → BMCP → FPCM

Required Fields:

Patient Name
Specialty
Location
Desired Gaining PCM
Assignment Reason
Report Family Appointment action.

Application Description:

The Family PCM Reassignment option allows you to reassign all or some of the enrolled members of a family to a new PCM. You enter the name of the patient, and specify which members of the patient's family are to be reassigned. You may assign a new PCM directly, or specify search criteria, and select the new PCM from the list of those who meet the search criteria. If reassigned family members have appointments booked with their prior PCM, a report of those appointments are generated.

Data Entry Process:

Reassign family members to a new Primary Care Manager (PCM):

Access the Family PCM Reassignment option on the Batch PCM Reassignment Menu

Select Patient Name

Select family members for reassignment

Select search criteria for change (Specialty, Location)

Select the desired gaining PCM

The user must select the Patient action to begin.

Access the Family PCM Reassignment option on the Batch PCM Reassignment Menu.

```
                              FAMILY PCM REASSIGNMENT
        Patient:                                  FMP/SSN:
      Specialty:                                      DDS:
       Location:                              Gaining PCM:
 Agreement Type:                           Provider Group:
-------------------------------------------------------------------------------



-------------------------------------------------------------------------------
Select (P)atient, or (Q)uit: P//
```

Figure 5-107. Family PCM Reassignment Screen

Select Patient Name

1. Enter patient name.
2. Confirm the patient name.

The Demographics Display screen displays.

1. Press <Return>.

   The system displays the Family PCM Reassignment Screen.

```
                              DEMOGRAPHICS DISPLAY
                  Name: PLAYER,SCOTT E               FMP/SSN: 20/572-69-4719
      Patient Category: USAF ACTIVE DUTY                 DDS:
          Patient Type: MCP/ACTIVE DUTY                   Sex: MALE
            MCP Status: ENROLLED                     DOB/Age: 07 Oct 1969/31Y
                   ACV: A-ACTIVE DUTY/MCP ENROLLED   DMIS ID: 0037
           Direct Care: ELIGIBLE                    Medicare:

          Sponsor Name: PLAYER,SCOTT E                   Rank: AIRMAN
          Station/Unit: 0009 AIR POSTAL         SQ        DSN:
          Home Address: 728 NORTH STAR RD
                  City: MC LEAN                        State: VIRGINIA
               ZIP Code: 22101                     Home Phone: 703-555-9739
            Duty Phone: 202-555-4567              Work Phone: 202-555-4567
 Registration Comment:
Last Registration Date: 09 Sep 1999@1621
Outpatient Record Room: OUTPATIENT RECORDS
       MCP Enroll Date: 20 Jun 2001          End Enroll Date: 10 Feb 2003
 Primary Care Manager: CHUNG,KYLE M               PCM Phone: 202 271-5850
           Primary OHI: NOT ASSIGNED               Case Mgmt: NO

Select (F)ull, (M)ini, (N)ew Patient, (C)ontinue, or (Q)uit DEMOGRAPHICS: C//
```

Figure 5-108. Demographics Display Screen

The Display window at the top of the screen displays the following fields:

Demographic Data

Patient
FMP/SSN
DDS - DEERS Dependent Suffix

Search Criteria

Specialty - Provider specialty required
Location - Preferred Provider Location
Agreement Type - Provider Agreement Type

Gaining PCM Criteria

Gaining PCM
Provider Group - Gaining PCM group

The Select window in the middle of the screen displays all family members associated with your patient. For each family member, the list also displays:

FMP/SSN
Current PCM

Enrollment Status - The valid enrollment statuses are:

C Conditional
IE Invalid Enrollment
E Enrolled
D Disenrolled
ID Invalid Disenrollment

Not Enrolled.

```
                              FAMILY PCM REASSIGNMENT
         Patient: PLAYER,SCOTT E                  FMP/SSN: 20/572-69-4719
       Specialty:                                     DDS:
        Location:                                Gaining PCM:
 Agreement Type:                            Provider Group:
-------------------------------------------------------------------------------
   Family Member                     FMP/SSN         Current PCM      Enr Status

   PLAYER,STEVEN E                   01/572-69-4719  CHUNG,KYLE M            E
   PLAYER,SCOTT E                    20/572-69-4719  CHUNG,KYLE M            E
   PLAYER,SARAH E                    30/572-69-4719  CHUNG,KYLE M            E
-----------------------------------------------------------------------------------------
Use SELECT key to select family members
```

Figure 5-109. Family PCM Reassignment

1. Select all family members for reassignment

2. Select the Reassign Family PCM action

Select the Change Search Criteria action

The following search parameters are listed in the Select window:

Specialty
Location
Agreement Type
Default Search Criteria

A specialty and location are required.

Select search criteria for new PCM

The following search parameters are available.

1. Specialty

2. Location

   This is the location by ZIP code(s) in which to search for the gaining PCM. Enter one or more ZIP codes consisting of 3 to 5 digits. You may enter up to five ZIP codes at this prompt. Separate each ZIP code by a comma.

   You may also enter the name of a ZIP code combination instead of entering separate ZIP codes.

Select the Search PCM action

After all the selected search criteria have been entered, the Family PCM Reassignment screen is displayed. The Search PCM action has been added to the PCM action bar.

1. Press <Return> to accept the Search PCM action. The Family PCM Reassignment screen displays.

   The Select window in the middle of the screen displays a list of the PCMs who meet the search criteria specified. For each Provider, the list also displays the following information:

   Certification Specialty (CS) - Indicates the level of Board Certification the provider holds for this specialty. Valid codes are:

   Blank Not Certified

   E Board Eligible

BO Board Certified

NA National Certification

Provider Specialty (Specialty)

Agreement Type (Agr)

Overall Discount Rate (Disc)

Total Available PCM Capacity (Avail) - Indicates the total available patient capacity for the provider. The system ensures that each PCM has sufficient capacity for the selected family members.

MTF providers display first, followed by providers listed in order of largest to smallest overall discount rate. MTF providers are designated by “MTF” displayed in the Discount field, instead of an actual discount percentage value.

1. Select the desired gaining PCM.

2. Select Assignment Reason.

   The reason abbreviation, GR, indicates that the patient is dissatisfied or has a grievance with the current PCM. An assignment reason must exist in the Assignment Reason file to be valid. You may enter additional assignment reasons to the Assignment Reason file by accessing the PCM Assignment Reason Enter/Edit (PCMA) option.

   After entering a reason, the reassignment process begins. The system displays the name of each reassigned patient at the bottom of the screen and informs you when the reassignment process is complete.

3. After the reassignment completes, the system checks each reassigned family member for pending appointments with the prior PCM. If pending appointments exist, the Report Family Appointments action displays. This report lists any pending appointments with the prior PCM that may need to be rescheduled with the gaining PCM. Select the Report Family Appt action.

4. Select DEVICE.

   The Family Appointments with a prior PCM screen displays. The report lists all family members that have prior primary care appointments with the losing PCM.

```
                Personal Data - Privacy Act of 1974 (PL 93-579)          Page 1
                      FAMILY APPOINTMENTS WITH A PRIOR PCM
Sponsor:  PLAYER,SCOTT E                                  Family SSN: 572-69-4719
==============================================================================
       New PCM: FONTANA,LUISA M                           Agreement Type: MTF
Provider Group: FAM PRAC MTF                               Discount Rate: 0
------------------------------------------------------------------------------
Patient                          FMP  Home Phone            Appt Date/Time
                                      Work Phone            Provider
==============================================================================

PLAYER,SARAH E                   30   H: 703-555-9739       10 Jul 2001@0800
                                      W:                    CHUNG,KYLE M

PLAYER,SCOTT E                   20   H: 703-555-9739       10 Jul 2001@0800
                                      W: 202-555-4567       CHUNG,KYLE M

PLAYER,STEVEN E                  01   H: 703-555-9739       10 Jul 2001@0830
                                      W:                    CHUNG,KYLE M


Press <RETURN> to continue
```

Figure 5-110. Family Appointments with a Prior PCM Screen

5.10.3 Active Duty Enrollee UIC Maintenance Report

Menu Path: BMCP → APCM → URPT

PART I

Contents:

This report shows, by enrolling division, those active duty beneficiaries whose unit of assignment has changed. The report shows the following for comparison:

- the former unit name and the patient's current PCM
- the new unit name and the PCM who is currently assigned to that unit.

Frequency/Use:

This report should be run at least weekly. This report should be used to identify those active duty beneficiaries whose PCM may need to be changed due to a change in unit assignment or because they left the area.

Special Instructions:

If an active duty member's unit of assignment has changed to a new unit in the area, their PCM may need to be changed also (if PCMs are assigned locally according to unit of assignment). If the PCM is changed, a corrected enrollment ID card should be issued by the user with the new PCM name.

On the other hand a new unit of assignment may indicate that the beneficiary has moved to another area. If so, the beneficiary will need to be monitored by the user. The user must determine (according to Service policy) whether a reciprocal disenrollment is issued by the gaining site within a reasonable time so that the local PCM slot is freed up. Policy must be developed locally by the sites on the procedures to follow if the gaining site does not issue a reciprocal disrenrollment within a reasonable amount of time.

PART II

Contents:

The second part of this report lists beneficiaries with UICs that are not standard values in the UIC table. These beneficiaries could have left the area and may need to be disenrolled.

Frequency/Use:

See above guidance in Part I for frequency. This report should be used to identify those active duty beneficiares with an invaled or non-standard UIC.

Special Instructions:

Refer to correction procedures in Part I above. The active duty member's UIC may need to be corrected to a standard value if the correct value is available in the CHCS UIC table. If the UIC is a correct value but is not in the table, a customer support call should be initiated to request that that value be included in the UIC table in the future.

```
NMC  PORTSMOUTH VA                                        09 Mar 1994@1451    Page 1
                      ACTIVE DUTY ENROLLEE/UIC MAINTENANCE REPORT
                  Part 1:  Active Duty Enrollees with a Change in UIC Code
Enrolling Division: MCDONALD (EUSTIS)
================================================================================
Name                                          Old UIC
   FMP/SSN             Current PCM                     Agr  Specialty
   New UIC             Default PCM                     Agr  Avail AD Capacity
--------------------------------------------------------------------------------
BAILEY,HAROLD                                 1912 COMMUNICATION
 20/359-46-8955        FAMILY PRACTICE LAFB            MTF  FAMILY PRACTICE P
 1 TFS                 FLIGHT MEDICINE LAFB            MTF       UNL

DE BLASIO,MICHAEL                             1 CRS
 20/234-50-5467        MERCER,MICHAEL                  MTF  INTERNIST
 1 MED                 DEL CARMEN,RICHARD              MTF       376

EISCHING,ELAINE B                             1EMS
 20/432-44-5487        FAMILY PRACTICE LAFB            MTF  FAMILY PRACTICE P
 1 CRS                 HARRIS,SCOTT                    MTF        0

--------------------------------------------------------------------------------
Footnote: Enrolle records have been updated with a new UIC code. The user must
determine if a change in PCM is appropriate.
```

Figure 5-111. Active Duty Enrollee/UIC Maintenance Report (Page 1 of 2)

```
NMC  PORTSMOUTH VA                                        09 Mar 1994@1451    Page 2
                      ACTIVE DUTY ENROLLEE/UIC MAINTENANCE REPORT
                  Part 2:  Active Duty Enrollees with invalid UIC Codes
Enrolling Division: MCDONALD (EUSTIS)
================================================================================
   FMP/SSN             Name                        UIC Code
--------------------------------------------------------------------------------
 20/234-54-7465        SANTOS,MERVIN               Langley
 20/432-44-3645        TJERNAGEL,STEVEN A          1st Medical
```

Figure 5-104. Active Duty Enrollee/UIC Maintenance Report (Page 2 of 2)

CHCS: MCP DESKTOP USER GUIDE

6. MANAGING MCP PATIENT APPOINTMENTS

Brief Outline

6.1 The Health Care Finder Menu (HMCP) 6-2
6.1.1 PCM Booking (PHCF) 6-3
6.1.2 Non-Enrolled Booking (NHCF). 6-32
6.1.3 Appointment Referral Booking (AHCF). 6-43
6.1.3.1 Enter an Appointment Referral for an Enrolled Patient 6-45
6.1.3.2 Find a Provider. 6-58
6.1.3.3 Print appointment referral products. 6-101
6.1.3.3.1 Print the Care Authorization Form. 6-103
6.1.4 Enter Appointment Refusals (EHCF) 6-106
6.2 Display Patient Appointments (DMCP) 6-117
6.3 Cancellation By Patient (CMCP). 6-121
6.4 Health Care Finder Output Products And Reports 6-131
6.4.1 Output Products (OHCF) 6-131
6.4.1.1 MCP Enrollment Form 6-131
6.4.2 Print Patient Address Label (LHCF) 6-135
6.4.3 Health Care Finder Reports Menu (RHCF). 6-136
6.4.3.1 Agreement Type Referral Summary 6-136
6.4.3.2 Specialty Type Referral Summary 6-137
6.4.3.3 Provider Network List 6-139
6.4.3.4 PCM Activity Report 6-141
6.4.3.5 Provider Patient Workload Report 6-146
6.4.3.6 Refused Appointments Report. 6-149

Introduction

Managing MCP Patient Appointments covers the options used to book primary care appointments and specialty care for both enrolled and non-enrolled patients. This section also explains how to display or print a patient's appointments, document a patient's refusal of an appointment, and how to cancel an appointment at a patient's request. How to generate appointment referral products; i.e., enrollment forms, membership ID, and patient labels, is also explained and samples of the output products are included. All the reports listed on the Health Care Finder Menu are explained and samples of each are included.

6.1 The Health Care Finder Menu (HMCP)

Menu Path: PAS System Menu → MAN → HMCP

Security Keys:

CPZ CCP
CPZ OHI*
CPZ CASE**
CPZ NAS***

* Only needed by users who will be entering other health insurance.
** Only needed by users who will be booking case management appointments.
*** Only needed by users who will be issuing Non-Availability Statements.

Introduction

The following capabilities represent support provided by the CHCS MCP Health Care Finder module to the TRICARE program.

1. Referral Tracking

- Collects data that can be used to identify PCM referral trends (by specialty, by geographic area, by ICD-9, or by CPT-4, etc.).
- Collects data on the type of care the contractor PCMs are referring into the direct care system and the frequency.
- Capability to track patient requirements against actual booked appointment.
- Support for documentation of pre-authorization of care.

2. Improved Eligibility Checking

- Eligibility checks required for each appointment. CHCS identifies ineligible beneficiaries real-time before the appointment is made. No need to retroactively cancel appointments made to ineligible beneficiaries as required in PAS.
- User can override ineligibility and book the appointment. The override will be documented in the system.

3. Workload Tracking

– Capability to break out enrollee versus non-enrollee appointing trends.

4. Access Tracking

– Capability to track outpatient access by high-level categories of patient access requirements; i.e., 24 hours, 48 hours, 72 hours, emergency, routine.

– Capability to assess distance traveled to see provider based on ZIP code of residence or work versus ZIP code of place of care.

There are three types of booking available on the Health Care Finder Menu (HMCP):

PCM Booking - allows you to book only enrolled patients with their assigned primary care manager (PCM).

Non-Enrolled Booking - allows you to book appointments with network and non-network providers for patients who are not currently enrolled in TRICARE, who are conditionally or pending enrolled, and who have invalid enrollments. The Non-Enrolled Booking option is also on the MCP main menu.

Referral Booking - allows you to enter or edit an appointment referral for specialty care for an enrolled or non-enrolled patient and book one or more appointments for the patient with network or non-network providers as a result of the referral.

Booking Primary Care Appointments

Three options on the MCP menus are used for booking primary care appointments: PCM Booking option (PHCF) and the Non-Enrolled Booking option (NHCF) on the Health Care Finder Menu, and Non-Enrolled Booking option (NMCP) option on the MCP main menu.The NHCF and NMCP options are identical.

6.1.1 PCM Booking (PHCF)

Menu Path: PAS System Menu ➔MAN ➔ HMCP ➔ PHCF

Security Keys:

CPZ CCP needed by all MCP users. No other security keys required to access this option.

Required Fields:

Patient name
Appointment type
Specialty
Time range
Days of week
Duration

Application Description:

The PCM Booking option allows you to book appointments for patients with their PCM. This option can be used only for patients who are enrolled in TRICARE. If the patient does not yet have an assigned PCM, you must assign one before you can book an appointment.You can also enter an appointment refusal and view appointment refusal history for the patient being processed.

Note: Appointments for non-enrolled, pending enrolled, and conditionally enrolled patients must be booked using the Non-Enrolled Appointment Booking option.

When you have finished processing a patient, you can select another patient name for processing or exit the option.

Business Rules:

PCMs must be members of the MCP network and must be designated as an individual provider, a group practice, MTF clinic, or a civilian institution.

Individual medical treatment facility (MTF) providers generally have schedules in CHCS; however, MTF group providers may not have schedules (refer to Figure 6-1. Appointment Searches for MTF Group Providers, page 6-5).

If a patient's eligibility has changed, a warning message displays to have the patient disenroll from the old entitlement so they can enroll in the new entitlement.

Note: Users with the proper access can create schedules for clinics that have been designated as PCMs using the Create Schedules option in the Schedules Menu on the PAS Scheduling Supervisor Menu.

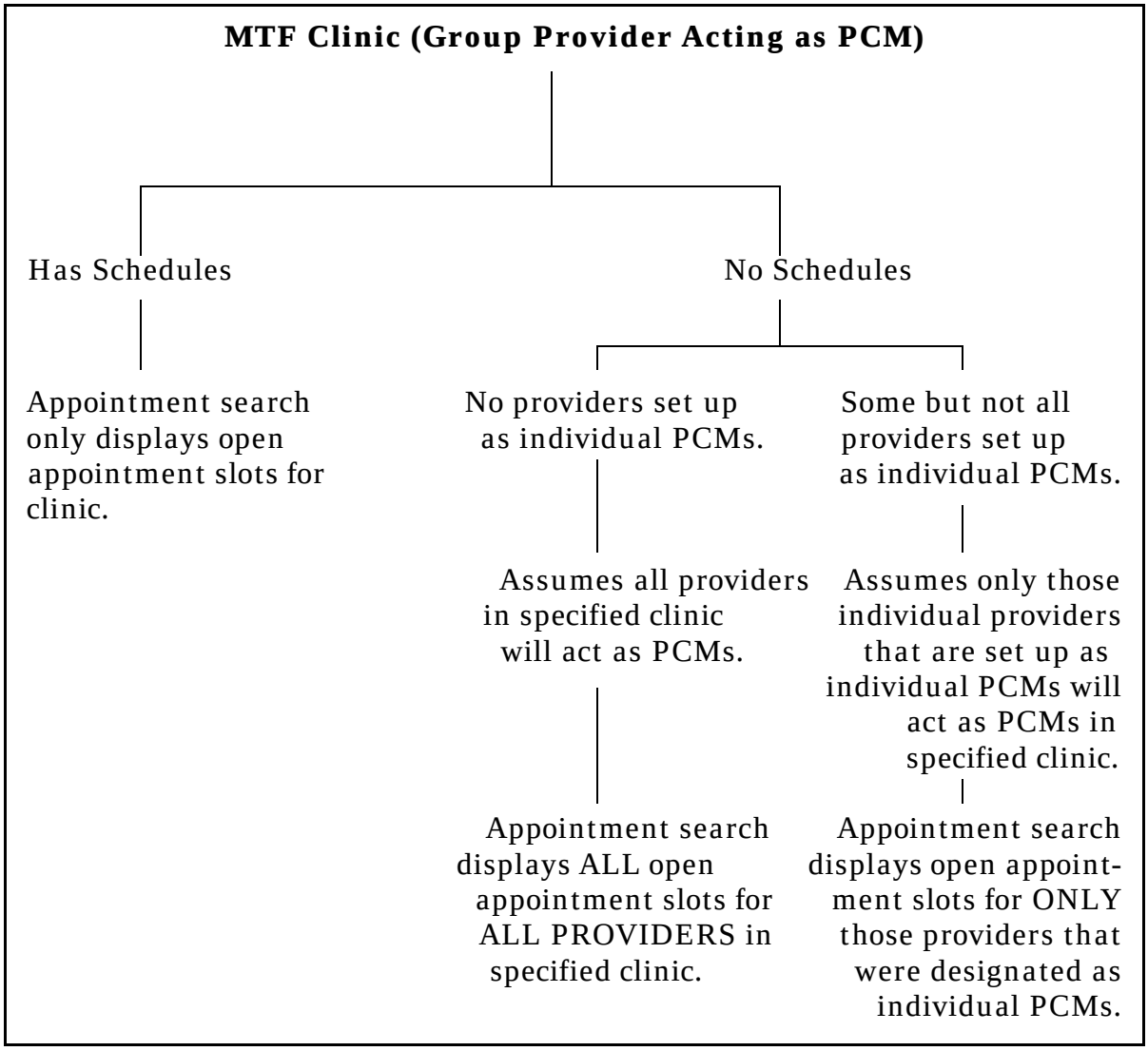


Figure 6-1. Appointment Searches for MTF Group Providers

Appointment Searches

Whenever an appointment search is initiated through the PCM Booking option, and the patient's PCM is an MTF clinic; i.e., MTF group provider, the system first checks to see if the clinic has schedules for the date range specified. (Refer to Figure 6-1. Appointment Searches for MTF Group Providers, page 6-5.)

1. PCM is a group provider (MTF clinic) with schedules:

If schedules exist for the specified MTF clinic the system displays ONLY available appointment slots for that specified MTF clinic.

You may select any of the open appointment slots and book an appointment for the patient. When the patient is checked in the clerk can then enter the name of the provider within the group who saw the patient, using the End-of-Day Processing option.

2. PCM is a group provider (MTF Clinic), no schedules, no providers set up as individual PCMs:

If no schedules exist for the clinic but exist for individual providers assigned to the hospital location, the system displays all available appointment slots that meet the search criteria for all those individual providers, even though these providers have not been designated as individual PCMs (assumes that all providers in the specified clinic will act as PCMs).

3. PCM is a group provider (MTF Clinic), no schedules, some providers set up as individual PCMs:

If no schedules exist for the MTF clinic designated as a PCM, but some providers assigned to this hospital location are designated as individual PCMs and these providers have schedules, the system displays ONLY the available slots for the PCMs and excludes the rest of the providers in that clinic.

4. PCM is a group provider (non-MTF place of care):

If the PCM assigned to a patient is a non-MTF place of care, the system displays the PCM Non-MTF Booking Search Criteria screen when you quit the Demographics Display screen. The system displays the name of the group provider designated as the patient's PCM and the place of care phone number in the Select window. The system also prompts you to select the PCM. You may accept the default or after contacting the place of care, enter the name of the individual PCM who will be seeing the patient.

Once the PCM has been entered, the system redisplays the PCM Non-MTF Booking Search Criteria Screen and allows you to continue processing by first creating the appointment slot and then booking the appointment.

Data Entry Process:

Booking a Patient Appointment with an Assigned Individual PCM or Group PCM with Schedules

Access the PCM Booking option (PHCF) on the Health Care Finder Menu

Select patient

Review current DEERS eligibility

Review patient demographics

Select specialty type

Determine Non-MTF or MTF booking

Select search criteria

Search for appointment(s)

Select appointment(s)

Book the appointment(s)

Print hard copy of patient's appointment(s)/wait list requests

Exit the option

Access the PCM Booking option (PHCF) on the Health Care Finder Menu

When you access the PHCF option, the system displays the PCM Booking Search Criteria screen shown in Figure 6-2. PCM Booking Search Criteria Screen, page 6-8, and prompts you to enter the name of a patient or to quit the option.

```
                          PCM BOOKING SEARCH CRITERIA
Patient:                                          FMP/SSN:
Patient Type:                                     Appt Type:
Clinic:                                           Specialty:
Clinic Phone:
Provider:                                         Duration:
Location:                                         Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                 Time Range: 0001 to 2400
_____________________________________________________________________________


_____________________________________________________________________________
Select (P)atient or (Q)uit: P//
```

Figure 6-2. PCM Booking Search Criteria Screen

The PCM Booking Search Criteria screen has three windows. The fields in the Display Window at the top of the screen are blank at this point, except the *Dates* and *Time Range* fields. The Select Window in the middle is also blank at this point. The Interact Window at the bottom displays the *Select (P)atient or (Q)uit: P//* prompt.

Select patient

1. Accept the default (P)atient action on the PCM Booking Search Criteria Screen.

   The *Select (P)atient or (Q)uit: P//* prompt is replaced with the *Select PATIENT NAME* prompt.

2. Enter patient ID.

   Enter the patient ID using your site's preferred method of patient lookup. If the patient is not registered in CHCS, the system asks you if you are adding a new patient. If you answer "Y," the system prompts you to register the patient using Mini Registration. If you answer "N," the system returns to the *Select PATIENT NAME* prompt.

   If the patient is registered, the system displays the patient's Family Member Prefix (FMP), the sponsor's social security number (SSN), the patient's date of birth (DOB), sex, and rank if the patient is the sponsor, and asks you to confirm the information is correct.

3. Verify sponsor name.

   If the sponsor name is correct, press <Return>.

Review current DEERS eligibility

The system then performs a DEERS Check or a Current DEERS Eligibility Display and a MCP CHCS/DEERS Discrepant Data Check as described in Section 4, DEERS Functions and Processes.

If a DEERS Check has been performed within the past five days, the system displays the Current DEERS Eligibility screen (refer to Figure 6-3. Current DEERS Eligibility Screen, page 6-9). If a DEERS eligibility check has not been performed within the last five days, a DEERS eligibility check is performed automatically. Enter an overirde code or quite if patient is ineligible.

```
                              CURRENT DEERS ELIGIBILITY
                 Name: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER         DDS: 20
             DOB/Age: 19 Feb 1966/35Y                 Sex: MALE
_____________________________________________________________________________
             Sponsor Rank: CAPTAIN
              Sponsor UIC: W4XEAA-RESOURCE SERVICES WASH
                  DMIS ID: 0037-WALTER REED AMC
                      ACV: A-ACTIVE DUTY/MCP ENROLLED
          ACV Start Date: 11 Mar 1999        Region Code: 02
  Care Authorization PH#: 555-2349          PCM Location: DIRECT CARE PC
             Direct Care: ELIGIBLE              Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 12 Mar 2001            CHAMPUS: NOT ELIGIBLE
  Dir Care Elig End Date: 10 Feb 2003
  Eligibility End Reason:

                                 BRAC Pharmacy Eligibility: NO
           Override Code:
         Date of Request: 17 Jun 2001
_____________________________________________________________________________
Select to (V)iew more DEERS data, (P)rint,(R)epeat DEERS check,(C)ontinue,
       or (Q)uit: C//
```

Figure 6-3. Current DEERS Eligibility Screen

At the Current DEERS Eligibility action bar, you can view more DEERS data, print a copy of the Current DEERS Eligibility data, repeat the DEERS check, continue or quit. For detailed information about the Current DEERS Eligibility screen, refer to Section 4, DEERS Functions and Processes.

1. Press <Return> to accept the default (C)ontinue action.

Review patient demographics

The Demographics Display screen displays (refer to Figure 6-4. Demographics Display Screen, page 6-10) allowing you to review patient demographic and enrollment data and select the next option.

```
                                DEMOGRAPHICS DISPLAY
                   Name: PICARD,ZACHARY E          FMP/SSN: 20/379-43-6114
      Patient Category: USA ACTIVE DUTY OFFICER      DDS: 20
          Patient Type: ACTIVE DUTY                  Sex: MALE
            MCP Status: ENROLLED                 DOB/Age: 19 Feb 1966/35Y
                   ACV: A-ACTIVE DUTY/MCP ENROLLED  DMIS ID: 0037
           Direct Care: ELIGIBLE                Medicare:
_____________________________________________________________________________
          Sponsor Name: PICARD,ZACHARY E            Rank: CAPTAIN
          Station/Unit: RESOURCE MGMT WASHINGTON     DSN:
          Home Address: 862 WEST WYLAND DR
                  City: FAIRFAX                    State: VIRGINIA
              ZIP Code: 22030                 Home Phone: 918-555-0287
            Duty Phone: 202-555-6802          Work Phone: 202-555-6802
  Registration Comment:
Last Registration Date: 02 May 1999@1032
Outpatient Record Room: MEDICAL RECORDS FILE ROOM
       MCP Enroll Date: 20 Jun 2001      End Enroll Date: 10 Feb 2003
  Primary Care Manager: ESPOSITO,FRANK M       PCM Phone: 202 271-5850
           Primary OHI: NOT ASSIGNED           Case Mgmt: NO
_____________________________________________________________________________
Select (F)ull, (M)ini, (E)nrollment, (P)CM, Ca(s)e, F(a)mily,(D)isenroll,
    (H)istory, (N)ew Patient, (C)ontinue, or (Q)uit DEMOGRAPHICS: C//
```

Figure 6-4. Demographics Display Screen

The Demographics Display screen has three windows. The Display Window features patient demographics. The Select Window displays the sponsor's name, station/unit, rank, and DSN number. The remaining data in the Select window pertains to the patient. The Interact Window displays an action bar with the following actions:

(F)ull = Full Registration action: When you select Full Registration, the system displays the Full Registration screens and allows you to edit the patient's registration. Upon completion, the system returns to the Demographics Display Action Bar.

(M)ini = Mini Registration action: When the you select Mini Registration, the system displays the Mini Registration screens and allows you to edit the appropriate fields (e.g., home address, home phone). Upon completion, the system returns to the Demographics Display Action Bar. Mini registration includes one demographics data entry screen and one display-only screen containing enrollee information.

(E)nrollment = Enrollment Enter/Edit action: When the you select the Enrollment action, the system displays the enrollment screens and allows you to enter/edit an MCP patient's enrollment. Upon completion, the system returns to the Demographics Display Action Bar. Anyone in Health Care Finder can do enrollments.

(O)HI = Other Health Insurance action: When you select OHI, the system allows you to enter/edit/view the patient's other health insurance (OHI) information. This action does not display for Active Duty Enrolled. Upon completion, the system returns to the Demographics Display Action Bar.You must have the proper security key to use this action.

(P)CM = Primary Care Manager action: When you select PCM, the system displays the PCM Assignment screen and allows you to change the patient's PCM. Upon completion, the system returns to the Demographics Display Action Bar. Changing the PCM will not change the enrolling division. Use enrollment to perform this function.

Ca(s)e = Case Management action: When you select Case, the system displays the Case Management screen and allows you to enter/edit exception provider information. Upon completion, the system returns to the Demographics Display Action Bar. This action is only available to users with the CPZ Case security key.

F(a)mily = Family Member Enrollment action: When you select Family, the system displays the Family Enrollment screen and allows you to enroll family member(s). Upon completion, the system returns to the Demographics Display Action Bar.

(D)isenroll = Disenrollment from MCP action: When you select Disenroll, the system displays the Disenrollment screen and allows you to disenroll the patient from MCP. Upon completion, the system returns to the Demographics Display Action Bar.

(H)istory = View/Print Enrollment History action: When you select History, the system displays the Enrollment History screen and allows you to print/view the patient's enrollment history. Upon completion, the system returns to the Demographics Display Action Bar.

(N)ew Patient = Selection of another patient action: When you select New Patient, the system returns to the SELECT PATIENT: prompt and then allows you to select a different patient for processing. Processing of the initially selected patient terminates when the New Patient selection is made from the Demographics Display Action Bar.

(C)ontinue: When you select Continue, the system displays the PCM Booking Search Criteria screen if you are in PCM Booking or the Appointment Referral Booking screen if you are in Appointment Referral Booking.

(Q)uit: When you select Quit, the system quits the AHCF-Demographics Action Bar and returns to the SELECT (P)ATIENT, OR (Q)UIT: prompt (the first step in this option).

Note: If the Patient Category (PATCAT) or DOB is missing from the registration data for this patient when you select the Quit action, the system displays a message informing you of this missing information. Select either Full or Mini Registration to enter the missing information.

If the patient is not enrolled in MCP, the system displays a message and action bar on the Demographics Display screen as shown in Figure 6-5. Demographics Display Action Bar and Message for Non-Enrolled Patient, page 6-12. Only network providers can be designated as PCMs and the patient must have an MCP status of Enrolled before you can continue.

```
              MCP Status must be enrolled, use Non-Enrolled Booking
Select(F)ull,(M)ini,(E)nrollment,(N)ew Patient,or(Q)uit DEMOGRAPHICS:Q//
```

Figure 6-5. Demographics Display Action Bar and Message for Non-Enrolled Patient

---

1. Press <Return> to accept the default (C)ontinue action from Demographics Display Screen (refer to Figure 6-4. Demographics Display Screen, page 6-10).

Select specialty type

When you accept the default (C)ontinue action, the system displays the PCM Booking Search Criteria screen shown in Figure 6-6. PCM Booking Search Criteria Screen, page 6-13.

```
                        PCM BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                        FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY                  Appt Type:
Clinic: FAM PRAC MTF/DIVA                      Specialty:
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                      Duration:
Location:                                    Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001              Time Range: 0001 to 2400
_____________________________________________________________________________
   FAMILY PRACTICE/PRIMARY CARE
   NURSING
   PRIMARY CARE NURSE PRACTITIONER QUALIFIED



_____________________________________________________________________________
Select one of the Specialty Types that contains the assigned PCM's
Provider Specialty of PRIMARY CARE NURSE PRACTITIONER QUALIFIED
```

Figure 6-6. PCM Booking Search Criteria Screen

1. Use the down-arrow key to position the cursor on the PCM speciality type linked to the assigned PCM. Press <Select> and then press <Return>.

Determine Non-MTF or MTF booking

As soon as you select the PCM's specialty type required by your patient, the system does one of two things, depending upon the type of PCM assigned to the patient:

- If the patient's PCM is a Non-MTF PCM, the system displays the PCM Non-MTF Booking Search Criteria screen with an action bar prompting you either to change the search criteria, enter an appointment refusal, book a single patient, or quit and return to the Select Patient or Quit action bar.

- If the patient's PCM is an MTF PCM, the system displays the PCM MTF Booking Search Criteria screen (refer to Figure 6-7. PCM MTF Booking Search Criteria Screen, page 6-14).

  The PCM Non-MTF Booking Search Criteria and the PCM MTF Booking Search Criteria screens are identical except for the heading.

The specialty and preferred location of the PCM are entered in order to locate appropriate PCM candidates.

```
                        PCM MTF BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY            Appt Type:
Clinic: FAM PRAC MTF/DIVA                Specialty: FAMILY PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M               Duration:
Location: 20307                          Days of Week:
Dates: 21 Jun 2001 to 01 Jan 2005        Time Range: 0001 to 2400
_____________________________________________________________________________
  Patient Home Phone: 918-555-0287      Patient Duty Phone: 202-555-6802




_____________________________________________________________________________
Select (C)hange Search Criteria,(B)rowse,(S)ingle Patient,Appt (R)efusal,
       (W)ait List Add, (T)el-Consult, or (Q)uit: S//
```

Figure 6-7. PCM MTF Booking Search Criteria Screen

The PCM MTF Booking Search Criteria screen (Figure 6-7. PCM MTF Booking Search Criteria Screen, page 6-14) has three windows. The top Display Window contains the same information as the Display Window of the PCM Booking Search Criteria screen (Figure 6-6. PCM Booking Search Criteria Screen, page 6-13.). The Select Window shows the patient's home phone number and duty phone if the patient is active duty. The Interact Window contains an action bar with the following actions:

(C)hange Search Criteria: This action allows you to select search criteria in order to narrow the search for an available appointment slot. **Note:** The most common and easiest method of booking an appointment with a PCM is to accept the default presented in Figure 6-7. PCM MTF Booking Search Criteria Screen, page 6-14, of (S)ingle patient rather than (C)hanging the search criteria. The top Display Window contains defaulted search criteria for this patient's PCM.

By accepting the PCM's default, CHCS accesses the screen in Figure 6-10. PCM MTF Booking Search Criteria Screen (with selected search criteria filled in), page 6-19. If you need to change the search criteria, you can narrow or expand the search by editing the defaulted information.

(B)rowse: This action allows you to search the schedule of the specified provider for a specific day to locate and display bookable appointment slots. This option cannot be used if the group is the PCM and individual providers are PCMs. If the PCM is an individual, you may overbook or join appointment slots.

(S)ingle Patient: This action allows you to search for available appointments based on the search criteria entered or defaulted from the patient's PCM.

Appt (R)efusal: This action allows you to enter an appointment refusal without searching for an open appointment slot. Appointment refusals can also be documented using Non-Enrolled Booking Appointment, Referral Booking, and using the Enter Appointment Refusals option (EHCF). Refer to Section 6.1.3 for details.

(W)ait List Add: This action allows you to place this patient on the Wait List for the specified MTF clinic. This action is only available if the specified clinic maintains an active Wait List.

(T)el-Consult: This action allows you to document a telephone call from a patient who calls a health care finder (HCF) to leave a message for a provider with whom they have a booked or pending appointment.

(Q)uit: This action allows you to quit the PCM MTF Booking Search Criteria screen and returns to the Health Care Finder Menu.

Select search criteria

When you choose the (C)hange Search Criteria action on either the PCM MTF Book Search Criteria screen or the PCM Non-MTF Booking Search Criteria screen, the system displays a list of search criteria in the center window (refer to Figure 6-8. PCM MTF Booking Search Criteria Screen with Selectable Search Criteria, page 6-16). You can identify appointment search criteria for the enrollee's PCM.

```
                        PCM MTF BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                 FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY             Appt Type:
Clinic: FAM PRAC MTF/DIVA                 Specialty: FAMILY PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                Duration:
Location: 20307                           Days of Week:
Dates: 21 Jun 2001 to 01 Jan 2005         Time Range: 0001 to 2400
_____________________________________________________________________________
   Appointment Type
   Specialty
   Dates
   Time Range
   Days of Week
   Duration
   Default Search Criteria
_____________________________________________________________________________
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 6-8. PCM MTF Booking Search Criteria Screen with Selectable Search Criteria

Use the down-arrow key to position the cursor next to the search criteria you want to change and press <Select>. An asterisk (*) displays beside each item you select. You can deselect an item by positioning the cursor on the asterisk and pressing <Select> again. When you have completed selecting, press <Return>. The system then prompts you to enter data for the search criteria you selected in the following order:

1. Enter specialty.

   When you select specialty, the system redisplays the PCM's specialties as shown in Figure 6-6. PCM Booking Search Criteria Screen, page 6-13. You can select the specialty the patient requires. When you have selected the specialty, the system prompts you for the remaining selected search criteria.

2. Enter start and stop dates.

   When you select "Dates," you are prompted to enter appointment start and stop dates.You can use this criteria to limit your search to a specific range of days. For example, if the patient needs an appointment approximately 30 days from today. You can enter T+30 as the start date and T+37 as the stop

date. The system only searches for open appointments during a seven-day period beginning 30 days from today.

The default start date is always today's date and the default stop date is always six weeks from today's date. You can change the start date to any date in the future and you can change the stop date to any date in the future as long as the stop date you enter is later than the start date.

3. Enter inclusive earliest time and inclusive latest time.

   When you select "Time Range" as a search criteria, the system prompts you for inclusive earliest time and inclusive latest time.You can use these two criteria to limit your search to a specific time of day. For example, your patient may ask for an afternoon appointment. For this patient, you might enter 1300 as the inclusive earliest time and 1700 as the inclusive latest time. Then the system only searches for open appointments between the hours of 1:00 PM and 5:00 PM.

   The default inclusive earliest time is 0001. The default inclusive latest time is 2400.

4. Select the acceptable days of the week.

   Figure 6-9. Prompt to Select Acceptable Days of the Week for an Appointment, page 6-17, shows the prompt that displays when you choose days of the week as a search criteria.

```
Select acceptable days of the week with an "X".  Press "Space Bar" to
remove an entry.  Enter "^" to accept all entries.  Use the Return and/or

Backspace keys to position the cursor on a specific day.

M:X  TU:X  W:X  TH:X  F:X  SA:X  SU:X
```

Figure 6-9. Prompt to Select Acceptable Days of the Week for an Appointment

Select this criteria for change if your patient needs the appointment on a specific day(s). For example, the patient's day off is Wednesday. Delete the Xs from all but "W," and the system only searches for open appointments on Wednesdays.

5. Enter the appointment's required duration.

   At the prompt for duration, enter the number of minutes required for the appointment as a one to three digit number.

6. Enter appointment type.

   Enter two question marks (??) at this prompt to view appointment types (such as new or follow-up) the PCM has available. You can only select from appointment types that have been previously entered in the PCM's profile.

7. Tell the system whether you want the criteria selections saved as your default selection criteria.

   After entering all the search criteria you selected, the system asks if you want to save your selections as your default selection criteria. If you accept the "Yes" default at this prompt, the next time you need to search for an appointment, the search criteria data you just entered will be defaulted into the top portion of the PCM MTF (NON-MTF) Booking Search Criteria screen for all patients.If you enter "N," the search criteria fields in the top window will revert to the system defaults.

Search for appointment(s)

The top window of the PCM MTF (NON-MTF) Booking Search Criteria screen is now filled in with the search criteria you specified (refer to Figure 6-10. PCM MTF Booking Search Criteria Screen (with selected search criteria filled in), page 6-19).

```
                          PCM MTF BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                 FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY             Appt Type: FOLLOW UP
Clinic: FAM PRAC MTF/DIVA                 Specialty: FAMILY PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                Duration:
Location: 20307                           Days of Week:M W
Dates: 21 Jun 2001 to 30 Jun 2001         Time Range: 0900 to 1700
_____________________________________________________________________________
  Patient Home Phone: 918-555-0287      Patient Duty Phone: 202-555-6802



_____________________________________________________________________________
Select (C)hange Search Criteria, (B)rowse, (S)ingle Patient,Appt (R)efusal,
    (W)ait List Add, (T)el-Consult, or (Q)uit: S//
```

Figure 6-10. PCM MTF Booking Search Criteria Screen (with selected search criteria filled in)

1. Accept the default “S” for (S)ingle Patient action,

Select appointment(s)

The system displays the PCM MTF (NON-MTF) Single Patient Booking screen with all the PCM’s open appointments that meet the criteria you specified in the center window (refer to Figure 6-11. PCM MTF Single Patient Booking Screen, page 6-20).

```
                        PCM MTF SINGLE PATIENT BOOKING
Patient: PICARD,ZACHARY E                  FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY              Appt Type: FOLLOW UP
Clinic: FAM PRAC MTF/DIVA                  Specialty: FAMILY PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                 Duration:
Location: 20307                            Days of Week:
Dates: 21 Jun 2001 to 01 Jan 2005          Time Range: 0001 to 2400
_____________________________________________________________________________
   FRI 1530 22 Jun 01 FOL    1/0
   FRI 1600 22 Jun 01 FOL    1/0
   FRI 1630 22 Jun 01 FOL    1/0
   MON 1500 25 Jun 01 FOL    1/0
   MON 1530 25 Jun 01 FOL    1/0
   MON 1600 25 Jun 01 FOL    1/0
   MON 1630 25 Jun 01 FOL    1/0
+ WED 1500 27 Jun 01 FOL    1/0
_____________________________________________________________________________
Use SELECT key to select appointment(s) to be booked
```

Figure 6-11. PCM MTF Single Patient Booking Screen

The day, time, open appointment date, appointment type, how many patients can be booked to the open slot, and how many patients have already been booked to that slot (1/0 indicates one patient can be booked and zero (0) have been booked) appear on this screen.

A plus (+) sign beside the top or bottom appointment slot indicates there are additional open slots that do not fit within the display window. Use the up- or down-arrow keys to display the hidden slots.

1. Position the cursor beside the appointment slot(s) you want to book for this patient, and press <Select>.

Note: Asterisks (*) appear next to the schedule time slots you have selected. You can deselect by pressing <Select> again.

---

2. When you have finished selecting the appointment(s), press <Return>.

Book the Appointment

The system displays the File Appointment screen (refer to Figure 6-12. File Appointment Screen, page 6-21).

```
                        FILE APPOINTMENT
Patient: PICARD,ZACHARY E                  FMP/SSN: 20/379-43-6114
Patient Type: MCP/ACTIVE DUTY              Appt Type: FOLLOW UP
Clinic: FAM PRAC MTF/DIVA                  Specialty: FAMILY PRACTICE/PRIM
Clinic Phone: 202 271-5850
Provider: ESPOSITO,FRANK M                 Duration:
Location: 20307
Days of Week:
Dates: 21 Jun 2001 to 01 Jan 2005          Time Range: 0001 to 2400
_____________________________________________________________________________
   FRI 1530 22 Jun 01 FOL    1/0
   FRI 1530 30 Jun 01 FOL    1/0

 ____________________________  Select Slot #1 of 1_________________________
Select (B)ook appt, or (Q)uit FILE APPOINTMENT: B//
```

Figure 6-12. File Appointment Screen

The File Appointment Display Window displays current demographic information and search criteria for this booking search.

The Select Window displays the appointment slot(s) (day, time, date, type, and slot) that you have selected. The first (or only) appointment slot is highlighted.

The Interact Window displays the message telling you to select Slot #1 of 3 to process, and an action bar with the following available actions:

(B)ook - allows you to book the selected appointment slots.

(S)kip - allows you to skip the first (highlighted) appointment slot and move to the next appointment slot on the list. The *Skip action only displays as a selection on the action bar if more than one appointment appears on the list.*

(V)iew - allows you to view the entire list of appointment slots selected and displayed for booking. You can override the sequential order of the picklist and select any appointment slot on the File Appointment screen where multiple appointment slots are listed. The *View action only displays as a selection on the action bar if there is more than one appointment slot selection on the list.*

(Q)uit - allows you to quit the booking process and return to the MTF Booking Search.

1. Press <Return> to accept the default to (B)ook appt.

   The system displays the secondary File Appointment Screen (refer to Figure 6-13. File Appointment Screen Continuation, page 6-22) with the cursor positioned at the Medical Expense and Performance Reporting System (MEPRS) Code field.

```
PATIENT APPOINTMENT: PICARD,ZACHARY E                      FILE APPOINTMENT

                     FRI 1500 22 Jun 01 FOL    1/0
  No reminder notice will be sent. Hand-carry Radiology/Patient records.
                Clinic Message: Arrive 10 minutes early.
  Clinic/Appt Type Instructions:
               Provider Message:
Provider/Appt Type Instructions:
                Arrival Message: 10 minutes
           Registration Comment:

                     MEPRS Code: BGAZ
             Requesting Service:
                    Referred By:
           Send Reminder Notice: NO
            Appointment Comment:
         Reason for Appointment:

Ask for Help = HELP    Screen Exit = F10     File/Exit = DO    INSERT OFF
```

Figure 6-13. File Appointment Screen Continuation

The secondary File Appointment screen top half contains information for the patient from both the clinic and provider regarding the proposed appointment. This information is display only and cannot be edited. It includes: Patient Name in the upper-left corner, the appointment data for the appointment being booked, and notice to the user if there is not enough time to send a reminder notice or pull the patient's medical/radiology records.

The Clinic Message, Clinic/Appt Type Instructions, and Arrival Message are pulled from the Clinic Profile. The Provider Message and Provider/Appt Type Instructions are pulled from the Provider Profile. The Registration Comment is pulled from Mini Registration.

1. Enter the correct MEPRS code.

The MEPRS code, formerly the Uniform Chart of Accounts (UCA) code, is a cost-accounting indicator. This permanent code is assigned to each clinic or location and is used to track the workload.

If the MEPRS code has been entered in the Clinic Profile, it is defaulted to the MEPRS Code field. You may accept the default or override it.

If no MEPRS code has been entered in the Clinic Profile, the system prompts you to enter a valid MEPRS code in this field. This is a required entry, and you cannot exit the field without the entry. You can enter a double question mark (??) to display a list of valid MEPRS codes by clinic/ location.

2. Enter requesting service.

   The system positions the cursor in this field only if "YES" has been entered in the Referral Required field for this appointment type in the specified Clinic or Provider Profile. If set to "NO," the system bypasses this field.

   If the cursor is positioned in this field and this appointment is being made in response to a referral from another location, this field displays the MEPRS code of the referring location. You can override this default and enter a different MEPRS code.

3. Enter Referred By data.

   If the Referral Requested field in the Clinic Profile is set to YES, enter Referred By data in this field. Otherwise, the system bypasses this field.

4. Send a reminder notice.

   If the associated field in the Clinic Profile is set to "YES," the system allows you to enter/edit this field at the appointment level only if enough time remains before the appointment to send a reminder notice. If the associated field in the Clinic Profile is set to "NO," the system does not allow you to enter/edit this line.

5. Enter appointment comment.

   You can enter from 3 to 75 characters of additional appointment information in this free-text field.

6. Enter reason for appointment.

   You can enter from 3 to 75 characters of additional information about the reason for the appointment in this free-text field.

7. File the data

The system displays an action bar allowing you to either file the data and exit, abort the process without filing, or edit. If you choose to edit the data, the cursor returns to the MEPRS Code field. When you choose the default to File/exit, the system displays the message - `Appointment Booked` - and returns to a blank PCM MTF Single Patient Booking screen. The *Remind patient of other appointments/ Wait List requests* prompt displays.

Print hard copy of patient's appointment(s)/wait list requests

This prompt allows you to print a copy of all the patient's appointments and wait list requests or display the information to the screen. Refer to Figure 6-70. Display Patient Appointments, page 6-119 for a sample Display Patient Appointments screen. The printed copy is identical to the screen display.

1. Press <Return> to accept the "Yes" default at the *Remind patient of other appointments/Wait List requests* prompt.

2. Enter device name.

3. Enter right margin. You can also display patient appointments through the Display Patient Appointments (DMCP) option. Refer to Section 6.2 for details.

4. Exit the option

5. Enter "N" at the *Remind patient of other appointments/Wait List requests* prompt. The system returns to the PCM MTF Booking Search Criteria Screen with the same action bar as shown in Figure 6-10. PCM MTF Booking Search Criteria Screen (with selected search criteria filled in), page 6-19.

6. At this action bar, you can continue booking appointments for the same patient.

7. Quit and return to the *Select (P)atient or (Q)uit: P//* action bar and book appointment(s) for another patient.

Booking a Patient Appointment with an Assigned Group PCM without Schedules

Access the PCM Booking option (PHCF) on the Health Care Finder Menu

Select patient

Review current DEERS eligibility

Review patient demographics

Select specialty type

Verify patient's PCM

Select search criteria

Search for appointment(s)

Add an appointment slot

Book the appointment(s)

Print hard copy of patient's appointment(s)/wait list requests

Exit the option

Access the PCM Booking option (PHCF) on the Health Care Finder Menu

Refer to Access the PCM Booking option (PHCF) on the Health Care Finder Menu, page 6-7.

Select patient

Refer to Select patient, page 6-8.

Review current DEERS eligibility

Refer to Review current DEERS eligibility, page 6-9.

Review patient demographics

Refer to Review patient demographics, page 6-10.

Select specialty type

Use the down-arrow key to position the cursor on the PCM speciality linked to the assigned PCM. Press <Select> and then press <Return>.

Verify patient's PCM

After you enter the specialty type required for the patient, the system displays the PCM Non-MTF Booking Search Criteria screen (Figure 6-14. PCM Non-MTF Booking Search Criteria Screen, page 6-26) and prompts you to select a PCM. The default is the patient's assigned PCM.

```
                        PCM NON-MTF BOOKING SEARCH CRITERIA
Patient: BLITON,STEVEN                          FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE             Appt Type:
Clinic: CLASSY MEDICAL CLINIC/MCPD              Specialty: FAMILY PRACTICE/
PRIM
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                   Duration:
Location: 92128                                 Days of Week:
Dates: 17 Feb 1997 to 31 Mar 1997               Time Range: 0001 to 2400
_____________________________________________________________________________
  Patient Home Phone: 0012345678        Patient Duty Phone: 3423444




_____________________________________________________________________________
Select PCM: CLASSY MEDICAL CARE//
```

Figure 6-14. PCM Non-MTF Booking Search Criteria Screen

1. Press <Return> to accept the default PCM.
2. The system echoes the PCM name and prompts you to verify that the name is correct.

Press <Return> again at the *OK? YES//* prompt to indicate the system has echoed the correct PCM name.

Select search criteria

Refer to Select search criteria, page 6-27.

Search for appointment(s)

Press <Return> to accept the (S)ingle Patient action on the PCM Non-MTF Booking Search Criteria action bar. The system displays the Add An Appointment screen (Figure 6-15. Add an Appointment Slot Screen, page 6-27).

```
                            ADD AN APPOINTMENT SLOT
Patient: BLITON,STEVEN                          FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE              Appt Type:FOL
Clinic: CLASSY MEDICAL CLINIC/MCPD              Specialty: FAMILY CARE
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                   Duration:
Location: 92128                                  Days of Week: M TU W TH F
Dates: 17 Feb 1997 to 31 Mar 1997               Time Range: 0900 to 1400
_______________________________________________________________________________




_______________________________________________________________________________
Select (A)dd appointments, or (Q)uit NON-MTF booking: A//
```

Figure 6-15. Add an Appointment Slot Screen

The action bar on the Add an Appointment Slot screen has only two actions, (A)dd appointments and (Q)uit Non-MTF booking.

Press <Return> to accept the default (A)dd appointments.

Add an appointment slot

If you have telephoned the provider to get a appointment time, enter the date and time of the appointment as shown in Figure 6-16. Add an Appointment Slot Screen, page 6-28.

```
                              ADD AN APPOINTMENT SLOT
Patient: BLITON,STEVEN                            FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE                Appt Type:
Clinic: CLASSY MEDICAL CLINIC/MCPD         Specialty: FAMILY PRACTICE/PRIM
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                     Duration:
Location: 92128                               Days of Week: M TU W TH F SU
Dates: 17 Feb 1997 to 31 Mar 1997                Time Range: 0900 to 1400
_____________________________________________________________________________
 20Feb@0900        <---Enter appointment date@time




_____________________________________________________________________________
Enter appointment date@time to be added to the provider's schedule or
Press <RETURN> to continue.
```

Figure 6-16. Add an Appointment Slot Screen

1. Press <Return> after entering the appointment date and time. If you leave out the year, the system assumes the current year.

The system displays the Non-MTF Booking - Add screen with the cursor positioned at the appointment type field. (Refer to Figure 6-17. Non-MTF Booking - Add Screen, page 6-29.) Notice that the provider, Classy Medical Care, is a group provider.

The Non-MTF Booking - Add screen has one window. Some of the information is display only and cannot be edited, including:

Appointment Slots -- the number of appointment slots selected and the number of those appointment slots filled.

Appointment Day, Time, Date -- the exact day, time, and calendar date of the appointment slot to be created.

Clinic Name -- the full name and location of the clinic.

Provider Name -- either the full name of the referred to provider or the name of the group provider.

Day of Week -- the day of the week of the appointment.

Appointment Slot Status -- the appointment slot status as open.

Appointment type, number of patients, and appointment slot comment must be completed or verified.

```
APPOINTMENT SLOTS: 1                                NON-MTF BOOKING - ADD

                                  THU 0900 20 Feb 97

                     Clinic: CLASSY MEDICAL CLINIC
                   Provider: CLASSY MEDICAL CARE
                   Division:
        Booked appointments:
  Maximum overbooks allowed:
                   Duration:     minutes
                Day of Week: THU
    Appointment Slot Status: OPEN

           Appointment Type:
         Number of patients:
   Appointment Slot Comment:



Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 6-17. Non-MTF Booking - Add Screen

1. Enter appointment type.

   This is a required field. The appointment type entered must be active for the specified clinic/provider. The appointment type must be an entry in the appointment type table. New appointment types can be added using the Appointment Type Enter/Edit (APRO) option on the Scheduling Supervisor Profiles Menu. Enter double question marks (??) and then press <Return> to display a list of active appointment types.

2. Number of patients.

   The system enters this number for you according to how the selected appointment was set up in the appointment file. The cursor bypasses this field. Some appointment types are set up to allow scheduling more than one patient into a slot. For example, a diabetes education class could be set up as an appointment type with the number of patients set at the desired class size.

3. Enter appointment slot comment.

   This field is optional and can be used to enter an additional 3 to 50 characters of information about the appointment slot.

4. File the data

   When you press <Return> at the Appointment Slot Comment field, the system adds an action bar to the Non-MTF Booking - Add screen that allows you to file the data and exit the option, abort, or edit. Press <Return> to accept the default File/exit action or use the right-arrow key to position the cursor on the Abort or Edit action and then press <Return>. If you choose Edit, the cursor returns to the Appointment Type field and you can edit the appointment type or appointment slot comments if desired. If you choose Abort, the system returns you to the Add an Appointment Slot screen where you can re-enter an appointment date and time.

   When you accept the default File/exit action, the system returns you to the Add an Appointment Slot screen, now showing the appointment you just entered (refer to Figure 6-18. Add an Appointment Slot with One Slot Already Created, page 6-31). You can enter another appointment slot or press <Return> to continue.

```
                              ADD AN APPOINTMENT SLOT
Patient: BLITON,STEVEN                          FMP/SSN: 06/278-55-5025
Patient Type: MCP/CHAMPUS ELIGIBLE              Appt Type:FOL
Clinic: CLASSY MEDICAL CLINIC/MCPD              Specialty: FAMILY CARE
Clinic Phone: 619-535-7116
Provider: CLASSY MEDICAL CARE                   Duration:
Location: 92128                                Days of Week: M TU W TH F
Dates: 17 Feb 1997 to 31 Mar 1997               Time Range: 0900 to 1400
_____________________________________________________________________________
 * THU 0900 20 Feb 97 FU     1/0   10 MIN  OPEN
                   <---Enter appointment date@time




_____________________________________________________________________________
Enter appointment date@time to be added to the provider's schedule or
Press <RETURN> to continue.
```

Figure 6-18. Add an Appointment Slot with One Slot Already Created

1. Press <Return> to continue.

   The system displays the File Appointment screen (refer to Figure 6-12. File Appointment Screen, page 6-21 for an example).

Book the appointment(s)

Refer to Book the appointment(s), page 6-31.

Print hard copy of patient's appointment(s)/wait list requests

Refer to 7. File the data, page 6-24.

Exit the option

Refer to 7. File the data, page 6-24.

6.1.2 Non-Enrolled Booking (NHCF)

Menu Path: PAS System Menu → MAN → NHCF

Alternate Menu Path: PAS System Menu → MAN → HMCP → NHCF

Security Keys:

CPZCCP needed by all MCP users. No other security keys required to access this option.

Required Fields:

Patient name
Patient type
Appointment type
Specialty
Location
Provider

Application Description:

The Non-Enrolled Booking option allows you to book primary care and specialty appointments with one network or non-network provider at a time for patients who are not currently enrolled in MCP. This option also allows you to book appointments for patients who are conditionally enrolled or pending enrolled.

Business Rules:

If the appointment is made as a result of a referral, use Appointment Referral Booking.

MTF appointments may be booked. Non-MTF appointments are only recorded in the database for reporting. Non-MTF appointments are not actually booked into the provider's schedule.

Eligibility checks are performed on all patients.

Ineligible patients may only book with an override.

Refer to Business rules, page 6-4 for other rules.

Data Entry Process:

Booking a Non-Enrolled Patient with an MTF Provider

> **Scenario:** You need to book an appointment in your MTF for a CHAMPUS patient not enrolled in TRICARE Prime.

Access the Non-Enrolled Booking option (NMCP) on the Managed Care Program menu or the Non-Enrolled Booking option (NHCF) on the Health Care Finder Menu

Select search criteria to change

Select patient

Review current DEERS eligibility

Review patient demographics

Enter provider search criteria

Search for a provider

Select a provider

Select appointment(s) or add an appointment slot

Book the appointment(s)

Print patient appointments/wait list requests

Exit the option

Access the Non-Enrolled Booking option (NMCP) on the Managed Care Program menu or the Non-Enrolled Booking option (NHCF) on the Health Care Finder Menu

When you select the NHCF option on the Managed Care Program Menu or the NHCF option on the Health Care Finder Menu, the system displays the Non-Enrolled Booking Search Criteria screen. (Refer to Figure 6-19. Non-Enrolled Booking Search Criteria Screen, page 6-34.)

```
                        NON-ENROLLED BOOKING SEARCH CRITERIA
Patient:                                          FMP/SSN:
Patient Type:                                     Appt Type:
Clinic:                                           Specialty:
Clinic Phone:
Provider:                                         Duration:
Location:                                         Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                 Time Range: 0001 to 2400
_____________________________________________________________________________




___Patient, Patient Type, Specialty, Location, Provider are required___
Select (C)hange Search Criteria, or (Q)uit: C//
```

Figure 6-19. Non-Enrolled Booking Search Criteria Screen

The Display Window at the top of the Non-Enrolled Booking Search Criteria screen contains the patient demographic and provider fields. These fields are blank at this point, but fill in as the search criteria are defined. The Dates and Time Range fields are defaulted by the system, but can be edited.

Note: Patient, Patient Type, Specialty, Location, and Provider fields are required search criteria fields.

The Select Window, in the middle, is also blank at this point, except for data selection instructions.

The Interact Window contains the action bar. There are only two actions available, (C)hange Search Criteria, or (Q)uit.

1. Press <Return> at the Non-Enrolled Booking Search Criteria action bar, to accept the default, (C)hange Search Criteria action.

Select search criteria to change

The system redisplays the Non-Enrolled Booking Search Criteria screen with selectable search criteria displayed in the select window. (Refer to Figure 6-20. Non-Enrolled Booking Search Criteria Screen, page 6-35.)

```
                        NON-ENROLLED BOOKING SEARCH CRITERIA
Patient:                                          FMP/SSN:
Patient Type:                                     Appt Type:
Clinic:                                           Specialty:
Clinic Phone:
Provider:                                         Duration:
Location:                                         Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001                 Time Range: 0001 to 2400
_____________________________________________________________________________
   Appointment Type
   Specialty
   Location
   Patient
   Patient Type
   Dates
   Time Range
+  Days of Week
___Patient, Patient Type, Specialty, Location, Provider are required__
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 6-20. Non-Enrolled Booking Search Criteria Screen

1. Use the down-arrow key to position the cursor next to each of the desired search criteria and then press <Select>.

Note: Patient, Patient Type, Specialty, Location, and Provider fields are required search criteria fields.

---

2. When you have finished selecting criteria to change, press <Return>. The system prompts you to enter the patient name only if you choose patient as one of the initial search criteria. You will be reprompted to change the criteria if any of the required criteria are not initially chosen.

Select patient

Refer to Select patient, page 6-8.

Review current DEERS eligibility

Refer to Review current DEERS eligibility, page 6-9.

Review patient demographics

Refer to Review patient demographics, page 6-10.

1. Enter C to select the (C)ontinue action.

Enter provider search criteria

The system displays the Non-Enrolled Booking Search Criteria screen pictured in Figure 6-21. Non-Enrolled Booking Search Criteria Screen 3, page 6-36.

```
                      NON-ENROLLED BOOKING SEARCH CRITERIA
Patient: PHOTON,ZACHARY N                      FMP/SSN:20/353-30-4614
Patient Type:                                  Appt Type:
Clinic:                                        Specialty:
Clinic Phone:
Provider:                                      Duration:
Location:                                      Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001              Time Range: 0001 to 2400
_______________________________________________________________________




_______________________________________________________________________
Select PATIENT TYPE:
```

Figure 6-21. Non-Enrolled Booking Search Criteria Screen 3

1. Enter patient type.

   The correct patient type is very important because the system matches it with compatible provider agreement types when locating a health care provider (HCP). Enter double question mark (??) to see the following list of patient types:

   AD ACTIVE DUTY
   CHA CHAMPUS
   MED MEDICARE
   OTH OTHER
   SCD SUPPLEMENTAL CARE DIAGNOSIS

2. Enter specialty type.

   Enter the type of medical specialty your patient requires. Enter double question marks (??) to display a list of choices.

3. Enter location.

   Enter the ZIP code where your patient is to receive medical care.

4. Enter start and stop dates.

   If you selected “Dates,” you are prompted to enter start and stop dates. You can use this criteria to limit your search to a specific range of days. For example, if the patient needs an appointment approximately 30 days from today enter T+30 as the start date and T+37 as the stop date. The system only searches for open appointments during a seven-day period beginning 30 days from today.

   The default start date is always today’s date and the default stop date is always six weeks from today’s date. You can change the start date to any date in the future and you can change the stop date to any date in the future as long as the stop date you enter is later than the start date.

5. Enter inclusive earliest and inclusive latest time.

   When you select “Time Range” as a search criteria, the system prompts you for inclusive earliest time and inclusive latest time.You can use these two criteria to limit your search to a specific time of day. For example, your patient may ask for an afternoon appointment. For this patient, you might enter 1300 as the inclusive earliest time and 1700 as the inclusive latest time. The system would only search for open appointments between the hours of 1:00 PM and 5:00 PM.

   The default inclusive earliest time is 0001. The default inclusive latest time is 2400.

6. Select the acceptable days of the week.

   Refer to Figure 6-9. Prompt to Select Acceptable Days of the Week for an Appointment, page 6-17.

7. Enter duration.

   If you selected duration as a search criteria, enter the number of minutes required for the appointment as a one to three digit number.

8. Enter appointment type.

   Enter double question marks (??) at this prompt to display appointment types. You can only select one appointment type from appointment types that have been previously entered in the facility profile.

Search for a provider

When you finish entering all the search criteria data selected, a new action bar displays on the Non-Enrolled Booking Search Criteria screen (refer to Figure 6-22. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar, page 6-38), with the patient home phone number in the select window and an action bar in the interact window.

```
                      NON-ENROLLED BOOKING SEARCH CRITERIA
Patient: PHOTON,ZACHARY N                      FMP/SSN: 20/353-30-4614
Patient Type: CHAMPUS                          Appt Type:
Clinic:                                        Specialty: DERMATOLOGY
Clinic Phone:
Provider:                                      Duration:
Location: DISTRICT OF COLUMBIA                 Days of Week:
Dates: 21 Jun 2001 to 02 Aug 2001              Time Range: 0001 to 2400
_____________________________________________________________________________
  Patient Home Phone: 410-555-0602      Patient Duty Phone:




_______________________Provider is required_____________________________
Select (C)hange Search Criteria, (P)rovider Search, or (Q)uit: P//
```

Figure 6-22. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar

1. Press <Return> to accept the default (P)rovider Search action.

   The action bar is replaced with the action bar shown in Figure 6-23. Provider Name, MTF, External, Non-Network Provider Search Action Bar, page 6-39.

```
Search for (P)rovider Name, (M)TF, (E)xternal, N(o)n-Network,
              or (Q)uit Provider Search:
```

Figure 6-23. Provider Name, MTF, External, Non-Network Provider Search Action Bar

1. Enter the type of provider search.

   The action bar shown in Figure 6-23. Provider Name, MTF, External, Non-Network Provider Search Action Bar, page 6-39, allows you to search for:

   – a specific provider by name

   – an MTF provider

     When you select MTF, the system searches for providers with an agreement type of either CON, MTF, PIC, or SUP and whose place of care has a location type of C (clinic) or S (same day surgery), that meet the other search requirements specified in the referral.

   – an external (civilian) provider

     When you select External, the system searches for providers with an agreement type of either PEX, NET, CON, or SUP and whose place of care has a location type of O, that meet the other search requirements specified in the referral.

   – a non-network provider.

2. Enter values to search for.

   If you choose the (P)rovider Name action, the system prompts you to select a provider name.

   If you choose the (M)TF, (E)xternal, N(o)n-Network actions, the system prompts you to select an appointment type.

   Enter double question marks (??) to view available appointment types. You can only select from appointment types that have been previously entered in the facility profile.

3. Quit.

Select a provider

If you do not enter an appointment type at this prompt, the system returns a list of providers matching your search criteria and all their open appointments.

If you choose the (Q)uit Provider Search action, the system returns you to the action bar shown in Figure 6-22. Non-Enrolled Booking Search Criteria Screen with Provider Search Action Bar, page 6-38.

If you enter a specific appointment type, the system returns a list of providers matching your search criteria with only the type of open appointments you entered. (Refer to Figure 6-24. Non-Enrolled Booking Search Criteria Screen with Available MTF Appointments, page 6-40.)

```
                      NON-ENROLLED BOOKING SEARCH CRITERIA
Patient: BLITON,JACK                          FMP/SSN: 20/353-30-4614
Patient Type: USA ACTIVE DUTY ENLISTED        Appt Type:NEW
Clinic:                                       Specialty: CARDIOLOGY
Clinic Phone:
Provider:                                     Duration:30
Location: SAN DIEGO                           Days of Week:M TU W TH F
Dates: 21 Jun 2001 to 02 Aug 2001             Time Range: 0800 to 1400

   Provider        CS Cat   Agr Place of Care   Zip    1st Available Appt
_____________________________________________________________________________
+   PARKWAY,ZELDA      MD    MTF CCG/OP MTF  20307   22 Jun 2001@0800
   PANTOUM,CAROL   E  MD    MTF CCG/OP MTF  20307   23 Jun 2001@0800
   PARAMOUNT,DOUGL B  MD    MTF CCG/OP MTF  20307   23 Jun 2001@0800
    PARANG,ELISA   B  MD    MTF CCG/OP MTF  20307   23 Jun 2001@0800
    PARAPH,FRANK   B  MD    MTF CCG/OP MTF  20307   27 Jun 2001@0800
    PARCAE,GEORGIA B  MD    MTF CCG/OP MTF  20307   27 Jun 2001@0800
    PARCENER,HENRY B  MD    MTF CCG/OP MTF  20307   27 Jun 2001@0800
    PARGET,IOLA M  B  MD    MTF CCG/OP MTF  20307   28 Jun 2001@0800
    PARITY,JOSEPH  B  MD    MTF CCG/OP MTF  20307   23 Jun 2001@0800
+  PANACHE,ZELDA M B  MD     MTF CCG/OP MTF 20307     28 Jun 2001@0800
_____________________________________________________________________________
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch
Codes
```

Figure 6-24. Non-Enrolled Booking Search Criteria Screen with Available MTF Appointments

1. Use the down-arrow key to scroll through the list to find the first available appointment acceptable to the patient.

2. When the cursor is positioned, press <Select>.

   The system displays the Non-Enrolled MTF or Non-Enrolled Non-MTF Booking Search Criteria screen. (Refer to Figure 6-25. Non-Enrolled MTF Booking Search Criteria Screen, page 6-41.) This screen allows you to perform other actions or to change your previous selection.

Note: The Non-Enrolled MTF Booking Search Criteria screen and the Non-Enrolled Non-MTF Booking Search Criteria screen are identical except for the screen title.

```
                    NON-ENROLLED MTF BOOKING SEARCH CRITERIA
Patient: BLITON,JACK                        FMP/SSN: 20/876-55-0505
Patient Type: USA ACTIVE DUTY ENLISTED      Appt Type:NEW
Clinic: CARDIOLOGY CARE CLINIC              Specialty: CARDIOLOGY
Clinic Phone: 202 456-9877
Provider: PARKWAY,ZELDA M                   Duration:30
Location: SAN DIEGO                         Days of Week:M TU W TH F
Dates: 21 Jun 2001 to 02 Aug 2001           Time Range: 0800 to 1400
_____________________________________________________________________
  Patient Home Phone: 410-555-0602      Patient Duty Phone:410-555-1234




____Provider eligibility dates are from 21 Jun 2001 to 02 Aug 2001____
Select (C)hange Search Criteria, (P)rovider Search, (B)rowse, (S)ingle Patient,
       Appt (R)efusal, (W)ait List Add, (T)el-Consult, or (Q)uit: S//
```

Figure 6-25. Non-Enrolled MTF Booking Search Criteria Screen

Actions on the Non-Enrolled MTF Booking Search Criteria Action Bar:

<u>(C)hange Search Criteria</u>: Choose this action to change the search criteria for the appointment requested.

<u>(P)rovider Search</u>: Choose this action to search for providers based on Patient Type, Specialty Type, and Location. Allows you to select the type of Provider to search for, i.e., MTF, civilian, or non-network.

<u>(B)rowse</u>: Choose this action to search the schedule of the selected provider for bookable appointment slots on a specific day. This search locates not only open appointment slots, but also locates and displays booked, frozen, wait listed, and

canceled appointment slots. Slots can be joined, split, and overbooked using the Browse action. You can also change the appointment type using the Browse action.

(S)ingle Patient: Choose this action to search for one or more bookable appointments for a single patient that meet the specified search criteria. Only open appointment slots are searched for and displayed.

Appt (R)efusal: Choose this action to enter a patient's appointment refusal. This may be done with or without booking an appointment or making a formal referral.

(W)ait List Add: Choose this action to place this patient on the Wait List for the specified MTF clinic. **Note:** This action is available only if the specified clinic maintains an active Wait List.

(T)el-Consult: Choose this action to document a telephone call from a patient who calls a HCF to leave a message for a provider.

(Q)uit: Choose this action to quit the MTF (or Non-MTF) Booking Search Criteria screen and return to the Managed Care Program Menu.

1. Press <Return> to accept the (S)ingle Patient action on the MTF Booking Search Criteria action bar.

Note: When you press <Return> to accept the default (S)ingle Patient action on the Non-Enrolled Non-MTF Booking Search Criteria screen, the system displays the Add an Appointment Slot screen. (Refer to Figure 6-15. Add an Appointment Slot Screen, page 6-27 to see an example.) An appointment slot is added in Non-Enrolled Booking the same as in PCM Booking (Refer to Add an appointment slot, page 6-28).

Select the appointment(s)

A list of the selected provider's open appointments that meet your selection criteria displays in the middle window. (Refer to Figure 6-26. Non-Enrolled MTF Single Patient Booking Screen, page 6-43.)

```
                    NON-ENROLLED MTF SINGLE PATIENT BOOKING
Patient: BLITON,JACK                        FMP/SSN: 20/876-55-0505
Patient Type: USA ACTIVE DUTY ENLISTED      Appt Type: NEW
Clinic: CARDIOLOGY CARE CLINIC              Specialty: CARDIOLOGY
Clinic Phone: 202 456-9877
Provider: PARKWAY,ZELDA M                   Duration: 30
Location: SAN DIEGO                         Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 02 Aug 2001           Time Range: 0800 to 1400
_____________________________________________________________________________
   FRI 0800 22 Jun 01 NEW    1/0
   FRI 0830 22 Jun 01 NEW    1/0
   FRI 0900 22 Jun 01 NEW    1/0
   FRI 0930 22 Jun 01 NEW    1/0
   FRI 1000 22 Jun 01 NEW    1/0
   FRI 1030 22 Jun 01 NEW    1/0
   FRI 1100 22 Jun 01 NEW    1/0
+  FRI 1130 22 Jun 01 NEW    1/0
_____________________________________________________________________________
Use SELECT key to select appointment(s) to be booked
```

Figure 6-26. Non-Enrolled MTF Single Patient Booking Screen

1. Position the cursor beside the appointment(s) acceptable to your patient, press <Select>, and then press <Return>.

Book the appointment

The system displays the File Appointment Screen (refer to Figure 6-12. File Appointment Screen, page 6-21).

Refer to Book the Appointment, page 6-20.

Print patient appointments/wait list requests

Refer to Print hard copy of patient's appointment(s)/wait list requests, page 6-24.

Exit the option

Refer to 4. Exit the option, page 6-24.

6.1.3 Appointment Referral Booking (AHCF)

Menu Path: PAS System Menu → MAN → HMCP → AHCF

Security Key Required:

CPZ CCP
CPZ OHI
CPZ CASE
CPZ NAS

Required Fields:

Patient name
Patient type
Specialty
Location

Application Description:

The Appointment Referral Booking option allows you to enter/edit an appointment referral for specialty care for an enrolled or non-enrolled patient and book one or more appointments for the patient with network or non-network providers. Patient preferences are considered when searching for appointments. Enrollees with an MCP status of pending, invalid, or conditional must be booked in Non-Enrolled Booking.

Although the system allows appointments to be canceled only through the Cancellation by Patient option in MCP, the system allows referrals without appointments to be deleted in this option. Appointments canceled by the facility must be entered in Patient Appointment and Scheduling (PAS).

Business Rules:

Eligibility checks are performed on all patients.

Ineligible patients may only be booked with an override.

Data Entry Process:

Scenario

Your first scheduling task is to add an appointment referral for an enrolled patient to see a dermatologist to have some suspicious skin lesions removed. After you enter the patient's name and verify that the demographic information is correct, you add an appointment referral for this patient in the local area for a one-time, routine visit. You find a health care provider, book the appointment, and print the Care Authorization Form.

6.1.3.1 Enter an Appointment Referral for an Enrolled Patient

Access the Appointment Referral Booking (AHCF) option on the Health Care Finder menu

Select patient

Review current DEERS eligibility

Review patient demographics

Enter Appointment Referral/Patient preference data

Access the Appointment Referral Booking (AHCF) option on the Health Care Finder menu

Select patient

1. Accept the default (P)atient action on the Appointment Referral Booking Screen.

   The *Select (P)atient or (Q)uit: P//* prompt is replaced with the *Select PATIENT NAME* prompt.

2. Enter patient ID.

   Enter the patient ID using your site's preferred method of patient lookup. If the patient is not registered in CHCS, the system asks you if you are adding a new patient. If you answer "Y," then the system prompts you to register the patient using Mini Registration. If you answer "N," the system returns to the *Select PATIENT NAME* prompt.

   If the patient is registered, the system displays the patient's FMP, the sponsor's SSN, the patient's DOB, sex, and rank if the patient is the sponsor and asks you to confirm the information is correct.

3. Verify sponsor name.

   If the sponsor name is correct, press <Return>.

Review current DEERS eligibility

Refer to Review current DEERS eligibility, page 6-9.

Note: Enrollment in USTF Managed Care: Following the DEERS check, the system searches the stored DEERS eligibility information to determine if the patient is assigned an ACV code of "U" (Enrolled in USTF Managed Care).

The Uniformed Services Treatment Facility (USTF) Managed Care Program is a network of Department of Defense (DOD)-owned, civilian contractor-staffed medical facilities that provides DOD-funded medical care to eligible participating DOD beneficiaries (patients). The USTF Managed Care Program may be offered, where available, to eligible beneficiaries (active duty patients are ineligible) as an alternative to other DOD managed care programs and direct care from the MTF. USTF beneficiaries should only receive care at an MTF by prior agreement or emergency.

If the specified patient is not assigned an ACV code of "U", the system allows you to continue the booking process without restriction. If the patient is assigned an ACV code of "U", the system displays the DEERS Eligibility Data screen with the message:

> This patient is a Uniformed Services Treatment Facility (USTF) enrollee who elected, in writing, to receive all non-emergency care from a USTF. Your facility will not be reimbursed for care provided to this patient unless the USTF agrees to pay your facility prior to you rendering services to the patient.

The system then allows you to choose either to proceed with the booking process, or to abort it for this patient.

If you choose to proceed, the system then allows you to continue the booking process for the selected patient without restriction.

If you choose to abort the current booking process for this patient, the system allows you to choose either to return to the change search criteria action to select another patient and/or to change other search criteria, or to quit the action.

Review patient demographics

Refer to Review patient demographics, page 6-10. Select “C” to continue.

The system displays the Appointment Referral Booking screen (refer to Figure 6-27. Appointment Referral Booking Screen, page 6-47.) This screen displays combined demographic and enrollment data about the patient and allows you to view existing open referrals and select an action.

```
                          APPOINTMENT REFERRAL BOOKING
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                  DDS: 20
      Patient Type: ACTIVE DUTY                      Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M           PCM Phone: 202 271-5850
Case Mgmt Provider:                            Case Mgmt: NO

    Referral#  Date/Time        Provider          Specialty       Status
_____________________________________________________________________________




____________________No Appointment Referrals found_______________________
Select (P)atient, (A)dd, or (Q)uit: A//
```

Figure 6-27. Appointment Referral Booking Screen

The Appointment Referral Booking screen Display Window lists the patient name, patient category, DOB/age, patient type, MCP status, assigned PCM, case management provider (if any), FMP and sponsor SSN, patient SSN, DEERS dependent suffix (DDS) if active duty, sex, assigned PCM's phone number, and whether the patient is a case management patient.The Case Management Provider and Case Management fields are automatically filled in if a referral has been entered or selected to be modified and a case management provider with the same specialty as entered in the referral has been assigned to the patient.

Note: The data shown in the display window of Figure 6-27. Appointment Referral Booking Screen, page 6-47, is from information in the CHCS data base, not from DEERS.

The middle window lists all referrals already on file for the patient, including the referral number, date and time the referral was entered, the provider referred to, the provider's specialty, and the status of the referral. If there are no referrals already on file, a message is displayed at the bottom of the middle window stating, "No referrals found." (Refer to Figure 6-27. Appointment Referral Booking Screen, page 6-47.)

Actions on the Appointment Referral action bar are:

(P)atient: Choose this action to select a new patient and restart the appointment referral process.

(A)dd: Choose this action to display the Interview/Referral screen and enter a new referral with the patient interview/ referral information.

(M)odify: Choose this action to modify an existing referral. When you select Modify, the system allows you to select a referral from the list of existing referrals. Referrals with no appointments or providers attached display at the top of the list in referral number order, followed by referrals with appointments linked to them. After you select a referral, the system displays the Interview/ Referral screens for the selected referral and allows you to advance through the fields and enter/edit data.

Note: The modify action only appears on the action bar if the patient has existing referrals.

(Q)uit: Choose this action to quit the appointment referral process and return to the Health Care Finder Menu.

Enter Appointment Referral/Patient preference data

When you choose the default (A)dd action from the Appointment Referral Booking action bar, the system displays the Interview/Referral Screen (refer to Figure 6-28. Interview/Referral Screen, page 6-49).

```
MCP REFERRAL: 200100058                                INTERVIEW/REFERRAL

          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                   DDS: 20
                                                      Sex: MALE
            Street: 862 WEST WYLAND DR               City: FAIRFAX
             State: VIRGINIA                     ZIP Code: 22030
           H Phone: 918-555-0287                  D Phone: 202-555-6802
           W Phone: 202-555-6802
               PCM: ESPOSITO,FRANK M            PCM Phone: 202 271-5850
Case Mgmt Provider:                             Case Mgmt:
==========================================================================
      Referral Number: 200100058       Referral Date/Time: 21Jun01@1439
           MCP Status: ENROLLED              Patient Type: ACTIVE DUTY
            Specialty:
             Location:
 Requested Start Time: 0001           Requested Stop Time: 2400
         Days of Week:                   Number of Visits:
 Treatment Start Date:                Treatment Stop Date:
             Priority:                  Gender Preference:
             Language:                       Primary OHI:
```

Figure 6-28. Interview/Referral Screen

The Interview/Referral screen has a two-window format.

The Display Window displays the current demographic information for the patient, as well as PCM, and Case Management information.

The Interact Window contains those fields that must be completed when specifying referral information. The system automatically enters the Referral Number, Referral Date/Time, and the patient's MCP Status fields. These fields cannot be edited. The cursor is positioned at patient type.

1. Enter patient type.

   This field defaults by the system from the patient's enrollment information in the patient file. You can either accept the default or edit this field.

Patient types include the following:

Enrolled:

MCA MCP/Active Duty (i.e., active duty, enrolled)

MCP MCP/CHAMPUS Eligible (i.e., not active duty, CHAMPUS eligible, enrolled)

MCD MCP/Non-CHAMPUS Eligible (i.e., not active duty, not CHAMPUS eligible, enrolled)

Non-Enrolled:

AD Active Duty (i.e., active duty, non-enrolled)

CHA CHAMPUS (i.e., not active duty, CHAMPUS eligible, non-enrolled)

OTH Other (i.e., direct care that is not CHAMPUS or MEDICARE, non-enrolled)

Enrolled or Non-Enrolled:

MED MEDICARE (i.e., not active duty, not CHAMPUS eligible enrolled or non-enrolled)

SCD Supplemental Care Diagnostics (i.e., a one-time offsite care authorization for a specific test or procedure (e.g., MRI), enrolled or non-enrolled). **Note:** This patient type is new with CHCS Version 4.5.

2. Enter specialty.

   Your entry in this field restricts the referral into a primary clinical area. It identifies the MCP Specialty Type used by the system to search for providers and to group referrals for reporting purposes. It also links provider specialties to specific specialty types allowing you to display a picklist with different specialties. For example, if “occu” is entered, the system lists all specialty types beginning with those letters for you to choose from. Individual specialties may be grouped under a more general specialty in file and table build so the search selects a broader range of appointments.

   If you are editing/modifying a previously entered referral, the specialty field is only available for editing if no appointments have yet been linked to this referral.

3. Enter location.

   You can enter either the ZIP code(s) for the area where the patient wants to receive medical care, or the geographical area (e.g., San Diego, Norfolk) already defined in the CHCS ZIP Code Combination file.

   If a ZIP code is entered instead of a geographical area name, up to five different ZIP codes can be entered in this field at one time (with commas and no spaces).

   You can also enter up to five "wild card" ZIP codes with at least the first three digits (e.g., 923) separated by commas. The system searches for all ZIP codes that contain those first three digits.

Note: In CHCS Version 4.4, the specialty and location fields did not restrict the ability to book appointments for this referral. In Version 4.5, these fields restrict the appointments as defined here.

---

4. Requested Start Time & Requested Stop Time.

   The Requested Start and Stop Time fields allow you to enter the patient's preference for the appointment time range. The time must be stated military style. The default start time is 0001, and the default stop time is 2400.

5. Enter the days of the week on which your patient can accept an appointment.

   After you enter the requested stop time, the system adds instructions for selecting days of the week on which your patient can accept an appointment. Refer to Figure 6-9. Prompt to Select Acceptable Days of the Week for an Appointment, page 6-17.

6. Enter number of visits.

   You must specify either the number of visits (a whole number between 0 and 99) or the treatment start and stop dates (date range). The system is very flexible at this point, and you can schedule the following:

   – An unlimited number of appointments within a specific date range by leaving the Number of Visits field blank and entering information into the Treatment Start and Stop Date fields.

   – An exact number of appointments for an unlimited date range by entering information in the Number of Visits field and leaving the

Treatment Start and Stop Date fields blank. If no date range is entered, the system defaults the date range from T (today) to T + 60.

– An exact number of appointments for a specific date range by entering information in all three fields.

7. Enter treatment start and stop dates.

   The Treatment Start and Stop Date fields allow you to enter the required date range in which to schedule the appointments linked to this referral. You can enter a specific date, or T to accept the system default date. If you enter T plus a number (e.g., T+15), the system defaults to the date plus the number of days specified.

8. Enter Priority.

   Priority codes are used to measure access to care. Allowable priority codes are:

   E Emergency

   U Urgent

   R Routine

   T Today

   7 Within 72 hours

   4 Within 48 hours

   2 Within 24 hours

9. Enter Gender Preference.

   You can enter (M)ale or (F)emale, or leave it blank. If the field is left blank, the system lists both male and female providers. You advance to the Referred By prompt on the Interview/Referral -- Continued screen (bypassing the Language and Primary OHI prompts. Both fields contain default enrollment information (if available) and cannot be edited.) (Refer to Figure 6-29. First Completed Interview/Referral Screen, page 6-53.)

```
MCP REFERRAL: 200100058                                INTERVIEW/REFERRAL

           Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER        Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
                                                        Sex: MALE
            Street: 862 WEST WYLAND DR                 City: FAIRFAX
             State: VIRGINIA                       ZIP Code: 22030
           H Phone: 918-555-0287                    D Phone: 202-555-6802
           W Phone: 202-555-6802
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt:

=========================================================================
      Referral Number: 200100058         Referral Date/Time: 21Jun01@1439
           MCP Status: ENROLLED                Patient Type: ACTIVE DUTY
            Specialty: DERMATOLOGY
             Location: 20307
 Requested Start Time: 0800            Requested Stop Time: 1600
         Days of Week: M TU W TH F        Number of Visits: 1
 Treatment Start Date: 21 Jun 2001     Treatment Stop Date: 06 Jul 2001
             Priority: ROUTINE           Gender Preference:
             Language:                          Primary OHI:
```

Figure 6-29. First Completed Interview/Referral Screen

When you press <Return> at the Gender Preference field, the system replaces the Interview/Referral screen with the Interview/Referral --Continuation screen with the cursor positioned at the Referred By field.

(Refer to Figure 6-30. Interview/Referral -- Continued (Completed), page 6-54, to see the second Interview/Referral screen completed for a patient.

```
MCP REFERRAL: 200100057                      INTERVIEW/REFERRAL -- CONTINUED

            Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:    379-43-6114
             DOB/Age: 19 Feb 1966/35Y                    DDS: 20
        Patient Type: ACTIVE DUTY                        Sex: MALE
          MCP Status: ENROLLED
                 PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
 Case Mgmt Provider:                               Case Mgmt:

==========================================================================
 Referred By: ESPOSITO,FRANK M                           UPIN:
 Referral From: BGAZ                               Related To:
 Reason for Referral:
  Suspicious skin lesions




Ask for Help = HELP    Screen Exit = F10    File/Exit = DO        INSERT OFF
```

Figure 6-30. Interview/Referral -- Continued (Completed)

When you press <Return> at the Reason for Referral field, the system displays the third Interview/Referral Screen (Refer to Figure 6-31. Interview/Referral -- Continued 2, page 6-56).

1. Enter the name of the PCM referring the patient for specialty care.

   Enter the name of the provider who is referring this patient for specialized care. For enrolled patients, the name of the patient's assigned PCM is defaulted unless the patient's assigned PCM is a provider group. If a provider group serves as a PCM or the patient is not enrolled, the system leaves the field blank, and you must enter the name of a specific provider who referred the patient. The help list lists all providers in the provider network.

2. UPIN field.

   This field defaults the provider's six-character Unique Physician Identification Number (UPIN) information from the Provider file. If this information was not entered into the Provider file, the field remains blank. The UPIN cannot be edited here so the cursor bypasses this field.

3. Referral From field.

   This field defaults to the MEPRS code for the clinic in which this patient's PCM is assigned. The MEPRS code cannot be edited here so the cursor bypasses this field. If the patient is not enrolled, this field is left blank.

4. Related To field.

   Enter the patient activity that caused the need for this referral.This field indicates when the cost of the care may be reimbursable from other patient benefit plans. This field should be completed if applicable.

   Allowable activity codes are as follows:

   WC Work Condition

   MS Military Service

   AA Auto Accident

   If none of these codes apply to the actual patient activity that resulted in the need for this referral, this field can be left blank.

5. Enter reason for referral.

   The Reason for Referral field is a word-processing field. You can enter unlimited narrative text about the reason for this referral. You can also leave this field blank.

```
MCP REFERRAL: 200100057                      INTERVIEW/REFERRAL -- CONTINUED

            Patient: PICARD,ZACHARY E                FMP/SSN:20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:   379-43-6114
            DOB/Age: 19 Feb 1966/35Y                     DDS:20
       Patient Type: ACTIVE DUTY                         Sex:MALE
         MCP Status: ENROLLED
                PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
 Case Mgmt Provider:                               Case Mgmt:
 ========================================================================
 Select Provisional Diagnosis:



 Select Provisional Diagnosis (Free Text):



 Select Referral Procedure:



Ask for Help = HELP     Screen Exit = F10     File/Exit = DO
```

Figure 6-31. Interview/Referral -- Continued 2

1. Enter provisional diagnosis.

   This field describes the PCM's request for a diagnostic consultation for the indicated condition.

   You must press <Return> one time before you can enter the code or anatomical name.

   You can enter the projected International Classification of Diseases (ICD-9) diagnosis code and/or the description that applies to the patient's medical condition for this referral; e.g., 172.5 is the ICD-9 code for malignant melanoma of the skin of the trunk.

   Enter a double question mark (??) to display a valid list of ICD-9 codes or enter an anatomical name (e.g., brain or femur) for a picklist of ICD-9 codes.

Once you have entered the code, the system asks you if you are adding that code as a new Provisional Diagnosis for this referral. Press <Return> to accept the default of Yes. If you have made an error, enter No and re-enter the correct code.

When you have verified that the code is correct, the system displays the description of the newly entered ICD-9 code next to the code you entered, in this example, 172.5 MALIGNANT MELANOMA OF SKIN OF TRUNK. The cursor is positioned just below the code you just entered.

2. Press <Return> one time and then enter additional ICD-9 codes in this field or press <Return> two times to go on to the next field.

3. Enter provisional diagnosis (Free Text).

   You can enter one line of free text in this field or you can leave it blank.

4. Enter referral procedure.

   The Referral Procedure field is used to enter CPT codes for a referral to identify specific treatment(s) for which a beneficiary is being referred. The system allows you to enter a 3-5 digit CPT code, an alpha string to display a picklist of possible matches, an alpha string of the CPT4 description, or a double question mark (??) to display a valid list of Referral Procedures. Separate, multiple entries can be made in the field. You cannot, however, enter a range of values. For example, if 272 is entered at the Select Referral Procedure field, the system displays a picklist of all procedures beginning with 272 (Refer to Figure 6-32. Interview/Referral -- Continued 3, page 6-58). You must select one of the values displayed.

   Once you have entered the code, the system asks you if you are adding that code as a new Referral Procedure. If you press <Return> to indicate “YES,” the system displays the description of the Referral Procedure.

5. File the data.

```
MCP REFERRAL: 200100057                      INTERVIEW/REFERRAL -- CONTINUED

            Patient: PICARD,ZACHARY E                FMP/SSN:20/379-43-6114
   Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:   379-43-6114
            DOB/Age: 19 Feb 1966/35Y                     DDS:20
       Patient Type: ACTIVE DUTY                         Sex:MALE
         MCP Status: ENROLLED
                PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
 Case Mgmt Provider:                               Case Mgmt:

 27200   27200   CLOSED TREATMENT OF COCCYGEAL FRACTURE
 27202   27202   OPEN TREATMENT OF COCCYGEAL FRACTURE
 27215   27215   OPEN TX ILIAC SPINE(S), TUBEROSITY AVULSION, ILIAC WING FXS
 27216   27216   SKEL. FIXATION POSTERIOR PELVIC RING FX AND/OR DISLOCATION
 27217   27217   OPEN TX ANTERIOR RING FRACTURE AND/OR DISLOC W/INT. FIXATION
 27218   27218   OPEN TX POSTERIOR RING FX AND/OR DISLOC W/INTERNAL FIXATION
 27220   27220   CLOSED TX ACETABULUM FRACTURE(S) WITHOUT MANIPULATION
+27222   27222   CLOSED TX ACETABULUM FX OR FXS W/MANIP. W/OR W/O SKEL. TRAC.
  Make choice = SELECT                        Exit = F10
  272
```

Figure 6-32. Interview/Referral -- Continued 3

Note: Instead of filing the data at this point, you can edit or abort the referral. When you choose abort, the system returns to the initial Add/Modify Referral Action Bar at the beginning of this action and purges all entries or changes that have occurred since the last entry was filed.

6.1.3.2 Find a Provider

After filing the data and entering a referral, the system displays the Add Appointment Referral screen. Notice the newly entered referral displays (Refer to Figure 6-33. Add Appointment Referral Screen, page 6-59).

```
                              ADD APPOINTMENT REFERRAL
           Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
      Patient Type: ACTIVE DUTY                         Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
Case Mgmt Provider:                               Case Mgmt: NO

     Referral#  Date/Time        Provider           Specialty        Status
_____________________________________________________________________________
     200100057                                     DERMATOLOGY



_____________________________________________________________________________
Select (I)nterview/Referral, (P)rovider, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: P//
```

Figure 6-33. Add Appointment Referral Screen

The Add Appointment Referral Screen Display Window displays the current demographics for the selected patient. The Patient Name and FMP/SSN are highlighted. The data displayed is from the CHCS system.

The Select Window displays all appointment referrals ever generated for this patient. Since this newly created referral has no appointments linked to it yet, the system displays only the Referral Number and the Specialty Type, without any booking information. If an appointment has already been booked, you cannot change the location and specialty. If an appointment has not been booked you may select and edit the referral.

The Interact Window displays the action bar with the following actions:

(I)nterview/Referral: Choose this action to return to the Interview/Referral screen where you can modify the newly created referral.

(P)rovider: Choose this action to activate the referred to provider search.

(E)xception: Choose this action to search for an Exception Provider assigned to the patient (only displayed on the action bar if the specified patient for the referral is a Case Management patient).

(O)utputs: Choose this action to generate a patient enrollment form, a patient membership ID card, a care authorization form, a patient mailing label, or a provider mailing label (if you have generated a care authorization form) for the selected appointment referral. After completing this action, the system returns to the Appointment Referral Action Bar.

(D)elete: Choose this action to delete the appointment referral. This action is only available for referrals that have no appointments linked to them and have never had appointments linked to them.

(N)AS: Choose this action to generate an NAS for the patient (only displayed on the action bar if the specified patient is CHAMPUS eligible). After completing this action, the system returns to the Appointment Referral Action Bar.

(Q)uit: Choose this action to quit the appointment referral process and return to the Appointment Referral Booking screen to select another appointment referral to process.

Note: If you are editing/modifying a previously entered referral, the Modify Appointment Referral Screen displays instead of the Add Appointment Referral screen. The Modify Appointment Referral Action bar has all the same actions as the Add Appointment Referral Action Bar, plus the following:

(B)ook: Choose this action to proceed to either the MTF Booking Action or the Non-MTF Booking Action, depending upon whether the patient's selected provider is an MTF provider or a non-MTF provider.

Find a Provider (Continued)

At the Add Appointment Referral action bar, press <Return> to accept the default (P)rovider action and the system displays the Provider Search screen (Refer to Figure 6-34. Provider Search Screen, page 6-61).

```
                                PROVIDER SEARCH
           Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
      Patient Type: ACTIVE DUTY                         Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M              PCM Phone: 202 271-5850
Case Mgmt Provider:                               Case Mgmt: NO
         Specialty: DERMATOLOGY                   Appt Type:
          Location: 20307
        Start Date: 21 Jun 2001                   Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F            Number of Visits: 1
          Priority: ROUTINE               Gender Preference:
          Language:                             Primary OHI: NOT ASSIGNED
_____________________________________________________________________________



_____________________________________________________________________________
Search for (A)ppt Refusal, (P)rovider Name, (M)TF, (E)xternal, N(o)n-Network,
            or (Q)uit Provider Search:
```

Figure 6-34. Provider Search Screen

The Provider Search Screen Display Window displays patient demographics, patient preferences, the patient's patient type, MCP status, assigned PCM, PCM phone number, specialty type, location, date to begin appointment search and date to end search. This window also displays the days of the week the patient can be available for the appointment, how many appointments are required, priority assigned to the referral, whether the patient prefers a specific gender provider, and whether the patient requires/requests a provider who speaks a language other than English. In addition, the patient's primary OHI also displays. All data is displayed from data on file in the CHCS system.

The Select Window is blank at this time.

The Interact Window displays the Provider Search Action Bar with the following actions:

(A)ppt Refusal: Choose this action to document a patient's refusal to schedule an appointment when appointments are available. Refer to 6.1.4 Enter Appointment Refusals (EHCF), page 6-106, for a complete description of the appointment refusal function.

(P)rovider Name = MTF Provider Search: Choose this action when you need to search for a specific provider by name. (Refer to Select a specific MTF provider by name.)

(M)TF = MTF Provider Search: Choose this action when you want to search for an MTF provider across the network of all MTF providers on the CHCS system. (Refer to Booking an appointment with an MTF provider.)

(E)xternal: Choose this action to search for a network provider outside the MTF. (Refer to Select an external providerpage 6-81)

N(o)n-Network: Choose this action to search for a non-network provider. Non-Network providers are those providers with an agreement type of NON, who offer no discount (zero percent discount). (Refer to Booking an appointment with a non-network providerpage 6-99)

(Q)uit: Choose this action to quit the Provider Search action bar and return to the Add Appointment Referral action bar.

Data Entry Process:

Booking an appointment with a specific provider by name

Many times the patient's PCM may wish to refer the patient to a particular specialty care provider for follow-up care. For example, a patient may have had a previously bad skin condition which was treated by a Dermatologist, improved, but now has flared up again. In this case, once a referral has been entered for the patient, the HCF would select the Provider Name Search from the action bar. If the specified patient has a case management provider (that is, an exception provider assigned for the specialty type entered in the referral) the system automatically defaults the name of the case management provider at the *Select Provider* prompt. The HCF is able to accept the default or enter the name of a

different provider. However, the provider whose name is entered must have an agreement type that will see the patient's specified patient type.

Note: The provider name entered for a search must have an agreement type that can accommodate the patient's specified patient type. Otherwise, the system will report that no provider was found.

Additionally, if the specified patient has a case management provider (that is, an exception provider assigned for the specialty type entered in the referral), the system automatically defaults the name of the case management provider at the *Select Provider* prompt. You can then accept the default or enter the name of a different provider.

Note: These search breakdowns are new to CHCS Version 4.5.

Access the Appointment Referral Booking (AHCF) option on the Health Care Finder menu

Select patient

Review current DEERS eligibility

Review patient demographics

Enter Appointment Referral/patient preference data

Select a specific MTF provider by name

View provider detail

Initiate the booking process

Book the appointment(s)

Print hard copy of patient's appointments/Wait List requests

Print appointment referral products

The first five steps listed in the box above are the same whether your patient needs an MTF provider or a civilian provider. Assume you've already completed those steps and you are now at the Add Appointment Referral screen shown in Figure 6-35. Provider Search Screen, page 6-64.

When you select the (P)rovider Name action on the Provider Search screen, the system prompts you to enter the name of the desired provider and then searches the data base for the provider. When found, the system displays identifying data and prompts you for verification that the correct provider has been located. After the provider has been identified, the system prompts for the appointment type to use for the appointment search. If you bypass the appointment type identification, the system searches for all available appointments for the specified provider. The system then displays a list of the places of care for the specified provider, meeting the search criteria.

Select a specific MTF provider by name

```
                                PROVIDER SEARCH
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                    DDS: 20
      Patient Type: ACTIVE DUTY                        Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO
         Specialty: INTERNAL MEDICINE            Appt Type:
          Location: 22203
        Start Date: 21 Jun 2001                  Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F           Number of Visits: 1
          Priority: ROUTINE              Gender Preference:
          Language:                            Primary OHI: NOT ASSIGNED
_____________________________________________________________________________



_____________________________________________________________________________
Search for (A)ppt Refusal, (P)rovider Name, (M)TF, (E)xternal, N(o)n-Net-
work,
```

Figure 6-35. Provider Search Screen

1. At the Provider Search Action Bar, enter “P” for Provider Name.

   The system replaces the action bar with a prompt to select provider name.

2. Enter and verify the provider name.

   The system prompts you to select appointment type.

3. Press <Return> at the *Select APPT TYPE* prompt or enter the desired appointment type.

   This requested appointment type must match the appointment types that are defined in the Master Appointment Type file and in the individual clinic/place of care and provider profiles (i.e., New, Consultation, or Follow-up). If you press <Return> the system searches for all appointment types for the MTF providers with the specialty type and location you are searching for.

   The system displays the Provider Search screen with the selected provider's name and other information in the Select Window. (Refer to Figure 6-36. Provider Search Screen, page 6-65.)

```
                                PROVIDER SEARCH
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                  DDS: 20
      Patient Type: ACTIVE DUTY                      Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M           PCM Phone: 202 271-5850
Case Mgmt Provider:                            Case Mgmt: NO
         Specialty: DERMATOLOGY                Appt Type:
          Location: 20307
        Start Date: 21 Jun 2001                Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F         Number of Visits: 1
          Priority: ROUTINE            Gender Preference:
          Language:                          Primary OHI: NOT ASSIGNED

    Provider       CS Cat Agr Place of Care  Zip   %Disc   Telephone
_____________________________________________________________________
  PANGLOSS,ANN M   B  MD  MTF DERM CARE MTF  20307  MTF    202 456-9877



_____________________________________________________________________
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch
Codes
```

Figure 6-36. Provider Search Screen

The Display Window still displays the same patient demographic and PCM information from the data in the CHCS system. The Select Window displays significant provider information:

– Provider Name -- A tilde (~) located next to a provider name indicates that this provider speaks the preferred language of the patient. MTF Providers are listed on the screen in ZIP Code order and within each ZIP Code by first available appointment.

– Certification Specialty (CS) -- This is the level of board certification that this provider holds for this specialty and is often of interest to the patient. Levels (with code) are:

  - Not certified (blank, no code)

  - Board certified (BO)

  - National certification (NA).

– Provider's Professional Category Code (CAT) -- The system contains more than 40 professional categories. Some of the more commonly used categories (with code) are:

  - Surgeon (SUR)

  - Medical Doctor (MD)

  - Nurse Practitioner (NPC)

  - Physician Assistant (PA)

  - Occupational Therapist (OTH).

– Group/Military Provider Agreement Type (AGR) -- This agreement indicates the type of patients that providers will accept. See Tables 1, 2, and 3 for provider agreement types and associated patient types.

– Place of Care -- The name of the clinic where the patient receives care.

– ZIP Code of the Place of Care (ZIP) -- coincides with the search criteria entered previously.

– 1st Available Appointment -- Shows the first available appointment for each of the providers, based on the type of appointment selected.

– The plus (+) sign at the left of the bottom provider name indicates that the list of providers is longer than the display space. Use the down-arrow key to scroll through the list entire list.

The Interact Window displays the message to either select the provider or press <F9> to view the daily Schedules, Discount Summaries (percent of discount off the CHAMPUS maximum allowable charge -- exception and only service available providers could have zero as their discount), Place of Care information such as directions, hours of service, or comments, or Watch Codes (inactivated indefinitely) for a particular provider.

1. Press <F9> (to access the Provider Discount Summary action bar).

   Actions on the Provider Discount Summary action bar are:

   (O)verall Summary: Choose this action to display the Individual Provider Discount Summary screen, which shows the overall discount rate for the selected provider.

   (S)pecialty Exceptions: Choose this action to display the Individual Provider Specialty Exceptions screen, which shows pricing exceptions for selected specialty care for this provider.

   (C)PT Exceptions: Choose this action to display the Individual Provider Procedure Exceptions screen, which shows pricing exceptions for specific medical procedures (CPT4) performed by this provider.

   (P)lace of Care: Choose this action to display the Provider Group Places of Care screen, which shows directions to, comments about, and hours of services for this providers place of care.

   (Q)uit: Choose this action to quit the <F9> expansion window and return to the Provider Search screen where you can continue your provider selection.

2. Press <Return> to accept the default to view the Overall Summary for this provider.

View Provider Detail

The system displays the MCP Individual Provider Discount Summary screen shown in Figure 6-37. MCP Individual Provider Discount Summary for an MTF Provider, page 6-68.

This screen shows the providers MCP Provider Group name, Agreement Type, the agreement's effective start and stop dates, overall discount rate (100% for an MTF provider), and whether the provider is designated as a PCM.

```
                    MCP INDIVIDUAL PROVIDER DISCOUNT SUMMARY


      MCP Provider: PANGLOSS,ANN M
MCP Provider Group: DERM CARE MTF
-------------------------------------------------------------------------
 Agreement  Effective                  Overall   FI
   Type       Date       Stop Date     Discount  Notified     Except  PCM
_________________________________________________________________________
   MTF      01 Jan 2001  01 Jan 2005   CA-100%




_________________________________________________________________________
Press <RETURN> to continue
```

Figure 6-37. MCP Individual Provider Discount Summary for an MTF Provider

1. Press <Return> to continue.

   The system returns you to the action bar.

2. Press <Return> to accept the (Q)uit action.

   The system positions the cursor beside the provider's name.

3. Press <Select>.

   The system returns to the Add Appointment Referral screen, and displays only the referral just generated. (Refer to Figure 6-38. Add Appointment Referral Screen, page 6-69.)

Initiate the booking process

The Add Appointment Referral screen shows you which referral you are processing.

```
                              ADD APPOINTMENT REFERRAL
           Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER      Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                  DDS: 20
      Patient Type: ACTIVE DUTY                      Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M           PCM Phone: 202 271-5850
Case Mgmt Provider:                            Case Mgmt: NO

    Referral#  Date/Time        Provider          Specialty       Status
_____________________________________________________________________________
     200100057                                    DERMATOLOGY




_____________________________________________________________________________
Select (I)nterview/Referral, (P)rovider, (B)ook, (O)utputs, (D)elete,
    or (Q)uit ADD APPOINTMENT REFERRAL: B//
```

Figure 6-38. Add Appointment Referral Screen

1. Press <Return> to accept the default to (B)ook the appointment.

   The system displays the MTF Booking Search Criteria screen. (Refer to Figure 6-39. MTF Booking Search Criteria Screen, page 6-70.)

```
                          MTF BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                     FMP/SSN: 20/379-43-6114
Patient Type: ACTIVE DUTY                     Appt Type:
Clinic: DERM CARE MTF/DIVA                    Specialty: DERMATOLOGY
Clinic Phone: 202 456-9877
Provider: PANGLOSS,ANN M                      Duration:
Location: 203                                 Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001             Time Range: 0900 to 1400
_____________________________________________________________________________
  Referral Number: 200100058          Referral Date/Time: 21 Jun 2001@1013
      Patient Type: ACTIVE DUTY                MCP Status: ENROLLED
     Pt Home Phone: 918-555-0287           Pt Duty Phone: 202-555-6802
               PCM: ESPOSITO,FRANK M            PCM Phone: 202 271-5850
          Priority: ROUTINE              Number of Visits: 1
      Appts Booked:                     Wait List Requests:
   Reason for Referral:



_____________________________________________________________________________
Select(C)hange Search Criteria,(P)rovider Search,(B)rowse,(S)ingle Pa-
tient,Appt (R)efusal, (W)ait List Add, (T)el-Consult, or (Q)uit: S//
```

Figure 6-39. MTF Booking Search Criteria Screen

The Display Window displays the current demographic, provider, and referral information for the selected patient and selected provider from CHCS.

The Select Window displays information for the selected referral. This screen is view only.

The Interact Window displays the action bar, which contains the following actions:

(C)hange Search Criteria: Choose this action to change the search appointment criteria for the referral requested. These criteria changes are limited to the Appointment Type, Time Range, Days of the Week, and Duration fields.

(P)rovider Search: Choose this action to select the type of Provider Search to be performed, e.g., MTF, External, Non-network.

(B)rowse: Choose this action to search the specified provider's schedule for a specific day to locate and display bookable appointment slots. This search is not limited to locating open appointment slots, but also locates and displays booked, frozen, wait listed, and canceled appointment slots. Using the Browse

action, slots may be joined, split, overbooked, or have the appointment type changed.

(S)ingle Patient: Choose this action to book one or more appointments, with the specified appointment type, for the designated MTF provider in a specified clinic, on one or more days for the specified patient. If no appointment type was entered, all available appointments for that provider are displayed. This search is confined to open slots only.

Appt (R)efusal: Choose this action to enter a patient's appointment refusal. An appointment refusal may be entered without selecting an appointment or creating a formal referral.

(W)ait List Add: Choose this action to put this patient on the Wait List for the specified MTF place of care linked to the referral (only available if the specified clinic maintains an active Wait List).

(T)el-Consult: Choose this action to document a telephone call from a patient who calls an HCF to leave a message for the provider with whom they have a booked or pending appointment, as a result of a particular referral.

(Q)uit: Chose this action to quit the MTF Booking Search Criteria screen and return to the Modify Appointment Referral screen.

1. Press <Return> to accept the (S)ingle Patient default action.

2. The system displays the MTF Single Patient Booking screen showing all the provider's open appointment slots, beginning with the first open slot. (Refer to Figure 6-40. MTF Single Patient Booking Screen, page 6-72.)

   The Select Window shows the day of the week, time, date and appointment type for all the provider's available appointments. The 1/0 at the right of each appointment slot, indicates that only one patient can be booked into the slot and, to date, no patients have been booked into the slot.

   Had you entered a specific appointment type earlier at the *Select APPT TYPE* prompt, only open appointments of that type would display.

```
                              MTF SINGLE PATIENT BOOKING
Patient: PICARD,ZACHARY E                        FMP/SSN: 20/379-43-6114
Patient Type: ACTIVE DUTY                        Appt Type:
Clinic: DERM CARE MTF/DIVA                       Specialty: DERMATOLOGY
Clinic Phone: 202 456-9877
Provider: PANGLOSS,ANN M                         Duration:
Location: 203                                   Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                Time Range: 0900 to 1400
_____________________________________________________________________________
   FRI 0800 22 Jun 01 NEW    1/0
   FRI 0830 22 Jun 01 NEW    1/0
   FRI 0900 22 Jun 01 NEW    1/0
   FRI 0930 22 Jun 01 NEW    1/0
   FRI 1000 22 Jun 01 NEW    1/0
   FRI 1030 22 Jun 01 NEW    1/0
   FRI 1100 22 Jun 01 NEW    1/0
   FRI 1130 22 Jun 01 NEW    1/0
+  FRI 1300 22 Jun 01 CON    1/0
_____________________________________________________________________________
Use SELECT key to select appointment(s) to be booked
```

Figure 6-40. MTF Single Patient Booking Screen

The Display Window displays current patient demographic information and referral information for this booking search from the data in CHCS for this appointment search.

The Select Window displays the available appointments for the selected MTF provider.

The Interact Window displays the message telling you to select the appointment(s) to be booked.

1. Position the cursor next to the desired appointment and press <Select>, then press <Return>.

   The maximum number of appointments that you may select depends upon the number of visits entered for this specific referral. You entered this information on the Interview/Referral screen.

   At this time, if you have selected more appointments for booking than the number of visits allowed for this referral, the system displays an error message. You must deselect the excess number of appointment slots before you can continue. Deselect an appointment by positioning the cursor beside the appointment and pressing <Select> again.

If you previously entered an appointment type in your search criteria, only those types of appointments display on this screen (e.g., New). If you leave the appointment type field blank, all available appointments for the provider display, regardless of the appointment type specified in the provider/clinic profile (i.e., New, Consultation, and Follow-up).

Note: Whenever an appointment slot is selected for booking, the system checks to see if the proposed appointment conflicts with any previously booked appointment. If the proposed appointment conflicts with an existing appointment, the system displays a warning message about the type of conflict found:

Direct Conflict–An override is not allowed if an existing appointment is already scheduled for the same time.

Close Proximity–You may book the appointment if the proposed appointment is in close proximity to a pending appointment. A close proximity appointment is determined by the appointment interval field in the facility profile in number of minutes.

After the warning message displays, depending on the conflict type, the system prompts you to indicate whether to override this conflict warning in order to book the proposed appointment.

---

2. The system displays the File appointment screen. (Refer to Figure 6-41. File Appointment Screen, page 6-74.)

Book the Appointment(s)

```
                                FILE APPOINTMENT
Patient: PICARD,ZACHARY E                        FMP/SSN: 20/379-43-6114
Patient Type: ACTIVE DUTY                        Appt Type:
Clinic: DERM CARE MTF/DIVA                       Specialty: DERMATOLOGY
Clinic Phone: 202 456-9877
Provider: PANGLOSS,ANN M                         Duration:
Location: 203                                   Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001                Time Range: 0001 to 2400
_____________________________________________________________________________
   FRI 0800 22 Jun 01 NEW    1/0




_________________________Select Slot #1 of 1_______________________________
Select (B)ook appt, or (Q)uit FILE APPOINTMENT: B//
```

Figure 6-41. File Appointment Screen

Refer to explanation following Figure 6-12. File Appointment Screen, page 6-21, for a full explanation of this screen.

1. Press <Return> to accept the (B)ook appt action.

2. The system displays the second File Appointment screen.

```
PATIENT APPOINTMENT: PICARD,ZACHARY E                    FILE APPOINTMENT

                         FRI 0800 22 Jun 01 NEW    1/0
    No reminder notice will be sent. Hand-carry Radiology/Patient records.
                   Clinic Message: Arrive 10 minutes early.
   Clinic/Appt Type Instructions:
                  Provider Message:
 Provider/Appt Type Instructions:
                   Arrival Message: 10 minutes
            Registration Comment:

                      MEPRS Code: BAPA
              Requesting Service:
                     Referred By:
            Send Reminder Notice: NO
             Appointment Comment:
          Reason for Appointment:


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 6-42. File Appointment Screen (Continuation)

Refer to the explanation following Figure 6-13. File Appointment Screen Continuation, page 6-22, for a full explanation and steps for completing this screen.

After you complete this screen and file the data, the system displays the message `-Appointment Booked -` and returns to the MTF Single Patient Booking Screen. The system asks if you want to print a copy of the patient's appointments/Wait List requests.

Print hard copy of patient's appointments/wait list requests

Refer to Print hard copy of patient's appointment(s)/wait list requests, page 6-24.

Print appointment referral products

See Sections 6.1.3.1 and 6.4.1.

Booking an appointment with an MTF provider

When you select the (M)TF action, the system searches for providers with an agreement type of either CON, MTF, PIC, or SUP, whose place of care has a location type of C (clinic) or S (same day surgery), and whose agreements and availability meet the other search requirements specified in the referral. Refer to Appendix A, Table 6-1, for a list of the MTF provider agreement types along with the eligible patient types for each agreement type.

EXAMPLE: Book Active Duty to Direct Care Provider

Example for Search: If the HCF enters an appointment referral for an enrolled Active Duty patient (Patient Type = MCA) in order that the patient may receive specialty care with a Cardiologist (Specialty Types under Cardiologist includes Cardiologist and Cardiac Surgeon) in the La Jolla area (ZIP Code Combination = La Jolla or as defined in the ZIP Code Combination file = 92121, 92122 and 92123), the HCF would accept the default of MCA in the PATIENT TYPE field, Cardiologist in the SPECIALTY field, and La Jolla in the ZIP CODE field.

EXAMPLE: Active Duty to Direct Care Provider

Example for Search: When the HCF elects (in the above example) to search for all active MTF providers with current agreements that not only meet the search criteria but also meet patient appointment preferences (for instance, the patient prefers an appointment on either Monday or Wednesday, between 0800 and 1000, with a female provider who speaks Spanish), the system first searches the MCP Provider file for all those female MCP providers with an agreement type of CON, MTF, or SUP with a provider specialty of either Cardiologist or Cardiac Surgeon, whose place of care ZIP Code is either 92121, 92122, or 92123, and who have an available appointment slot on Monday and/or Wednesday for the date range entered. If no date range is entered, the system, defaults to today plus six weeks.
When the list displays, any provider who speaks Spanish has a tilde (~) displayed next to her name. These providers are listed in ZIP Code order and within each ZIP Code by first available appointment.

Note: MTF providers with an agreement type of PIC do not appear on the provider list as those providers do not see active duty patients.

Access the Appointment Referral Booking (AHCF) option on the Health Care Finder menu

Select patient

Review current DEERS eligibility

Review patient demographics

Enter Appointment Referral/patient preference data

Select an MTF provider

View provider detail

Initiate the booking process

Book the appointment(s)

Print hard copy of patient's appointments/Wait List requests

Print appointment referral products

Assume the first five steps above have already been completed.

Select an MTF Provider

Refer to Section 6.1.3.2 Find a Provider, page 6-58.

Beginning at the Provider Search screen and action bar (see Figure 6-35. Provider Search Screen, page 6-64):

1. Enter "M" to access the (M)TF search action.

2. The system prompts you to select appointment type.

3. Enter appointment type.

   This requested appointment type must match the appointment types that are defined in the Master Appointment Type file and in the individual clinic/place of care and provider profiles (i.e., New, Consultation, or Follow-up). If you press <Return> the system searches for all appointment types for

the MTF providers with the specialty type and location you are searching for.

4. The system displays in the Provider Search Select Window, all MTF providers with the specialty type, location, and appointment type matching your search criteria. The first available appointment for each provider is also displayed. (Refer to Figure 6-43. Provider Search Screen (with MTF Providers Displayed in the Select Window), page 6-78.)

```
                                PROVIDER SEARCH
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                    DDS: 20
      Patient Type: ACTIVE DUTY                        Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO
         Specialty: DERMATOLOGY                  Appt Type:
          Location: 203
        Start Date: 21 Jun 2001                  Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F           Number of Visits: 1
          Priority: ROUTINE              Gender Preference:
          Language:                            Primary OHI: NOT ASSIGNED

    Provider        CS Cat   Agr Place of Care   Zip     1st Available Appt
_____________________________________________________________________________
    PANGLOSS,ANN M   B  MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
    PANACHE,BASIL M     MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
    PANTOUM,CAROL M  E  MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
+   PARAMOUNT,DOUGL  B  MD    MTF DERM CARE MTF   20307   22 Jun 2001@0800
_____________________________________________________________________________
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch
Codes
```

Figure 6-43. Provider Search Screen (with MTF Providers Displayed in the Select Window)

View provider detail

Refer to Figure 6-36. Provider Search Screen, page 6-65, and accompanying explanation of the Provider Search screen and the <F9> function.

Initiate the booking process

1. Use the down-arrow key to position the cursor next to the desired provider name. When the cursor is positioned, press <Select>.

   The system immediately returns to the Appointment Referral screen, except now the default action on the action bar is “B” for (B)ook. The referral number and specialty type displays in the Select Window. A message just above the action bar tells you the Provider eligibility dates. (Refer to Figure 6-44. Add Appointment Referral Screen with Provider Eligibility Dates, page 6-79.)

```
                              ADD APPOINTMENT REFERRAL
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                    DDS: 20
      Patient Type: ACTIVE DUTY                        Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO

    Referral#  Date/Time        Provider           Specialty       Status
_____________________________________________________________________________
     200100057                                     DERMATOLOGY



_____Provider eligibility dates are from 21 Jun 2001 to 06 Jul 2001____
Select (I)nterview/Referral, (P)rovider, (B)ook, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: B//
```

Figure 6-44. Add Appointment Referral Screen with Provider Eligibility Dates

1. Press <Return> to accept the default (B)ook action on the Appointment Referral Screen action bar.

   The system displays the MTF Booking Search Criteria Screen. (Refer to Figure 6-39. MTF Booking Search Criteria Screen, page 6-70.) Press <Return> to accept the “S” default for (S)ingle Patient action.

   The system displays the schedule for the selected MTF provider on the MTF Single Patient Booking screen. (Refer to Figure 6-40. MTF Single Patient Booking Screen, page 6-72.)

2. Select the desired appointment.

   Choose the first appointment acceptable to the patient. If additional appointments are required, use the arrow keys to browse the list to select additional appropriate appointment slots. When finished, press <Return> to indicate you have completed your selections.

3. Press <Return> to indicate you have completed your appointment selections.

4. After you confirm the appointment slot selection(s), the system displays the File Appointment screen. (Refer to Figure 6-41. File Appointment Screen, page 6-74.)

Book the appointment(s)

1. Press <Return> to accept the (B)ook appt action.

2. The system displays the second File Appointment screen. (Refer to Figure 6-42. File Appointment Screen (Continuation), page 6-75.)

Print hard copy of patient's appointments/wait list requests

Refer to Print hard copy of patient's appointment(s)/wait list requests, page 6-24.

Print appointment referral products

Refer to Section 6.1.3.3 Print appointment referral products, page 6-101 and Section 6.4.1 Output Products (OHCF), page 6-131.

Booking an appointment with an external (civilian) provider and printing directions to the providers place of care

Scenario

You have already added an appointment referral for an SCD patient who needs to see an internal medicine provider located in ZIP code area 22203. You now need to locate a provider, book the appointment, and give the patient written directions to the provider's place of care.

Access the Appointment Referral Booking (AHCF) option on the Health Care Finder menu

Select patient

Review current DEERS eligibility

Review patient demographics

Enter Appointment Referral/patient preference data

Find an external provider

View external provider detail

Initiate the booking process

Add an appointment slot

Book the appointment with the civilian provider

Print directions to the provider's place of care

Print hard copy of patient's appointments/Wait List requests

Print appointment referral products

Select an external provider

The External (Non-MTF) Provider Search allows you to search for Network (Non-MTF) providers with an agreement type of CON, NET, PEX, or SUP, and whose place of care has a location type of O (i.e., MCP Non-MTF). Refer to Appendix A, Table 6-2, External (Non-MTF) Provider Agreement Types and Eligible Patient Types.

An external provider is a member of the provider network, but is not located at the MTF. If there are no MTF providers who meet the search criteria for the appointment referral, the HCF searches the MCP provider file for an external (civilian) provider who meets the search criteria of agreement type, specialty, and ZIP code. The system lists external providers by percent discount, within discount by ZIP code in random order.

EXAMPLE: Book Non-Active Duty to External Provider

Example for Search: If the HCF elects to search for all active External (Non-MTF) providers with current agreements that meet the search criteria, the system first searches the MCP Provider file for all those MCP Providers with an agreement type of CON, NET, PEX, SUP, and NON with a provider specialty of either Cardiologist or Cardiac Surgeon whose place of care ZIP code is either 92121, 92122, or 92123.

When the list displays, the system first lists all External (Non-MTF) Network providers in ZIP code order. At the end of the list all Non-Network providers (that is, only service available and exception providers) with an agreement type of NON for the specialty type entered displays regardless of the ZIP code(s) or ZIP code location entered.

The first five steps listed in the box above are the same whether your patient needs an MTF provider or a civilian provider. Assume you've already completed those steps and you are now at the Add Appointment Referral screen shown in Figure 6-45. Add Appointment Referral Screen, page 6-83.

When the HCF elects to search for all active External providers with current agreements that meet the search criteria, the system searches the MCP Provider file for all External providers with the appropriate agreement types, specialty, and ZIP Code location. The External providers who meet the criteria appear in random order each time an HCF initiates a provider search. Schedules for external providers are not be entered in CHCS. The HCF selects a provider and calls that provider to determine appointment availability. Once the HCF has booked an appointment with an external provider from the list and a new search has been initiated, the selected provider and the patient for whom an appointment was booked displays at the bottom of the list within the appropriate ZIP code. The picklist is grouped by ZIP code and within ZIP code, by discount summary.

```
                              ADD APPOINTMENT REFERRAL
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                  DDS: 20
      Patient Type: ACTIVE DUTY                      Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M           PCM Phone: 202 271-5850
Case Mgmt Provider:                            Case Mgmt: NO

    Referral#  Date/Time        Provider          Specialty       Status
_____________________________________________________________________________
     200100058                                     INTERNAL MEDICI



_____________________________________________________________________________
Select (I)nterview/Referral, (P)rovider, (O)utputs, (D)elete,
       or (Q)uit ADD APPOINTMENT REFERRAL: P//
```

Figure 6-45. Add Appointment Referral Screen

1. Press <Return> to accept the default (P)rovider action.

   The system displays the Provider Search Screen shown in Figure 6-46. Provider Search Screen, page 6-84.

```
                                PROVIDER SEARCH
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                    DDS: 20
      Patient Type: ACTIVE DUTY                        Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO
         Specialty: INTERNAL MEDICINE            Appt Type:
          Location: 22203
        Start Date: 21 Jun 2001                  Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F           Number of Visits: 1
          Priority: ROUTINE              Gender Preference:
          Language:                            Primary OHI: NOT ASSIGNED
_____________________________________________________________________________



_____________________________________________________________________________
Search for (A)ppt Refusal,(P)rovider Name,(M)TF,(E)xternal,N(o)n-Network,
            or (Q)uit Provider Search:
```

Figure 6-46. Provider Search Screen

1. At the Provider Search Action Bar, enter “E” for External.

   The system replaces the action bar with a prompt to select appointment type.

2. Press <Return> at the *Select APPT TYPE* prompt or enter the desired appointment type.

   The system displays the Provider Search screen for external providers. (Refer to Figure 6-47. Provider Search Screen (for External Providers), page 6-85.)

```
                                PROVIDER SEARCH
          Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER        Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                      DDS: 20
      Patient Type: ACTIVE DUTY                          Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M               PCM Phone: 202 271-5850
Case Mgmt Provider:                                Case Mgmt: NO
         Specialty: INTERNAL MEDICINE              Appt Type:
          Location: 22203
        Start Date: 21 Jun 2001                    Stop Date: 06 Jul 2001
      Days of Week: M TU W TH F             Number of Visits: 1
          Priority: ROUTINE                Gender Preference:
          Language:                              Primary OHI: NOT ASSIGNED

   Provider         CS   Cat  Agr Place of Care Zip   %Disc   Telephone
_____________________________________________________________________________
   PARLANCE,ABBAS   MD   NET  FARRAGUT CENTER   22203 CA-12%  703 544 1232
   PAESTUM,BARBARA  MD   NET  FARRAGUT CENTER   22203 CA-12%  703 544 1232
   PAISLEY,CLIFTON  MD   NET  FARRAGUT CENTER   22203 CA-12%  703 544 1232
+  PRINGLE,DIANE C  MD   NET  FARRAGUT CENTER   22203 CA-12%  703 544 1232
_____________________________________________________________________________
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch
Codes
```

Figure 6-47. Provider Search Screen (for External Providers)

The Display Window provides the demographic information for the patient.

The Select Window shows the Provider Name, CS, CAT, AGR, Place of Care, and ZIP Code. It includes two additional columns not included for the MTF provider. These are the % Discount and the Telephone Number for the place of care. The discount rate applies to non-MTF providers only. A contractor may record their discounts on CHCS. The phone number is included for the HCF to contact the provider's place of care for available appointments. Once the HCF has contacted the place of care, the HCF can then create an appropriate appointment slot and book the appointment for the specified patient.

Note: The External providers who meet the criteria appear in random order each time a HCF initiates a provider search. Once the HCF has booked an appointment with an external provider from the list and a new search has been initiated, the previous provider selected and for whom an appointment was booked displays at the bottom of the list within the appropriate ZIP code. The picklist is grouped by ZIP code and within ZIP code, by discount summary.

The Interact Window displays the message to either select the provider or press <F9> to view the discount summaries or place of care or schedule.

View external provider detail

At this point in your provider search, you may want to review more specific information about provider discounts or place of care before you select a provider.

1. Use the down-arrow key to position the cursor next to the desired provider name. In this example, the cursor was moved to PEARY,ZACHARY C.

IMPORTANT: Do not press <Select> until after you have viewed the Provider Discount Summary action bar.

---

2. Press <F9> (to access the Provider Discount Summary action bar).

   Actions on the Provider Discount Summary action bar are:

   (O)verall Summary: Choose this action to display the Individual Provider Discount Summary screen, which shows the overall discount rate for the selected provider.

   (S)pecialty Exceptions: Choose this action to display the Individual Provider Specialty Exceptions screen, which shows pricing exceptions for selected specialty care for this provider.

   (C)PT Exceptions: Choose this action to display the Individual Provider Procedure Exceptions screen, which shows pricing exceptions for specific medical procedures (CPT4) performed by this provider.

(P)lace of Care: Choose this action to display the Provider Group Places of Care screen, which shows directions to and comments about the place of care for this provider.

(Q)uit: Choose this action to quit the <F9> expansion window and return to the Provider Search screen where you can continue your provider selection.

3. Press <Return> to accept the default to view the Overall Summary of this provider.

The system displays the MCP Individual Provider Discount Summary screen shown in Figure 6-48. MCP Individual Provider Discount Summary Screen, page 6-87.

```
                    MCP INDIVIDUAL PROVIDER DISCOUNT SUMMARY



      MCP Provider: PEARY,ZACHARY C
MCP Provider Group: FARRAGUT CENTER
-----------------------------------------------------------------------
 Agreement  Effective                  Overall   FI
   Type      Date         Stop Date    Discount  Notified     Except   PCM
_______________________________________________________________________
   NET      01 Jan 2001  01 Jan 2005  CA- 12%



_______________________________________________________________________
Press <RETURN> to continue
```

Figure 6-48. MCP Individual Provider Discount Summary Screen

This screen includes provider name, provider group name, agreement type, effective start and stop dates of discount agreement, overall discount rate, the FI notification date of changes to the agreement, whether the provider has exceptions and if the provider is a PCM.

1. Press <Return> to continue and select the Specialty Exceptions action (if you don't want to continue, press <Shift>-<^> to return to the Non-MTF Booking Search Criteria action bar).

The system displays the Specialty Exceptions screen shown in Figure 6-49. MCP Individual Provider Specialty Exceptions Screen, page 6-88.

```
                  MCP INDIVIDUAL PROVIDER SPECIALTY EXCEPTIONS


               MCP Provider: PEARY,ZACHARY C
         MCP Provider Group: FARRAGUT CENTER
-----------------------------------------------------------------------
-    Specialty                                      Discount          FI
Code             Start Date    Stop Date   Fee   Percent    Notified
_______________________________________________________________________
018              01 Jan 2001               $00     08%



Press <RETURN> to continue
```

Figure 6-49. MCP Individual Provider Specialty Exceptions Screen

The details displayed for each of the specialty exception codes for the selected MCP provider and MCP provider group are: start and stop dates, discount fee or discount off the cost, and FI notified date (date FI notified of changes to specialty exceptions).

1. Press <Return> to continue and then select the CPT Exceptions action

   The system displays the CPT Exceptions screen shown in Figure 6-50. MCP Individual Provider Procedure Exceptions Screen, page 6-89.

```
                  MCP INDIVIDUAL PROVIDER PROCEDURE EXCEPTIONS


               MCP Provider: PEARY,ZACHARY C
         MCP Provider Group: FARRAGUT CENTER
-----------------------------------------------------------------------
    CPT-4                                          Discount          FI
    Code         Start Date    Stop Date       Fee   Percent    Notified
_______________________________________________________________________
    43234        01 Jan 2001                   $225     00%



_________________________No Procedure Exceptions found____________________
Press <RETURN> to continue
```

Figure 6-50. MCP Individual Provider Procedure Exceptions Screen

The details displayed for each of the CPT (procedure) exceptions for the selected MCP provider and the MCP provider group are: start and stop dates, discount fee or percent of discount, and FI notified date (date FI notified of change to provider CPT4 discount).

1. Press <Return> to continue.

2. Select the Place of Care action to display the Provider Group Places of Care screen (shown in Figure 6-51. MCP Provider Group Places of Care, Page 1, page 6-90), which gives directions to, and comments on, the places of the care for the provider.

```
                        MCP PROVIDER GROUP PLACES OF CARE

Place of Care: FARRAGUT CENTER
Address: 221 Hanover Street                        City: ARLINGTON
State: VIRGINIA                                 Zip Code: 22203
Phone: 703 544 1232
_____________________________________________________________________
                        Directions to Place of Care

Located on Hanover Street near the corner of Waldorf and Woodlawn,one
block south of Curtis Memorial Pkwy.

                         Comments on Place of Care

  Handicapped parking and wheelchair access available.



_____________________________________________________________________
Press <RETURN> to continue
```

Figure 6-51. MCP Provider Group Places of Care, Page 1

1. Press <Return> to continue.

   The provider's hours of service are displayed as shown in Figure 6-52. MCP Provider Group Places of Care, Page 2, page 6-91.

```
                        MCP PROVIDER GROUP PLACES OF CARE

Place of Care: FARRAGUT CENTER
Address: 221 Hanover Street                          City: ARLINGTON
State: VIRGINIA                                  Zip Code: 22203
Phone: 703 544 1232
_____________________________________________________________________________
----------------------------- Hours of Service -----------------------

                    Day of Week         AM              PM
                    MONDAY          0700 - 1200     1201 - 1700
                    TUESDAY         0700 - 1200     1201 - 1700
                    WEDNESDAY       0700 - 1200     1201 - 1700
                    THURSDAY        0700 - 1200     1201 - 1700
                    FRIDAY          0700 - 1200     1201 - 1700
                    SATURDAY        0800 - 1200     0000 - 0000



_____________________________________________________________________________
Press <RETURN> to continue
```

Figure 6-52. MCP Provider Group Places of Care, Page 2

1. Press <Return> to continue and then select the Quit action to return to the Provider Search screen. Refer to Figure 6-47. Provider Search Screen (for External Providers), page 6-85.

At the Provider search screen:

1. Use the down-arrow key to position the cursor next to the same Non-MTF provider name as previously selected, PEARY,ZACHARY C in this example, and press <Select>.

2. The system returns to the Add Appointment Referral screen, and displays only the referral just generated. (Refer to Figure 6-53. Add Appointment Referral Screen, page 6-92.)

Initiate the booking process

The Add Appointment Referral screen shows you which referral you are processing.

```
                              ADD APPOINTMENT REFERRAL
          Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER       Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
      Patient Type: ACTIVE DUTY                         Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO

    Referral#  Date/Time        Provider           Specialty       Status
_____________________________________________________________________________
     200100057                                     INTERNAL MEDICINE




_____________________________________________________________________________
Select (I)nterview/Referral, (P)rovider, (B)ook, (O)utputs, (D)elete,
    or (Q)uit ADD APPOINTMENT REFERRAL: B//
```

Figure 6-53. Add Appointment Referral Screen

1. Press <Return> to accept the default to (B)ook the appointment.

   The system displays the Non-MTF Booking Search Criteria screen. (Refer to Figure 6-54. Non-MTF Booking Search Criteria Screen, page 6-93.)

```
                        NON-MTF BOOKING SEARCH CRITERIA
Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS    Appt Type:
Clinic: FARRAGUT CENTER/DIVA                 Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                    Duration:
Location: 22203                              Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001            Time Range: 0900 to 1400
_____________________________________________________________________________
  Referral Number: 200100057                Referral Date/Time: 21 Jun 2001@1152
     Patient Type: SUPPLEMENTAL CARE DIAGN           MCP Status: ENROLLED
    Pt Home Phone: 918-555-0287                    Pt Duty Phone: 202-555-6802
              PCM: ESPOSITO,FRANK M                     PCM Phone: 202 271-5850
         Priority: ROUTINE                       Number of Visits: 1
     Appts Booked:                             Wait List Requests:
  Reason for Referral:
  ACUTE ABDOMINAL TENDERNESS


_____________________________________________________________________________
Select (C)hange Search Criteria, (P)rovider Search, (S)ingle Patient,
       Appt (R)efusal, or (Q)uit: S//
```

Figure 6-54. Non-MTF Booking Search Criteria Screen

The Display Window displays current patient demographic, provider, and referral information.

The Select Window displays referral information, which cannot be edited.

The Interact Window displays an action bar with the following actions:

(C)hange Search Criteria: Choose this action to change the search criteria for the referral requested. These criteria changes are limited to the Appointment Type, Time Range, Days of the Week, and Duration fields. All other search criteria may be changed using the Interview/Referral screen.

(P)rovider Search: Allows you to select providers based on the type of Provider Search to be performed.

(S)ingle Patient: Choose this action to book one or more appointments, with the specified appointment type, for the designated External provider in a specified place of care, on one or more days for the specified patient.

Appt (R)efusal: Choose this action to document a patient's refusal of an appointment.

(Q)uit: Choose this action to quit the Non-MTF Booking Search Criteria screen and return to the Modify Appointment Referral screen.

1. Press <Return> to accept the default Single Patient Booking action.

Add an appointment slot

The system displays the Add An Appointment Slot screen. (Refer toFigure 6-55. Add an Appointment Slot Screen, page 6-94.) This screen creates a specific appointment slot in a dummy provider schedule maintained in CHCS only.

```
                              ADD AN APPOINTMENT SLOT
Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS    Appt Type:
Clinic: FARRAGUT CENTER/DIVA                 Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                    Duration:
Location: 22203                              Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001            Time Range: 0900 to 1400
____________________________________________________________________________




Select (A)dd appointments, or (Q)uit NON-MTF booking: A//
```

Figure 6-55. Add an Appointment Slot Screen

The Display Window displays current demographic information and referral information for this appointment referral.

The Select Window displays the appointment details. This window is blank at this point.

The Interact Window displays an action bar with the following actions:

(A)dd: Choose this action to add an appointment slot to the provider's schedule and then continue processing.

(Q)uit: Choose this action to quit Non-MTF booking.

1. Press <Return> to select the default Add appointments action.

   The system redisplays the Add an Appointment Slot screen with the following message in the Select Window:

   ```
   Enter appointment date@time to be added to the provider's schedule
   or Press <RETURN> to continue
   ```

2. Enter an appointment date@time in one of the following formats:

   22JUN01@0900
   22 JUN 2001@0900
   T+1@0900.

Note: You can add the number of appointment slots you specified in the *Number of Visits* field. If you try to add more, the system displays the following message at the bottom of the Add An Appointment Slot Screen:

```
___Number of appts selected EXCEEDS the number of visits allowed (n)___

Use SELECT key to deselect the excessive appointments.
```

Refer to Figure 6-17. Non-MTF Booking - Add Screen, page 6-29, to create an open appointment slot. File the data in accordance with instructions in Add an appointment slot, page 6-28.

The system redisplays the Add An Appointment Slot screen showing the appointment slot you just added. (Refer to Figure 6-56. Add an Appointment Slot 2, page 6-96.)

```
                              ADD AN APPOINTMENT SLOT
Patient: PICARD,ZACHARY E                    FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS    Appt Type: NEW
Clinic: FARRAGUT CENTER/DIVA                 Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                    Duration:
Location: 22203                              Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001            Time Range: 0900 to 1400
_____________________________________________________________________________
 * FRI 0900 22 Jun 01 NEW    1/0   30 MIN  OPEN
                   <---Enter appointment date@time




_____________________________________________________________________________
Enter appointment date@time to be added to the provider's schedule or
Press <RETURN> to continue.
```

Figure 6-56. Add an Appointment Slot 2

1. Press <Return> to book the newly created, preselected appointment slot.

Book the appointment with the civilian provider

The system displays the File Appointment screen. (Refer to Figure 6-57. File Appointment Screen, page 6-97.) The default of (B)ook appt allows you to formally record the appointment as booked for the patient. This is simply a record in CHCS that the appointment has been booked. It does not actually update the civilian provider's own schedule.

```
                                 FILE APPOINTMENT
Patient: PICARD,ZACHARY E                        FMP/SSN: 20/379-43-6114
Patient Type: SUPPLEMENTAL CARE DIAGNOSIS        Appt Type: CONSULT
Clinic: FARRAGUT CENTER/DIVA                 Specialty: INTERNAL MEDICINE
Clinic Phone: 703 544 1232
Provider: PEARY,ZACHARY C                        Duration:
Location: 22203                                Days of Week: M TU W TH F
Dates: 21 Jun 2001 to 06 Jul 2001               Time Range: 0900 to 1400
_____________________________________________________________________________
   FRI 1000 22 Jun 01 CON    1/0   20 MIN  OPEN



__________________________Select Slot #1 of 1_____________________________
Select (B)ook appt, or (Q)uit FILE APPOINTMENT: B//
```

Figure 6-57. File Appointment Screen

1. Press <Return> to accept the default (B)ook appt.

2. Complete the File Appointment screen.

   The system displays the File Appointment secondary screen with the cursor positioned at the MEPRS Code field (See Figure 6-13. File Appointment Screen Continuation, page 6-22 for an example and explanation of the File Appointment secondary screen.)

3. File the data.

   The system displays the following message:

   ```
   Appointment Booked
   ```

   and redisplays a blank Add An Appointment Slot screen. The action bar on the Add an Appointment Slot screen allows you to (A)dd appointments, (P)rint directions, or (Q)uit NON-MTF booking.

Print Directions to the Provider's Place of Care

1. Press <Return> to accept the default (P)rint directions action on the Add an Appointment Slot action bar.

2. Enter device (printer name) where you want the directions to print.

   If you press <Return> at the *DEVICE* prompt instead of entering a printer name, the Place of Care Directions/Comments displays.

3. Press <Return> to accept the right margin default of 80.

   The system prints/displays the providers' place of care information. (Refer to Figure 6-59. Place of Care Directions/Comments, Screen 2 of 2, page 6-99.)

.

```
                                                  21 Jun 2001@1353   Page 1
                        PLACE OF CARE DIRECTIONS/COMMENTS
Place of Care: FARRAGUT CENTER
==========================================================================
            Patient: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
           Provider: PEARY,ZACHARY C
     Appt Date/Time: 22 Jun 2001@0900

     Street Address: 221 Hanover Street
        City, State: ARLINGTON, VA
                Zip: 22203
  Appt Contact Name: Appointment Clerk
          Telephone: 703 544 1232

Place of Care Hours: From  To   From  To
             Monday  0700 1200  1201 1700
            Tuesday  0700 1200  1201 1700
          Wednesday  0700 1200  1201 1700
           Thursday  0700 1200  1201 1700
             Friday  0700 1200  1201 1700
           Saturday  0800 1200


Press <RETURN> to continue
```

Figure 6-58. Place of Care Directions, Screen 1 of 2

```
                                21 Jun 2001@1359   Page 2
                                    PLACE OF CARE DIRECTIONS/COMMENTS
Place of Care: FARRAGUT CENTER
=========================================================================

         Directions:
Located on Hanover Street near the corner of Waldorf and Woodlawn, one
block
south of Curtis Memorial Pkwy.

           Comments:
Handicapped parking and wheelchair access available.


Press <RETURN> to continue
```

Figure 6-59. Place of Care Directions/Comments, Screen 2 of 2

As soon as the Place of Care Directions/Comments have been printed, the system returns to the Add an Appointment screen, where you can either add another appointment referral or quit the Non-MTF booking process.

Print hard copy of patient's appointments/Wait List requests

If you choose to quit, the system asks if you want to remind the patient of other appointments/wait list requests. (Refer to Print hard copy of patient's appointment(s)/wait list requests, page 6-24, for details.)

Print appointment referral products

Refer to Sections 6.1.3.3 and 6.4.

<u>Booking an appointment with a non-network provider</u>

Non-network providers are those providers with an agreement type of NON, who offer no discount (zero percent discount). These providers include Only-Service-Available (OSA) providers and Exception providers, as well as non-network specialists who have no agreements with the government. Refer to Appendix A, Table 6-3, for a list of Non-Network/Exception provider agreement types along with the eligible patient types that a non-network provider may see.

An OSA provider is a non-network provider who provides a service (such as heart transplants) that is not available to the patients within the network. That provider is the only provider of that care in the area.

If a patient has an existing condition (such as a retiree who suffered a major stroke prior to enrolling to MCP) and the PCM agrees that the patient may continue to see the specialist for continuity of care, the provider could be assigned as the patient's case manager for the specified Specialty Type. This provider would be considered an Exception provider. An Exception provider with an agreement type of NON may be a Case Management provider.

Example for Search: When the HCF elects to search for all active Non-Network providers with current agreements that meet the search criteria, the system first searches the MCP provider file for all those MCP providers with an agreement type of NON with the required provider specialty regardless of ZIP code. If no date range is entered, the system defaults to today plus six weeks.

The system lists only those Non-Network providers (including, OSA and Exception providers) with an agreement type of NON for the specialty type entered regardless of the ZIP code(s) or ZIP code location entered.

To book appointments with a non-network provider, follow the same steps for booking appointments with network external (civilian) providers.

Note that the Provider Search screen shows NON as the agreement type and the %Disc (percent discount) column is blank (refer to Figure 6-60. Provider Search Screen with Non-Network Providers, page 6-101).

```
                                PROVIDER SEARCH
           Patient: BLITON,JERALD                FMP/SSN: 20/278-55-5025
  Patient Category: USA RET TDRL OFFICER         Pat SSN:    278-55-5025
           DOB/Age: 01 Jan 1960/37Y                  DDS: 20
      Patient Type: MCP/CHAMPUS ELIGIBLE             Sex: MALE
        MCP Status: ENROLLED
               PCM: CLASSY MEDICAL CARE       PCM Phone: 619-535-7116
Case Mgmt Provider:                           Case Mgmt: YES
         Specialty: CARD                      Appt Type:
          Location: SAN DIEGO
        Start Date: 01 Apr 1997               Stop Date: 16 Apr 1997
      Days of Week: M TU W TH F        Number of Visits: 1
          Priority: ROUTINE           Gender Preference:
        Language: SPANISH                    Primary OHI: CALIFORNIA CARE

    Provider         CS Cat   Agr Place of Care   Zip   %Disc   Telephone
_____________________________________________________________________________
    BARTON,FRANK       OTH   NON NONNETWORK CARD 92021 CA      234-2345
    CASTLE,RICHARD     OTH   NON OUTSIDE CARDIOL 98014 CA      234-0983
    STEVENS,BRIAN      OTH   NON OUTSIDE CARDIOL 98014 CA      234-0983
+   SHELTON,JAMES      OTH   NON OUTSIDE CARDIOL 98014 CA      234-0983
_____________________________________________________________________________
Use the SELECT key to Select the Provider to whom to refer the patient
Press F9 to view Schedule, Discount Summaries, Place of Care, or Watch
Codes
```

Figure 6-60. Provider Search Screen with Non-Network Providers

6.1.3.3 Print appointment referral products

When you accept the default (O)utputs action, the system displays the Generate Appointment Referral Products Screen. (Refer to Figure 6-61. Generate Appointment Referral Products Screen, page 6-102.)

```
                      GENERATE APPOINTMENT REFERRAL PRODUCTS
           Patient: PICARD,ZACHARY E                FMP/SSN: 20/379-43-6114
  Patient Category: USA ACTIVE DUTY OFFICER         Pat SSN:    379-43-6114
           DOB/Age: 19 Feb 1966/35Y                     DDS: 20
      Patient Type: ACTIVE DUTY                         Sex: MALE
        MCP Status: ENROLLED
               PCM: ESPOSITO,FRANK M             PCM Phone: 202 271-5850
Case Mgmt Provider:                              Case Mgmt: NO

     Referral#  Date/Time        Provider           Specialty       Status
_____________________________________________________________________________
    200100057                                        DERMATOLOGY


_____________________________________________________________________________
Select (E)nrollment Form, (M)embership ID, (C)are Authorization,
       (P)atient Label, Provider (L)abel, or (Q)uit Products: C//
```

Figure 6-61. Generate Appointment Referral Products Screen

The Display Window displays current patient demographic, provider, and referral information about the referral being processed.

The Select Window displays the current referral information. It is display only and cannot be edited.

The Interact Window displays an action bar with the following actions:

(E)nrollment Form: Choose this action to generate an enrollment form if the patient is an enrollee. This form cannot be printed to the terminal screen.

(M)embership ID: Choose this action to generate an embossed MCP membership ID card if the patient is an enrollee. The system does not allow the print request for the embosser card to be sent to a standard printer. The site must have a special embosser machine to generate these cards. After you enter the embosser format name, the system automatically gathers the information needed for this type of membership card.

Note: Instructions for customizing the Membership ID card for your site are in Appendix A.

(C)are Authorization: Choose this action to generate a Care Authorization Form. This selection appears on the action bar whether the current referral has an appointment linked to it or not.

(P)atient Label: Choose this action to generate mailing labels with the specified patient's name and address. These labels are used mainly for sending enrollment forms to the patient. The system does not allow you to print the patient label to the terminal screen or to a standard printer.

Provider (L)abel: Choose this action to generate mailing labels with the name and address of the referred to provider. These labels are used mainly for sending a Care Authorization Form to the provider. The Provider Label action appears on the action bar only if the current referral has at least one appointment linked to it. The system allows you to print this to a standard printer, but not to the terminal screen.

(Q)uit Products: Choose this action to quit Generate Appointment Referral Products action and return to the Add Appointment Referral screen.

These products can also be generated from the Outputs Products Menu (OHCF) option located on the Health Care Finder Menu.

An HCP creating referrals and/or booking appointments linked to a specific referral can produce the appropriate individualized MCP Care Authorization Form prior to booking an appointment. The system prints the appropriate standard text for the type of beneficiary on the Care Authorization Form. Sites may edit the text of the form for each type of beneficiary. The system determines which text to print based on the beneficiary's MCP patient type. See Figure 6-62. Care Authorization Form, Page 1, page 6-105, for an example of the Care Authorization Form.

6.1.3.3.1 Print the Care Authorization Form

1. Press <Return> to accept the default (C)are Authorization action.

   You can also access Output Products from the Output Products (OHCF) option on the Health Care Finder Menu (HMCP) and from the Non-MTF Booking action bar (C(a)re Auth Form).

2. When you accept the default (C)are Authorization action, the system displays the following three prompts at the bottom of the Generate Appointment Referral Products screen:

   Send Patient Records? No//
   Send Radiology Records? No//

Send Lab Results? No//

The default for all three prompts is “No.” Enter “Y,” for yes if any of these records are required by the referred-to provider.

3. Enter the name of the printer where you want the Care Authorization Form to print and accept the default right margin of 80.

4. Press <Return> at the *DO YOU WANT TO FREE UP THIS TERMINAL? NO//* prompt.

   The system prints the Care Authorization Form to the printer you indicated (refer to Figure 6-62. Care Authorization Form, Page 1, page 6-105, and Figure 6-63. Care Authorization Form, Page 2, page 6-106), and returns to the Generate Appointment Referral Products action bar where you can print other output products if desired.

   The bold print paragraph in Figure 6-62. Care Authorization Form, Page 1, page 6-105, is site definable through the MCP form text enter/edit (FORM) option (Menu Path: PAS System Menu →MAN →FMCP →ETAB →FORM). (Refer to Section 2.1.1.4) Text may be defined separately for each type of beneficiary, i.e., active duty, CHAMPUS eligible, Medicare, and direct care only (not Medicare).

```
TRAINING MEDICAL TREATMENT FACILITY                        21 Jun 2001@1307
                Personal Data - Privacy Act of 1974 (PL 93-579)
                            MCP CARE AUTHORIZATION FORM
==========================================================================
Referral Number: 200100057            Date/Time Issued:  21 Jun 2001@1300
        Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114

Patient Category: USA ACTIVE DUTY OFFICER          Pat SSN: 379-43-6114
         DOB/AGE: 19 Feb 1966/35Y                      DDS: 20
      Home Phone: 918-555-0287                  Duty Phone: 202-555-6802
    Patient Type: ACTIVE DUTY                   MCP Status: ENROLLED
     Primary OHI: NOT ASSIGNED                Sponsor Rank: CAPTAIN
     Referred To:


           PEARY,ZACHARY C
           FARRAGUT CENTER
           221 Hanover Street
           ARLINGTON, VA  22203

ACTIVE DUTY MCP ENROLLED

This Care Authorization covers necessary specialty care directed by the
primary care provider and authorized by the Primary Care Manager. The
care covered may be provided either within the MTF or by one of the
civilian network providers.

As a MCP HMO Option participant, the patient is responsible for cost
shares accrued during this episode of care.

Referred By: ESPOSITO,FRANK M       Referring Provider Phone: 202 427-1281
                                    Referring Provider Fax #:
        HCF: GARFIELD,JANE                     HCF Phone: 202 555-1111

Reason For Referral:
   Suspicious skin lesions



Provisional Diagnosis:
   172.5      MALIG MELANOMA TRUNK

Referral Procedure:
   17010       DESTRUCTION ANY METHOD BENIGN LESIONS COMPLICATED LESION(S)



 Authorization Begin Date: 21 Jun 2001 Authorization End Date: 06 Jul 2001
                  Priority: ROUTINE
```

Figure 6-62. Care Authorization Form, Page 1

```
TRAINING MEDICAL TREATMENT FACILITY                        21 Jun 2001@1307
             Personal Data - Privacy Act of 1974 (PL 93-579)
                        MCP CARE AUTHORIZATION FORM
==========================================================================
  eferral Number: 200100057            Date/Time Issued:  21 Jun 2001@1300
         Patient: PICARD,ZACHARY E              FMP/SSN: 20/379-43-6114
Number of Visits: 1
  Appt Date/Time: 22 Jun 2001@0900
      Send Patient Records: YES
    Send Radiology Records: NO
          Send Lab Results: NO
   Authorization Signature: FRANK M. ESPOSITO FNP
                MCP Office: OFFICE OF HEALTH CARE FINDER
            Street Address: 678 DUPONT CIRCLE
                      City: WASHINGTON
                     State: DC
                  Zip Code: 20307
              Office Phone: (442)234-0987
        Physician Findings:





      Note: Providers must generate a separate bill for each Referral.
```

Figure 6-63. Care Authorization Form, Page 2

Note: The Physician Findings field is left blank for the referred to physician's comments.

6.1.4 Enter Appointment Refusals (EHCF)

Menu Path: PAS System Menu → MAN → HMCP → EHCF

Required Fields:

Patient Name
Specialty
Refusal Status
Refusal Reason

Application Description:

The Enter Appointment Refusals (EHCF) option enables you to enter appointment refusals for enrolled and non-enrolled patients without entering referral/patient interview data or booking an appointment. The system automatically creates a dummy referral and assigns a unique referral number to it to support system technical requirements. You can add multiple appointment refusals at one time for the specified patient. You can also view all refusals previously entered for that patient for the date range specified, including any appointment refusals entered using the PCM Booking, Appointment Referral Booking, and/or Non-Enrolled Booking options.

The system allows you to document either enrolled or non-enrolled patient refusals for patients who have refused appointments with either an MTF or external civilian provider. The system allows the HCF to enter an appointment refusal with or without booking an open appointment slot first.

In addition to documenting appointment refusals using the Enter Appointment Refusals (EHCF) option, you can document appointment refusals using the appointment refusals action on the MTF Booking Search Criteria action bar and Non-MTF Booking Search Criteria action for enrolled patients. These are accessed through the Appointment Referral Booking (AHCF) option on the Health Care Finder Menu. You can also document appointment refusals using the appointment refusal action on the PCM Booking Search Criteria screen action bar using the PCM Booking (PHCF) option on the Health Care Finder Menu.The appointment refusal action also appears on the Non-Enrolled Booking Search Criteria and Non-Enrolled Non-MTF Booking Search Criteria screens for non-enrolled patients. These are accessed through the Non-Enrolled Booking (NMCP) option on the Managed Care Program Menu.

Note: The clerk or HCF does not have to search for an appointment to log an appointment refusal. The clerk or HCF may be aware that there are no appointments in the MTF available that meet the patient's needs. The clerk or HCF may inform the patient of the situation, and log the refusal if the patient refuses to be referred to a network civilian provider outside the MTF.

Document an Appointment Refusal By an Enrolled Patient

Scenario: A follow-up appointment has been recommended and booked for an enrolled patient. You need to document the patient's refusal.

Access the Enter Appointment Refusals (EHCF) option on the Health Care Finder Menu

Select refusal criteria to be changed

Select patient

Review the Demographics Display screen

Enter refusal criteria

Enter appointment refusal

View or print appointment refusal data

File the data and exit the option

Access the Enter Appointment Refusals (EHCF) option on the Health Care Finder Menu

When you access the EHCF option, the system displays the Appointment Refusals screen (Refer to Figure 6-64. Appointment Refusals Screen (EHCF option), page 6-108):

```
                              APPOINTMENT REFUSALS
Patient:                                          FMP/SSN:
Patient Type:                                     Appt Type:
Location:                                         Specialty:
Dates: 21 Jun 2001 to 21 Jun 2001                 Time Range: 0001 to 2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________________




_________________Patient and Specialty are required_______________________
Select (C)hange Search Criteria, or (Q)uit APPT REFUSALS: C//
```

Figure 6-64. Appointment Refusals Screen (EHCF option)

The Appointment Refusals screen has three windows.

When you access the Appointment Refusals screen through the EHCF option, the Display Window at the top of the screen displays the patient, patient type, location, FMP/SSN, appointment type, and specialty without data at this point.The dates field contains the default of today's date and the time range field contains the default of 0001 to 2400.

When this screen is accessed using the PCM Booking, Appointment Referral Booking, and/or Non-Enrolled Booking options, the current demographics for the selected patient and the provider information for the selected appointment display in these fields.

The Select Window in the middle is blank at this time regardless of how you accessed the screen.

After you have entered a refusal, the Select Window displays:

- the date and time that the patient refused to have the appointment booked
- the name of the HCF who noted the patient's refusal
- the reason for the patient refusal. The Reason for Refusal field contains the coded reason for refusal if both a coded reason and a free-text reason are entered. If only a free-text reason is entered, the system displays as much of the free text as fits in the field
- the status of the refusal. This field shows whether the appointments refused were MTF declined, Civilian (Civ) declined, or Non-Network (Net) declined.

The Interact Window at the bottom, displays the action bar. If you enter an appointment refusal through PCM Booking, Appointment Referral Booking, or Non-Enrolled Booking the action bar allows you to (A)dd Appt Refusal or (Q)uit Appt Refusals. When you enter an appointment refusal through the EHCF option, the action bar allows you to (C)hange Search Criteria or (Q)uit Appt Refusals (refer to Figure 6-65. Appointment Refusals with Selectable Search Criteria, page 6-110).

Select refusal criteria to be changed

At the EHCF Appointment Refusals action bar, press <Return> to accept the default (C)hange Search Criteria and the system adds selectable search criteria to the Select Window (Refer to Figure 6-65. Appointment Refusals with Selectable

Search Criteria, page 6-110). Select the refusal data elements needed to accurately document the conditions associated with the refusal.

```
                              APPOINTMENT REFUSALS
Patient:                                          FMP/SSN:
Patient Type:                                     Appt Type:
Location:                                         Specialty:
Dates: 21 Jun 2001 to 21 Jun 2001                 Time Range: 0001 to 2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________________
   Patient
   Specialty
   Patient Type
   Location
   Appointment Type
   Dates
   Time Range
   Default Search Criteria
_______________Patient and Specialty are required_______________________
Use SELECT key to select SEARCH CRITERIA to be changed
```

Figure 6-65. Appointment Refusals with Selectable Search Criteria

1. Use the down-arrow key to position the cursor beside the criteria you want to change and press <Select>.

   When you press <Select>, the system displays an asterisk (*) by your selection. You can deselect the item by positioning the cursor beside the item and pressing <Select> again. You <u>must select</u> patient and specialty. The remaining items are optional.

2. When finished selecting, press <Return>.

Select patient

Refer to Select patient, page 6-8.

Review the Demographics Display screen

(Refer to Review patient demographics, page 6-10.) When you've completed reviewing the Demographics Display screen, press <Return> to accept the default (C)ontinue action and the system displays the Appointment Refusals screen. (Refer to Figure 6-66. Appointment Refusals Screen, page 6-111.)

Enter refusal criteria

This screen is not searching for appointments but is collecting data to document the refusal.

```
                                APPOINTMENT REFUSALS
Patient: PICARD,ZACHARY E                        FMP/SSN: 20/379-43-6114
Patient Type:                                    Appt Type:
Location:                                        Specialty:
Dates: 21 Jun 2001 to 21 Jun 2001               Time Range: 0001 to 2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________
02Apr01@0900     WILSON,JUDITH    REQUESTED PROVIDER NOT AVAIL  MTF DEC
05Feb01@0900     JONES,JAMES      DISTANCE TOO GREAT TO TRAVEL  NON-MTF


_____________________________________________________________________
Select SPECIALTY:
```

Figure 6-66. Appointment Refusals Screen

The system prompts you to enter each of the additional refusal criteria you selected, beginning with specialty.

1. Enter specialty type.

   Enter the specialty type of the appointment the patient is refusing. The system returns the specialty type name and asks you to confirm that this is the correct specialty. Press <Return> at the *OK? YES//* prompt to indicate the selection is correct. If you enter N for no at the *OK? YES//* prompt, the system returns you to the *Select Specialty* prompt.

2. Enter patient type.

   If you selected patient type as a search criteria, enter one of the following codes:

   MCA – MCP/Active Duty (i.e., active duty, enrolled)

   AD – Active Duty (i.e., active duty, non-enrolled)

   MCP – MCP/CHAMPUS Eligible (i.e., not active duty, CHAMPUS eligible, enrolled)

CHA – CHAMPUS (i.e., not active duty, CHAMPUS eligible, non-enrolled)

MCD – MCP/Non-CHAMPUS Eligible (i.e., not active duty, not CHAMPUS eligible, enrolled)

MED – MEDICARE (i.e., not active duty, not CHAMPUS eligible, enrolled or non-enrolled)

OTH – Other (i.e., direct care that is not CHAMPUS or MEDICARE, non-enrolled)

SCD – Supplemental Care Diagnostics (i.e., a one-time offsite care authorization for a specific test or procedure (e.g., MRI), enrolled or non-enrolled) **Note:** This patient type is new with CHCS Version 4.5.

3. Enter location.

   You can enter either the ZIP code(s) for the area where the patient was to receive the medical care, or the geographical area (e.g., San Diego, Norfolk) already defined in the CHCS ZIP Code Combination file.

   If a ZIP code is entered instead of a geographical area name, up to five different ZIP codes can be entered in this field at one time (separated by commas and no spaces).

   You can also enter a "wild card" ZIP code of the first three digits (e.g., 923). The system searches for all ZIP codes that contain those first three digits.

4. Enter appointment type.

   You can enter the type of appointment your patient is refusing. Enter double question marks (??) to view a list of appointment types.

5. Enter start and stop dates.

   You can enter dates in the past up through today's date at both the start and stop date fields, such as T-1 or T-30. You cannot enter a date in the future and the stop date must be later than the start date. The default for both start and stop dates is today.

6. Enter inclusive earliest time and inclusive latest time.

   The default at the inclusive earliest time field is 0001 and the default at the inclusive latest time field is 2400. You can accept these defaults or narrow

the search if you know the exact or approximate time of the appointment the patient is refusing.

7. Indicate whether you want the current criteria selections to be saved as your default selection criteria.

   After you've entered all the search criteria you selected, the system asks if you want to save your selections as your default selection criteria. If you accept the "Yes" default at this prompt, the next time you need to search for an appointment, the search criteria data you just entered will be defaulted into the top portion of the Appointment Refusals screen. If you enter "N," the search criteria fields in the top window will revert to the system defaults.

Enter appointment refusal

When you've finished entering your search criteria, the system redisplays the Appointment Refusals screen with additional actions on the action bar as shown in Figure 6-67. Appointment Refusals Screen with Second Action Bar, page 6-113. This screen displays all refusals logged for the patient in order from most current to oldest.

```
                                APPOINTMENT REFUSALS
Patient: PHOTON,ZACHARY N                       FMP/SSN: 20/353-30-4614
Patient Type:                                   Appt Type:
Location:                                       Specialty: DERMATOLOGY
Dates: 21 Jun 2001 to 21 Jun 2001               Time Range: 0001 to 2400

   Refusal
   Date/Time     HCF              Reason for Refusal            Status
_____________________________________________________________________
02Apr01@0900     WILSON,JUDITH    REQUESTED PROVIDER NOT AVAIL  MTF DEC
05Feb01@0900     JONES,JAMES      DISTANCE TOO GREAT TO TRAVEL  NON-MTF



_____________________________________________________________________
Select (C)hange Search Criteria, (A)dd Refusal, (V)iew/Print History,
       or (Q)uit APPT REFUSALS: C//
```

Figure 6-67. Appointment Refusals Screen with Second Action Bar

Actions on the second Appointment Refusals action bar are:

<u>(C)hange Search Criteria</u>: Choose this action to change the search criteria and start over.

(A)dd Refusal: Choose this action to enter a new appointment refusal.

(V)iew/Print History: Choose this action to display more detailed information about the appointment refusals for this patient. When this action is selected, the system displays the Appointment Refusal History screen with information about the current appointment refusal.You may also print this data.

(Q)uit Appt Refusal: Choose this action to quit the Appointment Refusal process and returns to the Health Care Finder Menu.

When you enter A for (A)dd Refusal and press <Return>, the system displays the secondary Appointment Refusal Screen with the cursor at the Refusal Status field (refer to Figure 6-68. Appointment Refusal - Secondary Screen, page 6-114). Complete the data entry to document the refusal.

```
APPOINTMENT REFUSALS: 21 Jun 2001@150845              APPOINTMENT REFUSAL

          Patient: PHOTON,ZACHARY N              FMP/SSN: 20/353-30-4614
 Patient Category: USN RET LOS OFFICER           Pat SSN:    353-30-4614
          DOB/Age: 09 Dec 1943/57Y                   DDS:
        Case Mgmt: NO                                SEX: MALE
     Patient Type:                             MCP STATUS:
              PCM:                              PCM Phone:

==========================================================================
  Referral Number:                     Refusal Date/Time: 21 Jun 2001@1508
        Specialty: DERMATOLOGY                 Location:
              HCF: Jane Garfield
   Refusal Status:
   Refusal Reason:
 Refused Provider:
   Refusal Reason: (Free Text)



   HCF Comment:


Ask for Help = HELP    Screen Exit = F10    File/Exit = DO       INSERT OFF
```

Figure 6-68. Appointment Refusal - Secondary Screen

1. Enter refusal status.

The Refusal Status field identifies whether the appointment refused was an MTF declined, a Non-MTF declined (civilian network), or a Network declined appointment. Enter a double question mark (??) to display a picklist of acceptable values and use the down-arrow key and <Select> to choose the appropriate value.

MTF declined means the patient refused an appointment available at the MTF. Non-MTF declined means the patient refused an appointment available within the network but outside the MTF. Network declined means the patient refused all available appointments.

2. Enter refusal reason.

   The Refusal Reason field identifies the coded MCP appointment refusal reason that explains why the MCP patient refused an available appointment. Enter a double question mark (??) to display a picklist of acceptable values or enter the MCP appointment refusal reason code or description. Use the down-arrow key to position the cursor next to the appropriate reason and press <Select>.

   If the Refusal Status is “MTF declined,” chose from the following Refusal Reasons:

   - Requested provider not available
   - Appointment date/time unacceptable
   - Unhappy with MTF service/provider(s)
   - Distance too great to travel
   - Wanted a civilian appointment.

   If the Refusal Status is “Non-MTF” or “Network declined" choose from the following Refusal Reasons:

   - Cost share too high
   - Appointment date/time unacceptable
   - Unhappy with group/provider
   - Distance too great to travel
   - Wanted an MTF appointment.

You may not add site-defined entries to the Refusal Reason file.

Note: If UNHAPPY WITH MTF SERVICE/PROVIDER(S) or UNHAPPY WITH GROUP PROVIDER is entered as the Refusal Reason, the cursor moves to the Refused Provider field where the HCF can enter the refused provider's name. Otherwise, the cursor skips the Refused Provider field and moves to the Refusal Reason free text field.

---

3. Enter free text refusal reason.

   This is a word processing field you can use to enter a more detailed description of why the patient refused the appointment.

4. Enter HCF comment.

   This field allows you to enter additional comments on the MCP patient and why the specified patient may have declined the appointment.

5. File the data.

   The system redisplays the initial Appointment Refusals screen where you can change the search criteria, add another appointment refusal, view the patient's refusal history or quit.

View or print appointment refusal data

When you choose the (V)iew/Print Refusal History action, the system displays the appointment refusal you just entered, and any other appointment refusals for this patient. The Interact Window instructs you to use <Select> to select one of the patient's individual appointment refusals to view or print or press <Return> to continue.

1. To select a refusal, position the cursor next to it and press <Select> and then press <Return>.

2. At the *Select Device* prompt, press <Return> or enter a printer name if you need a hard copy.

3. Press <Return> to accept the default of 80 at the *Right Margin* prompt.

4. The system displays or prints the appointment refusal as shown in Figure 6-69. Appointment Refusal Printout, page 6-117. Press <Return>.

5. Exit the option.

Press <Return> until you reach the action bar where you can change the search criteria, add another refusal, view/print history, or quit appointment refusals.

```
APPOINTMENT REFUSALS: 21 Jun 2001@1537                APPOINTMENT REFUSAL

         Patient: PHOTON,ZACHARY N              FMP/SSN: 20/353-30-4614
Patient Category: USN RET LOS OFFICER           Pat SSN: 353-30-4614
         DOB/AGE: 09 Dec 1943/57Y                   DDS:
       Case Mgmt: NO                                SEX: MALE
    Patient Type:                             MCP Status:
             PCM:                              PCM Phone:
=========================================================================
 Referral Number:                       Refusal Date/Time: 21Jun2001@1508
       Specialty: DERMATOLOGY                     Location:
             HCF: GARFIELD,JANE
  Refusal Status: MTF DECLINED
  Refusal Reason: APPOINTMENT DATE/TIME UNACCEPTABLE
Refused Provider:
  Refusal Reason:  (Free Text)


     HCF Comment:



Press <RETURN> to continue
```

Figure 6-69. Appointment Refusal Printout

6.2 Display Patient Appointments (DMCP)

Menu Path: PAS System Menu → MAN → DMCP

Security Keys:

CPZ CCP needed by all MCP users. No other security keys required to access this option.

Required Fields:

Patient Name
Output Device

Application Description:

The Display Patient Appointments option allows you to display and/or print a patient's past, future, Wait List or specific date selected appointments. The system provides an Appointment Confirmation notice -- a printed copy to remind the patient of the pending appointments. The system produces the notice in the clinic at the time the appointment is booked, thus making it available to hand to the patient if the appointment is made in person. All of the patient's pending appointments are listed with the necessary instructions for each. The system adds all patient Wait List requests to the end of the patient's future appointment file.

Data Entry Process:

Scenario

You have just booked a follow-up appointment for a patient who is present in the office. You want to give the patient a printed copy reminder of the appointment.

Access the Display Patient Appointments (DMCP) option on the Managed Care Program Menu

Enter patient ID

Select future, past, wait list or specific date appointments

Display or print the report

Display or print appointments of other family members

Access the Display Patient Appointments (DMCP) option on the Managed Care Program Menu

Enter patient ID

Use your site's preferred method of patient lookup to enter the patient ID. Review the patient data returned by the system and press <Return> at the *OK? Yes* prompt if the information is correct.

Select future, past, wait list or specific date appointments

1. When you press <Return> to verify that the system has found the correct patient, the system prompts you to select the type of appointments to

display, either future, past, Wait List, or from a specific date forward. The system also allows you to quit the Display Patient Appointments option at this prompt. If you specify future appointments, or appointments from a specific date forward, the system also includes Wait List requests for the patient specified.

2. If you want to display/print appointments for a specific date, the system prompts you to enter the specific date.

Display or print the report

1. The system then prompts you to select the output device. Press <Return> at the *Select Device* prompt to display the list to your screen or enter a printer name to print a hard copy.

2. Press <Return> at the *Right Margin* prompt to accept the default of 80. (Refer to Figure 6-70. Display Patient Appointments, page 6-119.)

```
                          DISPLAY PATIENT APPOINTMENTS

                Personal Data - Privacy Act of 1974 (PL 93-579)
               FUTURE APPOINTMENTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV                   PROVIDER     DATE/TIME         TYPE   STATUS
=====================================================================
GEORGETOWN MED/DIVA          PUSHKIN,ZELD  02 Jul 2001@0800   FOL    BOOKED
                                        Arrive 10 min early


                WAIT LIST REQUESTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV                   TYPE   PRI  DATE IN     TARGET DATE  PROVIDER
=====================================================================


                                NO WAIT LIST REQUESTS!
```

Figure 6-70. Display Patient Appointments

If the request is for future appointments or past appointments, the display/copy contains clinic, division, provider, date and time of the appointments, appointment type and status.

If the request is for Wait List requests, the display contains clinic, division, appointment type, priority, entry date (date in), target date, and provider.

If the specified patient was booked from the Wait List through the automatic booking function, the system lists this information beneath the appointment data.

Display or print appointments of other family members

```
                          DISPLAY PATIENT APPOINTMENTS

                Personal Data - Privacy Act of 1974 (PL 93-579)
               FUTURE APPOINTMENTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV                   PROVIDER     DATE/TIME         TYPE   STATUS
=====================================================================
GEORGETOWN MED/DIVA          PUSHKIN,ZELD  02 Jul 2001@0800   FOL    BOOKED
                                        Arrive 10 min early


                WAIT LIST REQUESTS FOR PHOTON,ZACHARY N  20/353-30-4614
CLINIC/DIV             TYPE   PRI  DATE IN      TARGET DATE  PROVIDER
=====================================================================
FAMILY PRACTICE/ADIV  NEW    2    08 Feb 1996  09 Feb 1996  HENRY,JAMES
CARDIOLOGY CLINIC     NEW    2    08 Dec 1995  09 Dec 1995  ALEXANDER,NI
CARDIOLOGY CLINIC     FOL    2    14 Dec 1995  15 Dec 1995  PARKS,JAMES
Press <RETURN> to continue
Display/Print Appointment History of Other Family Members? NO// y  (YES)

     1   278555025 01  PHOTON,MARK     01/353-30-4614 16 Apr 1982 M
     *** Ward:  4B                     ADIV
     2   278555025 02  PHOTON,S        02/353-30-4614 09 Jun 1986 M
Type '^' to stop, or
Choose 1-5:
```

Figure 6-71. Family Appointment History

When you press <Return> at the screen display the system prompts you to display other family members' appointment histories. If you elect to display the appointment histories of other family members, the Display Patient Appointments process repeats for each family member.

Note: The system only recognizes patients booked under the same sponsor SSN as being members of the same family.

The system then exits the option and returns to the Managed Care Program Menu.

6.3 Cancellation By Patient (CMCP)

There are two methods for canceling an appointment. You can cancel at the patient's request or at the facility's request. Canceling an appointment at the facility's request is not covered in this user guide.

Menu: PAS System Menu → MAN → CMCP

Security Keys:

CPZCCP needed by all MCP users. No other security keys required to access this option.

Required Field:

Patient Name

Application Description:

The Cancellation by Patient (CMCP) option allows you to cancel and, optionally, reschedule future appointments for an enrolled or non-enrolled patient who has an appointment with any MCP provider, without exiting from the Cancellation by Patient option. Appointments may have been booked through PCM, Non-Enrolled, Appointment Referral, or PAS booking.The system prompts you to enter a patient name and other selection criteria, and then searches for all appointments, for the specified patient, that meet the search criteria. For each appointment slot found during the search, the system gives you the option of canceling only or of canceling and rescheduling.

Note: This option allows you to reschedule an appointment slot only if the provider's agreement data has not been modified since the time that the original appointment was booked. To reschedule appointments with a patient's PCM, use the PCM Booking option.

When you have completed processing the appointments, the system allows you either to process appointments for another patient, or exit the option.

Note: When appointments are cancelled using this option, the name of the user and the date/time of cancellation are stored in the Patient Appointment file and are displayed on the End-of-Day Processing report.

Data Entry Process:

<u>Cancel an Appointment at the Patient's Request</u>

Scenario

You are an HCF working in the Service Center. A patient calls to cancel an appointment and does not wish to reschedule. You need to document the cancellation.

Access the Cancellation by Patient (CMCP) option on the MCP main menu

Select search criteria to change

Select patient

Review the Demographics Display screen

Enter cancellation search criteria

Search for appointment(s)

Select appointment(s) to cancel

Cancel or cancel/reschedule the appointment(s)

Access the Cancellation by Patient (CMCP) option on the MCP main menu

When you access the CMCP option, the system displays the Cancellation by Patient Search Criteria screen with an action bar prompting you to change the search criteria, search for appointments that meet predefined search criteria, or to quit and exit the option. (Refer to Figure 6-72. Cancellation by Patient Search Criteria Screen, page 6-123.)

```
                    CANCELLATION BY PATIENT SEARCH CRITERIA
Patient:                                          FMP/SSN:
Clinic:                                           Appt Type:
Clinic Phone:
Provider:                                         Service:
Time Range: 0001 to 2400                          Duration:
Dates: 21 Jun 2001 to 20 Jun 2002                 Days of Week:
_____________________________________________________________________



_____________________________________________________________________
Select (C)hange Search Criteria, (S)earch for Appointments, (Q)uit: S//
```

Figure 6-72. Cancellation by Patient Search Criteria Screen

The Display Window at the top of the Cancellation by Patient Search screen contains the patient demographic, and provider information fields. These fields are blank at this point, but fill in as the search criteria are defined. The Dates and Time Range fields are defaulted by the system, but they can be edited.

The Select Window in the middle of the screen is also blank at this point.

The action bar in the Interact Window provides the following options:

(C)hange Search Criteria: Choose this action to change the following fields:

- Patient
- Place of care
- Provider
- Time range
- Dates
- Appointment type
- Default search criteria.

(S)earch for Appointments: Choose this action to search for appointments to cancel based upon the search criteria entered. If the patient name was not previously specified in the search criteria, the system prompts you for the patient name before searching for appointments to cancel.

(Q)uit: Choose this action to quit the cancel by patient process and return to the MCP main menu.

Select search criteria to change.

When you select the (C)hange Search Criteria action on the Cancellation by Patient Search Criteria action bar, the system displays a list of selectable search criteria and prompts you to select the criteria to enter/edit. (Refer to Figure 6-73. Cancellation by Patient Search Criteria Screen with Selectable Search Criteria, page 6-124.)

```
                    CANCELLATION BY PATIENT SEARCH CRITERIA
Patient:                                          FMP/SSN:
Clinic:                                           Appt Type:
Clinic Phone:
Provider:                                         Service:
Time Range: 0001 to 2400                          Duration:
Dates: 21 Jun 2001 to 20 Jun 2002                 Days of Week:
_____________________________________________________________________
   Patient
   Place of Care
   Provider
   Time Range
   Dates
   Appointment Type
   Default Search Criteria
_____________________________________________________________________
Use SELECT key to select SEARCH CRITERIA to be change
```

Figure 6-73. Cancellation by Patient Search Criteria Screen with Selectable Search Criteria

The patient name is required; the place of care, provider, time range, dates, and appointment type are optional. The system allows you to specify that the currently selected search criteria become the default search criteria for further processing actions.

1. Use the down-arrow key to position the cursor beside the criteria you want to change and press <Select>.

   When you press <Select>, the system displays an asterisk (*) by your selection. You can deselect the item by positioning the cursor beside the item and pressing <Select> again. You <u>must select</u> patient and specialty. The remaining items are optional.

2. When finished selecting, press <Return>.

Select patient.

Refer to Select patient, page 6-8.

Review the Demographics Display screen.

Refer to Figure 6-4. Demographics Display Screen, page 6-10. When you've finished reviewing the Demographics Display screen and press <Return> to continue, the system redisplays the Cancellation by Patient Search Criteria Screen. (Refer to Figure 6-74. Cancellation by Patient Search Criteria Screen, page 6-125.)

Enter cancellation search criteria.

This criteria will be used to identify the appointment to cancel.

```
                    CANCELLATION BY PATIENT SEARCH CRITERIA
Patient: PICARD,ZACHARY E                       FMP/SSN: 20/379-43-6114
Clinic:                                         Appt Type:
Clinic Phone:
Provider:                                       Service:
Time Range: 0001 to 2400                        Duration:
Dates: 21 Jun 2001 to 20 Jun 2002               Days of Week:
_______________________________________________________________________
_______________________________________________________________________
Select (C)hange Search Criteria, (S)earch for Appointments, (Q)uit: S//
```

Figure 6-74. Cancellation by Patient Search Criteria Screen

1. Press <Return> to accept the default (S)earch for Appointments.

   The system prompts you to enter/edit the values of the selected cancellation search criteria.

2. Enter place of care (optional).

   Enter the clinic name where the appointment is currently booked.

3. Enter provider (optional).

Enter the specific provider the appointment is booked with.

4. Enter inclusive earliest time and inclusive latest time (optional).

   The default inclusive earliest time is 0001 and the default inclusive latest time is 2400. If you know the appointment in question is scheduled in the afternoon, you could change the inclusive earliest time to 1200 and the inclusive latest time to 1700, for example. If you know the appointment in question is scheduled for 0900, you could change the inclusive earliest time to 0900 and the inclusive latest time to 0900.

5. Enter start and stop dates.

   The default start date is today and the default stop date is one year from today. You can enter specific dates or you can enter T + n (examples: T for today and T + 1 for tomorrow, T + 30 for thirty days from today). Neither the start or stop dates can be before today's date and the stop date must be later than the start date. If the year is omitted, the system assumes a future date.

6. Enter appointment type.

   You can enter the specific appointment type (e.g., new, follow up, consult). Enter a double question mark (??) at the *Select Appt Type* prompt to view a list of possible entries.

   As you enter search criteria, the system enters the data you enter into the display window fields on the Cancellation by Patient Search Criteria screen. When you've finished entering the search criteria, the system redisplays the initial action bar as shown in Figure 6-75. Cancellation by Patient Search Criteria Screen with Search Criteria Entered, page 6-127.

```
                    CANCELLATION BY PATIENT SEARCH CRITERIA
Patient: PHOTON,ZACHARY N                        FMP/SSN: 20/353-30-4614
Clinic: DERM CARE MTF/DIVA                       Appt Type:New
Clinic Phone:
Provider: PANACHE,BASIL M                        Service:
Time Range: 0900 to 1600                         Duration:
Dates: 21 Jun 2001 to 21 Jul 2001                Days of Week:
_____________________________________________________________________________

_____________________________________________________________________________
Select (C)hange Search Criteria, (S)earch for Appointments, (Q)uit: S//
```

Figure 6-75. Cancellation by Patient Search Criteria Screen with Search Criteria Entered

Search for appointment(s).

When you accept the default (S)earch for Appointments action on the initial action bar, the system searches for all appointments that meet the search criteria you entered. All appointments that meet the criteria display in the select window of the Cancel/Reschedule Patient Appointments screen (refer to Figure 6-76. Cancel/ Reschedule Patient Appointments Screen, page 6-128). The system prompts you to select the one(s) to be canceled or rescheduled.

Note: If there are no appointments for this patient during the specified times, the system displays a blank Cancellation by Patient Search Criteria screen with the message - No appointments for this patient after the start date specified. If this is the case, you can either use the Change Search Criteria action on the action bar and enter new dates, or you can quit the screen and return to the Managed Care Program Menu.

Select appointment(s) to cancel.

```
                    CANCEL/RESCHEDULE PATIENT APPOINTMENTS
Patient: PHOTON,ZACHARY N                        FMP/SSN: 20/353-30-4614
Clinic: DERM CARE MTF/DIVA                       Appt Type:NEW
Clinic Phone: 202 456-9877
Provider: PANTOUM,C                              Service:
Time Range: 0900 to 1600                         Duration:
Dates: 21 Jun 2001 to 21 Jul 2001                Days of Week:
_____________________________________________________________________
   WED 0900 27 Jun 01 NEW    DCM    PANTOUM,C
   FRI 0900 29 Jun 01 NEW    DCM    PANTOUM,C



_____________________________________________________________________
Use SELECT key to select appointments to be cancelled/rescheduled
```

Figure 6-76. Cancel/Reschedule Patient Appointments Screen

1. Use the down-arrow key to position the cursor next to the appointment(s) you want to cancel and then press <Select>.

2. When you have finished selecting appointments to cancel, press <Return>.

   The system highlights the first appointment you selected and displays a message telling you which option was used to book the appointment. The action bar now allows you to cancel or reschedule the appointment, skip to the next appointment you selected, or quit. (Refer to Figure 6-56. Cancel/ Reschedule Patient Appointments Screen Ready to Process First Selected Appointment.)

Cancel or cancel/reschedule the appointment

```
                    CANCEL/RESCHEDULE PATIENT APPOINTMENTS
Patient: PHOTON,ZACHARY N                        FMP/SSN: 20/353-30-4614
Clinic: DERM CARE MTF/DIVA                       Appt Type:NEW
Clinic Phone: 202 456-9877
Provider: PANTOUM,CAROL M                        Service:
Time Range: 0900 to 1600                         Duration:
Dates: 21 Jun 2001 to 21 JuL 2001                Days of Week:
_____________________________________________________________________
   WED 0800 27 Jun 01 NEW    DCM    PANTOUM,C
   FRI 0800 29 Jun 01 NEW    DCM    PANTOUM,C



____________________Select appointment #1 of 2____________________________
This appointment was booked from Non-Enrolled Booking
Select (C)ancel, (R)eschedule,(S)kip,(V)iew,or(Q)uit CANCEL/RESCHEDULE:
```

Figure 6-77. Cancel/Reschedule Patient Appointments Screen Ready to Process First Selected Appointment

Actions on the Cancel/Reschedule Patient Appointments action bar:

(C)ancel: If the appointment is an MTF appointment, the system cancels the appointment.

If the appointment is a non-MTF appointment, the system prompts you to indicate whether the place of care has been notified of the cancellation. The system cancels the appointment only if the answer is affirmative.

In either case, if there is another appointment in the list, the system returns you to the Search for Appointments action bar to process that appointment. If there are no more appointments, the system returns you to the initial action bar.

(R)eschedule: If the appointment is an MTF appointment the system displays the MTF Booking Search Criteria Screen (refer to Figure 6-39. MTF Booking Search Criteria Screen, page 6-70), and allows you to book new appointments. The system then cancels the original appointment.

If you reschedule an MTF appointment without leaving the Cancellation by Patient option, the appointment status changes to Open and it becomes

available for rebooking from the Wait List if the specified clinic has an active Wait List and through PAS/MCP.

Note: Refer to PAS: Appointment Booking for further information on the process for rescheduling an appointment that has been canceled by the patient, and the process for rebooking the canceled appointment from the Wait List.

If the appointment is a non-MTF appointment, the system displays the Non-MTF Booking Search Criteria screen, where you can book a new appointment. The system then cancels the original appointment. (Refer to Figure 6-39. MTF Booking Search Criteria Screen, page 6-70.)

In either case, if there is another appointment in the list, the system returns you to the action bar shown in Figure 6-76. Cancel/Reschedule Patient Appointments Screen, page 6-128, where you can process the remaining appointments you selected. If there are no more appointments, the system returns you to the initial action bar where you can change the search criteria, process additional appointments for the same patient, change the search criteria and cancel or reschedule appointments for another patient, or quit the option and return to the MCP main menu.

(S)kip action: The system bypasses the current appointment in the list. If the current appointment is the last, the system advances to the first unprocessed appointment in the list. Otherwise, it advances you to the next unprocessed appointment in the list. The system then returns you to the action bar described above in the Search for Appointments section to process that appointment.

(V)iew appointments: The system lists all appointments and enables you to select the appointment to process next. The system then returns you to the action bar described above in the Search for Appointments section to process that appointment.

1. Select the (C)ancel action.

   If the appointment is an MTF appointment, the system cancels the appointment when you select the (C)ancel action on the Cancel/Reschedule Patient Appointments action bar.

2. If the appointment is a civilian appointment, the system prompts you to indicate whether the place of care has been notified of the cancellation. The system cancels the appointment only if the answer is affirmative.This only cancels the local CHCS appointment record, not the appointment in the civilian's own office.

3. In either case, if there is another appointment in the list, the system returns you to the action bar shown in Figure 6-76. Cancel/Reschedule Patient Appointments Screen, page 6-128, where you can process the remaining appointments you selected.

4. If there are no more appointments to process, the system returns you to the initial action bar where you can change the search criteria, process additional appointments for the same patient, change the search criteria and cancel or reschedule appointments for another patient, or quit the option and return to the MCP main menu.

   You can verify that the appointment has been canceled by accessing the Display Patient Appointments (DMCP) option on the MCP main menu.

   You can also view cancellation data using the End-of-Day Processing option via this menu path: PAS System Menu → Clerk Scheduling Menu → EOD

6.4 Health Care Finder Output Products And Reports

6.4.1 Output Products (OHCF)

6.4.1.1 MCP Enrollment Form

Menu Path: PAS System Menu → MAN → HMCP → OHCF

Security Keys:

CPZ CCP needed by all MCP users. No other security keys required to access this option.

Required Fields:

Patient Name
Referral ID
Sponsor Name
Output Device

Application Description:

The Output Products option enables you to generate an Enrollment Form, an enrollment Membership ID, or a Patient Label for a specified patient (refer to Section 6.4.2 6.4.2 Print Patient Address Label (LHCF), page 6-135. This option

also allows you to generate a Care Authorization Form or a Provider Label for a specified patient referral.

Note: To access this option, you should be entered as an HCF using the MCP Health Care Finder Profile Enter/Edit (HEAL) option on the Facility File/ Table Maintenance Menu. The HCF's record in the system should contain name, telephone number, and the MCP office assigned. This information prints on the Care Authorization Form.

When a provider is entered as an HCF using the Health Care Finder Profile Enter/Edit option, the following fields from the HCF record print on the Care Authorization Form: Name, telephone number, and the MCP office to which the provider is assigned.

Data Entry Process:

Select patient.

Review Demographics Display.

Print the output product.

Select patient.

Refer to Select patient, page 6-8.

Review Demographics Display.

Refer to Review patient demographics, page 6-10.

Print the output product.

When you finish reviewing the Demographics Display screen press <Return> to continue. The system displays the Generate Appointment Referral Products screen. (Refer to Figure 6-61. Generate Appointment Referral Products Screen, page 6-102.)

1. Enter "E" for (E)nrollment Form at the Generate Appointment Referral Products action bar.

2. Enter device name and confirm right margin of 80.

   If you press <Return> at the *Select DEVICE* prompt, the system returns a message that you can't print to HOME device, i.e. the screen.

3. When you enter a printer name, the system returns the question:

   ```
   Do you want to free up this terminal? No//
   ```

   Press <Return> to accept the "No" default.

   The system prints the enrollment form (refer to Figure 6-78. Managed Care Enrollment Form) to the printer you named and returns to the Generate Appointment Referral Products action bar where you can print a membership ID card, patient address label, provider label, Care Authorization Form (refer to Print appointment referral products on page 6-101) for the same patient, choose a new patient or quit.

```
BALBOA NAVY MEDICAL CENTER                                20 Jan1996@0901
            Personal Data - Privacy Act 1974 (PL 93-579)
                MANAGED CARE PROGRAM ENROLLMENT FORM
_____________________________________________________________________
  ENROLLMENT DATE: 20 Jun 2001  END ELIG/ENROLL DATE:10 Feb 2003
_____________________________________________________________________
     PATIENT NAME: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
 Patient Category: USA ACTIVE DUTY OFFICER         DDS: 20 Sex: MALE
          Address: 862 WEST WYLAND DR          DOB/Age: 19 Feb 1966/35Y
             City: FAIRFAX                 Patient SSN: 379-43-6114
            State: VA                       Home Phone: 918-555-0287
         Zip Code: 22030                    Work Phone: 202-555-6801
---------------------------------------------------------------------
     SPONSOR NAME: PICARD,ZACHARY E            FMP/SSN: 20/379-43-6114
 Patient Category: USA ACTIVE DUTY            DOB/Age: 19 Feb 1966/35Y
          Service: ARMY                            Rank: CPT
     Station Unit: RESOURCE MGMT WASHINGTON Duty Phone: 202-555-6802
     Duty Address: 788 GRANT ST
             City: WASHINGTON                    State: DC
         Zip Code: 20310
_____________________________________________________________________
PRIMARY CARE MANAGER: ESPOSITO,FRANK M        PCM PHONE: 202-271-5850
       Place of Care: FAM PRAC MTF
             Address: 6885 16TH STREET
                City: WASHINGTON                  State: DC
            Zip Code: 20307
_____________________________________________________________________
  INSURANCE COMPANY:                                PHONE:
      POLICY NUMBER:
            Address:
               City:                                State:
           Zip Code:
      Policy Holder:                                 SSN:
     Effective Date:                    Expiration Date:
   CASE MANAGEMENT: NO
_____________________________________________________________
I understand that my enrollment in the Managed Care Program is
contingent upon my continuing eligibility for health care under the
MHSS.I understand the benefits and patient responsibilities of
enrollment in the Managed Care Program and that enrollment remains in
effect until I disenroll. I understand that enrollment is dependent on
CHAMPUS eligibility as shown in DEERS and that CHAMPUS eligibility
ceases upon eligibility for MEDICARE Part A.I further understand that
my failure to follow the rules of this program may result in either
increased cost share or complete non-reimbursement.
-------------------------------------------------------------------
```

Figure 6-78. Managed Care Enrollment Form

6.4.2 Print Patient Address Label (LHCF)

Menu Path: PAS System Menu → MAN → HMCP → LHCF

Security Keys:

CPZ CCP needed by all MCP users. No other security keys required to access this option.

Required Fields:

Patient Name
Output Device

Application Description:

The Patient Address Label option permits you to print an address label for one or more patients, provided the patient(s) have complete home or duty addresses.

Process Overview:

The system enables you to proceed through the Managed Care Program Menu to the Health Care Finder Menu and select the Print Patient Address Label option.

The system prompts you to begin by specifying the patient name. The system then prompts for confirmation of the patient name and then prompts for the output device.

The system then prompts you to select another patient as described above or exit the option.

ZACHARY E PICARD
862 WEST WYLAND DR
FAIRFAX, VA 20030

Figure 6-79. Patient Address Label

6.4.3 Health Care Finder Reports Menu (RHCF)

Menu Path: PAS System Menu → MAN → HMCP → RHCF

Alternative Menu Path: PAS→MAN→OMCP→HRPT

Security Key: No

```
1    Agreement Type Referral Summary
2    Specialty Type Referral Summary
3    Provider Network List
4    PCM Activity Report
5    Provider Patient Workload Report
6    Refused Appointments Report

Select Health Care Finder Reports Menu Option:
```

Figure 6-80. Health Care Finder Reports Menu

The Health Care Finder Reports Menu options enable you to generate information on agreement type referrals, specialty type referrals, the provider network, PCM activity, provider patient workload, and refused appointments. (Refer to Figure 6-80. Health Care Finder Reports Menu, page 6-136.)

6.4.3.1 Agreement Type Referral Summary

Menu Path: HMCP → RHCF → 1

Alternate Menu Path: OMCP → HRPT → 1

Contents: This report lists, by division, the number of referrals issued during the user specified report period for each agreement type and specialty. The total number of referrals for each selected division is also printed.

Use/Frequency: This report is run as needed to determine referral activity by specialty

```
TIDEWATER                                        06 Jul 1993@1427    Page 1
            REFERRAL SUMMARY FOR AGREEMENT TYPES By SPECIALTY
                    From: 22 May 1993   To: 16 Jul 1993
Division:TRIPLER ARMY MEDICAL CENTER
==========================================================================
Agreement/   Description                                          Number of
Specialty                                                        Referrals
==========================================================================
NET        MCP/CIVILIAN NETWORK PROVIDER
-----------------------------
Allergy                                                                 50
Audiology                                                               25
Cardiology                                                               0
Dermatologist                                                           15
Emergency Medicine                                                      10
Agreement Type Total:                                                  100
MTF        MTF HOSPITAL (CIVIL SERVICE)
----------------------------------------
Allergy                                                                 15
Cardiologist/Pediatric                                                  10
Endocrinologist                                                          0
Agreement Type Total:                                                   25

Division Total                                                          125
```

Figure 6-81. Agreement Type Referral Summary by Specialty

6.4.3.2 Specialty Type Referral Summary

Menu Path: HMCP → RHCF → 2

Alternate Menu Path: OMCP → HRPT → 2

Contents: This report lists, by division, the number of referrals issued during the user specified report period for each specialty. Subtotals are also printed by each provider supporting the specialty. The total number of referrals for each selected division is also printed.

Use/Frequency: This report is run as needed to determine referral activity for each specialty and by provider.

```
A Division                                          06 Jul 1993~1424 Page 1
          Personal Data - Privacy Act 1974 (PL 93-579)
                     REFERRAL SUMMARY BY SPECIALTY TYPE
                   From: 22 May 1993  To: 16 Jul 1993
Division: AIR FORCE MTF DIVISION
=========================================================================
Specialty Type/             Professional                        Number of
 Provider                   Category                            Referrals
=====================-=================================================
CARDIOLOGIST
------------
  CRAWFORD.JACQUI                   PHYSICIAN (OTHER THAN SURGEON)    16
  CRAWFORD,JOSEPH                   PHYSICIAN (OTHER THAN SURGEON)     4
                                              Specialty Type Total:   20
FAMILY PRACTICE PHYSICIAN
-------------------------
  CORBIN. ANTHONY                  PHYSICIAN (OTHER THAN SURGEON)     10
  FLETCHER,THOMAS                  PHYSICIAN (OTHER THAN SURGEON)     15
  MADISON , MICHAEL                PHYSICIAN [OTHER THAN SURGEON)     15
                                              Specialty Type Total:   40
OTORHINOLARYNGOLOGIST
---------------------
  GROVER,GLEN                      PHYSICIAN (OTHER THAN SORGEON)     22

OTORHINOLARYNGOLOGY RESIDENT
----------------------------
  WINTERS,SHARON                    PHYSICIAN (OTHER THAN SURGEON)    19
PEDIATRICIAN
------------
  ALEXANDER, STEPHEN                PHYSICIAN (OTHER THAN SURGEON)    12
  BOWER,KENNETH                     PHYSICIAN (OTHER THAN SURGEON)    18
                                              Specialty Type Total:   30

                                                  Division Total:    131
```

Figure 6-82. Specialty Type Referral Summary

6.4.3.3 Provider Network List

Menu Path: HMCP → RHCF → 3

Alternate Menu Path: OMCP → HRPT → 3

Contents: This report summarizes, by type of agreement and specialty, the places of care available for each specialty with the hours of operation and the providers at each place of care. Each provider's PCM capacities (maximum, assigned, and available) are also indicated if the provider is a PCM.

Use/Frequency: This report is run when the site needs to analyze the geographic distribution of the places of care available in the network.

```
TRIPLER ARMY MEDICAL CENTER                          31 Aug 1993@1~45   Page 2
                   Personal Data - Privacy Act 1974 (PL-93-579)
                             PROVIDER NETWORK LIST
=========================================================================
Agreement/                                                PCM    PCM      PCM
 Specialty   Provider                              PCM   CAP    ASSIGN AVAIL
=========================================================================
CIVILIAN NETWORK PROVIDER
-------------------------
  FAMILY PRACTICE PHYSICIAN

        POC Group: R E LARUE
         POC Name: R E LARUE OFFICE
 POC Appt Contact: LORRAINE SMITH
        POC Phone: (804)560-6543
      POC Address: 14557 J CLYDE MORRIS A
                   GLOUCESTER, VA  23061
        POC Hours: MON 0800-1200 1201-1700
                   TUE 0800-1200 1201-1700
                   WED D800-1200 1201-1700
                   THO 0800-1200 1201-1700
                   FRI 0800-1200 1201-1700

             LARUE,R E                            YES    50            50

        POC Group: DEL CARMEN & HARRIS
         POC Name: DEL CARMEN & HARRIS CLINIC
 POC Appt Contact: ALMA JONES
        POC Phone: (804)265-3452
      POC Address: 2245 JEFFERSON AVE
                   NEWPORT NEWS, VA  23601
        POC Hours: MON 0800-1200 1201-1700
                   TUE 0800-1200 1201-1700
                   WED 0800-1200 1201-1700
                   THU 0800-1200 1201-1700
                   FRI 0800-1200 1201-1700
           CRAWFORD,JACQUI                        NO
           DEL CARMEN, GLEN R                   YES      50      3     47
           HARRIS,SCOTT D                       YES      50      O     50
  POC Provider total:  3
```

Figure 6-83. Provider Network List

```
TRIPLER ARMY MEDICAL CENTER                          31 Aug 1993@1~45   Page 2
                  Personal Data - Privacy Act 1974 (PL-93-579)
                            PROVIDER NETWORK LIST
================================================================================
Agreement/                                                   PCM   PCM    PCM
  Specialty   Provider                                     PCM  CAP   ASSIGN AVAIL
 ===============================================================================
CIVILIAN NETWORK PROVIDER (continued)
-------------------------------------
   FAMILY PRACTICE PHYSICIAN  (continued)

        POC Group: FAMILY PRACTICE ASSOCIATES
         POC Name: FAM PRAC ASSOC
 POC Appt Contact: GORGETTA BAIN
        POC Phone: (804)398=765
      POC Address: 4410 MERCURY BLVD
                   NEWPORT NEWS, VA 23601
        POC Hours: MON 0800-1200 1201-1700
                   TUE 0800-1200 1201-1700
                   WED 0800-1200 1201-1700
                   THU 0800-1200 1201-~700
                   FRI 0800-1200 1201-1700

          EAKLE,THOMAS K                                 YES    100          100

          EATON,GARY M                                   YES    100          100

          ELLIS,BARBARA M                                YES    100          100

          EVANS,RICK                                     YES    100          100

   POC Provider total:  4
```

Figure 6-84. Provider Network List (Continued)

6.4.3.4 PCM Activity Report

Menu Path: HMCP → RHCF → 4

Alternate Menu Path: OMCP → HRPT → 4

Alternate Menu Path: EMCP → OENR → PRPM → 3

Contents: This report can be printed for selected individual PCMs, provider groups, or specialties for a specified date range. The report lists, for the selected providers or specialties, the following information: the provider, group name, PCM maximum capacity, PCM assigned enrollees, and PCM unassigned capacity. The report columns contain totals as follows:

- number of enrollee primary care visits to the provider
- number of emergency room visits made by the PCM's enrollees
- number of referrals made by the PCM for their enrollees
- number of visits made by the PCM's enrollees to other providers without a referral (includes all scheduled and unscheduled visits made in PAS and MCP for direct and civilian care)
- number of visits made by the PCM's enrollees to other providers with a referral (includes all scheduled and unscheduled visits made in PAS and MCP for direct and civilian care)

A high-level analysis is presented of how the PCM is performing in the managed care environment. The report indicates possible breaches of agreement by the enrollees who seek care in the emergency room or without a referral. The high-level analysis is also available by specialty and provider group.

Use/Frequency: This report is run monthly to analyze the referral performance of the PCM and the care being sought by the PCM's enrollees.

```
WALTER REED AMC                                          21 Jun 2001@1326  Page 1
               Personal Data - Privacy Act of 1974 (PL 93-579)
                PCM ACTIVITY REPORT By Provider Group
                     FROM: Jun 2001 TO: Jun 2001
                                                   Provider Group: FAM MFD MTF
==========================================================================R
                                     ENROLLEE                ENROLLEE
PCM/            PCM            PCM   #PCM    #ER      #REF  #VISITS    #VISITS
 Agreement      CAP   #ASSIGN AVAIL VISITS  VISITS  MADE   W/REF      W/O REF
==========================================================================
FAM MED MTF
MTF            500    57   443
Provider Total:500    57   443

Agreement Total:
 MTF           500    57   443
Grp Grand Total:500   57   443
```

* Individual Provider Available Capacity may be LIMITED by the OVERALL Maximum Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned to OTHER PCMs,who may have other Specialties within the PROVIDER GROUP.

Figure 6-85. PCM Activity Report by Provider Group

```
WALTER REED AMC                                          21 Jun 2001@1326  Page 1
               Personal Data - Privacy Act of 1974 (PL 93-579)
                PCM ACTIVITY REPORT By Individual PCM
                     FROM: Jun 2001 TO: Jun 2001

==========================================================================P
rovider/      Individual          ENROLLEE              ENROLLEE
Group/         PCM            PCM  #PCM    #ER      #REF  #VISITS    #VISITS
 Agreement     CAP   #ASSIGN AVAIL VISITS  VISITS  MADE   W/REF      W/O REF
==========================================================================
ARIAS,GILBERT
-------------
  INT MED BC
    MTF        500       4   485*
  Group Total: 500       4   485*

ARRIBA,GILBERT
--------------
  ACUTE CR BC
    MTF        500       4   485*
  Group Total: 500       4   485*

ARTURA,GILBERT
  FAM PRAC BC
   MTF         500       4   485*
  Group Total: 500       4   485


* Individual Provider Available Capacity may be LIMITED by the OVERALL
Maximum Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned
to OTHER PCMs,who may have other Specialties within the PROVIDER GROUP.
```

Figure 6-86. PCM Activity Report by Individual PCM

```
WALTER REED AMC                                          21 Jun 2001@1326  Page 1
               Personal Data - Privacy Act of 1974 (PL 93-579)
                PCM ACTIVITY REPORT By Specialty
                     FROM: Jun 2001 TO: Jun 2001

==========================================================================S
pecialty/                        ENROLLEE                 ENROLLEE
ProviderGroup/    PCM   PCM    #PCM  #ER      #REF       #VISITS   #VISITS
 Agreement        CAP  #ASSIGN AVAIL VISITS  VISITS  MADE  W/REF     W/O REF
==========================================================================
PRIMARY CARE NURSE PRACTITIONER QUALIFIED
-----------------------------------------
  POPPETT,DEAN M
    PREV MED MTF
        MTF       500     0    500
    Group Total:  500     0    500

  PRATT,MURIEL
    PREV MED MTF
        MTF       500     10   490
    Group Total:  500     10   490

  PYPER,ALBERTO
    FAM PRAC
        NET       500     0    500
    Group Total:  500     0    500

Specialty Total:  1500    20   1490









* Individual Provider Available Capacity may be LIMITED by the OVERALL
Maximum Patient Capacity of the PROVIDER GROUP and Patients ALREADY assigned
to OTHER PCMs,who may have other Specialties within the PROVIDER GROUP.
```

Figure 6-87. PCM Activity Report by Specialty

6.4.3.5 Provider Patient Workload Report

Menu Path: HMCP → RHCF → 5
OMCP → HRPT → 5

Contents: This report shows the number of outpatient visits being supported and the number of different patients being seen by a provider during the user specified date range. Subtotals are printed by agreement type as well as by type of provider; e.g., by MTF provider and contractor provider. A grand total of the total visits supported for an agreement type is printed.

Use/Frequency: This report is run as needed to analyze the outpatient care being received through direct care and contractor providers.

```
TIDEWATER                                          12 Aug 1993@1648 Page 1
              Personal Data - Privacy Act 1974 (PL-93-579)
             PROVIDER PATIENT LOAD REPORT by Provider Group
                From: 28 Jun 1993    To: 22 Aug 1993
=========================================================================
Agreement/           Patient Category              Number of  Number of
 Group/Provider      Status                        Visits     Diff Ptns
=========================================================================
CONTRACT
--------
  CRAWFORD CARDIOLOGY
      CRAWFORD,JACKIE
                  ACTIVE DUTY                          2          2
        HAVERFORD,MICHELLE
                  ACTIVE DUTY                          9          3
                  FAM MBR OF ACTIVE DUTY               7          2
                  RETIRED                             10          2
                  FAM MBR OF RETIRED                   5          1
        Group total:                                  33         1.0

   CRAWFORD AND HARRIS
         EDDY,JEANNINE
                  ACTIVE DUTY                          9          2
       Agreement total:                               20          7

     MTF Provider Total:                               5          5*

     Non MTF Provider Total:                          15          5*

     Total Provider Visits:                           20         10*
```

* More than one appointment may be linked to a referral. If a referral has an MTF appointment and a non-MTF appointment linked to it, the patient will be counted once under the MTF total and once under the non-MTF total. *
A patient seen by two different providers will be counted once in the totals

Figure 6-88. Provider Patient Workload Report by Provider Group

```
TIDEWATER                                          12 Aug 1993@1649  Page 1
                 Personal Data - Privacy Act 1974 (PL-93-S79)
                   PROVIDER PATIENT LOAD REPORT by Provider
                    From: 28 Jun 1993    To: 22 Aug 1993
=========================================================================
Agreement/      Patient Category              Number of  Number of
 Provider/Group Status                        Visits     Diff Ptns
=========================================================================
CONTRACT
--------
  CRAWFORD , JACKIE
    CRAWFORD CARDIOLOGY
              ACTIVE DUTY                                15        2
              FAM MBR OF ACTIVE DUTY                      5        4
              RETIRED                                    10        2
              FAM MBR OF RETIRED                         17        7
  Agreement total:                                       47       15

 MTF STAFF
----------
  ALEXANDER, STEPHEN
     PEDIATRICS LAFB
              ACTIVE DUTY                                 1        1

  Agreement total:                                        1        1

SUPPLEMENTAL CARE/DIAGNOSTIC SERVICES
---------------------~~----------------
   THOMAS,LARRY
     WATSON MEDICINE GROUP
              ACTIVE DUTY                                 4        1
              FAM MBR OF ACTIVE DUTY                      1        1

    Group total:                                          5        2

  Agreement total:                                        5        2

 MTF Provider Total:                                     10        6*

 Non MTF Provider Total:                                 43       15*

 Total Provider Visits:                                  53       21*

* More than one appointment may be linked to a referral. If a referral has
an MTF appointment and a non-MTF appointment linked to it. the patient
will be counted once under the MTF total and once under the non-MTF total.
A patient seen by two different providers will be counted once in the to-
tals under the Number of Different Patients column.
```

Figure 6-89. Provider Patient Load Report by Provider

6.4.3.6 Refused Appointments Report

Menu Path: HMCP → RHCF → 6
OMCP → HRPT → 6

Contents: This report lists, by type of appointment refusal (MTF declined, Network declined, and Non-network declined), the patients who have refused an appointment during the user-specified report period. The user may select specific patients.

Use/Frequency: This report is run when there is a need to assess the frequency of appointment refusals or to determine whether a patient is truly unable to obtain an appointment when a patient complaint is filed.

```
A Division                                          06 Jul 1996@1437   Page 2
                        Personal Data - Privacy Act 1974 (PL 93-579)
                       REFUSED APPOINTMENTS REPORT for ALL PATIENTS
                          From: 22 May 1993      To: 16 Jul 1993
=============================================================================================
Refused Status/             FMP/SSN     DDS Patient Category     Pat Home Ph'               Specialty #
Patient Name                HCF             Referral#             Refusal Time               Location
Refusal Reason
=============================================================================================
NON-MTF DECLINED (continued)
----------------------------
   CRAWFORD,MINDY (Cont.)20/354-27-7242 USN ACTIVE DUTY
CRAWFORD,JACQUI 93000010430Jun93Q0959
UNHAPPY WITH GROUP/PROVIDER
FREE TEXT NON-MTF
```

Figure 6-90. Refused Appointments Report

CHCS: MCP DESKTOP USER GUIDE

7. INTERACTIVE NON-AVAILABILITY STATEMENT (NAS)/CARE AUTHORIZATION PROCESSING

Brief Outline

7.1 Interactive NAS Processing Menu (IMCP) 7-1
7.1.1 Non-Availability Statement Processing (NNAS) 7-2
7.1.1.1 Print or Cancel an Individual NAS 7-3
7.1.1.2 Issuing an NAS: 7-8
7.1.1.3 View NAS History 7-26
7.2 Reports for NAS (RNAS) 7-26
7.2.1 Printing a Report to a Spooled Document 7-26
7.2.2 Printing a Spooled Document 7-26
7.2.3 Branch of Service Summary Report (BNAS) 7-27
7.2.4 NAS Statistical Report (NNAS) 7-29
7.2.5 Reason for Issue by Patient Category Report (PNAS) 7-30
7.2.6 Reason for Issue Summary Report (SNAS) 7-32

7.1 Interactive NAS Processing Menu (IMCP)

Introduction

Medical Treatment Facilities (MTFs) issue non-availability statements (NASs) to authorize using Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds to pay for inpatient care that cannot be provided by the MTF. Outpatient NASs are no longer required. NASs are issued for CHAMPUS eligible patients only and are filed; i.e. recorded, on the Defense Enrollment Eligibility Reporting System (DEERS). NASs are not stored in CHCS.

The Non-Availability Statement Processing (NNAS) option on the Interactive NAS Processing Menu (IMCP) is used to issue a new NAS, cancel or print an NAS, or view a patient's NAS history data filed on DEERS. The NAS Processing Menu is described as interactive, because NAS processing cannot be batch processed. NAS processing can only be accomplished in real time with DEERS online.

The DEERS database summarizes the NAS data every month. After the data has been summarized by DEERS, CHCS users can request the following summary reports through the Reports for NAS Menu (RNAS):

– Branch of Service Summary Report

– NAS Statistical Report

– Reason for Issue by Patient Category Report

– Reason for Issue Summary Report.

7.1.1 Non-Availability Statement Processing (NNAS)

Menu Path: PAS System Menu → MAN → IMCP → NNAS

Security Keys:

CPZ CCP
CPZ NAS
CPZ OHI

Required Fields:

Patient name or NAS number
Issue type
Issue reason
DMIS ID
Issuing officer
Major diagnostic category (MDC)**
Admitting facility*
Admission date*
NAS status
Issuing type
Medically inappropriate code
Treatment facility**
Treatment facility city**
Treatment facility state**
Treatment facility ZIP**
Mileage**
Output device

* Only required if issue type is retroactive.
** Only required if issue reason is medically inappropriate.

Application Description:

This option allows you to issue, print, or cancel NASs in DEERS. Canceled NASs are not deleted from DEERS, but remain available within the system to be queried and printed. NASs are available to be accessed either by NAS number or by patient name. This option functions only when DEERS is online.

Business Rules:

NASs are filed only for CHAMPUS eligible beneficiaries.

Note: The NNAS option does not allow you to issue an NAS for an active duty patient.

A beneficiary must be registered on DEERS and an NAS must be filed on DEERS before claims can be paid.

Data Entry Process:

7.1.1.1 Print or Cancel an Individual NAS

Access the Non-Availability Statement Processing (NNAS) option on the Interactive NAS Processing Menu

Select the NAS number or select the patient name

Query DEERS for NAS

Print the NAS

Cancel the NAS

Quit and return to the initial action bar

Access the Non-Availability Statement Processing (NNAS) option on the Interactive NAS Processing Menu

```
  NNAS   Non-Availability Statement Processing
  RNAS   Reports for NAS

Select Interactive NAS Processing Menu Option: NNAS
```

The system prompts you to begin by displaying the initial action bar prompting you either to access an individual NAS by number, select a patient to print or cancel their NASs, or quit and exit the option.

Select the NAS number

Refer to Figure 7-1. NAS Processing Initial Action Bar and First Prompt When Selecting by NAS Number, page 7-4.

```
NAS PROCESSING


Select (N)AS Number, (P)atient Name, (Q)uit: P//N

Select NAS NUMBER: 00373207001
```

Figure 7-1. NAS Processing Initial Action Bar and First Prompt When Selecting by NAS Number

1. Enter "N" at the initial action bar.

2. The system prompts you to enter an NAS number.

   Enter the NAS number at the *Select NAS NUMBER* prompt.

   The NAS number is an 11-digit identifier (e.g., 0702 6320 200) composed of the following elements:

   Positions 1-4 = DMIS ID
   Position 5 = Year of the claim
   Positions 6-8 = Julian date of NAS issuance
   Positions 9-11 = NAS serial number:
   - 001 - 669 = regular NAS condition
   - 700 - 799 = chronic/retroactive
   - 800 - 899 = chronic
   - 900 - 999 = retroactive

Note: Sites may issue only 99 retroactive NASs per day.

(Refer to Figure 7-15. NAS Display Screen, page 7-22, for an example of an NAS number on a Non-Availability Statement.)

Select the patient name

Refer to Figure 7-2. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name, page 7-5.

```
NAS PROCESSING


Select (N)AS Number, (P)atient Name, (Q)uit: P//

Select PATIENT NAME: parrot,wendy
                                        30/101-10-0035 02 Feb 1953 F
         OK? YES//   (YES)
SPONSOR NAME: PARROT,VINCENT//
```

Figure 7-2. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name

Query DEERS

The system then queries DEERS (Refer to Figure 7-3. Processing DEERS Request Message, page 7-5) and performs a CHCS/DEERS Discrepant Data Check and a DEERS Check as described in Section 4, DEERS Functions and Processes. CHCS/DEERS Discrepancy Data Screen on page 4-21 and Figure 4-14. CHCS/DEERS Discrepancy Data Continued on page 7-22.)

```
CHCS-DEERS                  Processing DEERS Request


Waiting To Process.
Processing Request..


     Press ‘Q’ to quit and not process this DEERS request.
```

Figure 7-3. Processing DEERS Request Message

If the NAS is not in DEERS, the system displays an error message and returns to the initial action bar. Refer to Figure 7-4. DEERS NAS Response Error Message, page 7-6, for an example of an error message received from DEERS. The number, 86, is the error code that corresponds to the text, NAS Record Not Found.

```
      Personal Data - Privacy Act of 1974 (PL 93-579)

DEERS NAS RESPONSE       DATA RETURNED FROM DEERS     21 Jun 2001@1242

   NAS Response: 86 NAS Record Not Found



Press <RETURN> to continue
```

Figure 7-4. DEERS NAS Response Error Message

If the NAS is found in DEERS, the system displays the NAS data and an action bar permitting you either to print the NAS or to cancel the NAS (if it is still active). (Refer to Figure 7-5. NAS Display Screen, page 7-6.) (See Appendix A-20 for a list of discrepancies that will keep you from receiving a completed NAS display screen.) Also listed are the related areas and screens where the discrepancies may be corrected.

```
                                   NAS DISPLAY
         Patient: Parrot,Wendy                    FMP/SSN: 30/101-10-0035
Patient Category: A41                                  DDS: 30
         DOB/AGE: 02 Feb 1953/48Y                      Sex: FEMALE
             ACV: C-CHAMPUS/DIRECT CARE ELIGIBLE
_____________________________________________________________________________
        NAS Number: 00373207001                   Issue Date: 21 Jun 2001
            Status: UNCONDITIONAL
      Issue Reason: 3 - MEDICALLY INAPPROPRIATE
               MDC: 65 ARTHROSCOPY
          Facility:                           Admission Date:
   Other Insurance: N                          Policy Number:
 Insurance Company:
   Issuing Officer: JOHNSON,RICHARD
         Remarks 1:
                 2:
                 3:
  Medically Inapp Code: Other                       Mileage: 999
              Facility:Palomar/Pomerado Hospital
                 City:San Marcos                    State:CA    ZIP:92069
_____________________________________________________________________________
Select (P)rint, (C)ancel, or (Q)uit: P//
```

Figure 7-5. NAS Display Screen

Print the NAS

1. If you elect to print the NAS, press <Return> to accept the (P)rint action on the action bar.

2. The system displays the *OK TO PRINT? Yes//* prompt. If you enter "N," for NO, the system returns you to the NAS Display action bar. If you press <Return> to accept the Yes default, the system prompts you to select the output device and confirm the right margin.

Note: If the patient is not yet registered in CHCS, the system prompts you at this time to register the patient using the Mini Registration option. You cannot print the NAS until the patient is registered in CHCS. Refer to explanation following Figure 5-10. Mini Registration Screen, on page 5-27, for details.

```
Patient: PEARL,ZACHARY N.                                Mini Registration
FMP/SSN: 20/569-69-4415       DOB: 12Jun75       PATCAT: N11    Sex: M
                 Personal Data - Privacy Act of 1974 (PL 93-579)
      Patient: PEARL,ZACHARY N.                        DOB: 12 Jun 1975
       PATCAT: N11 (USN ACTIVE DUTY)                   FMP: 20
   Home Phone: 974-2333        W:                      SSN: 569-69-4415
 Patient Addr: 1020 NEWPORT DRIVE                      Sex: MALE
         City: HAMPTON               St/Cntry: VA      Zip: 23665

      Sponsor: PEARL,ZACHARY N.                   Service: NAVY
          FMP: 20                              Sponsor SSN: 569-69-4415
       PATCAT: N11 (USN ACTIVE DUTY)                   DOB: 12 Jun 1975
  Command Sec:                                        Rank:
 Station/Unit:
 Duty Address:
         City:                        St/Cntry:         Zip:
   Duty Phone:                                          DSN:

  O/P Rec Loc:
  O/S Rec Loc:
  Primary Phy:
  Reg Comment:
```

Figure 7-6. Sample Mini Registration Screen

3. As soon as the data has been sent to the printer, the system returns you to the NAS Display action bar for the current NAS, where you can either print the NAS again, cancel it (if it has not been canceled), or quit processing the current NAS and return to the initial action bar.

Cancel the NAS

1. If you elect to cancel the NAS, enter “C” at the action bar.

2. The system prompts you to confirm the cancellation. If you elect to cancel, the system sends a transaction to DEERS to cancel the NAS.

   If you elect to quit without canceling, the system returns you to the *Select PATIENT NAME* prompt where you can press <Return> and then enter “Q” to quit and return to the Interactive NAS Processing Menu.

7.1.1.2 Issuing an NAS:

Business Rules:

If the Patient Category or Date of Birth (DOB) is missing from the registration data for this patient when you select the Quit action, the system displays a message informing you of this missing information. Select either the Full or Mini Registration actions to enter the missing information.

If the patient belongs to a patient category that is not CHAMPUS eligible (that is, a patient category implying active duty or reserve status, or beginning with the letters K or X), the system displays the following alert message on the Demographics Display screen just above the action bar:

```
Patient Category makes this Patient ineligible for NAS Issuance
```

When the patient category makes the patient ineligible for NAS Issuance, the Demographics Display action bar permits you only to enter/edit the patient registration using the Full Registration or Mini Registration options, or to quit the screen and return to the initial action bar to select another patient or NAS.

There is no default on the Demographics Display action bar. You must enter the letter enclosed in parentheses to make your choice; i.e., enter “C” to continue.

If the patient is DEERS ineligible or not found in DEERS (or if the patient’s sponsor is in DEERS and you enter a DEERS Eligibility Override Code because the patient is clearly DEERS eligible), the Demographics Display action bar permits you to enter/edit the patient registration using the Full Registration or Mini Registration options, to enter/edit other health insurance (OHI) using this functionality, or to perform a Repeated DEERS check. The action bar also permits you to quit the screen and return to the initial action bar, to select another patient, or to continue and process NASs for the current patient.

The action bar on the NAS History screen permits you to issue a new NAS, to print an existing NAS, or to cancel an active NAS when the patient has previously

issued NASs. If the patient has no previously issued NASs, the action bar allows you to either issue an NAS or quit.

In the lower portion of the NAS Issue screen, the NAS Number is blank at this point. DEERS issues the NAS number after you file the data entered through the NAS Issue screen. Issue date is always today, and the status defaults to the patient's status on DEERS.

Unconditional status means the patient is on DEERS and is CHAMPUS eligible. Conditional status means that the patient is not found on DEERS.

If a patient is not found on DEERS, validate that you have entered the correct social security number (SSN) and DOB.You cannot enter or edit data in the NAS Number, Issue Date, or Status fields from this screen.

Once an NAS is filed, you can never change it. To correct the NAS you must cancel the NAS and reissue it with a new NAS number.

Data Entry Process:

Access the Non-Availability Statement Processing (NNAS) option on the Interactive NAS Processing Menu

Select patient

Verify the sponsor

Review the Current DEERS Eligibility screen

Review the CHCS/DEERS Discrepant Data screen

Review the Demographics Display

View NAS history

Select the (I)ssue action

Enter NAS Issue data

Enter medically inappropriate data

Review the NAS Display screen.

Print the NAS

Access the Non-Availability Statement Processing (NNAS) option on the Interactive NAS Processing Menu

Select patient

The system prompts you to begin by displaying the initial action bar prompting you either to process an individual NAS (by number), select the patient who will be issued NAS(s), or quit and exit the option.

```
NAS PROCESSING


Select (N)AS Number, (P)atient Name, (Q)uit: P//<Return>

Select PATIENT NAME: P0035
     1   P0035  PARROT,VINCENT         20/101-10-0035 09 Feb 1960 M FO5
     2   P0035  PARROT,WENDY           30/101-10-0035 02 Feb 1953 F
     3   P0035  PARROT,BRIAN           01/101-10-0035 20 May 1976 M
     4   P0035  PRESCOTT,LOWELL L      20/100-24-0035 01 Sep 1953 M NE7
Choose 1-4: 2  PARROT,WENDY
SPONSOR NAME: PARROT,VINCENT//<Return>
```

Figure 7-7. Non-Availability Statement Processing Initial Action Bar and Patient Selection Prompts

1. Press <Return> to accept the default (P)atient Name action.

2. Enter patient ID.

   The system prompts you to enter a patient name, however, you should follow your site's accepted method of entering patient ID. When you enter the first letter of the patient's last name and the last four digits of the sponsor's SSN, the system displays a picklist (refer to Figure 7-7. Non-Availability Statement Processing Initial Action Bar and Patient Selection Prompts, page 7-10) of all registered patients with that letter and number combination.

   Select the patient whose family member prefix (FMP), sponsor SSN, and patient DOB match the patient who needs the NAS.

   If the patient is not yet registered in CHCS, the system prompts you to register the patient using the Mini Registration option. (Refer to Figure 7-6 and explanation following Figure 5-10. Mini Registration Screen, on page 5-27, for details on Mini Registration.)

Note: If the SSN and DOB are correct and the patient is still not found on DEERS, direct the patient to the MTF administration office to register on DEERS. Claims are not paid until the patient is registered on DEERS. If the patient is clearly CHAMPUS eligible and urgently needs care not available at the MTF, but is not yet registered on DEERS (a newborn, for example), the patient can be provided the necessary care prior to registration. In this case, a conditional NAS is issued in CHCS. As soon as the patient is registered in DEERS, the claim can be processed.

---

3. Verify the sponsor.

   Press <Return> to verify that the sponsor name is correct.

Review the Current DEERS Eligibility screen

After you verify the sponsor, the system queries DEERS (refer to Figure 7-3. Processing DEERS Request Message, page 7-5) and performs a CHCS/DEERS Discrepant Data Check and a DEERS Check as described in Section 4, DEERS Functions and Processes. (Refer to Figure 4-13. CHCS/DEERS Discrepancy Data Screen, page 4-21, and Figure 4-14. CHCS/DEERS Discrepancy Data Continued, page 4-22.)

If a DEERS eligibility check has been performed within the last five days, the system displays the Current DEERS Eligibility screen. If a DEERS eligibility check has not been performed within the last five days, a DEERS eligibility check is performed automatically and the DEERS Eligibility Data screen displays showing actual patient status today on DEERS. The DEERS Eligibility Data screen is not the same data displayed on the Current Eligibility screen which displays data from information stored in CHCS up to five days ago, not directly from DEERS. (Refer to Figure 7-8. Current DEERS Eligibility Screen, page 7-12.)

```
                              CURRENT DEERS ELIGIBILITY
               Name: PARROT,WENDY                FMP/SSN: 30/101-10-0035
  Patient Category: USA FAM MBR AD                 DDS: 30
           DOB/Age: 02 Feb 1953/48Y                Sex: FEMALE
_____________________________________________________________________________
             Sponsor Rank: CAPTAIN
              Sponsor UIC: S31LFJSQ-0459 OPERATIONS GP
                  DMIS ID: 0037-WALTER REED AMC
                      ACV: C-CHAMPUS/DIRECT CARE ELIGIBLE
          ACV Start Date: 11 Mar 1999    Region Code: 02
  Care Authorization PH#: 555-2349      PCM Location: DIRECT CARE PC
             Direct Care: ELIGIBLE          Medicare: NOT ELIGIBLE
Dir Care Elig Start Date: 12 Mar 2001        CHAMPUS: ELIGIBLE
  Dir Care Elig End Date: 10 Feb 2003
  Eligibility End Reason:

                              BRAC Pharmacy Eligibility: NO
           Override Code:
         Date of Request: 17 Jun 2001
_____________________________________________________________________________
Select to (V)iew more DEERS data,(P)rint,(R)epeat DEERS check, (C)ontinue,
       or (Q)uit: C//
```

Figure 7-8. Current DEERS Eligibility Screen

1. At the Current DEERS Eligibility action bar, you can view more DEERS data, print a hard copy of the Current DEERS Eligibility data, repeat the DEERS check, continue or quit. (For detailed information about the Current DEERS Eligibility screen, see Section 4, DEERS Functions and Processes.)

Review the Demographics Display

When you press <Return> to accept the default (C)ontinue action at the Current DEERS Eligibility screen action bar or DEERS Eligibility Data screen action bar, the system displays the Demographics Display screen. (Refer to Figure 7-9. Demographics Display Screen, page 7-13.)

```
                              DEMOGRAPHICS DISPLAY
                  Name: PARROT,WENDY            FMP/SSN: 30/101-10-0035
      Patient Category: USA FAM MBR AD              DDS: 30
          Patient Type:                             Sex: FEMALE
            MCP Status:                          DOB/Age: 02 Feb 1953/48Y
                  ACV: C-CHAMPUS/DIRECT CARE EL  DMIS ID:
           Direct Care: ELIGIBLE               Medicare:
_____________________________________________________________________________
          Sponsor Name: PARROT,VINCENT             Rank: CAPTAIN
          Station/Unit: 0459 OPERATIONS     GP      DSN:
          Home Address: 867 GIBSON BLVD
                  City: FAIRFAX                   State: VIRGINIA
              ZIP Code: 22030                Home Phone: 918-555-2227
            Duty Phone: 202-555-1117         Work Phone:
  Registration Comment:
Last Registration Date: 20 Feb 2001@1030
Outpatient Record Room:
       MCP Enroll Date:                  End Enroll Date:
  Primary Care Manager:                       PCM Phone:
           Primary OHI: NOT ASSIGNED          Case Mgmt:
_____________________________________________________________________________
Select (F)ull, (M)ini, (O)HI, (N)ew Patient, (R)epeat DEERS, (C)ontinue,
       or (Q)uit DEMOGRAPHICS:
```

Figure 7-9. Demographics Display Screen

The Demographics Display screen has a three-window format.

The Display Window features patient demographics.

The Select Window displays the sponsor's name, station/unit, rank, and DSN number. The remaining data in the Select window pertains to the patient. This data is display only.

The Interact Window displays an action bar with the following actions:

(F)ull = Full Registration action: When you select Full Registration, the system displays the Full Registration screens and allows you to edit the patient's registration. Upon completion, the system returns to the Demographics Display Action Bar.

(M)ini = Mini Registration action: When the you select Mini Registration, the system displays the Mini Registration screens and allows you to edit the appropriate fields (e.g., home address, home phone). Upon completion, the system returns to the Demographics Display Action Bar.

(O)HI = Other Health Insurance action: When you select OHI, the system allows you to enter/edit/view the patient's other health insurance information. Upon completion, the system returns to the Demographics Display Action Bar.

(N)ew Patient = Selection of another patient action: When you select New Patient, the system returns to the *Select PATIENT*: prompt and allows you to select a different patient for processing. Processing the initially selected patient terminates when the New Patient selection is made from the Demographics Display Action Bar.

(C)ontinue: When you select Continue, the system displays the NAS History screen.

(Q)uit: When you select Quit, the system returns to the NAS Processing action bar. Refer to Figure 7-2. NAS Processing Initial Action Bar and First Prompt When Selecting by Patient Name on page 7-5. The following edits are performed before issuing the NAS.

1. If the Patient Category or Date of Birth is missing from the registration data for this patient when you select the Quit action, the system displays a message informing you of this missing information. Select either Full or Mini Registration to enter the missing information.

2. If the patient belongs to a patient category that is not CHAMPUS eligible (that is, a patient category implying active duty or reserve status, or beginning with the letters K or X), the system displays the following alert message on the Demographics Display screen just above the action bar:

   ```
   Patient Category makes this Patient ineligible for NAS Issuance
   ```

3. When the patient category makes the patient ineligible for NAS Issuance, the Demographics Display action bar permits you only to enter/edit the patient registration using the Full Registration or Mini Registration options, or to quit the screen and return to the initial action bar to select another patient or NAS.

4. There is no default on the Demographics Display action bar. You must enter the letter enclosed in parentheses to make your choice; e.g., enter "C" to continue.

5. If the patient is DEERS ineligible or not found in DEERS (or if the patient's sponsor is in DEERS and you enter a DEERS Eligibility Override Code because the patient is clearly DEERS eligible), the Demographics Display action bar permits you to enter/edit the patient registration using the Full Registration or Mini Registration options, to enter/edit OHI, or to perform a Repeated DEERS check. The action bar also permits you to quit the screen

and return to the initial action bar, to select another patient, or to continue and process NASs for the current patient.

View NAS History

When you select the Continue action, the system displays the NAS history of the patient (Refer to Figure 7-10. NAS History Screen, page 7-15), listing all active and canceled NASs). If the patient has four or fewer NASs in DEERS, the system will obtain complete information on all NASs during the initial DEERS check on the patient. If the patient has more than four NASs in DEERS, the system obtains only summary information on the NASs during the initial DEERS check; complete information on any given NAS can be obtained from DEERS only if a specific NAS is selected to process.

```
                        NAS HISTORY
         Patient: PARROT,WENDY        FMP/SSN: 30/101-10-0035
Patient Category: A41                     DDS: 30
         DOB/AGE: 02 Feb 1953/48Y         Sex: FEMALE
             ACV: CHAMPUS/DIRECT CARE ELIGIBLE
------------------------------------------------------------
   NAS Number   Status  MDC  Reason for Issue




________No previously issued NAS for this  patient__________
Select (I)ssue, or (Q)uit: I//
```

Figure 7-10. NAS History Screen

6. The action bar on the NAS History screen permits you to issue a new NAS, to print an existing NAS, or to cancel an active NAS when the patient has previously issued NASs. If the patient has no previously issued NASs, the action bar allows you to either issue an NAS or quit.

Select the (I)ssue action

When you elect to issue a new NAS, the system displays the NAS Issue screen. (Refer to Figure 7-11. NAS Issue Screen, page 7-17.)

The upper portion of the NAS Issue screen displays patient name, FMP/SSN, Patient Category, DEERS dependent suffix (DDS), Sex, DOB/Age, and alternate

care value (ACV). The ACV indicates the patient's DEERS eligibility and enrollment plan. You cannot edit any of these fields from this screen.

7. In the lower portion of the NAS Issue screen, the NAS Number is blank at this point. DEERS issues the NAS number after you file the data entered through the NAS Issue screen. Issue date is always today, and the status defaults to the patient's status on DEERS.

8. Unconditional status means the patient is on DEERS and is CHAMPUS eligible. Conditional status means that the patient is not found on DEERS.

9. If a patient is not found on DEERS, validate that you have entered the correct SSN and DOB.You cannot enter or edit data in the NAS Number, Issue Date, or Status fields from this screen.

Note: If the SSN and DOB are correct and the patient is still not found on DEERS, direct the patient to the MTF administration office to register on DEERS. Claims are not paid until the patient is registered on DEERS. If the patient is clearly CHAMPUS eligible and urgently needs care not available at the MTF, but is not yet registered on DEERS (a newborn, for example), the patient can be provided the necessary care prior to registration. In this case, a conditional NAS is issued. As soon as the patient is registered in DEERS, the claim can be processed.

Enter NAS Issue data

You will enter all data required to issue a conditional or unconditional NAS, which is retroactive, chronic, non-chronic or combinations of the above.

```
NAS DATA: PARROT,WENDY                                NAS ISSUE

         Patient: PARROT,WENDY        FMP/SSN: 30/101-10-0035
Patient Category: USA FAM MBR AD          DDS: 30
             Sex: FEMALE              DOB/Age: 02 Feb 1953/48
             ACV: CHAMPUS/DIRECT CARE
=====================================================================
           NAS Number:             Issue Date: 21 Jun 2001
            Issue Type:                 Status: UNCONDITIONAL
         Issue Reason:               DMIS ID:
                  MDC:
   Admitting Facility:
       Admission Date:

      Other Insurance:Yes, CHAMPUS Supplemental
    Insurance Company:BLUE CROSS/BLUE SHIELD, NC
        Policy Number:6782

      Issuing Officer:
            Remarks 1:
                    2:
                    3:

Ask for Help = HELP     Screen Exit = F10     File/Exit = DO  INSERT
OFF
```

Figure 7-11. NAS Issue Screen

1. Enter Issue Type.

   There are four issue types:

   R Retroactive/Chronic (valid for one year in the past)

   Y Retroactive/Nonchronic (valid for 30 days or less in the past)

   C Nonretroactive/Chronic (valid for one year in the future)

   N Nonretroactive/NonChronic (valid for 30 days or less in the future).

   If care does not occur within the valid period indicated above, the NAS must be canceled and a new NAS issued before the care is authorized.

2. Enter Issue Reason.

   Issue reason is the reason why the MTF cannot provide the care inside the facility. Choices are:

Non-Enrolled Patients

3 Medically inappropriate (Example: The patient becomes ill where no government MTF is nearby and travel to the nearest MTF is impractical.)

4 Facility temporarily not available (Example: The MTF is doing a light system upgrade and all the operating rooms are closed.)

5 Professional capability temporarily not available (Example: The patient requires an orthopedic surgeon and the only MTF orthopedic surgeon is on TDY for a month.)

6 Facility or professional capability permanently not available (Example: The patient requires an orthopedic surgeon and the MTF does not have an orthopedic surgeon or facilities for doing orthopedic surgery.)

Enrolled Patients

7 Care authorization inside network (Example: CHAMPUS-eligible and enrolled in MCP.)

8 Care authorization outside network (Example: CHAMPUS-eligible and enrolled in MCP.)

Obsolete

9 Non-enrollee (Authorizes CHAMPUS-eligible patients not enrolled in MCP to see a network provider. Not currently used and is against policy.)

3. Enter DMIS ID.

   Enter the Defense Medical Information Systems Identification (DMIS ID) of the issuing MTF. This can be any valid DMIS ID, provided your site reports workload for this DMIS ID. DEERS must recognize this as a valid DMIS ID. If DEERS does not recognize the DMIS ID, contact the DEERS office and resolve the discrepancy.

4. Enter MDC.

   The medical diagnostic code (MDC) describes, in broad terms, the type of medical care the patient requires. Enter two question marks (??) to see a list of choices. Refer to Appendix A, Major Diagnostic Codes (MDC) on page A-24 for a list of these codes.

5. Enter admitting facility and admission date.

   The name of the admitting facility and the admission date are only required when the issue type is retroactive/chronic or retroactive/nonchronic. The admission date must be a past date. The admission date could be the date of care given; i.e., a patient does not have to be admitted.

6. Enter other insurance information.

   The primary policy information defaults into the Other Insurance, Insurance Company, and Policy Number fields if the patient has OHI entered in CHCS. If the patient has OHI entered in CHCS, one of these codes displays in the Other Insurance field:

   S CHAMPUS Supplement

   C CHAMPUS/CHAMPVA

   CO Commercial

   GR Employer Group

   MS MEDICARE

   SD Student

7. Enter Issuing officer.

   Enter double question marks (??) to view a list of site definable choices.

Note: The issuing officer must be entered into the NAS Issuing Officer file using the NAS Issuing Officer Enter/Edit (ISSO) option on the Facility File/ Table Maintenance Menu. (Refer to Section 2.1.2.7.) Users must be assigned security keys CPZ CCP and CPZ FILE in order to access the Facility File/ Table Maintenance Menu.

---

8. Enter remarks.

   Enter up to three lines at 30 characters per line in the remarks field to further explain the reason for the NAS.

Enter medically inappropriate data

If the issue reason is "medically inappropriate," the system requires you to complete a second screen to enter a medically inappropriate code, treatment facility name, facility location (i.e., ZIP code, city, and state), and mileage.

```
NAS DATA: PARROT,WENDY                                                NAS ISSUE

          Patient: PARROT,WENDY                    FMP/SSN: 30/101-10-0035
Patient Category: USA FAM MBR AD                       DDS: 30
              Sex: FEMALE                           DOB/Age: 02 Feb 1953/48
              ACV: CHAMPUS/DIRECT CARE
==============================================================================
 Medically Inappropriate Code:
           Treatment Facility:
                     ZIP Code:
                         City:
                        State:
                      Mileage:
_____________________________________________________________________________
File/exit    Abort    Edit
File changes and exit.
```

Figure 7-12. NAS Issue Second Input Screen

1. Enter the Medically Inappropriate Code.

   Choices for medically inappropriate code are:

   Other
   PCS (between permanent duty assignments)
   TDY (Temporarily away from permanent residence)
   TRV (Travel difficult or costly).

2. Enter treatment facility name and ZIP code.

   Enter the name of the facility where treatment was rendered, then enter the ZIP code. As soon as you enter the ZIP code, the city and state will be entered for you and the system displays the following prompt at the bottom of the screen:

   `Are Treatment Facility City and State correct? Yes//`

   If you enter “N,” to indicate the city and/or state are not correct, the cursor returns to the city field and you can manually enter the city and state.

3. Enter mileage.

   In this field, enter the number of miles from where the patient received care to the closest MTF.

4. File the data

Upon completion of the second NAS Issue screen (Figure 7-12. NAS Issue Second Input Screen, page 7-20), you can either file the data, abort without filing, or edit the NAS. You may wish to review the NAS prior to filing. Use the edit option to do so. Once an NAS is filed, you can never change it. To correct the NAS you must cancel the NAS and reissue it with a new NAS number.

When you file the data, the NAS is processed. If the process is successfully completed, DEERS returns the message as shown in Figure 7-13. Transaction Complete Message, page 7-21.

```
                Personal Data - Privacy Act of 1974 (PL 93-579)

DEERS NAS RESPONSE       DATA RETURNED FROM DEERS     21 Jun 2001@1257

NAS Response:  99  Transaction Complete

Press <RETURN> to continue
```

Figure 7-13. Transaction Complete Message

If there is any discrepancy between your data and the data on DEERS, you receive a message as shown in Figure 7-14. DEERS Data Discrepancy Message, page 7-21.

```
                Personal Data - Privacy Act of 1974 (PL 93-579)

DEERS NAS RESPONSE       DATA RETURNED FROM DEERS     21 Jun 2001@1257

NAS Response:  60  Invalid DMIS ID number.

This discrepancy can be corrected on the NAS ISSUE SCREEN.

Press <RETURN> to continue
```

Figure 7-14. DEERS Data Discrepancy Message

Review the NAS Display screen and print the NAS

As soon as you press <Return> at the transaction complete message, the processing continues and the NAS Display screen displays. Refer to Figure 7-15. NAS Display Screen, page 7-22, where you can print the NAS.

Print the NAS

```
                                    NAS DISPLAY
           Patient: PARROT,WENDY                      FMP/SSN: 30/101-10-0035
   Patient Category: A41                                  DDS: 30
        DOB/AGE: 02 Feb 1953/48Y                          Sex: FEMALE
           ACV: CHAMPUS/DIRECT CARE ELIGIBLE
_____________________________________________________________________________
  NAS Number: 00373207700                            Issue Date: 21 Jun 1996
      Status: UNCONDITIONAL
Issue Reason: 3 - Medically inappropriate
          MDC: 02  DISEASES AND DISORDERS OF THE EYE
     Facility: Palomar/Pomerado                 Admission Date: 22 May 1996
 Other Insurance:  S                              Policy Number: 6702
    Insurance Company: BLUE CROSS/BLUE SHIELD, NC
      Issuing Officer: SMITH,JAMES A
        Remarks 1:
                 2:
                 3:
Medically Inapp Code: Temporarily away from per       Mileage: 150
            Facility: Palomar/Pomorado
              City: San Marcos                       State: CA   ZIP: 92069
_____________________________________________________________________________
OK TO PRINT? Yes//
```

Figure 7-15. NAS Display Screen

1. When you accept the default to print the NAS, you must enter a device name.

2. After you enter the device name at the *OK TO PRINT* prompt, the system prints the NAS to the printer you named.

3. For samples of the Uniformed Services Medical Treatment Facility Nonavailability Statement (NAS), DD Form 1251 (automated version) - 1990.), refer to Figure 7-16. Nonavailability Statement for an Enrolled Patient on page 7-24 and Figure 7-17. Nonavailability Statement for a Non-Enrolled Patient on page 7-25.

4. The system then returns to the NAS History screen where you can issue another NAS for the same patient or quit. If you choose to quit, the system

returns you to the initial prompt. Refer to Figure 7-10. NAS History Screen on page 7-15.

Note: Keep a copy of each NAS on file. If the patient ID changes in CHCS after an NAS is issued, the system will not be able to find the NAS on DEERS. If you have a copy of the NAS, you can use the NAS number to access it on DEERS.

Functionality Interactions:

Interactive NAS processing cannot be performed unless DEERS is online. NAS reports generated by a previous run can be printed/listed from a copy of the report(s) residing on disk without accessing DEERS; i.e. DEERS need not be online.

Troubleshooting:

Problem - Claims are denied for an NAS. You log onto CHCS and access the patient's NAS History Screen and do not see the NAS in question.

Solution - The site may have inadvertently issued the NAS to the wrong family member. To check this, access the NAS by number and check the beneficiary name and birth date and the sponsor SSN to make sure the NAS is being applied to the correct beneficiary. If the NAS has been applied to the wrong family member, cancel the incorrect NAS and issue a new NAS for the correct family member.

Problem - DEERS will not display a patient's NAS if a conditional NAS is issued when the patient has a sponsor record on DEERS but their own eligibility record is not on DEERS.

S**olution** - Once the beneficiary's eligibility is established on DEERS, the NAS should display (provided the beneficiary is valid).

If the beneficiary seems to be correct, with the correct birth date, and the NAS is not conditional, call customer support to report the problem.

Problem - DEERS will not display a patient's NAS when you identify the patient by name.

Solution - Print a copy of the issued NAS to determine whether the patient's identification has changed in CHCS. Access the NAS by NAS number.

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY REPORT CONTROL SYMBOL
NONAVAILABILITY STATEMENT (NAS)

PERSONAL DATA - PRIVACY ACT OF 1974 (PL 93-579 SUSC5F52A)

1. NAS Number: 0120 7035 801

2. PRIMARY REASON FOR ISSUANCE:

8 - Care authorization outside network

3. MAJOR DIAGNOSTIC CATEGORY FOR WHICH NAS IS ISSUED:
22 BURNS

4.PATIENT DATA:

a. Name: STEWART,RENATE R

b. DATE OF BIRTH: 22 Sep 48 c. SEX: F

d. ADDRESS:
232 DUCKSIDE DR
HAMPTON, VIRGINIA 23669

e. PATIENT CATEGORY:
B - FAM MBR OF RETIRED

f. OTHER NON CHAMPUS HEALTH INSURANCE:
N - No Insurance

5. SPONSOR DATA:

a. NAME: STEWART,JOHNNY E

b. SPONSOR'S OR RETIREE'S SSN:
457-76-9605

6. ISSUING OFFICIAL DATA:

a. NAME: STONER,SUSAN

b. TITLE: TECHNOLOGIST

d. PAY GRADE: GS18

c. SIGNATURE:

e. DATE ISSUED: 04 Feb 1997

7. REMARKS (INDICATE BLOCK NUMBER TO WHICH ANSWER APPLIES.)

1. STATUS: UNCONDITIONAL

1. ADMITTING FACILITY:
ADMISSION DATE:

REMARKS:
1:
2:
3:

DD FORM 1251 (AUTOMATED VERSION) - 1990

Figure 7-16. Nonavailability Statement for an Enrolled Patient

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY REPORT CONTROL SYMBOL
NONAVAILABILITY STATEMENT (NAS)

PERSONAL DATA - PRIVACY ACT OF 1974 (PL 93-579 SUSC5F52A)

1. NAS Number: 0120 7035 800

2. PRIMARY REASON FOR ISSUANCE:

4 - Facility temporarily not available

3. MAJOR DIAGNOSTIC CATEGORY FOR WHICH NAS IS ISSUED:
03 DISEASES AND DISORDERS OF THE EAR, NOSE AND THROAT

4.PATIENT DATA:

a. Name: PARKER,STACEY N

b. DATE OF BIRTH: 08 May 84 c. SEX: F

d. ADDRESS:
PT ADDR
HAMPTON, VIRGINIA 23666

e. PATIENT CATEGORY:
A - FAM MBR OF ACTIVE DUTY

f. OTHER NON CHAMPUS HEALTH INSURANCE:
N - No Insurance

5. SPONSOR DATA:

a. NAME: PARKER,THOMAS G

b. SPONSOR'S OR RETIREE'S SSN:
424-96-8396

6. ISSUING OFFICIAL DATA:

a. NAME: STONER,SUSAN

b. TITLE: TECHNOLOGIST

d. PAY GRADE: GS18

c. SIGNATURE:

e. DATE ISSUED: 04 Feb 1997

7. REMARKS (INDICATE BLOCK NUMBER TO WHICH ANSWER APPLIES.)

1. STATUS: UNCONDITIONAL

1. ADMITTING FACILITY:
ADMISSION DATE:

REMARKS:
1:
2:
3:

DD FORM 1251 (AUTOMATED VERSION) - 1990

Figure 7-17. Nonavailability Statement for a Non-Enrolled Patient

7.1.1.3 View NAS History

Refer to View NAS History on page 4-15.

7.2 Reports for NAS (RNAS)

Menu Path: PAS System Menu → MAN → IMCP → RNAS

The Reports for NAS Menu (RNAS) contains the options which allow you to generate NAS reports for a DMIS ID within a user specified period of time, broken down by such criteria as MDC, branch of service, reason for issue, and patient category.

DEERS must be online to generate reports because NASs are not stored in CHCS. Also, because NAS reports must be downloaded from DEERS, you cannot run CHCS ad hoc reports on NAS data.

If a report has already been generated by a previous run of an NAS report option and saved as a spool document, CHCS stores the report, allowing you to reprint the NAS report, as necessary, without accessing DEERS; i.e., DEERS need not be online.

7.2.1 Printing a Report to a Spooled Document

1. At the *DEVICE* prompt, enter **SPOOL**. You are asked for the name of your spool document.

2. At the *Select SPOOL DOCUMENT NAME* prompt, enter the name of your document. Enter a name that is representative of the report you are printing; e.g., SERVICE_SUMMARY, NAS_STAT, REASON_PATCAT, or REASON_SUMMARY.

3. At the *Are you adding '<document name>' as a new SPOOL DOCUMENT?* prompt, enter **Y**.

4. At the *SPOOL DOCUMENT EXPIRATION DATE: <date>//* prompt, press <Return> to accept the default date or enter a date when the system should automatically delete this document.

7.2.2 Printing a Spooled Document

The Spooling Menu [ZISPLMGR] is used to list, print, and delete spooled documents. You can request that your system administrator add this option to your secondary menu. Once added to your secondary menu, you can access this option from any menu by entering SPO.

```
        Delete A Spool Document
        List Spool Documents
        Print A Spool Document

Select Spooling Menu Option:
```

1. Access the Spooling Menu option.
2. At the *Select Spooling Menu Option* prompt, enter **P**.
3. At the *Select SPOOL DOCUMENT NAME* prompt, enter the name of your spooled document; e.g., NAS_STAT. You may enter ?? to view a list of spooled documents.
4. At the *Number of Copies: 1//* prompt, press <Return> to print one copy or enter the number of copies you want to print.
5. At the *Output to* prompt, enter the name of the printer where you want the document to print.
6. Press <Return> to exit the Spooling Menu option.

7.2.3 Branch of Service Summary Report (BNAS)

Menu Path: PAS System Menu → MAN → IMCP → RNAS → BNAS

Contents:

This report lists the total number of NASs issued under a given DMIS ID in a user-specified month, broken down by MDC and branch of service. Running this report requires that DEERS be online. If the report for the given DMIS has not yet been generated, the system accesses DEERS to query the DEERS database and generate the report. You may request data up to four months in the past. (Refer to sample report, Figure 7-18. Branch of Service Summary Report, page 7-28.) Once downloaded, multiple copies may be printed (Refer to sections 7.2 through 7.2.2).

Note: The system displays the Processing DEERS Request screen while report generation is in progress.

Use/Frequency:

Monthly or as needed.

TRIPLER ARMY MEDICAL CENTER 15 Apr 1996@1344 Page 1

NONAVAILABILITY STATEMENTS

BRANCH OF SERVICE SUMMARY REPORT

DMIS ID: 0124 NH PORTSMOUTH Month/Year: Feb 1996

DIAGNOSTIC CODE/DESCRIPTION	USA	USN	USAF	USMC	USCG	NOAA	PHS	UNK	TOTAL
0l NERVOUS SYSTEM	001	023	000	000	000	000	000	000	024
02 EYE	000	000	001	000	001	000	000	000	002
03 EAR. NOSE, AND THROAT	000	000	000	000	000	000	001	000	001
04 RESPIRATORY SYSTEM	001	000	001	000	000	000	000	000	002
05 CIRCULATORY SYSTEM	001	001	001	001	000	000	000	000	004
06 DIGESTIVE SYSTEM	000	002	000	000	000	000	000	000	002
07 HEPATOBILIARY & PANCREA	001	000	000	000	000	000	000	000	001
08 MOSCULOSKELETAL	001	000	000	000	000	000	000	000	001
09 SKIN & BREAST	000	000	000	000	001	000	000	000	001
l0 ENDOCRINE/NURT/METABOL	000	000	001	000	000	000	000	000	001
ll KIDNEY & URINARY	001	001	000	000	000	000	000	000	002
12 MALE REPRODUCTIVE	000	000	000	000	000	000	000	001	001
13 FEMALE REPRODUCTIVE	000	000	000	000	000	001	000	000	001
14 PREGNANCY	143	027	006	209	001	023	300	000	719
15 NEWBORNS	000	001	000	000	000	000	000	000	001
16 BLOOD	001	000	000	000	000	000	000	002	003
17 MYELOPROLIFERATE	000	002	000	000	000	000	000	000	002
18 INFECTIOUS DISEASES	000	000	000	007	000	000	000	000	007
19 MENTAL DISEASES	015	008	005	005	000	000	000	000	033
20 ALCOHOL & DRUG USAGE	000	001	001	000	000	000	000	000	002
21 INJURIES & POISONINGS	000	001	000	000	000	000	000	000	001
61 GYN LAPAROSCOPY	003	000	000	002	000	000	000	000	005
62 CATARACT REMOVAL	001	001	000	000	001	000	000	000	003
63 GI ENDOSCOPY	001	007	003	000	001	000	089	000	101
64 MYRINGOTOMY/TYMPANOTOM	000	000	007	000	003	000	000	072	082
65 ARTHROSCOPY	000	000	000	000	000	001	000	000	001
66 DILATION & CURETTAGE	000	000	001	000	000	000	000	000	001
67 TONSILLECTOMY/ADENOID	003	000	002	000	000	002	000	000	007
68 CYSTOSCOPY	003	000	000	000	000	000	000	000	003
69 HERNIA REPAIR	021	000	037	000	016	008	001	000	083
70 NOSE REPAIR	000	000	000	000	000	000	000	001	001
71 LIGATION	003	000	000	002	000	000	000	000	005
72 STRABISMUS REPAIR	000	000	001	001	000	000	000	000	002
73 BREAST MASS EXCISION	000	000	000	000	001	000	000	000	001
74 NEUROPLASTY	000	000	000	000	000	000	000	001	001
TOTAL FOR ALL DIAGNOSTIC CODES:	210	075	067	227	025	035	391	077	1208

Figure 7-18. Branch of Service Summary Report

7.2.4 NAS Statistical Report (NNAS)

Menu Path: PAS System Menu → MAN → IMCP → RNAS → NNAS

Contents:

This statistical report, for a specified DMIS ID, shows the total number of NASs generated, the total number canceled, and the difference between the two. These three totals are shown for both the current month that the user specifies and the most recent prior month. This option functions only when DEERS is online.

If the report for the given DMIS ID and the current month has not yet been generated, the system accesses DEERS to query the DEERS database and generate the report. (Refer to sample, Figure 7-19. Monthly Statistical Report, page 7-29.) Once downloaded, multiple copies may be printed (Refer to sections 7.2 through 7.2.2).

Note: The system displays the Processing DEERS Request screen while report generation is in progress.

Use/Frequency:

Monthly or as needed.

```
TRIPLER ARMY MEDICAL CENTER                              15 Apr 1996@1354 Page 1
                                 NONAVAILABILITY STATEMENTS
                                 MONTHLY STATISTICAL REPORT
DMIS ID: 0124 NH PORTSMOUTH                                 Month/Year: Apr 1993
================================================================================
                                     Total     Total        Total Issued Less
                                     Issued    Canceled    Total Canceled
--------------------------------------------------------------------------------

     Current Month                     692         011              681

     Previous Month                   1232         042             1190
```

Figure 7-19. Monthly Statistical Report

7.2.5 Reason for Issue by Patient Category Report (PNAS)

Menu Path: PAS System Menu → MAN → IMCP → RNAS → PNAS

Contents:

This report lists the total number of NASs in a given DMIS ID for a given reason for issue, for a given month. The report displays the number of NASs issued for each MDC within each Issue Reason. A total is given for each patient category. Running this report requires that DEERS be online.

If the report for the given DMIS, reason for issue, and the current month has not yet been generated, the system accesses DEERS to query the DEERS database and generate the report. (Refer to sample, Figure 7-20. Reason for Issue by Patient Category Report, page 7-31.) You may request data for up to four months in the past, including the current month. Once downloaded, multiple copies may be printed (Refer to sections 7.2 through 7.2.2).

Note: The system displays the Processing DEERS Request screen while report generation is in progress.

Use/Frequency:

Monthly or as needed.

TRIPLER ARMY MEDICAL CENTER 15 Apr 1996@1420 Page 1

NONAVAILABILITY STATEMENTS

REASON FOR ISSUE BY PATIENT CATEGORY

Issuing DMIS ID: 0124 NH PORTSMOUTH Month/Year: Feb 1993

Reason for Issue: Medically Inappropriate

DIAGNOSTIC CODE/DESCRIPTION	FAM MBR AD	RET	RET	FRM SP	SURV	TOTAL
0l NERVOUS SYSTEM	001	023	000	000	000	024
02 EYE	000	000	001	000	001	002
03 EAR, NOSE, AND THROAT	000	001	000	000	000	001
04 RESPIRATORY SYSTEM	001	000	001	000	000	002
05 CIRCULATORY SYSTEM	001	001	001	001	000	004
06 DIGESTIVE SYSTEM	000	002	000	000	000	002
07 HEPATOBILIARY & PANCRE	001	000	000	000	000	001
08 MUSCULOSKELETAL	001	000	000	000	000	001
09 SKIN & BREAST	000	000	000	000	001	001
10 ENDOCIiINE/NURT/METABOL	000	000	001	000	000	001
ll KIDNEY & URINARY	001	001	000	000	000	OD2
12 MALE REPRODUCTIVE	001	000	000	000	000	001
13 FEMALE REPRODUCTIVE	000	001	000	DOO	000	001
14 PREGNANCY	143	027	006	209	201	586
15 NEWBORNS	101	001	074	213	072	461
16 BLOOD	001	000	000	002	000	003
17 MYELOPROLIFERATE	000	002	000	000	000	002
18 INFECTIOUS DISEASES	000	000	000	007	000	007
19 MENTAL DISEASES	015	008	005	005	000	033
20 ALCOHOL & DRUG USAGE	000	001	001	000	000	002
21 INJURIES & POISONINGS	000	001	000	000	000	001
61 GYN LAPAROSCOPY	003	000	000	002	000	005
62 CATARACT REMOVAL	001	001	000	000	001	003
63 GI ENDOSCOPY	001	007	003	000	001	012
64 MYRINGOTOMY/TYMPANOTOM	000	072	007	000	003	082
65 ARTHROSCOPY	000	001	000	000	000	001
66 DILnTIoN & CURETTAGE	000	000	001	000	000	001
67 TONSILLECTOMY/ADENOID	003	000	002	000	000	005
68 CYSTOSCOPY	003	000	000	000	000	003
69 HERNIA REPAIR	021	000	037	000	016	074
70 NOSE REPAIR	000	007	000	000	000	007
71 LIGATION	003	000	001	001	000	002
73 BREAST MASS EXCISION	000	000	000	000	001	001
74 NEUROPLASTY	000	000	000	003	000	003
Total:	312	157	141	445	297	1352

Figure 7-20. Reason for Issue by Patient Category Report

7.2.6 Reason for Issue Summary Report (SNAS)

Menu Path: PAS System Menu → MAN → IMCP → RNAS → SNAS

Contents:

This report lists the total number of NASs in a given DMIS ID in a given month, and shows each MDC within each Issue Reason with subtotals by issue reason. The report also gives an overall total for the specified DMIS ID. Running this report requires that DEERS be online.

If the report for the given DMIS and the current month has not yet been generated, the system accesses DEERS to query the DEERS database and generate the report. (Refer to Figure 7-21. Reason for Issue Summary Report, page 7-33.) Once downloaded, multiple copies may be printed (Refer to sections 7.2 through 7.2.2).

Note: The system displays the Processing DEERS Request screen while report generation is in progress.

Use/Frequency:

Monthly or as needed.

```
TRIPLER ARMY MEDICAL CENTER                          15 Apr 1996@1420   Page 1
                            NONAVAILABILITY STATEMENTS
                         REASON FOR ISSUE SUMMARY REPORT

Issuing DMIS ID: 0124 NH PORTSMOUTH                        Month/Year: Feb 1993
==============================================================================
REASON FOR ISSUE/
 DIAGNOSTIC CODE/DESCRIPTION                   NORM RET CHR C/R     TOTAL
------------------------------------------------------------------------------
 Facility or professional capability permanently non available
 -------------------------------------------------------------
  19   MENTAL DISEASES                         021 057   000 000        078
  20   ALCOHOL & DRUG USAGE                    000 023   001 003        026

  Subtotal:                                    021  080  001  003       104

 Facility temporarily not available
 ----------------------------------
  04   NERVOUS SYSTEM                          001  020  000  082       103
  05   CIRCULATORY SYSTEM                      041  002  000  027       070
  07   HEPATOBILIARY & PANCREAS                000  001  072  013       086
  08   MUSCULOSKELETAL                         007  001  000  007       015
  ll   KIDNEY & URINARY                        010  023  008  001       042
  14   PREGNANCY                               005  002  014  000       021
  15   NEWBORNS                                000  001  000  003       004
  19   MENTAL DISEASES                         019  033  002  023       077
  20   ALCOHOL & DRUG USAGE                    002  002  035  000       039
  21   INJURIES & POISONINGS                   000  041  000  000       041
  62   CATARACT REMOVAL                        001  070  000  039       110
  63   GI ENDOSCOPY                            005  000  0~3  022       060
  65   ARTHROSCOPY                             001  049  003  000       053
  68   CYSTOSCOPY                              007  000  001  000       008

  Subtotal:                                    099  245  168  217       729

 professional capability temporarily not available
 -------------------------------------------------
   05  CIRCULATORY SYSTEM                      013  040  001  021       075
   08  MUSCULOSKELETAL                         001  000  000  003       004
   ll  KIDNEY & URINARY                        000  017  021  022       060
   14  PREGNANCY                               049  001  002  011       063
   62  CATARACT REMOVAL                        032  009  001  001       043
   63  GI ENDOSCOPY                            006  001  016  038       061
   65  ARTHROSCOPY                             021  000  005  000       026
   68  CYSTOSCOPY                              001  042  001  040       084
   72  STRABISMUS REPAIR                       007  001  001  013       012

   Subtotal:                                   130  111  048  149       438
 TOTAL:                                        250  436  217  369      1272
```

Figure 7-21. Reason for Issue Summary Report

CHCS: MCP DESKTOP USER GUIDE

Appendix A
Reference Materials

List of Reference Materials

Tables

		Page
A-1.	File Access Codes for Common, PAS, and MCP Files	A-3
A-2.	Access Code Legend	A-6
A-3.	MCP Security Keys	A-6
A-4.	Direct Care Provider Agreement Types and Eligible Patient Types	A-14
A-5.	External (Non-MTF) Provider Agreement Types and Eligible Patient Types	A-16
A-6.	Non-Network/Exception Provider Agreement Type and Eligible Patient Types	A-17

Reference Materials

MCP Taskman Options A-9
MCP Mail Group Bulletins A-11
Customizing the Membership ID Card for Your Site A-18
ACV Codes A-19
DEERS DISCREPANCY CODES A-20
DEERS ELIGIBILITY OVERRIDE CODE PICKLIST A-22
PATIENT CATEGORIES A-23
MAJOR DIAGNOSTIC CODES (MDC) A-24

Diagram

CHCS ENROLLMENT: Active Duty All Sites and Non-Active Duty in Regions 1, 2, 5, and 6 . . . . . A-25

Table A-1. File Access Codes for Common, PAS, and MCP Files

File #	File Name	Access		
		Read	Write	LAYGO
Common Files				
40.8	Medical Center Division	S	#	#
45.7	Department and Service		#	#
8119	MEPRS Codes		#	#
5.8002	Zip Code		#^	#^
40.5	Holiday		#	#
44	Hospital Location	Ss	Ss	Ss
7	Provider Class		#	#
3.1	Title	@	#	#
3	User		#	#
6	Provider		#P	#P
8111	Unit Ship ID		#	#
PAS Files				
44.5	Appointment Type	Ss	S	
44.6	PAS Profile Template	Ss	S	S
MCP Files				
8557	MCP Agreement Modifications	S	S	S
8573	MCP Agreement Type	Ss	^	^
8563	MCP Alternate Care Value	Ss	^	^
8561	MCP Assignment Reason	Ss	S	S
8565.5	MCP Beneficiary Categories	Ss	^	^
8563.5	MCP CHAMPUS Dental Code	@	@	@
8564	MCP Disenrollment Reason	Ss	S	S

Table A-1. File Access Codes for Common, PAS, and MCP Files (continued)

File #	File Name	Access		
		Read	Write	LAYGO
8572	MCP Enrollee Lockout Override Reason	Ss	Ss	Ss
8582	MCP Enrollment Block Reasons	SsZ	SsZ	SsZ
8575	MCP Entitlement Discrepancy Codes		@	@
8560	MCP Form Text	S	S	S
8555	MCP Office	Ss	Ss	Ss
8556	MCP HCF	Ss	Ss	Ss
8577	MCP Zip Code Combination	Ss	Ss	Ss
8566	MCP Facility Type	Ss	S	Ss
8583	NAS Issuing Officer	S	S	S
8552	MCP Patient	Ss	Ss	Ss
8565	MCP Patient Type	Ss	^	^
8574	MCP Policy Holder	Ss	Ss	Ss
8576	MCP Provider Type	S	^	^
8567	MCP Provider Group	Ss	S	
8568	Professional Category	Ss	S	S
8569	Military Status	Ss	S	S
8550	MCP Provider Group	Ss	S	
8553	MCP Place of Care	Ss	S	
8551	MCP Provider	Ss	S	S
8554	MCP Referral	Ss	Ss	Ss
8570	MCP Appointment Refusal Reason	S	@	@

Table A-1. File Access Codes for Common, PAS, and MCP Files (continued)

File #	File Name	Access		
		Read	**Write**	**LAYGO**
8578	MCP Parameters	S	S	S
8579	MCP Unit PCM	Ss	Ss	@
8582	NAS Issue Reason	#	^	^
PAD Files				
8064	Insurance Company		Aa	Aa
39.4	Embosser Format	#DdSs	#DS	#DS

FM-00398-2

Table A-2. Access Code Legend

Each functionality has its own file security code, which is listed as an uppercase letter and a lowercase letter. These define either a manager/supervisor or clerk/ end-user access to subsystem files. Generally, the uppercase code is assigned to an individual with high accountability. The lowercase code is assigned to an individual with less accountability.

File Security	Functional Area
A,a	Medical Services Accounting (MSA) **Note:** In the MSA subsystem, a lowercase 'a' indicates supervisory access.
D,d	Patient Administration
S,s	Patient Appointment and Scheduling (PAS)
P,p	Pharmacy
@, #, ^, Z, z	Tools

Table A-3. MCP Security Keys

Security Key	Description
MCP Security Keys	
CPZ CCP	Allows holders to access the Managed Care Program Menu [MCP MAIN MENU] on the PAS Main Menu [SD PAS MAIN MENU]. All HCFs and MCP File and Table POCs should be assigned this key.
CPZ NET	Allows holders to access the Provider Network Management Menu [MCP NET MAINTAIN MENU] option on the Managed Care Program Menu [MCP MAIN MENU]. MCP File and Table POCs should be assigned this key.
CPZ FILE	Allows holders to access the File and Table for MCP Menu [MCP FILE TABLE MAINT MENU] on the Managed Care Program Menu [MCP MAIN MENU]. MCP File and Table POCs should be assigned this key.
CPZ AGRMOD	Allows holders to access the Modify Group Agreement Effective Date [MCP AGREEMENT MODIFICATION] option on the Provider Network Management Menu [MCP NET MAINTAIN MENU]. This is a central processing unit (CPU)-intensive option and should only be assigned to a few select MCP File and Table POCs.
CPZ AGREEMENT	Allows holders to access the Agreement Type Enter/Edit [MCP AGREEMENT TYPE ENTER EDIT] option on the Provider Network File/Table Maintenance Menu [MCP HCP NET FILE MAINT MENU]. Allows users with the CPZ FILE security key to edit the agreement types for the MTF. This key should only be assigned to a few select MCP File and Table POCs.
CPZ OHI	Allows PAS users to enter other health insurance (OHI) via the PAS Demographics Display Action Bar.
CPZ CASE	Allows holders to enter/edit case managers (non-network providers/exception providers) for patients. PAS users who hold the CPZ OHI security key in addition to this key have the capability to add case managers via the OHI option on the Demographics Display screen.

Table A-3. MCP Security Keys (continued)

Security Key	Description
MCP Security Keys	
CPZ NAS	Allows holders to access the Interactive NAS Processing Menu [MCP NAS MAIN MENU] option on the Managed Care Program Menu [MCP MAIN MENU]. This option allows users to enter non-availability statements (NASs).
CPZ PCM BATCH	Allows holders to access the Batch PCM Reassignment [MCP BATCH PCM REASSIGNMENT] option from the Managed Care Program Menu [MCP MAIN MENU]. This is a CPU-intensive task that should be restricted to selected personnel.
CPZ ADHOC	Allows holders to access the MCP Ad Hoc Report Menu (CP AD HOC REPORTING). This menu allows users to print, search, and inquire into file entries.
CPZ LABEL	Allows holders to generate provider labels, and mailing labels for individual patients or by family (batch).
CPZ ZIP	Allows holders to override a patient's residential zip code if that zip code has been defined as being outside the enrollment (catchment) area for the site.
CPZ PARAMETER	Allows holders access to the MCP Parameters file. Allows the site to set restrictions on enrollment mix and zip codes, and to determine if the site is going to run in Local Empanelment Mode or Full Enrollment Mode.

MCP TaskMan Options

Menu Path: Systems Manager Menu (EVE) → TM → STT

CP Enrollment Bulletin

Frequency/Time of Day: Daily/Evening

Description:

1. Adjusts MCP status according to DEERS response.
2. Disenrolls those with CE status for 120 days.
3. Checks end enrollment dates for those who need to be disenrolled and disenrolls them.

CP NAS Daily Cleanup

Frequency/Time of Day: Daily/Evening

Description: Purges temporary DEERS data held in CHCS for Non-availability statement (NAS) transactions.

CP NET HCP Bulletin

Frequency/Time of Day: Daily/Post midnight

Description: Performs checks on inactivated providers and notifies recipients of the CP HCP Inactivation Mail Bulletin. Also encourages Discrepancy Avoidance Report check.

CP NET POC Bulletin

Frequency/Time of Day: Daily/Evening

Description: Same as CP NET HCP Bulletin, but for inactivated places of care.

CP UIC Enrollee Maintenance

Frequency/Time of Day: Weekly

Description: Checks all MCP enrollees for change of Unit Identification Code (UIC), and updates all UIC cross references. Verifies code is valid in Unit Ship ID file. If Unit Ship ID code is invalid, prompts user to run discrepancy report.

CP Update Candidate File

Frequency/Time of Day: Daily/Evening

Description: Checks changes in and updates the potential active duty patient candidate file to ensure readiness for enrollment.

CP Update ENR End Date -- OBSOLETE

Frequency/Time of Day: Daily

Description: The DEERS ELIG/REG RESPONSE file stored the DEERS eligibility responses that contained the eligibility end date. This stored information was used to update the active duty end enrollment date each time a DEERS eligibility check was performed in PAS/MCP. This prevented overlapping enrollment episodes in DEERS. The system now automatically checks the eligibility end date with active duty patient enrollment end dates during each DEERS eligibility transaction. If the date does not match, the system modifies the enrollment end date to match with eligibility end date.

CP Reciprocal Disenroll Process

Frequency/Time of Day: Daily

Description: Sends request to DEERS to retrieve the list of those reciprocally disenrolled from their Defense Medical Information Systems Identification (DMIS ID) that day. This, in turn, starts an automatic disenrollment for all the names received.

CP Enrollment Update --- OBSOLETE

Frequency/Time of Day: Daily

Description: This routine ran if the enrollment mode was switched from local empanelment to DEERS Enrollment Mode. When this occured, a batch job was initiated to reprocess all current AD enrollments. This function is now addressed with the CP Enrollment Bulletin.

MCP Mail Group Bulletins

Menu Path: Systems Manager Menu (EVE) → MM → EBUL

Bulletins:

CP AD BATCH ENR COMPLETE – States that the Batch enroll AD candidates option has been completed.

CP AD BATCH UPD COMPLETE – Notifies the mail group that the process for updating potential AD enrollment candidate file is complete.

CP AGREEMENT MODIFICATION – Notifies the mail group and the user who changed the agreement start date for an existing agreement.

CP BATCH IDENTIFY AD ENR – Notifies the mail group once the job Identify Potential Active Duty Candidates is completed (IPADC).

CP BATCH PCM – Notifies the group when a batch job reassigning beneficiaries from one PCM to another under the Batch PCM option is completed.

CP BATCH PCM ABORT – Notification that the batch job for reassigning beneficiaries from one PCM to another was unsuccessful.

CP BATCH DISEN COMPLETE – Notifies the user when the Batch Disenrollment is complete.

CP BATCH DISENROLL COMPLETE – Notifies that the process of changing from DEERS enrollment (Full Enrollment) to LOCAL EMPANELMENT has completed.

CP ENR DIV CHANGE – Notifies the user and mail group when the option CHANGE ENROLLING DIVISION is complete. Used with DMIS Realignment.

CP HCP INACTIVATION DATE – Generated daily to show any inactive providers, and serves as a reminder to check the Discrepancy Avoidance report.

CP HCP INACTIVATION – Generated when a provider is inactivated or reactivated from one provider group or from all provider groups.

CP INVAILD ENROLLMENT – Notification that beneficiaries were found to have discrepancies between DEERS and CHCS during an Enrollment/ Disenrollment transaction. This bulletin recommends that the Enrollment/ Disenrollment Discrepancy report be printed to reserve and correct the discrepancies.

CP MULTIPLE BATCH PCM – Notifies a group when a batch job for reassigning beneficiaries from one PCM to multiple PCMs under the Batch PCM option has completed.

CP NEW UIC CODE – Notifies recipients that a new UIC code downloaded from DEERS does not match an entry in the Unit/Ship ID file. It recommends updating the file and editing the patient's mini-registration.

CP PCM REACHED MAX CAPACITY – Generated during Auto Enrollment if the user accepts the defaulted PCM and that PCM has reached maximum overall capacity or maximum active duty capacity. A warning displays for the user who may continue with the enrollment by assigning an alternate PCM.

CP POC INACTIVATION – Generated when a place of care is inactivated.

CP POC INACTIVATION DATE – Generated daily to show any discrepancies that exist for places of care that have been inactivated.

CP RECIPROCAL DISENR COMPLETE – Generated when the Auto Reciprocal Disenrollments have completed and whether discrepancies have been identified. The spool document of discrepancies will be deleted after 14 days. A bulletin is also generated when no discrepancies are noted.

CP RENEW AGREEMENT BATCH PCM – Notifies the group that an agreement was RENEWED and the listed providers had their PCM patients reassigned.

CP RENEW AGREEMENT NON-PART – Notifies the group that an agreement was RENEWED and the listed providers are NON-PARTICIPANTS in the renewed agreement with PCM patients assigned.

CP RENEW AGREEMENT W-OUT BATCH – Notifies that an agreement was RENEWED and the listed providers have PCM patients that were not reassigned. They were no reassigned either because the user did not have the key to perform the function or the PCM was not selected to have their patients reassigned.

CP UIC MAINT RPT AVAIL – Notifies the group that the UIC Maintenance report is available for printing. The report identifies those enrolled AD members whose UIC is invalid in CHCS or whose UIC has been changed.

CP UIC WITHOUT PCM – Generated during Auto Enrollment if the UIC matches an entry in the Unit/Ship ID file but has not been linked to a PCM (UIC/ PCM Link). A user may still complete the enrollment by directly assigning a PCM.

CP INACTIVATE UIC IN AUTO ENROLLMENT – Notification that an auto enrollment was performed for a patient whose UIC has been inactivated. It recommends that the patient's mini registration be updated.

CP BATCH RENEW COMPLETE – Notification that the process to Batch Renew Enrollment has completed and to generate the Batch Renewal Disenrollment Roster.

CP BATCH DISEMPANEL COMPLETE – Notification that non-active duty members have been Disempanled after switching from Local Empanelment to the DEERS Enrollment mode.

CP PARAMETERS – Notification that the dates to perform annual and monthly eligibility checks are incomplete in the MCP PARAMETERS option.

Table A-4. Direct Care Provider Agreement Types and Eligible Patient Types

Agreement Types	Patient Types
CON CONTRACT	AD Active Duty
	SCD Supplemental Care Diagnosis
	MCD MCP/Non CHAMPUS Eligible
	MCA MCP/Active Duty
	MED Medicare
	MCP MCP/CHAMPUS Eligible
	OTH Other
	CHA CHAMPUS
MTF MTF STAFF	AD Active Duty
	SCD Supplemental Care Diagnosis
	MCD MCP/Non CHAMPUS Eligible
	MCA MCP/Active Duty
	MED Medicare
	MCP MCP/CHAMPUS Eligible
	CHA CHAMPUS
	OTH Other
PIC PARTNER INTERNAL	MCP MCP/CHAMPUS Eligible
	CHA CHAMPUS
SUP SUPPLEMENTAL CARE/ DIAGNOSTIC SERVICE	AD Active Duty
	SCD Supplemental Care Diagnosis
	MCD MCP/Non CHAMPUS Eligible

Table A-4. Direct Care Provider Agreement Types and Eligible Patient Types (continued)

Agreement Types	Patient Types
	MCA MCP/Active Duty
	MED Medicare
	MCP MCP/CHAMPUS Eligible
	OTH Other
	CHA CHAMPUS

Table A-5. External (Non-MTF) Provider Agreement Types and Eligible Patient Types

Agreement Types	Patient Types
CON CONTRACT	AD Active Duty
	SCD Supplemental Care Diagnosis
	MCD MCP/Non CHAMPUS Eligible
	MCA MCP/Active Duty
	MED Medicare
	MCP MCP/CHAMPUS Eligible
	OTH Other
	CHA CHAMPUS
NET CIVILIAN NETWORK PROVIDER	SCD Supplemental Care Diagnosis
	MED Medicare
	MCP MCP/CHAMPUS Eligible
	CHA CHAMPUS
PEX PARTNER EXTERNAL	MCP MCP/CHAMPUS Eligible
	CHA CHAMPUS
SUP SUPPLEMENTAL CARE/ DIAGNOSTIC SERVICE	AD Active Duty
	SCD Supplemental Care Diagnosis
	MCD MCP/Non CHAMPUS Eligible
	MCA MCP/Active Duty
	MED Medicare
	MCP MCP/CHAMPUS Eligible
	OTH Other
	AD Active Duty
	CHA CHAMPUS

Table A-6. Non-Network/Exception Provider Agreement Type and Eligible Patient Types

Agreement Types	Patient Types
NON NON-NETWORK EXCEPTION	SCD Supplemental Care Diagnosis
	MCP MCP/CHAMPUS Eligible
	CHA CHAMPUS

Customizing the Membership ID Card for Your Site

The system allows you to customize the membership card (i.e., edit the emboss card format) using the Edit Embosser Cards (EEC) option on the System Definitions Menu (SDM) option located on the PAD System Menu, the Enrollment File/Table Maintenance Menu (ETAB), and the MCP Embosser Card Enter/Edit option.

At your site, you can customize embossed cards as follows:

- Add or delete the number of rows of print, including blanks, on each embossed card.
- Edit the number of cards to be printed for each patient when generated.
- Add or delete fields to be included on the embossed card, as well as reposition the location of the individual fields.
- Display some of the fields (e.g., Patient Name and FMP/SSN) in "double height" so that they stand out on the card.

MCP membership ID card fields may include the following:

- Patient Name
- FMP/SSN
- DDS
- Enrollment Start Date
- Other Health Insurance Flag (i.e., OHI: YES)
- OHI Policy Number
- PCM Name and Phone Number.

ACV Codes

Code	Description
A	Active-Duty/MCP Enrolled
B	CHAMPVA Eligible
C	CHAMPUS/Direct Care
D	MCP Enrolled/CHAMPUS Ineligible
E	MCP Enrolled/Dir Care, CHAMPUS Eligible
K	Luke AFB/Williams AFB CAM (Obsolete on 4/1/97)
N	Not Enrolled/CHAMPUS Ineligible (Direct Care Eligible if not enrolled)
S	Continued Health Care Benefit Plan (CHCBP)
U	Enrolled in USTF Managed Care

DEERS DISCREPANCY CODES

The following is list of discrepancies that will keep you from receiving a completed NAS Display screen. Also listed are the related areas and screens where these problems might be corrected:

	Discrepancy	Related Area
60	Invalid DMIS number	NAS Issue Screen
61	nvalid reason for issue	NAS Issue Screen
64	Med inapp city required	NAS Issue Screen
65	Med inapp state required	NAS Issue Screen
66	Med inapp zip required	NAS Issue Screen
67	Med inapp mileage required	NAS Issue Screen
68	Med inapp code required	NAS Issue Screen
69	Invalid patient category	Mini Reg
70	Invalid admission date	NAS Issue Screen
71	Admitting hospital required	NAS Issue Screen
72	Invalid major diagnostic categ.	NAS Issue Screen
73	Issuing officer name required	NAS Issue Screen
74	Issuing officer grade required	NAS Issue Screen
75	Issuing officer title required	NAS Issue Screen
76	"J" type transaction required	NAS Issue Screen
77	Terminal ID required	Retransmit to DEERS
78	Invalid signature date	NAS Issue Screen
79	Invalid other insurance	OHI
80	Other insurance policy required	OHI
81	Other insurance co. required	OHI
82	Sponsor name required	Mini Reg
83	Patient name required	Mini Reg
84	Patient sex required	Mini Reg
85	Patient found on DEERS Conditional NAS Issue	Repeat DEERS Eligibility Query
89	Unable to issue NAS	NAS Issue Screen
90	Patient address not on DEERS	Mini Reg
91	Invalid Monthly Report Type	Re-request Report
92	Monthly Report not available for type/date requested	Re-request Report
93	Patient state required on Conditional NAS	Mini Reg
94	Patient zip code required on Conditional NAS	Mini Reg

	Discrepancy	Related Area
95	Issuing officer grade	NAS Issue Screen
96	Patient category does not match DDS	Mini Reg
97	Patient category not consistent with sponsor status	Mini Reg
98	Sponsor must be deceased for patient category of survivor	Mini Reg
A1	Med inapp hospital required	NAS Issue Screen

DEERS ELIGIBILITY OVERRIDE CODE PICKLIST

Select DEERS ELIGIBILITY OVERRIDE CODE:

10 DEERS enrollment exception - billing determine response.

01 Care Denied - Not treated

02 Presented valid DD Form 1172 and valid ID card

03 Patient recently eligible (less than 120 days). Patient not on DEERS.

04 Sponsor recently entered active duty for greater than 30 days.

05 Newborn infant less than 1 year old

06 Patient has valid ID issued within 120 days (shown DEERS ineligible).

07 Emergency Care - Eligibility and billing determination still required.

08 Sponsor duty station outside the 50 states or with APO/FPO address.

09 Survivor of deceased sponsor - one time exception.

PATIENT CATEGORIES

Some patients are not eligible for NAS processing because they are not CHAMPUS eligible. These patients are screened out of NAS processing based upon their patient category. This will minimize unnecessary DEERS transactions. The ineligible patient categories are:

1. All categories that imply an active duty or reserve status (x11, x12, x13, x14, x15, x21, x22, x23, x26, x27, and x28).

2. All categories that start with the letters K or X.

All other PATCATS will be "sorted" into the following five. DEERS PATCATs when NAS data is transmitted to DEERS:

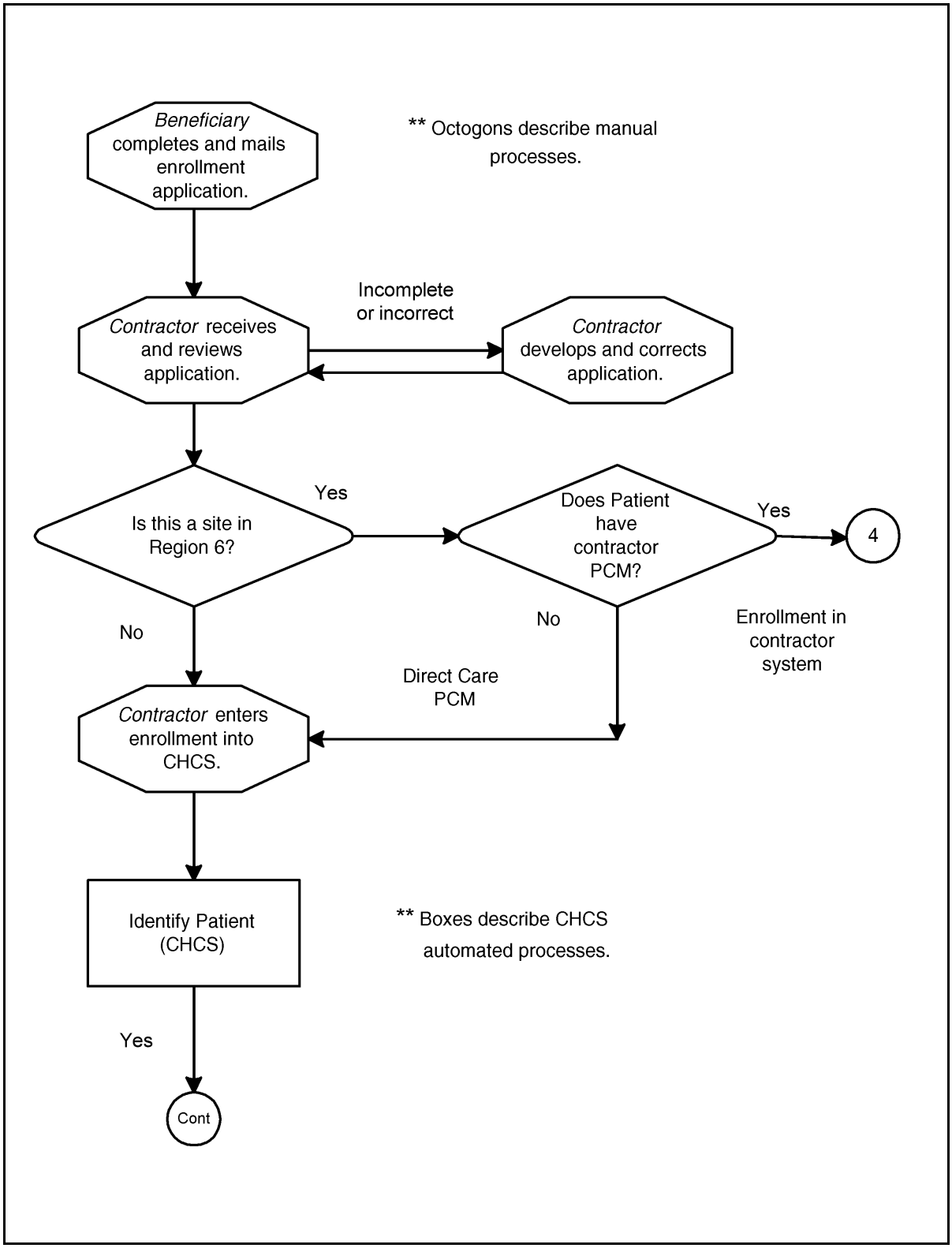
1.	Retired	A24	A25	A31	A32	A33		
		B24	B25	B31	B32	B33		
		C24	C25	C31	C32	C33		
		F24	F25	F31	F32	F33		
		M24	M25	M31	M32	M33		
		N24	N25	N31	N32	N33		
		P24	P25	P31	P32	P33		
2.	Dependent AD	A41	B41	C41	F41	M41	N41	P41
3.	Dependent Ret	A43	B43	C43	F43	M43	N43	P43
4.	Former Spouse	A48	A49	B48	B49	C48	C49	F48 F49
		M48	M49	N48	N49	P48	P49	
5.	Survivor	A45	A47	B45	B47	C45	C47	F45 F47
		M45	M47	N45	N47	P45	P47	

X = Any alpha character that indicates a branch of service, such as A, B, C, F, M, N or P.

MAJOR DIAGNOSTIC CODES (MDC)

Code	Reason
01	Diseases and Disorders of the Nervous System.
02	Diseases and Disorders of the Eye.
03	Diseases and Disorders of the Ear and Throat.
04	Diseases and Disorders of the Respiratory System.
05	Diseases and Disorders of the Circulatory System.
06	Diseases and Disorders of the Digestive System.
07	Diseases and Disorders of the Hepatobiliary System and Pancreas.
08	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
09	Diseases of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth and Puerperium.
15	Normal Newborns and Other Neonates with Certain Conditions.
16	Diseases and Disorders of the Blood and Blood Forming Organisms.
17	Myeloproliferative Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Site).
19	Mental Diseases and Disorders.
20	Alcohol, Drug Use and Alcohol/Drug Induced Organic Disorders.
21	Injuries, Poisonings, and Toxic Effect of Drugs.
22	Burns
23	Factors Influencing

CHCS ENROLLMENT: Active Duty All Sites and Non-Active Duty in Regions 1, 2, 5, and 6



CHCS: MCP DESKTOP USER GUIDE

Appendix B
Glossary

Appendix B. Glossary

Term	Definition
Access	The process of requesting an entry in a particular file or in certain fields in a given file. Also refers to data security functions for files or certain fields in a file.
Access Code	See User Security.
Access/Verify Codes	The Access and Verify codes are used in the logon process to identify a legitimate user and to gain access to CHCS. Both codes are site-specific and established by the CHCS System Manager. Only the verify code may be changed by the individual user. The codes do not show on the screen when entered.
Action Bar	A horizontal bar that provides two or more functions to choose from by typing the character(s) within the parentheses and pressing <Return>. The selected function is performed and control is then returned to this action bar. (See also Smart Action Bar.)
Active Parameter	A specific value for a search criterion that the system will use to search for open schedule slots. Active parameters are displayed in the Display Window of a Search Criteria screen.
Ad Hoc Reports	Reports that consist of variable data and that are generated locally for a particular purpose or need.
Admission	The process of bringing a patient into the medical treatment facility (MTF) as an inpatient.
Alternate Care Value (ACV)	Information used by DEERS to define a patient's eligibility and enrollment plan. This information is generated by CHCS for TRICARE. A value of U indicates that the patient is enrolled in a United States Treatment Facility (USTF) and is not eligible for care in a medical treatment facility (MTF). A value of E

Glossary (continued)

Term	Definition
	indicated that the patient is enrolled in TRICARE PRIME.
Ancillary	Any work area that supports the care of patients on the ward or in the clinics. “Ancillary to” the ward or clinic.
Ancillary Workcenter	Those supporting workcenters targeted for automation (e.g., LAB, RAD, PAD, PHR, PAS, and DTS).
ANSI MUMPS	American National Standards Institute accepted standard for the Massachusetts General Hospital Utility Multi-Programming System (MUMPS) programming language.
Application Software	Software that runs CHCS and performs functions necessary to control or make the system work.
Appointing	Synonymous with “appointment booking” or just “booking.”
Appointment, Patient	A specific time reservation for a patient to see a specified care provider. Patients are said to have appointments; clinics and care providers are said to have schedules.
Appointment Booking	The process of searching for, selecting, and reserving an appropriate schedule slot for a specified patient booking.
Appointment Referral	A patient appointment request for specialized care generated by the primary care manager (PCM).
Appointment Search Criteria	See Search Criteria.
Appointment Slot	A single time opening in a provider's template or schedule for a certain type of appointment. The

Glossary (continued)

Term	Definition
	slot has a begin and end time, and the maximum number of patients that can be seen during that period. This is also referred to as a schedule time slot.
Appointment Type	A broad generic designation of the type of care to be provided during an appointment or encounter.
Appointment Type, Alternate	A secondary appointment type for a schedule slot that is not filled within a specified time (e.g., 48 hours before the appointment). Used for changing unused appointment slots into different usable slots shortly before the appointment day.
Archive/Purge	The process of storing historical patient data in the archive database (archive) while removing nonhistorical patient data from the production database (purge).
Arrival Time (Appointment)	The time patients are told to arrive for their appointments. This may or may not be different from the beginning time or booking time, which is the time at which they are actually scheduled to be seen.
At Sign (@)	1) An edit response meaning delete the current value and leave the field empty of data. 2) Used to show appointment times (e.g., 13Jun@1000).
Attribute	Information describing a file or data element. Types of attributes include data types, ranges, descriptions, and checks performed upon entry of a data element.
Authority	Having all required security keys needed to perform specified functions using CHCS.

Glossary (continued)

Term	Definition
Authorization Level (Order Entry and RAD)	In order entry and Radiology, there are five authorization levels: Clerk, Nurse, and three kinds of health care provider (HCP): **Clerk Authorization:** The system prompts clerks to provide the ordering/authorizing HCP. Clerks may only transcribe written orders. Although clerks may enter new orders, these orders do not become active until they are signed by a nurse or physician. **Nurse Authorization:** The system prompts nurses to provide the ordering/authorizing HCP and the order origin (verbal, telephone, or handwritten). The orders that nurses enter become active, but they must be signed by a physician. **HCP Authorization:** This is the standard physician authority and the highest level needed for all orders except those special procedures requiring a countersignature. Physicians are not prompted for ordering or authorizing HCP or order origin. **HCP Requiring Countersignature:** This authorization level is similar to the nurse in that countersignature is always required. This level of authorization is usually assigned to interns, physician assistants, and medical students. The orders that they enter may be signed by anyone with HCP authorization. These do not require the Countersigning HCP authorization level. **Countersigning HCP:** This level of authority allows the physician to countersign orders for special procedures. For example, this authorization level would be assigned to

Glossary (continued)

Term	Definition
	radiologists who need to approve certain tests and procedures.
Backspace/Delete Key	See Computer Control Keys.
Batch PCM Reassignment	Allows the reassignment of a group of enrollees in the Managed Care Program (MCP) from one primary care manager (PCM) to another without having to do individual reassignments.
Beneficiary Type	Synonymous with “patient type”
Block Booking	A processing function of the Book Appointments option, Block Booking allows the user to book multiple patients for appointments in multiple time slots.
Booking Authority	A restriction on an appointment slot that allows booking only by specified classes of appointers. For example, certain slots may be designated as being bookable only by persons with greater medical knowledge who would be assigned a higher booking authority. This is independent of, and distinct from, any other booking restrictions based on, for example, clinic (perhaps one clinic may not be allowed to book into another), or function (some users may be allowed to register patients, but not book them or may be allowed to book appointments but not to maintain schedules). Booking authority is managed via the use of site-specific security keys.
Borrower	In Record Tracking, a borrower is defined as a location, entity, or individual to whom records are loaned. This may be a physician, a hospital employee, a clinic, a ward, a hospital location, or a patient.

Glossary (continued)

Term	Definition
Browse Action (PAS)	The Browse options are used to display a provider's schedule, overbook scheduled appointment slots, or modify slots for a specific booking need. Slots can be modified by changing appointment type, splitting one slot into two slots, or joining several slots into one slot. Browse is accessed by selecting the Browse Action from either the Search Action Bar or the Appointments Action Bar when booking appointments.
Bulletin	A MailMan message sent to a mailgroup by the Postmaster or automatically by the system based on a CHCS event.
Cancellation	The process of voiding a pending appointment. There are two modes of cancellation: 1) Patient-initiated cancellation, in which the patient calls in to cancel an appointment. In this case, the canceled slot becomes free for another appointment. 2) Clinic-initiated cancellation, in which the health care provider (HCP) and/or clinic cancels an appointment or an entire block of appointments (or schedule slots). In this case, a list of patients with booked appointments in the schedule block is printed so that they can be contacted and informed of the cancellation. (As some sites, cancellation notices are mailed to the patients.) When a clinic cancellation occurs, the slots are no longer available for booking.
Catchment Area	A catchment area is the geographical area roughly within a 40-mile radius of a medical treatment facility (MTF).

Glossary (continued)

Term	Definition
Cathode Ray Tube (CRT)	A TV-like type of video display terminal for interacting with an online computer system. See Keyboard Video Display Terminal.
Check-In	The data entry function, whereby the facts of a completed appointment are entered into the system to "close the loop." Check-in data include primarily the indication of whether the patient did or did not keep the appointment (Show or No-Show), and which provider treated this patient.
Class Evaluation Report	Form used by CHCS presenters to document their perception of how effective the class was and what measures could be taken to make the class presentation better.
Clinic	An outpatient workcenter defined as a hospital location.
Clinical Service	A clinical specialty within a medical treatment facility (MTF).
Clinical Subsystem (CLN)	The Clinical Subsystem includes order-entry capabilities, automated due lists related to patient care activities, and results-entry capabilities. Special management activities include patient acuity, nursing care hours, nursing-specific bed management procedures, and Nursing quality assurance. The clinical subsystem's primary users include physicians, nurses, and allied health personnel.

Glossary (continued)

Term	Definition
Clinic Scheduling	The process of entering and maintaining clinic schedules. Refers also to the entire area of scheduling and entry/maintenance of clinic, care provider, facility, and profile data.
Command Security	Command security refers to Personnel Reliability Program, Presidential Support Program, and sensitive compartmented information.
Composite Health Care System (CHCS)	An integrated medical information system. CHCS facilitates the coordination of health care activities and patient information among all departments within a medical treatment facility (MTF) and its medically integrated outlying clinics.
Computer	An electronic device used to perform high-speed data processing operations and that can store the data for retrieval.
Computer-Based	A system that makes use of computer-related hardware (physical components of a computer) and software (programs that control computer operations). CHCS is computer-based.
Computer Control Keys	The following is a list of the basic computer control keys used in CHCS, and their specific location and function. **Backspace/Delete Key:** Located in the upper-right corner of the keyboard's main keypad, this key is used to delete (erase) the character to the left of the cursor. It is identified on the keyboard by a large left-arrow symbol containing an X. **Caret (^) Key:** Entered using <Shift>, <6> on the keyboard's main keypad, this key is used to exit the current activity. This key is not the same as an “up-arrow” key.

Glossary (continued)

Term	Definition
	Cursor Control Keys: Located to the right of the keyboard's main keypad. These keys allow the user to move between fields in Screen Mode. (These keys are also referred to as the up-arrow, down-arrow, left-arrow and right-arrow keys.) **Help:** Help text is available throughout CHCS to assist users: 1) Press ? or <Help> at menu prompts for online help. 2) Press ?? for a list of secondary menu options. 3) Press ??? for a brief description of options. 4) Press ? [option] for the OLUM text on an option. When accessing help from a field (in a prompt series on a screen): 1) Press ? or <Help> for a quick one-line help message. 2) Press ?? for extended help. 3) Press ??? to access the OLUM. **Note:** Refer to the glossary entry for the Online User Manual (OLUM). **<Hold Screen> Key:** Located on the far upper-left corner of the keyboard, in line with the function keys, this key is used to stop data from scrolling off the screen. Press it again to resume data scrolling. **<Lock> Key:** This key locks the alphabetical characters of the keypad into uppercase. It is located on the left side of the keyboard above the

Glossary (continued)

Term	Definition
	<Shift> key. A light indicates when the keyboard is "locked." A locked keyboard does not affect symbol/numeric keys. Most data should be entered in uppercase. To unlock the keyboard, just press <Lock> again. **Question Mark (?) Key:** Located on the lower right side of the keyboard's main keypad, it can be used to access CHCS Help Menu at most prompts. There are three levels of help available: – Enter ? to access the first level. – Enter ?? to access the second level. – Enter ??? to access the third level. **Note:** Refer to the glossary entry for Online User Manual. **<Return> Key:** Located on the right side of the keyboard's main keypad, it is used to tell the computer to process data just entered. **<Select> Key:** Located on the editing keypad, it is used to choose an item for editing or review. Once <Select> is pressed, an asterisk (*) appears next to the chosen item. Some selections are activated automatically, for others you must press <Return>. To deselect an item, press <Select> again. **<Shift> Key:** Located on the left and right sides of the keyboard's main keypad, these keys are used to enter individual uppercase alphabetic characters, or to enter symbols above the numeric keys.

Glossary (continued)

Term	Definition
	Spacebar: A space is entered by pressing the spacebar at the bottom of the keyboard's main keypad. **Spacebar, <Return>:** Entered by pressing the spacebar, then <Return> on the keyboard's main keypad. This sequence of keys is used to recall the most recent value entered at any Select prompt. The <Return> key must be pressed after data is entered; otherwise, the computer does not know that the response to a prompt has been given.
Cost Pool Code	These are codes used to account for expenses that cannot be directly assigned to specific services or summary accounts but are known to be associated with a selected group of services. The cost pool is a valid entry in the Medical Expense and Performance Reporting System (MEPRS) Code Table. The third character in a cost pool is always X (e.g., BCXA).
Current Appointment	An appointment that has been booked, but not yet kept. The status of such an appointment is marked by the system as “pending.” Also sometimes called a "future" appointment or a pending appointment, although these terms also have other meanings. A current appointment is not on a waiting list.
Current Procedural Terminology (CPT)	A system developed by the American Medical Association, for standardizing the terminology and coding used to describe medical services and procedures. The number affixed to the acronym represents the current version. In the Managed Care Program (MCP), these procedure and medical service codes are used to define services offered and exceptions to the

Glossary (continued)

Term	Definition
	overall discount schedule for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) allowable (CA) and Usual and Customary (UC) fees.
Cursor	The flashing rectangle or underscore on the screen showing where the character is entered as the user types in responses or data.
Data	A specific value in a field for a given record. All the data for a file is stored in a data global.
Database	A collection of data organized into files fundamental to an application.
Database Management System (DBMS)	This software serves as the interface between the application programs and the database. FileMan is the CHCS database management system.
Data Element	A field within a specified file defined by specific attributes. Also, the field characteristics and the data entered in accordance with those characteristics.
Data Type	A specification associated with each field that indicates the kind of information to be entered, the format for entering information, and the way in which data is stored and retrieved. See Field. Valid data types are as follows: **Computed:** A field whose value is computed from other data. No data is actually stored in a field possessing this data type. **Date/Time:** A field that allows time data, including year, month, day, and time of day.

Glossary (continued)

Term	Definition
	Entries to this field are based on the system's built-in “clock”; the user may enter a partial date/time and the system will enter the remaining data. **Free Text:** A field containing any combination of alphabetic characters, numbers, and punctuation marks. The user may enter any text in the field. The characters may be limited to a minimum and/or a maximum, and the exact form can be specified, such as the Social Security number (SSN). **Numeric:** A field that allows only data containing numbers. **Pointer to a File:** A field that provides a reference to data in a different file to preclude the reentering of redundant data. The possible entries for this field type “point” to another file that provides choices available for response. For example, this field type may point to the states in the United States, or procedures in the Radiology Procedures file. Data entry from different prompts in different options into the pointed-to file may or may not be controlled. – **Controlled Entry:** At the prompt, the user must select from existing entries in the pointed to file. – **LAYGO (Learn As You Go) Entry:** At the prompt, the user may select from existing entries in the pointed-to file, or add to the list of entries. **Set of Codes:** A field that provides for the creation of a simple set of codes (alphabetic,

Glossary (continued)

Term	Definition
	numeric, or symbols) in order to input standard data choices. The possible responses to this field type are limited to a list of available entries or their abbreviations. **Word Processing:** A field that allows multiline text to be treated as a single unit, even though its data can be edited one line at time. This field type provides for word processing input, such as is required for Radiology Exam Result. The system software provides a variety of word processing editing options.
Days of Week	A search criterion where the parameter identifies specific day(s) from Monday through Sunday.
DEA Number	This is a unique number defined by the Drug Enforcement Administration (DEA) and associated with the provider. The DEA numbers have the following format: A or B followed by the first letter of the provider's last name, followed by seven digits (e.g., AZ7654321). This number, if assigned, should be inserted in the DEA number field of the provider profile.
Default	This is the text provided by the system in response to a field or prompt. A default allows entry of the most commonly used answer or the most recently inserted field value, with only one keystroke; that is, you press <Return> to accept the default.
Default Division	The division accessed by the user at logon.
Default Response	An expected response of the most common answer to a prompt. The default response may

Glossary (continued)

Term	Definition
	be provided by FileMan or defined by the user to save keystrokes and is followed by two slashes (//).
Default Search Criteria	The search criteria identified by a user as that user's default criteria selections, that is, the criteria for which the user wishes to change parameters continually. Default Search Criteria retain their select marks so the user does not have to reselect them.
Default View Basket	This option allows you to choose the MailMan basket into which the View Text messages are sent. If you do not indicate a basket, the View Text messages are sent to your IN basket. It is suggested that you create a mail basket (called View Text or some similar name) and specify it as your default view basket. This will keep your IN basket from being cluttered with view text.
Defense Enrollment Eligibility Reporting System (DEERS)	A Department of Defense (DOD) program for determining and ensuring the eligibility of potential patients for military health care.
Defense Medical Information System (DMIS-ID)	The Expense Assignment System (EAS) uses each division's DMIS-ID to define how workload is sorted and reported. Each division has a unique DMIS-ID and a parent DMIS-ID. The parent DMIS-ID defines divisions that combine their workload. The group DMIS-ID contains the DMIS-ID code of the parent organization to whom its underlying units and divisions report and rollup their workload.
Dietetics Subsystem (DTS)	The DTS Subsystem provides dietetics personnel with access to patient demographic and clinical information, and provides other system users with a mechanism for

Glossary (continued)

Term	Definition
	communicating diet orders and diet consults to the Dietetics Department.
Directory Setup Screen	The screen that displays the various setups for the VT320. It is used to access all other setup screens.
Display	In CHCS documentation, this heading refers to the display of a menu or a screen of information, as opposed to a prompt or a message.
Display Window	In Patient Appointment and Scheduling (PAS), the top section of the Search Criteria screen. Active search parameters are displayed in this window.
Disposition	The end point of a patient's hospitalization (inpatient episode). There are numerous disposition types, i.e., discharge, death, or the patient's leaving against medical advice.
Duplicate Patient	Two patient data records that actually belong to the same patient, or a patient registered twice in the system.
Emergency Contact	Person to contact in case of patient emergency.
Emergency Encounter Form	See SF558.
Encounter	There are two types of encounters: 1) A visit by a patient to an outpatient clinic. 2) All data related to an outpatient visit.
End-of-Day Processing	The update of patient appointment data for an outpatient clinic on a specified day. Patient appointment data includes, but is not limited to, appointment status and type, provider, clinic, and checked-in (date and time).

Glossary (continued)

Term	Definition
Entry	A data value within a field, record, or file.
Environment	The place in the computer in which the user is working, and its characteristics.
Episode	All data related to an inpatient visit, starting with admission and continuing through disposition.
EVE Menu	Also called the Systems Manager Menu, this is the very first menu that will appear after logon. This menu is the parent of all other CHCS menus.
External Provider	A non-network provider who is a member of a provider network; who has the CON,NET,PEX, or SUP agreement types; and who has a location type of Other.
Facility	See Medical Treatment Facility.
Family Booking	Appointments in multiple clinics for multiple related or unrelated patients.
Family Member Prefix (FMP)	A two-digit code that identifies a patient's relationship to the sponsor (e.g., son, daughter, spouse, dependent parent, etc.). FMPs are as follows: 01-19 = 1st through 19th child; 20 = sponsor; 30 = spouse; 40 = mother of sponsor; 45 = father of sponsor; 50 = mother-in-law; 55 = father-in-law; 60 = 1st other eligible dependent; 61 = 2nd other eligible dependent; 98 = civilian emergency; 99 = other.

Glossary (continued)

Term	Definition
Field	1) The space in a record used to define a data element. A field has attributes, such as a data type, storage location, and label. Data element and field are often used interchangeably. 2) A labeled area within a screen in which the user may enter and edit text.
File	1) A grouping of items with a single functional purpose. Patient information is stored in the Patient file. Ward locations, clinics, and all other hospital locations are stored in the Hospital Location file. 2) As in "to file," used in Screen Mode when data is stored.
File Manager (FileMan)	The database management system (DBMS) used in CHCS. A general-purpose DBMS based on the Massachusetts General Hospital Utility Multi-Programming (MUMPS) programming language used to create and maintain files.
Free Text	See Data Type.
Frequency	1) This term is used to refer to how often a medication is given (e.g., Q6H, or given with a frequency of every 6 hours). 2) The estimated hours, listed on the particular intravenous (IV) bottle, that the IV will run.
Frozen Schedule Slot	A schedule slot on hold. Frozen slots will not display during appointment booking. These slots are temporarily frozen and are either released manually by the user, or automatically by the system on a user-specified date.
General Set-Up Screen	The screen used to set up the general user preference features of the VT320 terminal.

Glossary (continued)

Term	Definition
Health Care Finder (HCF)	A clerk who uses the Managed Care Program (MCP) to book appointments for enrolled patients with their primary care managers (PCMs), add/modify appointment referrals for enrolled and non-enrolled patients, book appointments with network providers for non-enrolled patients, cancel and reschedule appointments, and generate membership identification cards, care authorization forms, and patient/provider mailing labels.
Health Care Provider (HCP)	The specific member of the health care team providing health services to the patient. Usually, this is a physician; however, the HCP may be a nurse practitioner, dentist, physical therapist, clinical dietitian, etc. HCP is not used in reference to nurses, who represent a special category in themselves. An HCP is someone who has the authority to construct patient orders for entry into the system. See Provider Class.
Health Record	Outpatient medical record.
Historical Data	Information that is considered to be relevant for direct patient care and is removed from the production database and stored in the archive database.
<Hold Screen> Key	See Computer Control Keys.
Home	The device name used to specify output to the screen.
Home Location	In Record Tracking, the place of residence for a medical record or film jacket (X-ray file) when it is not being borrowed. This home location is usually a file room.
Identifier	The fields that are displayed when selecting an entry in order to aid in the unique identification of the record to be selected.

Glossary (continued)

Term	Definition
Inactive	See Order Status.
Initialization (INIT)	The act of starting up a system.
Insert Mode	As text is entered where text exists, the entered characters are inserted at the cursor position, pushing existing text to the right.
Interact Window	In Patient Appointment and Scheduling (PAS), the bottom section of the Search Criteria screen. Messages, prompts, and action bars appear in this window.
Internal Entry Number (IEN)	A unique number assigned to each file. It is used internally in the software to identify specific records within a file.
John (Jane) Doe	A male (female) patient whose identity is unknown.
Keyboard	A typewriter-like instrument used to enter information to be sent to the computer.
Keyboard Set-Up Screen	The screen used to set up the keyboard characteristics, such as keyclick and bells.
Keyboard Video Display Terminal (KVDT)	A terminal complex that includes a keyboard and a video display. See CRT.
Laboratory Subsystem of CHCS (LAB)	The software programs that process orders for lab tests; specifically, the programs that allow the user to log in specimens, to track order status, to enter and certify results, to maintain lab files, and to generate lab reports.
Learn As You Go (LAYGO)	The process of adding records to a file through data entry into other file(s). When a field is defined as a pointer, the creator indicates whether the user is allowed to enter new data into the pointed-to file. Without LAYGO, the user must select from existing entries in the

Glossary (continued)

Term	Definition
	pointed-to file. With LAYGO, the user may enter new records into the pointed-to file. See Field.
Local Empanelment	Process used to conduct managed care activities on a local level, without changing the Alternate Care Value (ACV) of the non-active duty beneficiaries on the DEERS database.
Login	A process that records that a sample was received in the lab for testing.
Logoff	The user process to end a CHCS session. Three logoff choices are available: **Halt:** Allows the user to log off from any menu prompt. **Restart:** Allows the user to return directly to the Access Code prompt. **Continue:** Allows the user to end the session with the system remembering the user's location in the system. Allows the user to directly return to that system location when logging on again.
Logon	The user process to gain access to the CHCS system and begin a CHCS session.
Lookup	The process of selecting one particular entry or record from a file.
Mail Basket	Electronic file folder where the user can save MailMan mail messages. All MailMan messages are received in the IN mail basket.
Mail Box	The user file to which MailMan messages are addressed.

Glossary (continued)

Term	Definition
Mailers	Mailed notices of canceled or missed appointments. There are five different types of mailers available: Cancel Notifications, No-Show Notices, Strong No-Show Notice, Wait List, and Reminder Notices.
Mailgroup	A group of MailMan users, set up by the Postmaster, to which the user can address messages.
Mail Manager (MailMan)	The online electronic mail system of CHCS.
Managed Care Program (MCP)	A software program designed to assist military treatment facilities in the local management of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds. MCP provides the capability to profile both military and civilian providers in terms of the type of medical care offered and the costs associated with the care. The software also provides the ability to enroll beneficiaries and assign a primary care manager (PCM). Referral and booking options provide the capability to record patient care needs, search for providers, book appointments, and issue care authorizations.
MCP Agreement	A provider's agreement with the government, stating the medical care to be provided to eligible beneficiaries at a negotiated rate.
MCP Enrollment	The act of enrolling a beneficiary into the Managed Care Program.
MCP Patient Type	Classifications are MCP/Active Duty, MCP/Non CHAMPUS Eligible, MCP CHAMPUS.
MCP Status	Used to determine a patient's enrollment status within the Managed Care Program (MCP). Statuses are as follows:

Glossary (continued)

Term	Definition
	Enrolled: A patient is currently enrolled in the MCP. **Invalid Enrollment**: A discrepancy response is received from Defense Enrollment Eligibility Reporting System (DEERS) as a result of filing a patient's enrollment into the MCP. **Conditional Enrollment**: An ineligible response is received from DEERS when enrolling a dependent patient who is not registered on DEERS; however, if the patient's sponsor is DEERS-registered and the ineligibility is overridden, the MCP status is displayed as Conditional Enrollment. **Pending Enrollment**: A response from DEERS was delayed (for example, if the DEERS line is busy and the inquiry must be batched) during patient enrollment, or the MCP enrollment date is a future date. **Disenrolled**: A patient formerly enrolled in the MCP is no longer enrolled. **Invalid Disenrollment**: A discrepancy response is received from DEERS after sending a Disenrollment transaction. **Blank**: A patient has no enrollment history in the MCP.
Medical Expense and Performance Reporting System (MEPRS)	The Medical Expense and Performance Reporting System for fixed military medical and dental treatment facilities. MEPRS provides consistent principles, standards, policies, definitions, and requirements for accounting and reporting of expense, manpower, and performance by Department of Defense (DOD) fixed medical facilities.

Glossary (continued)

Term	Definition
Medical Record	The physical record of a patient's care containing printed (paper) copies of the documents detailing the patient's treatment in either inpatient or outpatient settings.
Medical Treatment Facility (MTF)	A military hospital and its outlying affiliated workcenters. Also called Facility.
Menu	A list of options (choices) presented by the software that represents a decision point in the running of the program. The menus available to individual users are determined when the CHCS system manager sets up the User Record. **Secondary Menu:** A list of system options available when you enter ??. **CHCS Orientation Menu:** A special menu designed to support Orientation classes. **Menu Management:** A CHCS tool that is used to maintain menus, options, security keys, and help text.
MEPRS Code	A four-character alpha code used to identify cost centers at the medical treatment facility (MTF). The MEPRS code is used for workload accounting purposes. These codes are assigned to each transaction to track who ordered the transaction and to calculate workloads. MEPRS codes at the 4th level are unique at the CHCS Group/Division Level and consist of three Department of Defense (DOD) standard characters to identify the service provided and a unique fourth character assigned by the MTF.
Message	1) Short for system message. It means information supplied by the system in response to user input, for example, ** END OF REPORT **.

Glossary (continued)

Term	Definition
	2) When used with MailMan, message means an electronic note that has been transmitted.
Mini Registration	An abbreviated patient registration function. A series of screens used to create or update a basic patient record.
Mnemonic	A device designed to aid recall; for example, the menu synonyms used in the CHCS menu selection, such as ORE for Order Entry or BOK for Book Appointments.
Monitor	The part of the terminal containing the screen. Also called a visual display terminal (VDT) or visual display unit (VDU). (See Screen.)
MTF-Specified/Defined	A parameter specified at the division level in a multidivisional medical treatment facility (MTF) or at the MTF level if there is only a single division. This neither requires nor precludes that there be a specification at both the medical treatment facility (MTF) and division level.
MTF-Specified Time Period	A period of time determined by each medical treatment facility (MTF) that may be modified periodically.
Multiple Clinic Booking	Several appointments in multiple clinics for one patient.
Multiple Field	Often simply called a multiple, it is a field that can have more than one unique value. In effect, a multiple is a minirecord within a record. An indicator of a multiple is the Select prompt.
NAS Issuing Officer	The military medical commander or designee who is authorized to issue non-availability statements (NASs).

Glossary (continued)

Term	Definition
Network Provider	These are individual providers, organized as part of provider groups or institutions, that have an agreement with the medical treatment facility (MTF) to provide services at a discount rate to Managed Care Program (MCP) enrolled beneficiaries or to non-enrolled beneficiaries as part of a Preferred Provider Organization (PPO). The PPO may benefit non-enrolled patients, since non-enrolled patients may be booked to an MCP provider who charges less than Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
Nonhistorical Data	Information that is no longer vital to patient-specific medical care and is purged or erased from the production database.
Non-Network Provider	Only Service Available or Exception providers with an agreement type of NON and a location type of Other. Individual providers (which may be organized as provider groups or institutions) with whom the medical treatment facility (MTF) does not have an agreement to provide services to eligible beneficiaries at a discounted rate.
Nonsearchable Schedule Slot	A schedule slot into which patients Schedule Slot cannot be booked. The system automatically appends a nonsearchable appointment type with an asterisk (*), and these slots become place holders only in a provider's schedule. Examples of nonsearchable slots are lunch, meeting, TDY, rounds, etc.
Online Users Manual (OLUM)	The OLUM consists of the user instructions for the CHCS basic system, MailMan, ad hoc reporting options of FileMan, and each subsystem. Each subsystem volume provides the menu hierarchy, functional description for

Glossary (continued)

Term	Definition
	each option, step-by-step user instructions, and samples of screens and reports. 1) Enter **OLUM** at the Secondary Menu or any menu/option selection prompt to get to the OLUM Menu. 2) Enter **?OPTION NAME** at menu/option selection prompt (only where the menu/ option is displayed) to go directly to the option description in the OLUM. 3) Enter **???** after enter/edit prompt within any option to go directly to the option description in the OLUM.
Option	One of a list of processes on a menu that allows the user to access data in a file or to access another menu.
Order	A request for procedure, service or item to be performed or delivered.
Order Status	Indicates an order's current level of execution: **Active:** An order that is current and available for workcenter and/or ancillary processing. **Countersignature Due:** A previously signed order to which a countersignature must be added to confirm and activate the order. **Expiring:** An order that will soon be no longer active, contingent upon the duration of the order. **HCP Signature Due:** An order that requires a physician's verification or signature. **Inactive:** An order that is not being executed at the present time.

Glossary (continued)

Term	Definition
	Modified: An order partially activated at patient arrival. **Nurse Signature Due:** An order that requires a nurse's verification or signature. **On Hold:** An order suspended until reactivation (e.g., preadmission orders remain on hold until altered). **Pending:** An active order awaiting further action (e.g., pending appointments). **Pending Appointment:** An order awaiting appointment scheduling from another subsystem. (This is different than Pending Appointment in PAS.) **Preactive:** An order that has not been activated; user is still entering orders for his batch.
Outpatient Encounter Form	See SF600I.
Overbook	To book more patients in a schedule slot than was allocated when the schedule was created. An overbooked schedule slot has more booked patients than the maximum number of patients per slot set for the slot when the schedule was created.
Panel	1) In the Laboratory Subsystem, a group of related tests with the same collection sample, which may be ordered as a group. In most cases such as “Chem 7,” the tests on the panel can also be ordered individually. 2) Also, a group of health care providers (HCPs) to which a family is assigned in a family practice clinic.

Glossary (continued)

Term	Definition
Parameters	Fixed limits or boundaries that establish by what restrictions the system will perform a function.
Patient Administration (PAD) Subsystem and Medical Services Accounting (MSA)	The PAD Subsystem facilitates the collection recording of patient information regarding the admission, disposition, and transfer of patients. This subsystem also manages ward and bed status within the medical treatment facility (MTF). A component of the PAD Subsystem, MSA focuses on the initiation and monitoring of patient billing. The United States Military Services provide health care for millions of patients each year. The goal of Defense Medical Information Management (DMIM) is to enable military MTFs and clinics to use CHCS to enhance the quality of health care delivery provided. With an increase in the number and diversity of tasks performed by medical personnel, as well as an expansion of health-related technology, an improved approach to the management of medical information was needed. CHCS meets this need. As an integrated, computer-based system, CHCS provides an automated online alternative to many manually implemented tasks (i.e., writing patient care orders, documenting medication administration, generating reports, etc.), thus significantly reduces potentially massive amounts of paperwork.

Glossary (continued)

Term	Definition
Patient Appointment and Scheduling Subsystem (PAS) of CHCS	This subsystem enables individual clinics or providers to control their own scheduling, booking, and appointments, and alerts other system users to potentially conflicting schedules.
Patient Category Code	Patient Category codes indicate patient type (i.e., Active Duty Enlisted Air Force, Civilian Employee, Naval Officer's Dependent).
Patient Identifying Data	Patient name, family member prefix/Social Security number (FMP/SSN), date of birth (DOB), and sex.
Patient Inquiry	The act of retrieving CHCS-stored data regarding a selected patient.
Patient Record	A collection of data relative to a patient (e.g., patient name, Social Security number, date of birth, etc.).
PCM Beneficiary	Patients are designated as case management when they require an exception provider for specialty care.
PCM Beneficiary Category	The beneficiary categories for the PCM enrollment mix are: Active Duty, Active Duty Family Member, Retiree, Retiree Family Member, Other. For the PCM enrollment mix, these beneficiary categories replace the MCP Patient Types.
Pending Appointment	See Order Status.
Pharmacy Subsystem of CHCS (PHR)	The PHR Subsystem provides a versatile drug reference library. It allows flexibility in ordering medications (i.e., by trade or generic name, by drug component, route of administration, etc.) and provides online information regarding drug-to-drug interactions.

Glossary (continued)

Term	Definition
Place of Care	A medical treatment facility (MTF) or non-MTF clinic in the Managed Care Program (MCP).
Postmaster	The user responsible for managing mail groups, users, bulletins, and mail system protocol. The postmaster job is an assigned MailMan position. The position is often, but not necessarily, filled by the system manager.
Power Switch	Located on the left side of the terminal, this switch is used to turn on the terminal.
Preadmission	The process of entering admission data into CHCS for a potential patient.
Preadmission Order	An order written in anticipation of a future admission date and time.
Preop	See Priority.
Prefix	The two-to-four-character namespace assigned to routines and globals, distinguishing applications.
Prescription	Used to refer to a drug, administration schedule, and instructions ordered for an outpatient.
Primary Care Manager (PCM)	A Managed Care Program (MCP) health care provider (HCP) who is assigned as a primary physician for a patient. The PCM may be either an individual provider or a group provider.
Primary Menu	A user's initial or starting menu.
Printer	May be referred to as a printer device or output device: **Shared Printer:** A printer that is available to two or more terminals or output devices.

Glossary (continued)

Term	Definition
	Line Printer: A printer that prints a line or more at a time. (Line printer speeds are expressed in lines per second [lps] and may be over 100 lines per second.) **Slave Printer:** A printer attached directly to a terminal and used to print from that terminal only.
Print Template	A set of field specifications that allow exact print formats and specified data records to be used when printing reports. This allows the use of the same print logic again and again.
Privilege(s)	The capabilities allowed within the database management system (DBMS) based on the level of protection specified for any process, file, or user.
Profile	A collection of administrative, scheduling, and appointment information applicable to a specific facility, division, clinic, and provider. Patient Appointment and Scheduling (PAS) profiles define the basic rules and instructions by which the facility, division, clinic, and provider provide care; and they provide the parameters that control the way the system processes data.
Prompt	1) A system-generated request for response. 2) A word or statement on the screen that tells the user what action needs to be taken or what information must be entered (i.e., Select Patient Name).
Provider	See Health Care Provider.
Provider Class	Description of provider groups such as nurse, social worker, or physician. Each provider class is linked to a signature class. Provider classes are medical treatment facility (MTF)-definable.

Glossary (continued)

Term	Definition
Provider Group	A provider group is one or more providers who have jointly negotiated an agreement to provide services to eligible beneficiaries. A provider group can have multiple individual providers, multiple places of care, and/or multiple agreements.
Pseudo SSN	A false system-generated Social Security number used in a patient data record when the real number is unknown.
Pull List	A list of all patients whose medical records must be pulled for a specified date.
Question Mark (?) Key	See Computer Control Keys.
Radiology Subsystem of CHCS (RAD)	The RAD Subsystem is designed to meet the functional requirements of the Radiology Department and Nuclear Medicine, including patient processing and room scheduling, defining and implementing site-specific radiology procedure requirements, work load statistics, and management reports.
Record Number	Also known as the record identifier number This is a unique sequential number assigned to each record within the Record Tracking functionality upon its creation. The record may be accessed by entering this number at any Select Record prompt.
Record Room	Location of patient records.
Record Tracking	The procedure for determining where records are physically located.
Registration	A registration must be completed on all patients, whether inpatient or outpatient, before CHCS can support any care or services rendered.

Glossary (continued)

Term	Definition
Reminder Notices	A form mailed to patients to remind them of upcoming appointments.
Requesting Location	A specific location within the medical treatment facility (MTF) from which the patient services are requested, i.e., a ward, clinic or other location, and receiving credit for the orders placed, and to which test results and orders will be sent.
Response	An action to be taken in response to a specific prompt generated by the CHCS System. (For instance, Enter Provider Name: **[variable data]**.) In CHCS documentation, a required response is identified by **FULL CAP BOLD** text.
Retrieve	1) The ability to review a patient's past medical history. 2) Process of retrieving historical patient data that has been archived.
<Return> Key	See Computer Control Keys.
Routing Card	A card attached to the medical record itself that is sent around with the record. This card indicates where the record is to go, based on the clinics in which that patient has appointments.
Schedules	An array of available time slots for a certain provider in a specified clinic for a specified date range.
Schedule Time Slot	A single time opening in a provider's template or schedule for a certain type of appointment.The slot has a beginning and an end time, and a maximum number of patients that can be seen during that period. This is also referred to as an appointment slot.

Glossary (continued)

Term	Definition
Screen	1) The part of the visual display terminal (VDT) that presents information sent from the computer or information typed on the keyboard. 2) This term is also used to describe a single display of information that takes up the whole screen.
Screen Mode	See Prompt Series.
Scroll Mode	The system's request for information, presented one prompt at a time. The bottom line on the screen is replaced with new information. The user moves between prompts using <Return>, or the up-arrow or down-arrow keys. See Screen Mode.
Search	The process of locating an unknown number of records, in one file, based on one or more user-specified criteria. **Null:** Used to determine fields that contain no entries. No value can be placed on the NULL condition. This is abbreviated with the letter N.
Search Criteria	The rules by which the system searches for information. In Patient Appointment and Scheduling (PAS), the items that the system uses to search for open schedule slots. Search criteria in Booking can be Dates, Provider, Time Range, Days of Week, Appointment Type, Clinic, Duration, or Specialty. A user must identify the specific value or parameter for each selected search criterion. The system tries to find open schedule slots that match the parameters for all selected search criteria.

Glossary (continued)

Term	Definition
Search Logic	Expressions that define the parameters of the search. Valid logic parameters are: **AND:** The system extracts a data record when all stated search conditions have been met. **NOT:** The system extracts a data record when none of the specified search conditions are met. **OR:** The system extracts a data record when any of the combined search conditions are met.
Search Parameter	In Patient Appointment and Scheduling (PAS), the specific value for a search criteria that the system uses to search for open schedule slots.
Secondary Menu	See Menu.
Security Checks	The system checks accessibility to CHCS as the user enters a series of codes (Username and Access/Verify codes).
Security Key	A code that relates to the ability to use a certain process. Some security keys are already defined in the system. Other security keys are defined by the system manager. The naming conventions and strategy for the use of these keys is determined at each facility. The system manager assigns security keys to users as appropriate for their use of CHCS.
Select	Function that defines how to decide what the value will be by selecting one from among two or more possible values. Select is used if the actual value that will exist when the data element is used cannot be precisely predicted.
<Select> Key	See Computer Control Keys.

Glossary (continued)

Term	Definition
Select Mark	A tilde (~) or asterisk (*) that appears when the <Select> key is pressed. This mark identifies a selected item on a list.
Select Window	In Patient Appointment and Scheduling (PAS), the middle section of the Search Criteria screen. The window lists items for user selection.
Service	A clinical specialty within a medical treatment facility (MTF).
SF558	Record of emergency room encounter information from arrival to disposition. This form contains patient demographics, specifics about the arrival, medical status, disposition information, and discharge instructions to the patient.
SF600	Record of an outpatient clinic visit. This form contains patient demographics, appointment information: date, time, location, appointment type, and sections for recording comments and patient vital signs.
<Shift> and <Lock> Keys	See Computer Control Keys.
Single Patient Booking	One or several appointments for one patient in one clinic.
Slot	See Appointment Slot.
Spacebar	See Computer Control Keys.
Spacebar, <Return>	See Computer Control Keys.
Space Character	A special character that does not have an associated graphic representation. It is displayed as the absence of any character, where one might otherwise appear.

Glossary (continued)

Term	Definition
Specialty	In Patient Appointment and Scheduling (PAS), a search criterion in Booking for which the parameter is a clinic service. The clinic specialty is identified in the clinic profile (for example, dental care, family practice, pediatrics).
Sponsor	Person who qualifies the patient for health care (e.g., active-duty father is the sponsor of the dependent patient daughter).
Sponsorship	The organization that entitles the patient to health care (e.g., Army, Navy, Dept. of Education, Veterans Administration, etc.).
Switch Divisions	The user process to switch to an alternate division from the default division, or back to the default division from an alternate. See Menu.
System Manager (SYSMAN)	Used generically to describe functions that must be accomplished to support CHCS initialization and operation at each site where CHCS is installed. Functions include database administration, system security management, installation management, and telecommunications management.
Table	A list of available choices. A table displays when ?? is entered at a field that has a table connected to it. A table cannot be appended from the field, but must be set up through the appropriate menu options or through FileMan.
Target Audience	The audience for which the training is designed.
Template	1) A predefined structure that controls a data entry dialogue, a printed report format, a sort sequence of an output, or a series of search conditions. Templates may be used repeatedly by entering the assigned name in brackets [ ] at the appropriate prompt.

Glossary (continued)

Term	Definition
	2) In Patient Appointment and Scheduling (PAS), an array of schedule slots governed by the rules entered in the profiles. Templates are linked to specific providers, but not to any particular date range.
Template ID	In Patient Appointment and Scheduling (PAS), a unique identifier for a particular template. It is recommended that the template ID include the following information: day, clinic, provider, and template type (master, temporary, etc.).
Terminal	A device used to enter and send information to the computer. The keyboard and screen are terminal components.
Terminal Digit	This is the last two digits of the sponsor's Social Security number (SSN), starting at 00 and ending with 99.
Time Range	A search criterion for which parameters indicate a begin and end time.
Troop Medical Clinic (TMC)	The Army term for an outpatient clinic designated for active-duty walk-in or sick-call patients.
Type-ahead	A setting in the User file that allows the user to type ahead of what the computer is actually reading. The computer stores the keystrokes and reads them at its own pace.
Unique Patient Identifier	A set of data elements that uniquely identifies a patient in the central patient database, composed of sponsor Social Security number and patient family member prefix.
Update	The addition, deletion or modification of existing data.

Glossary (continued)

Term	Definition
User	A person authorized by the medical treatment facility (MTF) to initiate a process in CHCS via a terminal. User authorization will be determined through the virtual memory system (VMS) and CHCS system security functions.
User Attributes	Characteristics or settings. User attributes, for example, include the settings for use of the system (e.g., type-ahead allowed, time-out setting, access authorization, etc.).
Username	See User Security.
Username/Password	User security checking at the virtual memory system (VMS) level. Codes provide user access to VMS files.
User Security	A series of codes that serves to protect the system from unauthorized users. These codes are checked when a user is accessing the system. Username and Access/Verify codes are the two levels of security checking. **Access Code:** This code, together with the verify code, is used in the logon process to identify a legitimate user and gain access to CHCS. The code is site-specific and established by the CHCS system manager. It usually cannot be changed by the individual user. **Username:** The first level of security checking and the first code entered into CHCS at logon. **Verify Code:** This code, together with the access code, is used in the logon process to identify a legitimate user and gain access to CHCS. The code is established by the CHCS system manager at the medical treatment facility (MTF) and may be changed by the individual user from the Edit User Characteristics option of the Secondary Menu.

Glossary (continued)

Term	Definition
	The code does not show on the screen when entered.
Users Manual	The Users Manual volumes for each subsystem provide information addressed primarily to the users of a particular subsystem. This user manual is also available online (OLUM). The OLUM can be accessed by entering "???" at any action prompt. Some sites may not load OLUM due to disk space limitations; the CHCS Training Database contains the MailMan volume only. Volume 1: Basic System Volume 2: General PAD Volume 3: PAD MSA Volume 4: PAS Volume 5: MCP Volume 6: LAB Volume 7: RAD Volume 8: PHR Volume 9: CLN Volume 10: CLN DTS Volume 11: CLN FQA Volume 12: RT There are three unnumbered OLUM volumes: – Release Notes – MailMan Users Guide – FileMan Ad Hoc Users Guide
User-Specified	Parameters input by the user at the time the function is being called/executed.
Validity Check	CHCS utility that determines data inconsistencies gathered during the registration process (e.g., entry of an Air Force patient category for a Navy patient, fields left blank with no entry, etc.).

Glossary (continued)

Term	Definition
Viewgraphs	Viewgraphs, also called transparencies, are diagrams or text reproduced on transparent material used for projecting information on a screen.
Virtual Memory System (VMS)	The operating system that runs the VAX computer. It manages the memory of the computer in such a way that the memory appears to be virtually unlimited to the average user.
Wait List	All Wait List requests for a particular clinic. The clinic Wait List identifies those patients waiting for open schedules slots for that clinic. The clinic profile indicates whether a specific clinic has a Wait List. This allows the entry of Wait List requests for that clinic.
Wait List Request	A patient request for an appointment in a specific clinic when no open slots or overbooks are available in a certain clinic.
Ward	A defined hospital area that contains a designated number of patient beds. It often corresponds to a medical specialty area such as Orthopedics (e.g., Orthopedics Ward).
Word Processing Data Type	See Data Type.
Workcenter	A functional or organizational subdivision of a medical treatment facility (MTF) for which provision is made to accumulate and measure expenses and to determine workload performance. Designation of a workcenter varies from facility to facility depending upon the MTF organizational structure. CHCS workcenters include clinics used in Patient Appointment and Scheduling (PAS), pharmacies, laboratories, and radiology imaging locations.

Glossary (continued)

Term	Definition
Workload/MEPRS Reports	Quality control reports containing statistics and management data generated by the system to monitor specific military and medical treatment facility (MTF) workload statistical reporting requirements.
Zip Code Combination	A name that represents a range of zip codes. This site-definable name can be used during Managed Care Program (MCP) provider searches.

Glossary (continued)

Acronyms	Definition
ACV	Alternate Care Value
ADT	Admission, Disposition, and Transfer
AHP	Allied Health Professional
AQCESS	Automated Quality of Care Evaluation Support System
ASAP	As Soon As Possible
ASMRO	Armed Services Medical Regulatory Office
AWOL	Absent Without Leave
BC/BS	Blue Cross/Blue Shield
CAS	Central Appointments Service
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CSU/DSU	Channel Service Unit/Data Service Unit
DEA	Drug Enforcement Administration
DEERS	Defense Enrollment Eligibility Reporting System
DOB	Date of Birth
DOD	Department of Defense
DRT	Delinquent Record Tracking
DTS	Dietetics Subsystem of CHCS
DWC	Divided Workcenter

Glossary (continued)

Acronyms	Definition
EAS	Expense Assignment System
ER	Emergency Room
ERD	Emergency Room Death
FI	Fiscal Intermediary
FileMan	File Manager
FMP	Family Member Prefix
FQA	Facility Quality Assurance of CHCS
HCF	Health Care Finder
HCP	Health Care Provider
HCP-ID	Health Care Provider Identification
HMO	Health Maintenance Organization
Ht	Height
ID	Identification
IEN	Internal Entry Number
INIT	Initialization
IP	1) Inpatient 2) Internet Protocol
JCAHO	Joint Commission on Accreditation of Health Care Organizations
KVDT	Keyboard Video Display Terminal
LAB	Laboratory Subsystem of CHCS

Glossary (continued)

Acronyms	Definition
LAYGO	Learn As You Go
MailMan	Mail Manager
MAR	Medication Administration Record
MCP	Managed Care Program
MEPRS	Medical Expense and Performance Reporting System
MSA	Medical Services Accounting
MSAO	Medical Services Accounting Office
MTF	Medical Treatment Facility
MTRC	Medical Treatment Record Card
MUMPS	Massachusetts General Hospital Utility Multi-Programming System
MVVR	Master Version Validation Report
N	1) No 2) Variable number
NAS	Non-Availability Statement
NEC	Not Elsewhere Classified
OCONUS	Outside the Continental United States
OCR	Optical Character Reader recognition
OHI	Other Health Insurance
OHMIS	Occupational Health Management Information System

Glossary (continued)

Acronyms	Definition
OLUM	Online Users Manual
OP	Outpatient
OSA	Only Service Available
PAD	Patient Administration Subsystem of CHCS
PAD MSA	PAD Medical Services Accounting Subsystem of CHCS
PAS	1) Patient Appointment and Scheduling Subsystem of CHCS 2) PAS Order
PATCAT	Patient Category
PCM	Primary Care Manager
PCS	Permanent Change of Station
PEB	Physical Evaluation Board
PHR	Pharmacy Subsystem of CHCS
PNT,PT	Patient
PRP	Personal Reliability Program
PTF	Patient Treatment File in DHCP
PTID	Patient Identifier Number (FMP/SSN)
QA	Quality Assurance
RAD	1) Radiology Subsystem of CHCS 2) RAD Order

Glossary (continued)

Acronyms	Definition
RX	1) Outpatient medication 2) Receive
SAIC	Science Applications International Corporation
SDSMGR	PAS Scheduling Manager
SSN	Social Security Number
STD	Standard
SW	Software
SYSMAN	System Manager
T	1) In the context of a data value that is expected to refer to a date, FileMan interprets the letter "T" to mean the date of the current day (i.e., Today). 2) Temperature
TBD	To Be Determined
TDB	Training Database
TMC	Troop Medical Clinic
UCI	User Class Identifier
UPIN	Unique Physician Identification Number
UR	Utilization Review
VAX	Virtual Address Extension
VT320 Terminal	The CHCS terminal used in most workstation configurations

Glossary (continued)

Acronyms	Definition
WCS	Workcenter Support
Y	Yes
Y/N	Yes/No

CHCS: MCP DESKTOP USER GUIDE

Appendix C
Index

A

Action Bar 1-8, 4-12
CHCS/DEERS discrepancy data 4-21
Current DEERS Eligibility 4-15, 5-17
Current DEERS Eligibility screen 4-15, 5-16
DEERS Eligibility Data screen 4-12
Active Duty 1-2, 4-7, 4-12, 4-18, 4-31, 5-3, 5-5, 5-6, 5-10, 5-12, 5-14, 5-15, 5-20, 5-23, 5-24, 5-26, 5-36, 5-39, 5-41, 5-47, 5-56 5-67, 5-76, 5-87, 5-94, 5-99, 5-101, 5-103, 5-112, 5-123, 5-135, 5-137, 5-142, 5-166, 5-171, 5-172, 5-175, 5-178, 5-184, 5-185, 5-193, 5-194, 5-197, 5-198, 5-216, 5-218, 5-225, 6-36, 6-46, 7-3, 7-8, 7-14, 7-25
Batch enroll 2-29, 5-120, 5-127
Beneficiaries 5-3
DDS 6-47
Enrollment Roster for Active Duty Family Members by Unit 5-173
Identify potential active duty candidates 5-120, 5-121
Identify potential active duty candidates warning message 5-121
Non-active duty 4-7
Non-active duty beneficiaries 5-3
Patient Type 6-50, 5-38, 6-36 6-111
Potential active duty candidate file 5-122
Potential Active Duty Candidate Update/Report 5-121, 5-124
To update/print/enroll potential active duty candidates 5-123
Unit Identification Code (UIC) 5-216
Update/Print/Enroll potential active duty candidates 5-127, 5-123
While in local empanelment mode 4-7
Activity 5-120, 6-55
Allowable activity codes 6-55
Medical 5-122, 5-123
Medical activity date 5-120, 5-122
PCM 6-136
PCM Activity Report 6-141
PCM Activity Report by Individual PCM 6-144
PCM Activity Report by Provider Group 6-143
PCM Activity Report by Specialty 6-145
Referral 6-136, 6-137
ACV 4-18, 5-3, 5-103, 6-9, 6-10, 6-46, 7-16
Alternate care value 5-3
Agreement Type 3-6, 5-52, 5-80, 5125, 5-216, 5-220, 5-221, 5-222, 5-224, 5-225, 5-226, 5-227, 5-228, 5-229, 6-36, 6-39, 6-62, 6-63, 6-66, 6-76, 6-81, 6-87, 6-99, 6-100, 6-146, 2-140
Agreement Reports 3-11
Agreement Type Referral Summary 6-136
Agreement Type Referral Summary by Specialty 6-137
Agreements entry 2-140
Discount Provider Agreement Roster 3-14
Expiration Date Provider Agreement Roster 2-222, 3-14
Group Member Roster 3-7
Modify group agreement effective date 3-6
PCM 2-184
Provider 6-36

Agreement Type (continued)
Provider Alphabetic Agreement Roster 3-11
Provider batch address labels - build utility 3-16
Selecting providers 2-228
Specialty provider agreement roster option 3-12
Valid agreement type 5-52
View the agreement history records 3-6
When selecting providers by agreement type 3-16
ZIP Code Agreement Roster 3-15
Agreements Type
Alternate Care Value 4-18, 5-3
ACV 1-12, 4-18, 4-27, 5-3, 5-103
Alternate Care Value 1-12, 7-15
Appointment Refusal Status
MTF declined 6-115
Network decline 6-115
Network declined 6-115
Non-MTF declined 6-115
Appointments 1-1, 2-85, 3-5, 3-18, 4-31, 4-32, 5-5, 5-223, 6-1
Add an appointment slot 6-94
Book 6-74, 6-80
Book appointment with a civilian provider 6-97
Booking an appointment with a non-network provider 6-99
Cancel and reschedule 5-223
Civilian MTF provider 1-15
Close proximity 6-73
Direct conflict 6-73
Display Patient Appointments Report 5-95
Family Appointments with a Prior PCM screen 5-229
Initiate the booking process 6-92
Initiate the booking process 6-69, 6-79
Non-enrolled booking 5-15
Patient Appointment and Scheduling Subsystem (PAS) 1-5
PCM 6-4
PCM appointments 1-15
PCM Booking 6-3
PCM booking 2-181, 5-15
Pending 5-95, 5-159, 5-228, 6-15, 6-71, 6-73, 6-118
Primary care 2-90
Print appointment referral products 6-75, 6-99
Print appointments/wait list requests 6-75, 6-80, 6-99
Referral booking 5-15
Reschedule 5-228
Scheduled 5-161

B

Batch 1-7, 2-15, 3-16, 4-7, 5-34, 5-40
Address labels 2-228, 2-229
Batch process 5-26
Batch renew enrollments 5-134
Bulletins 2-237
DEERS check 5-110
DEERS eligibility check 5-12
Disenrollment 2-15
Enroll AD candidates 2-237, A-10
Enrollment 5-15
Enrollment transactions 4-7
Hours for running batch enrollments field 2-67
If the batch enrollment process was aborted 2-76
Job 4-31
Mail group, BATCH PCM 5-223
Miscellaneous Network Reports 3-15
Notifications 2-47
PCM reassignments 2-45
Processed 5-119
Provider batch address labels - build utility 3-16

Batch (continued)
Provider batch address labels - print utility 3-16
Renewal 2-15
Renewal/disenrollment letters 2-47
Transactions 4-7
Updating potential AD enrollment candidate file 2-237, A-10
Batched 5-15
DEERS eligibility requests 5-101
Eligibility check 5-15
Enrollment transaction 5-47
Beneficiary 2-10, 3-10, 4-18, 4-21, 5-3, 5-5, 5-12, 5-34, 5-39, 5-53, 5-87, 5-96, 5-97, 5-99, 5-102, 5-105, 5-129, 5-132, 5-133, 5-135, 5-138, 5-142, 5-143, 5-149, 5-161, 5-175, 5-176, 5-179, 5-182, 5-183, 5-192, 5-196, 6-57
Agreement types 2-140
Assignment reason enter/edit 2-10
Beneficiaries 3-2, 3-3, 3-10
Categories 2-208, 3-10
DOD 4-18, 4-31
Eligibility 1-2
Enrollment 1-12
Enrollment mix 2-172
Enrollment of beneficiaries 3-1
Mix 2-141
Non-active duty 2-66
PCM enrollment mix discrepancy statistical summary option 2-208
PCM Enrollment Mix Discrepancy Summary Report 2-210
Type 2-65
Types 2-152
USTF 6-46
Beneficiary Categories 5-218
Booking 6-62
Browse
Action 6-42, 6-70
Using arrow keys 6-80

C

Canceling an NAS 7-8
Care Authorization 1-1, 2-15, 5-24, 5-25, 5-74, 5-118, 6-9, 6-44, 6-60, 6-132, 6-133, 7-1, 7-12, 7-24
Action 6-103
Care Authorization Form, Page 1 6-105
Care Authorization Forms 1-10
Inside network (enrolled patients) 7-18
Non-availability statement 5-15
Non-Availability Statement Forms 1-10
Outside network (enrolled patients) 7-18
Print the 6-103
Supplemental Care 6-50
Supplemental care 6-112
To edit a form 2-15
Which offices will be allowed to process? 2-45
Whose names will print on? 2-48
Will the MTF or TRICARE contractors issue? 2-45
Case Management 1-3, 5-80, 5-83, 5-85, 5-164, 5-171, 6-2, 6-47, 6-49, 6-134
action 6-11
Case Management Enter/Edit screen 5-83
Case Management screen 5-82
Enter/Edit exception provider 5-80
Exception provider 1-13, 5-81, 5-171
Only service available provider 1-13
Patient 6-59
Provider 6-63, 6-100
View provider information 5-86
Catchment Area 1-2, 5-5, 5-33, 5-50, 5-92, 5-101
Catchment-wide integration 1-2
ZIP code combinations 5-50

Certification Specialty (CS) 5-52, 5-221, 6-66
Valid codes 5-52
CHAMPUS 1-2, 1-12, 3-3, 5-3, 5-5, 5-11, 5-14, 5-23, 5-24, 5-25, 5-26, 5-36, 5-38, 5-53, 5-60, 5-61, 5-66, 5-67, 5-68, 5-70, 5-71, 5-74, 5-75, 5-77, 5-78, 5-82, 5-83, 5-84, 5-86, 5-87, 5-88, 5-99, 5-103, 5-118, 6-9, 6-26, 6-27, 6-28, 6-31, 6-33, 6-36, 6-38, 6-50, 6-60, 6-67, 6-111, 6-112, 6-134, 7-1, 7-3, 7-6, 7-8, 7-9, 7-11, 7-12, 7-13, 7-14, 7-15, 7-16, 7-17, 7-18, 7-20, 7-22, 7-24, 7-25
Civilian Health and Medical Program of the Uniformed Services 3-3, 5-3
File claims with 2-109
Number 2-113
Support for civilian places of care 2-106
CHCS 4-5
CHCS/DEERS discrepant data check 4-6
Current DEERS eligibility hard copy printout 4-17, 5-19
Current DEERS Eligibility, second screen 4-16, 5-18
Family Member screen 4-5
CHCS/DEERS Discrepancy Data Continued 4-22
CHCS/DEERS Discrepancy Data Screen 4-21
CHCS/DEERS Discrepant Data Check 4-19
Codes 1-6, 3-8, 5-5, 6-23, 6-112
Activity 6-55
ACV 5-13, 5-26, 5-36, 6-46
Appointment refusal reason 6-115
Certification Specialty (CS) 5-52, 5-221, 5-227, 6-66
CPT 6-57
CPT procedure 6-57
Diagnostic 7-28
DMIS ID 5-13, 5-97, 5-99, 5-103
DMIS/ID 5-5
FileMan access 1-6, 5-64
FileMan access security 1-7
ICD-9 6-56, 6-57
Ineligibility override 5-118
International Classification of Diseases 6-56
MCP status 5-34
Medically Inappropriate 7-2, 7-6, 7-18, 7-19, 7-20, 7-22, 7-31
MEPRS 5-37, 6-22, 6-23, 6-24, 6-55, 6-97
Other insurance field 7-19
Patient category 5-10, 5-56
Patient Type 6-111
Priority 6-52
Procedure 3-8
Provider Category (Cat) 5-52
Provider category (CAT) 5-221
Provider professional category (CAT) 6-66, 6-85
Refusal reason 6-109
Specialty exception 6-88
To display a list of valid patient category codes 5-10, 5-56
UCA 6-23
Valid override 5-26
Watch 6-67
ZIP 3-15, 6-37, 6-51, 6-66, 6-80, 6-81, 6-82, 6-85, 6-86, 6-112
ZIP code "wild card" 6-51
ZIP code combination 6-51, 6-112
ZIP Codes 5-49
ZIP codes 5-50, 5-166
ZIP codes in location field 6-112
CPT 5-184, 6-67, 6-86
Codes 2-166
Exceptions 6-67, 6-86, 6-88
CPT Procedure 6-56, 6-57, 6-89
MCP Individual Provider Procedure Exceptions screen 6-89
CPT4
Discount 6-89

D

DDS 6-47, 7-6, 7-12, 7-13, 7-15, 7-17, 7-20, 7-22
DEERS 1-1, 2-4, 4-1, 5-3, 5-4, 5-5, 5-6, 5-7, 5-9, 5-10, 5-11, 5-13, 5-14, 5-15, 5-56, 7-1, 7-2, 7-3
And NAS reports 7-26
And USTF 6-46
Batched DEERS eligibility requests 5-101
CHCS/DEERS discrepancies 5-20
CHCS/DEERS discrepant data check 4-6, 7-5
CHCS/DEERS discrepant data check action 6-9
Check 6-46
Check action 6-9
Checks/Updates 1-4
Conditional status 7-9, 7-16
Current DEERS Eligibility screen 5-74, 7-12
Current eligibility action bar 6-9
Current eligibility display action 6-9
Current Eligibility screen 6-9
data discrepancy message 7-21
Database 1-12
DEERS and Uniformed Services Treatment Facility (USTF) Enrollment 5-11
DEERS Dependent Suffix (DDS) 5-172
DEERS Eligibility Data screen 5-118
DEERS Eligibility screen 5-58
DEERS Interactive Request screen 5-109, 5-116
DEERS site parameters 2-40
Defense Eligibility Enrollment Reporting System 1-3, 4-1
DMIS ID incorrectly mapped by EDS to the DEERS site ID 2-44
DMIS option 2-5
Eligibility override code 7-8, 7-14
Enrollee DMIS ID update 2-35
Enrollment 2-4, 2-64, 2-66, 5-4
Enrollment mode 1-12, 4-7, 5-3
Family Member screen 4-4
Historical 1-5, 4-8
Historical eligibility 4-12
If a patient is DEERS ineligible 7-8, 7-14
If a patient not found in DEERS 7-8, 7-14
If the DMIS ID update process fails to finish 2-38
If the SSN and DOB are correct and the patient is still not found on 7-16
Indicators of eligibility 7-16
Ineligibility Report 5-160
Interactive DEERS eligibility request 5-114
Mode 2-4
NAS response error message 7-6
NAS transactions 2-63
Native DEERS (NDEERS) function 5-102
New enrollments transactions 2-35
Override DEERS ineligibility 5-118
PAS DEERS Ineligibility Report 5-161, 5-162
PAS DEERS Ineligibility Report (continued) 5-163
Patients not yet registered on 7-11
Print a hard copy of current DEERS eligibility 6-9
Processing DEERS request message 7-5
Query 7-5
Reciprocal enrollment/ disenrollment action 5-99
Registration 1-11

DEERS (continued)
Sample DEERS Eligibility Data screen for an eligible patient 5-24
To change the DEERS purge parameter 4-30
To update the DMIS ID 2-36
Transaction complete message 7-21
Unconditional status 7-9, 7-16
View historical DEERS 5-118
View more DEERS data 5-25, 5-118, 6-9
DEERS Dependent Suffix (DDS) 5-172, 7-15
Default Selection Criteria 6-18
Demographic 7-12
Current information on File Appointment screen 6-21
Current patient information on Add Appointment Referrals screen 6-59
Current patient information on Interview/Referral screen 6-49
Display screen 6-6, 6-10
Information on non-enrolled booking search criteria screen 6-34
Patient information on Add an Appointment Slot screen 6-94
Patient information on Appointment Refusals screen 6-109
Patient information on Cancellation by Patient Search Criteria screen 6-123
Patient information on Generate Appointment Referral Products screen 6-102
Patient information on MTF Booking Search Criteria screen 6-70
Patient information on MTF Single Patient Booking screen 6-72
Patient information on Non-MTF Booking Search Criteria screen 6-93
Patient information on Provider Search screen 6-61, 6-65, 6-85
Verify demographic information 6-44
Demographic 4-2, 4-7, 4-13, 4-21, 4-31, 4-32, 5-58, 6-94
Demographics Display screen 5-225
Family Member Demographics Move screen 5-58
Demographics Display Screen
Case management action 6-11
Continue action 6-12
Disenrollment from MCP action 6-11
Enrollment enter/edit action 6-11
Enrollment history action 6-11
Family member enrollment action 6-11
Full registration action 6-10
Mini registration action 6-11
Other health insurance action 6-11
Primary care manager action 6-11
Quit action 6-12
Department 1-1, 2-78
Department and service file 2-78
DoD 1-2, 1-4, 1-10
To enter a new Department and/or Service 2-80
Department of Defense 1-1
Direct Care 4-1, 4-8, 4-18, 4-31, 6-9, 6-10, 6-46, 6-50, 6-112, 6-146, 7-6, 7-12, 7-13, 7-15, 7-17, 7-20, 7-22
Discount 3-14
Discrepancy Avoidance Report 2-230
Discrepant Data Check 6-9

Disenrollment 1-12, 4-1, 4-7, 4-18, 5-5, 5-92, 5-93, 6-11
All family members 5-94
Auto reciprocal disenrollment at the losing facility 5-97
Batch Renewal Disenrollment Roster 2-239, A-12
Batch disenrollments/renewals 2-45
Batch renewal/disenrollment 2-68
Before disenrollment... 5-94
Checking DEERS eligibility during enrollment or reciprocal disenrollment 4-2
CP BATCH DISEN COMPLETE Bulletin 2-237, A-10
CP INVAILD ENROLLMENT 2-237, A-10
CP RECIPROCAL DISENR COMPLETE Bulletin 2-238, A-11
Disenroll 5-20
Disenroll a patient 5-93
Disenrollees for period by reason code 5-177
Disenrollees for Period By Reason Report 5-178
Disenrollees for Period by Reason Report 5-99
Disenrollment and renewal notification letters 2-15
Disenrollment letters 2-47
Disenrollment screen 5-90, 5-91, 5-94
Disenrollment summary by reason 5-189
Disenrollment Summary By Reason Report 5-190
Disenrollment/Renewal notification forms 2-17
Eligibility for reciprocal enrollment/ disenrollment 5-99
Enrollment bulletin 2-234
Enrollment/Disenrollment Discrepancy Report 5-156, 5-158
Family Member screen 5-104
from MCP action 6-11
Individual family members 5-94
Invalid 5-35
INVALID DISENROLLMEN 4-22
Invalid disenrollment 4-19, 4-27, 5-21
New disenrollment reasons 5-102
Reason enter/edit 2-12
Reciprocal Disenrollment by Reason Roster 5-98, 5-181
Reciprocal Disenrollment Discrepancy Report 5-98, 5-181
Reciprocal Disenrollment Discrepancy Report (Page 1 of 2) 5-183
Reciprocal Disenrollment Discrepancy Report (Page 2 of 2) 5-183
Reciprocal disenrollment processing 5-15, 5-96
Reciprocal disenrollments 2-68
Reciprocal enrollment/ disenrollment 5-99
Reciprocal enrollments/ disenrollments 5-5
Screen 6-11
To enter a new disenrollment reason 2-13
Valid disenrollment reasons 5-91, 5-96
DMIS ID 2-5, 4-6, 4-10, 4-11, 4-15, 4-17, 4-18, 4-21, 4-22, 4-23, 4-24, 5-17, 5-19, 6-9, 6-10, 7-2, 7-4, 7-12, 7-13, 7-17, 7-18, 7-21, 7-27, 7-28, 7-29, 7-30, 7-31, 7-32, 7-33
DMIS ID update 2-35
To restart the DMIS ID update 2-38
To update the DMIS ID 2-36

E

Empanelment 1-12, 2-4, 4-7
Enrollment mode 5-4
Enrollment/Empanelment Information screen 5-31
Local 1-12, 2-4, 2-64, 2-66, 2-237, 2-239, 4-7, 5-3, 5-26, 5-37, 5-92, 5-96, 5-119, 5-142, A-10, A-12
Mode 5-137
Enrollee Lockout
To enter a new enrollee lockout override reason code 2-32
Enrollment 1-1, 3-1, 5-1, 5-11, 5-13, 5-57, 6-1, 7-1
AD Family Member by Unit Enrollment Roster 5-172
Alphabetic Enrollment Roster by Service 5-173
Alphabetic Enrollment Roster by Service screen 5-174
Assign a PCM 5-43
Batch renew enrollments 5-134
Cancel 5-108
Cancel an enrollment 5-89
Cancellation 5-95
Case Management Program Enrollment Roster 5-175
Conditional 5-34, 5-105, 6-3, 6-4, 6-32
Conditional enrollment processing 5-106
Conditional Enrollment Processing screen 5-107
DEERS 2-4, 5-4
DEERS and Uniformed Services Treatment Facility (USTF) Enrollment 5-11
DEERS check (Enrollment/Family Member screens) 5-11
DEERS enrollment mode 5-26
DEERS/Enrollment maintenance reports 5-153
Defense Enrollment Eligibility System (DEERS) 5-3
Disenrollment from MCP action 6-11
Display Enrollment History screen 5-113
Display or print the history of a patient's 5-20
Eligibility for reciprocal enrollment/ disenrollment 5-99
Enroll a patient 5-6
Enrolling division 5-126
enrollment 5-10, 5-56
Enrollment block flag 5-125
Enrollment History screen 5-112
Enrollment Mix Discrepancy Report 3-5, 3-7, 3-11
Enrollment Mix Discrepancy Statistical Summary 3-7, 3-10
Enrollment roster exception conditions 5-179
Enrollment Roster Exception Conditions Report 5-179
Enrollment rosters menu 5-171
Enrollment Summary Report 5-190, 5-194
Enrollment/Disenrollment Discrepancy Report 5-156, 5-158
Enrollment/Empanelment Information screen 5-31
Enter or edit enrollment 5-20
Enter/Edit 5-4, 5-15, 5-43
Enter/Edit action 6-11
Enter/edit action 6-11
Entering enrollment data without the eligibility data 5-12
Entitlement discrepancy flags 5-23
Family 5-71
Family batch enrollment labels 5-166

Enrollment (continued)
Family Batch Enrollment Labels - Print Utility screen 5-168
Family batch enrollment labels build utility 5-165
Family batch enrollment labels print utility 5-167
Family Enrollment screen 5-76
Family member action 6-11
Family member enrollment action 6-11
File/Table maintenance 2-4, 2-5
Form 6-131, 6-134
Forms 2-15, 6-1
Generate an Enrollment Form 6-102
If there are discrepancies between DEERS data and CHCS data 5-22
In USTF Managed Care 6-46
Invalid 5-35
Invalid enrollment 5-35
Labels for sending Enrollment Forms 6-103
Local empanelment mode 5-3
MCP Conditional Enrollment Roster 5-153, 5-155
MCP Enrollment - - Continuation screen 5-37, 5-60, 5-77
MCP Enrollment Form 5-214
MCP Enrollment screen 5-41, 5-61, 5-78
MCP Renewal - - Continuation screen 5-88
MCP status field 5-34
Membership ID 6-131
Modes 5-3
OHI Enrollment Summary 5-195
OHI Enrollment Summary Report 5-195
Outputs action 6-60
Patient Category Enrollment Summary Report (enrollee totals by patient category) 5-197
Patient Category Enrollment Summary Report (patient category by service) 5-198
Patient label 6-131
PCM enrollment mix 3-4, 3-5
Pending 5-34, 6-3, 6-4, 6-32
Print Enrollment Form 5-53
Print/Display enrollment history 5-110, 5-111
Reciprocal enrollment 5-5
Reciprocal enrollments/ disenrollments 5-5
Renew 5-20
Renew a patient's enrollment 5-86
Renew enrollments 5-5
Renewal policies and procedures 5-86
Restricted by residential address 5-33
Sample Enrollment Form 6-133
Sample enrollment form 6-134
Status 5-226
To clear entitlement discrepancies 5-24
To enter a new enrollment block reason code 2-29
To process a conditional enrollment patient 5-105
to reactivate the batch enrollment option 2-77
TRICARE 5-36
USTF managed care 6-46
View/print enrollment history 6-11
View/Print enrollment history action 6-11
Enrollment Summary Report
By patient category 5-190
By PCM 5-193

Exception Provider 5-80, 5-81, 5-82, 5-83, 5-85, 5-171, 5-175, 5-179, 5-181, 6-11, 6-59, 6-63, 6-99, 6-100
Assign an exception provider 5-81
Enrollment roster exception conditions 5-179
Exception provider field 5-83
Non-network 3-3
Only-service-available 3-2
OSA provider 3-4
Exceptions 3-4
Group level 3-8
Indicator 3-11
Indicators 3-12
Specialty 3-4

F

Facility 2-4, 3-13, 7-6, 7-18, 7-22, 7-24, 7-25, 7-33
Admitting 7-2, 7-17, 7-19
File/Table maintenance 2-4, 2-39, 7-19
MCP Division Profile 2-42
MCP division profile 2-39, 2-40
MCP office 2-39
To enter a new Facility Type 2-59
To enter a new TRICARE/MCP office 2-46
Treatment 7-2, 7-20
Uniformed Services Medical Treatment Facility NAS 7-22
Family 1-3, 4-1, 4-3, 4-10, 4-18, 5-6, 5-8, 5-10, 5-45, 5-56
Active-duty family member 5-36
Active-duty family members 5-39
Appointment history 6-120
Batch enrollment labels 5-152
Batch enrollment labels build utility 5-165
DEERS check (Enrollment/Family Member screens) 5-11
Disenroll members 5-20
Disenrollment 5-93
Display/print appointments for other family members 6-120
Enroll family members 5-54
Enroll family members using the family action 5-71, 5-73
Enroll members 5-20
Enrollment 5-71
F9 View of family members 5-13, 5-58
Family enrollment option 5-100
Family Enrollment screen 5-76
Family Member Demographics Move screen 5-58
Family member prefix (FMP) 5-55
Family member prefix 7-15
Family member prefix (FMP) 4-24, 5-9, 7-10
Family member prefix field 4-26
Family Member screen 5-12, 5-57, 5-104
Patients booked under the same SSN 6-120
Pick list of all family members 4-27
View family assignments 5-45
View family PCM assignments 5-43
Family Member Enrollment 6-11
FI 5-4, 6-87, 6-89
Notification date 6-87
Fiscal Intermediary 1-11, 2-145
FI 1-12, 2-145, 2-147, 2-149, 2-150, 2-171, 2-195
Notification date 6-87
Fiscal Intermediary (FI) 5-4
FMP 6-8, 6-9, 6-10, 6-13, 6-14, 6-16, 6-19, 6-20, 6-21, 6-26, 6-27, 6-28, 6-31, 6-34, 6-35, 6-36, 6-38, 6-40, 6-41, 6-43, 6-45, 6-47, 6-53, 6-54, 6-56, 6-58, 6-59, 6-61, 6-64, 6-79, 6-83, 6-84, 6-85, 6-93, 6-94, 6-96, 6-97, 6-98, 6-102, 6-105, 6-106,

FMP (continued)
6-109, 6-110, 6-114, 6-117, 6-123, 6-124, 6-127, 6-128, 6-129, 6-134, 6-149
Family member prefix 7-10

G

Groups 1-3, 2-4, 2-126, 2-139, 3-3
Provider 1-11
Agreement type 1-11
Agreement types 2-140
CHAMPUS number field 2-113
Clinic (group) 2-169
Discrepancy Avoidance Report 3-17
Group 2-103
Group (Team) 2-5
Group and provider agreements 2-122
Group enter/edit 2-78
Group Member Roster 3-7
Group network 2-139
Group profile/agreement enter/edit 2-4
Group Profile/Agreement Maintenance screen 2-158
GRP PL2 - Provider group places of care 2-135
GRP PL3 – Provider Group Places of Care screen 2-136
If the group is a PCM 2-140
If the group is to be a PCM 2-155
Mail 2-4
MTF provider 3-3
New MCP provider groups 3-4
Non-network providers 3-3
Only-service-available 3-4
Patient Category 5-184
PCM Enrollment Mix Discrepancy Statistical Summary 3-10
Provider 1-9, 1-10, 3-3, 6-142
Provider flag field 2-105
Provider Group Agreement History screen 2-143, 2-146, 2-147
Provider group name field 2-113
Provider Group Overall Discount screen 2-144
Provider group places of care 2-133
Provider Group Procedure Exceptions screen 2-150
Provider group profile/agreement maintenance 2-142
Provider group profile/agreement maintenance action bar 2-142
Provider group prompt 2-112
Provider Group Report 3-8
Provider Group Specialty Exceptions screen 2-148, 2-149
Provider type Field 2-113
Short group ID field 2-113
Specialty Provider Agreement Roster 3-12
Tax ID field 2-113
To add a new member to an existing MCP Provider Group 2-187
To add a provider to the group 2-159
To associate providers with a provider group 2-156
To complete the provider group profile 2-130
To enter a new agreement for a group 2-141
To establish linkages between a PCM and the unit for which he/she/group is responsible 2-69
To inactivate/reactivate a group or provider place of care or an individual provider through the GNET menu option 2-175
View the agreement history records 3-6

H

HCF 6-81, 6-85, 6-86
Health 6-3, 6-15
Health Care Finder 1-9, 2-15, 3-4, 5-132, 5-145, 6-1, 6-81, 6-132
HCF 1-4, 1-10, 3-4, 6-76
MCP HCF profile 2-50
Menu 2-15, 6-2, 6-3, 6-15, 6-33, 6-48, 6-103, 6-114, 6-135
Output products and reports 6-131
Profile 2-39
Profile enter/edit 2-48
Profile enter/edit option 6-132
Profile enter/edit option (HEAL) 6-132
Record in the system 6-132
Reports menu (RHCF) 6-136
To enter a new Health Care Finder 2-49
Troubleshooting 2-51
Historical 1-5, 4-8
DEERS eligibility 4-12
DEERS eligibility data 5-25, 5-26, 5-118, 5-119
DEERS eligibility information 4-8
Eligibility data 4-9
History 3-6
Agreement history 3-6
Appointment refusal 6-114
Appointment Refusal History screen 6-114
Appointments refusal 6-4
View refusal history action 6-116
View/Print appointment refusal history 6-117
View/Print enrollment history action 6-11

I

ICD-9 6-57
International Classification of Diseases 6-56
Indicates 5-56
Individual 2-173
Provider 6-6
Insurance 2-5, 7-17
Insurance company enter/edit 2-5
Other 7-6, 7-17, 7-22
To enter a new insurance company 2-6
International Classification of Diseases
ICD-9 6-56
Issue Reason 7-2, 7-6, 7-17, 7-19, 7-22, 7-30, 7-32
Issue Type 7-2, 7-17, 7-19
Issuing an NAS 7-8

K

Keys 2-230

M

Mail Bulletins 1-7, 2-4, 5-122
CP BATCH DISEN COMPLETE 2-237, A-10
CP BATCH DISENROLL COMPLETE 2-237, A-10
CP BATCH RENEW COMPLETE 2-239, A-12
CP ENR DIV CHANGE 2-237, A-10
CP HCP INACTIVATION DATE 2-237, A-10
CP INACTIVATE UIC IN AUTO ENROLLMENT 2-238, A-12
CP INVAILD ENROLLMENT 2-237, A-10
CP MULTIPLE BATCH PCM 2-237, A-11
CP PCM REACHED MAX CAPACITY 2-238, A-11
CP POC INACTIVATION 2-238, A-11
CP POC INACTIVATION DATE 2-238, A-11
CP RECIPROCAL DISENR COMPLETE 2-238, A-11

Mail Bulletins (continued)
CP RENEW AGREEMENT BATCH PCM 2-238, A-11
CP RENEW AGREEMENT NON-PART 2-238, A-11
CP RENEW AGREEMENT W-OUT BATCH 2-238, A-11
CP UIC MAINT RPT AVAIL 2-238, A-11
CP UIC WITHOUT PCM 2-238, A-11
NEW UIC CODE 2-238, A-11
Mailing Labels
Patient 6-60, 6-103
Provide 6-60
Provider 6-103
MCP DEERS Ineligibility Report 4-32
MCP Status 2-234, 4-7, 4-21, 4-22, 4-23, 4-27, 4-33, 5-22, 5-34, 5-94, 5-112, 5-113, 5-159, 5-174, 5-175, 5-177, 5-179, 5-184, 5-185, 5-225, 6-10, 6-12, 6-47, 6-49, 6-53, 6-54, 6-56, 6-58, 6-59, 6-61, 6-79, 6-83, 6-85, 6-93, 6-102, 7-13
Conditional enrollment 2-234, 4-7
Enrolled 4-7, 6-12
Invalid enrollment 4-7
Pending enrollment 2-234, 4-7
Medical Expense and Performance Reporting System (MEPRS) 6-22
Medically Inappropriate Code 7-2, 7-19, 7-20
MEPRS 2-83, 2-87, 2-90, 2-96, 2-97, 2-102, 2-106, 2-168, 5-37, 6-22, 6-23, 6-55
By clinic/location 6-23
by referring location 6-23
Field 6-24, 6-97
field 6-22
Formerly UCA 6-23
If MEPRS workload is inaccurate 2-83
Mini Registration 5-20, 5-23, 5-26, 5-27, 5-54, 5-58, 5-93, 5-118, 6-8, 6-11, 6-12, 6-22, 6-45, 7-7, 7-8, 7-10, 7-13, 7-14
Screen 5-27, 5-59
Modify 5-43
Data for a PCM 5-44
Patient ID 5-94
PCM history 5-43, 5-45

N

NAS
Processing initial action bar and patient selection prompts 7-10
Network Management 3-6
Reports 3-6
Non-Active Duty 5-3, 5-4, 5-5, 5-6, 5-39, 5-53, 5-65, 5-76, 5-87, 5-101, 5-130, 5-132, 5-135, 5-137, 5-143, 5-191
Non-Availability Statement 5-15

O

Other Health Insurance 1-3, 5-20, 5-53, 5-76, 5-189, 5-195, 6-61, 7-8, 7-13, 7-14, 7-19
Action on Demographics Display screen action bar 6-11
Copy OHI action 5-67
Edit action 5-66
Enrollment Summary Report 5-195
Enter information 7-19
Enter/Edit screen 5-66
OHI Enrollment Summary 5-195
OHI Enrollment Summary Report 5-195
Other Health Insurance 7-8, 7-14
Other Health Insurance action on Demographics Display action bar 6-11

Other Health Insurance (continued)
Other Health Insurance - Enter/ Edit screen 5-70
Other Health Insurance Enter/Edit screen 5-67
Other Health Insurance screen 5-71
Policy number field 7-19
Screen 5-66
Security key for entering 6-2
Overall Discount Rate 5-221, 5-222, 5-228, 6-67, 6-86, 6-87
Overall Discount Rates
Valid overall discount rates 5-53

P

PAS DEERS Ineligibility Report 4-30
Patient Category 4-11, 4-12, 4-13, 4-15, 4-16, 4-17, 4-21, 4-22, 4-23, 5-10, 5-17, 5-18, 5-19, 5-56, 6-9, 6-10, 6-12, 6-47, 6-49, 6-53, 6-54, 6-56, 6-58, 6-59, 6-61, 6-64, 6-69, 6-79, 6-83, 6-84, 6-85, 6-92, 6-102, 6-105, 6-114, 6-117, 6-134, 6-147, 6-148, 6-149, 7-8, 7-12, 7-14, 7-15, 7-17, 7-22, 7-24, 7-25, 7-26
PATCAT 5-10, 5-56
Patient Category Enrollment Summary Report (patient category by service) 5-198
Patient Category Enrollment Summary Report (enrollee totals by patient category) 5-197
Reason for Issue by Patient Category Report 7-2, 7-30, 7-31
Patient Type 2-140, 2-173, 3-8, 5-8, 5-26, 5-36, 5-37, 5-41, 5-60, 5-61, 5-66, 5-67, 5-70, 5-71, 5-75, 5-77, 5-78, 5-80, 5-82, 5-83, 5-84, 5-86, 5-88, 5-112, 5-113, 5-216, 5-221, 5-225, 6-8, 6-10, 6-13, 6-14, 6-16, 6-19, 6-20, 6-21, 6-26, 6-32, 6-34, 6-35, 6-36, 6-38, 6-40, 6-41, 6-43, 6-44, 6-47, 6-49, 6-50, 6-53, 6-54, 6-56, 6-58, 6-59, 6-61, 6-63, 6-64, 6-70, 6-76, 6-79, 6-81, 6-83, 6-84, 6-66 6-85, 6-93, 6-94, 6-96, 6-97, 6-99, 6-102, 6-103, 6-105, 6-109, 6-112, 7-13
List of 6-36, 6-50, 6-111
MCP/Active duty 5-38
Provider agreement types and eligible 2-143
Relation to agreement type 6-63
PCM 1-2, 2-208, 3-4, 3-5, 3-8, 3-15, 3-18 4-11, 4-15, 4-17, 5-3, 5-4, 5-6, 5-8, 5-15, 5-17, 5-19, 5-20, 5-25, 5-31, 5-35, 5-37, 5-42, 5-41, 5-60, 5-61, 5-75, 5-77, 5-78, 5-88, 5-113, 5-145, 5-225
Activate group PCM field 2-185
Agreement 2-152
Agreement type 2-152, 3-11
Agreement types 2-184
Assign a 5-61
Batch assignment/reassignment of enrollees 5-214
Batch PCM Reassignment screen 5-218, 5-219, 5-222
Batch PCM Search Criteria screen 5-220
Batch reassignment 5-216
Booking 6-3, 6-4, 6-6
Booking a patient appointment with an assigned individual PCM or group PCM with schedules 6-7
Business rules 2-181
Capacity 5-53, 5-221, 5-228
CP BATCH PCM ABORT Bulletin 2-237, A-10
CP BATCH PCM Bulletin 2-237, A-10
CP MULTIPLE BATCH PCM Bulletin 2-237, A-11

PCM (continued)
CP PCM REACHED MAX CAPACITY Bulletin 2-238, A-11
CP RENEW AGREEMENT BATCH PCM Bulletin 2-238, A-11
CP UIC WITHOUT PCM Bulletin 2-238, A-11
Direct Assignment screen (expanded provider record) 5-63
Enrollment mix action 2-172
Enrollment Mix Discrepancy Statistical Summary 2-208
Family Appointments with a Prior PCM screen 5-229
Family PCM reassignment 5-223, 5-226
Four (4) flags to set to YES when designating PCMs 2-180
Gaining 5-220
Group PCM specialties 2-182
Group provider at a non-MTF place of care 6-6
Group provider with schedules 6-6
Group provider without schedules 6-6
If a provider cannot be seen when enrolling patients or when booking 2-174
If a provider is not a participant of an agreement that is a PCM 2-170
If the group is a PCM 2-159
If unable to access the desired PCM 2-186
Individual Provider PCM Capacity screen 2-173
Location 7-12
Mail group, BATCH PCM 5-223
Other important considerations 2-181
Patients assigned to providers as PCMs 3-18
PCM activation 2-180
PCM capacity 3-10
PCM count 2-195, 2-234
PCM Reassignment screen 5-224
PCM status 2-195
Primary care manager 3-4
Primary care manager action 6-11
Print PCM 5-45
Provider group PCM capacities 2-185
Provider Group PCM Capacity screen 2-151
Provider Group Report 2-198
Reassign a patient from one PCM to another PCM 5-217
Search criteria 5-45
To create PCMs 2-181
To enter a new PCM assignment reason 2-11
To make an individual provider a PCM 2-186
View family assignments 5-45
PCM Booking
Business rules 6-4
Percent Discount 6-85
Place of Care 1-13, 2-5, 2-78, 2-83, 2-179, 3-2, 3-5, 3-8, 3-17, 3-19, 5-6, 5-46, 5-52, 5-53, 5-63, 5-64, 5-126, 5-214, 5-215, 5-216, 5-221, 5-222, 6-6, 6-39, 6-65, 6-66, 6-67, 6-76, 6-77, 6-81, 6-85, 6-86, 6-93, 6-124, 6-125
Clinic 1-15
CP POC INACTIVATION Bulletin 2-238, A-11
Directions to 5-46
Directions/Comments 6-98
Directions/Comments screen 6-99
Discrepancy Avoidance Report 2-230
Facility field 2-88
Facility type enter/edit 2-58
Field 1-11
Group place of care action 2-177

Place of Care (continued)
GRP PL2a Place of Care screen 2-92
If a group has multiple places of care 2-181
If the Individual PCMs work at more than one place of care 2-181
Inactivate or reactivate the place of care 2-179, 2-193
Inactivation/Reactivation of Place of Care screen 2-178
Inactive flag 2-91
Location 5-44
MCP group 2-111
Non-MTF 6-6
Notify of appointment cancellations 6-130
On Provider Network List 6-139
Other important considerations 2-111
PCM Direct Assignment screen (place of care) 5-64
Place of care enter/edit 2-83
Print directions to provider's 6-98
Profile 2-89
Provider network area 2-56
Provider place of care action 2-177
Search criteria 6-123
Service field 2-89
To enter a new TRICARE/MCP place of care 2-85
To inactivate/activate a provider place of care 2-179
To inactivate/reactivate a group or provider place of care 2-175
To inactivate/reactivate a group place of care 2-177
UIC/PCM Maintenance screen w/ POC 2-73
ZIP code combination 2-53
ZIP code of 6-66
Policy Type 5-67, 5-68
Priority 5-36, 6-49, 6-52, 6-53, 6-61, 6-64, 6-84, 6-85, 6-93, 6-105, 6-119
Codes 6-52
Professional Category
To enter a new professional category 2-118
Provider 1-1, 2-4, 3-1, 5-20, 5-43, 6-32, 6-123, 7-18
Action on Case Management screen 5-82
Add an appointment slot to schedule 6-28, 6-94
Agreement data 6-121
Agreement type 5-52, 6-99
Agreement type (Agr) 5-221, 5-228
Agreement type related to patient type 6-63
Agreement types 6-36, 6-76
Agreement types and eligible patient types 6-81
Appointment Referral Screen with provider eligibility dates 6-79
Appointment type 6-29
Appt type instructions 6-22
Assign an exception provider 5-80
Audit trail For provider network menu 2-122
Book appointment with civilian provider 6-97
Booking a non-enrolled patient with a MTF provider 6-33
Booking an appointment with a specific provider by name 6-62
Booking an appointment with an MTF 6-76
Browse schedule 6-41, 6-70
Business rules 2-103
Cancellation by Patient (CMCP) 6-121
Case management 6-47, 6-62, 6-63, 6-100

Provider (continued)
Case Management Enter/Edit screen 5-83
Certification Speciality (CS 5-227
Certification Specialty (CS) 5-52, 5-221, 6-66, 6-85
Civilian 3-2
Clinic profile 6-73
CP HCP INACTIVATION Bulletin 2-237, A-10
CP HCP INACTIVATION DATE 2-237, A-10
CP HCP INACTIVATION DATE Bulletin 2-237, A-10
CP NET HCP BULLETIN 2-235
CP RENEW AGREEMENT NON-PART Bulletin 2-238, A-11
Creating the network 3-2
Designating an individual provider or a group provider as a PCM 2-180
Discount Provider Agreement Roster 2-219, 2-220
Discount rate 3-4, 3-12, 3-14, 6-85, 6-86
Discount summary action bar 6-67, 6-86
Discount Summary screen 6-67, 6-86
DOD Add Provider screen 2-105
Eligibility dates 6-79
Enrollment Roster Exception Conditions Report 5-179
Enter/Edit exception 5-80
Exception 6-11, 6-59, 6-62, 6-63, 6-99, 6-100
Exception or case management 5-20
Exception provider 3-2, 3-3, 3-4
Exception providers 3-3
Expand the record 5-62
Expiration Date Provider Agreement Roster 2-222, 2-223
External 3-2, 6-81, 6-86, 6-93
External (non-MTF) provider search 6-81
External civilian 6-107
External provider search action 6-62
Field 5-83, 6-34
field 6-35
File 6-54, 6-81
Find an external 6-81
First available appointment 6-66
Functionality interactions 2-174
Gender 5-53, 5-221, 6-52, 6-61
GNET – providers 2-155
Group 1-11, 6-4, 6-29, 6-28 6-54
Group data changes 2-126
Group field 1-10
Group Member Roster 2-195
Group Places of Care screen 6-67, 6-87
Group Places of Care, Page 1 6-90
Group Places of Care, Page 2 6-91
Group with schedules 6-6
Group without schedules 6-6
Group/Military provider agreement type 6-66
Groups 6-142
If a provider cannot be seen when enrolling patients or when booking 2-174
If a provider in a particular area fails to appear on screen during a search 2-53
Inactivate provider action 2-177
Inactivation 2-175
Individual 6-4, 6-15
Individual Provider Agreement Exception History screen 2-171
Individual Provider Agreement Participation screen 2-146, 2-170
Individual Provider Discount Summary screen 6-87

Provider (continued)
Individual Provider PCM Capacity screen 2-173
Individual Provider Procedure Exceptions screen 6-89
Individual Provider Profile - IND PL1 screen 2-164
Individual Provider Profile - IND PL2 screen 2-165
Individual Provider Profile - IND PROF1 screen 2-160
Individual Provider Profile - IND PROF3 2-161
Individual Provider Profile - IND PROF4 screen 2-162
Individual Provider Profile - IND PROF5 screen 2-163
Individual Provider Profile screen 2-158
Individual provider profile/ agreements enter/edit 2-187
Individual Provider Services Offered Profile screen 2-166
Information fields on Cancellation by Patient Search Criteria screen 6-123
Information on Appointment Refusals screen 6-109
Information on Display Patient Appointments screen 6-119
Information on File Appointment screen 6-22
Internal 3-2
Label action 6-103
Language 6-61
List by percent discount 6-81
List of 6-40
List of open appointments 6-42
Location 2-102
Location (Locat) 5-221
Mailing label 6-132, 6-133
Mailing labels 6-60
Max # of appts per day field 2-168
MCP Exception Information - - Continuation screen 5-84
Message 6-22
Military 3-2
Military status enter/edit 2-120
MTF 6-4, 6-60, 6-71, 6-72, 6-79
MTF group 6-6
MTF provider search action 6-62
MTF provider search action on provider search action bar 6-62
Name 6-29, 6-66, 6-85
Name search 6-62
Network 1-1, 2-69, 2-155, 2-162, 3-3, 6-3, 6-12, 6-62, 6-136
Network (non-MTF) provider search 6-81
Network civilian 6-107
Network file/table maintenance 2-4
Network List 6-139, 6-141
Network management 1-3, 3-1
Non-enrolled booking search criteria screen with provider search action bar 6-38
Non-MCP 1-13
Non-MTF 6-6, 6-60
Non-network 2-162, 3-2, 6-3, 6-32, 6-44, 6-62
Notification Roster 5-215
Only-service-available 3-2, 3-4, 6-99, 6-100
OSA 1-13
Other important considerations 2-103
Overall discount rate (Disc) 5-53, 5-221, 5-228
Patient Load Report by Provider 6-149
Patient workload 6-136
Patient Workload Report 6-146
Patient Workload Report by Provider Group 6-147
PCM 1-16
PCM Activity Report by Provider Group 6-143
PCM capacities 6-139

Provider (continued)
PCM Direct Assignment screen (expanded provider record) 5-63
Place of care 5-53
Place of Care Directions/Comments, Pages 1 & 2 6-99
Preferred provider option 1-2
Preferred Provider Organization (PPO) 3-3
Print directions to place of care 6-98
Print roster with open appts field 2-168
Procedure Exceptions screen 6-67, 6-86
Professional category code (CAT) 6-66, 6-85
Professional category enter/edit 2-118
Profile 6-22, 6-23, 6-65, 6-77
Provider Alphabetic Roster 2-213
Provider category (CAT) 5-52, 5-221
Provider class field 2-106
Provider file 2-159
Provider flag field 2-105
Provider Group Agreement History screen 2-143, 2-147
Provider Group Overall Discount screen 2-144
Provider Group PCM Capacity screen 2-151
Provider Group Places of Care – GRP PL1 screen 2-133
Provider Group Report 2-198
Provider List by Speciality 2-207
Provider location field 2-106
Provider name field 2-168
Provider network area field 2-56
Provider place of care action 2-177
Provider Search screen 6-61
Provider Search Screen (with MTF Providers Displayed in the Select Window) 6-78
Provider specialty field 2-105
Provider type field 2-113, 2-162
Quit search action 6-67, 6-87
Referred to 6-47, 6-103
Referred to search 6-59
Referring 6-54
Refused provider field 6-116
RENEW AGREEMENT BATCH PCM Bulletin 2-238, A-11
RENEW AGREEMENT W-OUT BATCH Bulletin 2-238, A-11
Requested provider not available refusal reason 6-115
Resources 1-4
Search action 6-41, 6-93
Search action bar 6-62
Search action on MTF Booking Search Criteria screen 6-70
Search for 6-38, 6-39
Search screen 6-64, 6-84
Searches for MTF group providers 6-5
Select a 6-40
Select an MTF provider 6-77
Single service 2-162
Specialties 6-142
Specialty 5-221, 5-228, 6-47
Specialty care 6-62
Specialty Exceptions screen 6-67, 6-86
Specialty Provider Agreement Roster 2-216, 2-217
Specialty Provider Agreement Summary 2-218
Specialty type 6-50
Specialty type enter/edit 2-115
Specialty Type Referral Summary by Specialty 6-137
Telephone consult action 6-71
Telephone consults 6-42
To add a new member to an existing MCP Provider Group 2-187
To add a provider to the group 2-159
To enter a new provider into CHCS and MCP 2-104

Provider (continued)
To enter a new provider specialty type 2-116
To inactivate/activate a provider place of care 2-179
To inactivate/reactivate a group or provider place of care or an individual provider through the GNET menu option 2-175
To make an individual provider a PCM 2-186
Total available PCM capacity 5-221, 5-228
Total available PCM capacity (Avail) 5-53
Troubleshooting 2-110
Types of provider networks 3-2
Unable to locate a provider based on his specialty 2-117
Unique Physician Identification Number (UPIN) 6-54
Using the INET option to edit an individual provider profile 2-193
Valid network provider types 3-3
Valid non-network provider types 3-3
View patient's exception provider history 5-85
View provider detail 6-67, 6-78, 6-86
ZIP Code Agreement Roster 2-225
Provider Batch Address Labels - Print Utility 3-17
Provider Specialty 5-84
Provisional Diagnosis 6-56, 6-57, 6-105
Free text field 6-57

R

Reciprocal Disenrollment
To disenroll a patient from another facility and enroll the patient in your facility 5-103
Reciprocal Enrollment/ Disenrollment
Currently registered family members 5-100
Enrollment end date 5-100
Enrollment start date 5-100
Family members 5-100
Family members not registered 5-100
When you cancel 5-101
Referral Procedure 6-57
CPT codes 6-57
Displaying a valid list of 6-57
Refusal Reasons 6-115
For MTF declined 6-115
For non-MTF declined or network declined 6-115
Registration 1-5, 2-6, 2-69, 2-76, 4-7, 5-5, 5-7, 5-10, 5-13, 5-22, 5-27, 5-56, 5-57, 5-101, 5-225, 6-12, 7-7, 7-8, 7-11, 7-14
CHCS 1-11
Comment 6-22, 7-13
Comment field 5-8
DEERS 1-11, 7-16
Edit a patient's 5-20
Full 5-20, 5-23, 5-27, 5-93, 6-10, 7-8, 7-13, 7-14
Mini 1-11, 2-238, 5-8, 5-20, 5-23, 5-26, 5-27, 5-54, 5-58, 5-93, 5-118, 6-8, 6-11, 6-12, 6-22, 6-45, 7-7, 7-8, 7-10, 7-13, 7-14, A-11
Mini registration 2-238, A-12
Mini Registration screen 5-27, 5-59
Modify 5-27
Updating data in CHCS 5-23
Renew 3-4
Group agreements 3-4
Renewal
Address used for notification letters 5-132
Batch disenrollments/renewals 2-45

Renewal (continued)
Batch enroll candidates who qualify for renewal 5-130
Batch renew enrollments 5-133
Batch renewal and disenrollment 5-133
CP BATCH RENEW COMPLETE Bulletin 2-239, A-12
MCP Renewal - - Continuation screen 5-88
Multiple batch renewal 5-129
Notification candidates file 5-132
Notification letter 5-129
Notification Letter Candidates screen 5-131
PCM 5-135
Renew action 2-148
Renewal & Disenrollment Processing screen and action bar 5-134
Renewal Batch Processing screen 5-136
Renewal notification letters 2-15
Renewal policies and procedures 5-86
Sample Renewal Notification Letter 5-145
Restrict Enrollment 2-67
By patient category 2-64
By residential address 2-54, 2-64, 2-67
For active duty family members 2-67
For retired beneficiaries 2-67
For retired family members 2-67
Restrict enrollment 2-68

S

Scheduled Task Jobs 1-7
Reschedule 2-234
Taskman 1-7
Search Criteria 1-8, 2-51, 2-70, 2-194, 2-228, 2-229, 3-16, 3-17, 4-27, 6-12, 6-42, 6-46, 6-66, 6-79, 6-81, 6-82, 6-107, 6-109, 6-121, 6-122, 6-127, 6-129, 6-130, 6-131
Appointment Refusals screen with Selectable Search Criteria 6-110
Appointment type 6-18, 6-38, 6-126
Appointment types 6-73
Batch PCM Search Criteria screen 5-220
Booking Search Criteria screen 6-8, 6-13
Cancellation by patient search criteria action bar 6-124
Cancellation by Patient Search Criteria screen 6-123, 6-125
Cancellation by Patient Search Criteria screen with Selectable Search Criteria 6-124
Change 6-70, 6-93, 6-109, 6-113, 6-123, 6-124
Change search criteria 2-74, 5-44
Change Search Criteria action 6-14
Change search criteria action 2-71
Data 6-113
Dates 6-16, 6-37
Days of the week 6-17, 6-37
Default 5-48, 5-51, 6-123
Default Search Criteria 2-71
Duration 6-37
Location 6-37
MTF Booking Search Criteria Screen (with selected search criteria filled in) 6-19
MTF Booking Search Criteria screen with Selectable Search Criteria 6-16
Non-Enrolled Booking Search Criteria screen 6-34, 6-35

Search Criteria (continued)
Non-Enrolled Booking Search Criteria screen with Available MTF Appointments 6-40
Non-Enrolled Booking Search Criteria screen with provider search action bar 6-38
Non-enrolled MTF booking search criteria action bar 6-41
Non-Enrolled MTF Booking Search Criteria screen 6-41
Non-MTF Booking Search Criteria screen 6-26, 6-93
On File Appointment screen 6-21
Patient type 6-36, 6-111
PCM 5-42
PCM Booking Search Criteria screen 6-7
PCM MTF Booking Search Criteria screen 6-14
PCM non-MTF booking 6-6, 6-7
PCM Non-MTF Booking Search Criteria screen 6-14
PCM non-MTF Booking Search Criteria screen 6-13
PCM search criteria (change search criteria) 5-48, 5-62
PCM Search Criteria screen 5-44, 5-45
Place of care 6-125
Provider 6-6, 6-125
Provider Search 2-145
Provider search 2-51, 2-93, 2-108, 2-110, 2-116
Required fields in non-enrolled booking 6-35
Search PCM 5-44
Select 6-15
Specialty 6-16
Specialty type 6-37, 6-111
Start and stop dates 6-126
Time Range 6-37
Time range 6-17, 6-126
View search criteria action 5-148, 5-168
Searches 3-1, 6-12, 6-70
By specialty and location 3-2
Creating a cross-reference 5-51
Criteria 3-16, 3-17
DEERS eligibility information 5-11
For a gaining PCM with any PCM agreement 5-220
For label batches 5-167
For stored DEERS eligibility information 5-117
Gaining PCM by agreement type 5-220
Locations 5-220
Patient file 5-166
Provider 3-16
Range of ZIP codes 5-50
Security 1-6, 2-5, 5-64
Family member SSN 7-15
FileMan 2-5, 2-63, 2-83, 2-102
FileMan access 1-7
FileMan access codes 5-64
For insurance company file 5-64
Key 6-136
Key required for case management action 6-11
Key required for Other Health Insurance action 6-11
Keys 1-7, 2-5, 2-10, 2-12, 2-15, 2-17, 2-20, 2-25, 2-28, 2-31, 2-35, 2-37, 2-40, 2-45, 2-48, 2-51, 2-54, 2-58, 2-60, 2-63, 2-69, 2-76, 2-78, 2-83, 2-102, 2-110, 2-115, 2-118, 2-120, 2-127, 2-129, 2-140, 2-155, 2-175, 2-180, 2-187, 2-195, 2-198, 2-206, 2-208, 2-210, 2-212, 2-216, 2-218, 2-219, 2-222, 2-225, 2-228, 2-229, 2-230, 2-234, 5-89, 5-120, 6-2, 6-3, 6-32, 6-44, 6-117, 6-121, 6-131, 6-135, 7-2
Menu assignments 1-6

Security (continued)
Social security number 6-59
Sponsor SSN 7-10
Single Patient 6-24
Action 6-42
Book a 6-14
Booking action 6-94
MTF Booking screen 6-79
Non-Enrolled MTF Single Patient Booking screen 6-43
PCM MTF (Non-MTF) Single Patient Booking screen 6-19
PCM MTF Single Patient Booking screen 6-20
Specialty 5-44, 5-45, 5-48, 5-49, 5-52, 5-63, 5-80, 5-81, 5-82, 5-83, 5-84, 5-85, 5-86, 5-179, 5-221, 5-227
Certification 5-227
Certification Specialty (CS) 5-52
File 5-52
Specialty Type 3-12, 6-62, 6-63, 6-79, 6-100
Appointment refusal 6-111
CP Provider Specialty Type screen 2-117
Information in HCF reports 6-136
On Add Appointment Referral screen 6-59
On Provider Search screen 6-61
Provider search criteria 6-41, 6-50, 6-70, 6-93
Referral Summary 6-137, 6-138
Select PCM 6-13
To enter a new provider specialty type 2-116
Specific Medical Procedures (CPT) 6-67, 6-86
Standard Insurance Company Table 5-64
Status
Appointment 6-119, 6-129
Appointment refusal 6-109, 6-114, 6-115
Appointment Slot 6-29
Group 6-148
Referral 6-47

T

Track User Report 5-183
By family 5-184
By patient category group 5-185

U

UCA 6-23
UIC 4-11, 4-15, 4-17, 4-21, 4-23, 5-17, 5-19, 5-22, 5-23, 5-24, 5-30, 5-47, 5-74, 5-118, 5-123, 5-124, 5-125, 5-126, 5-216, 5-218, 5-219, 5-220, 5-222
Code 5-23
Code processing 5-124
CP INACTIVATE UIC IN AUTO ENROLLMENT Bulletin 2-238, A-12
CP NEW UIC CODE Bulletin 2-238, A-11
CP UIC MAINT RPT AVAIL Bulletin 2-238, A-11
CP UIC WITHOUT PCM Bulletin 2-238, A-11
Edit a UIC screen 2-74
Edit a UIC screen with Data 2-75
If CHCS will not accept a UIC 2-76
Reassign a group of active duty enrollees by 5-215
Sponsor 7-12
UIC/PCM Maintenance screen 2-71
UIC/PCM Maintenance screen w/POC 2-73
Uniformed Service Treatment Facility (USTF) 1-4, 4-1, 4-7, 4-17, 4-18, 4-31, 5-14, 5-108, 5-117, 5-161, 6-46

Unique Physician Identification Number (UPIN) 6-54

V

View 2-195, 3-4, 4-4, 5-67
A patient's exception provider history 5-85
A patient's NAS history data 7-1
A patient's other health insurance information 7-14
ACV 5-4
Additional DEERS data 5-15
Agreement history records 3-6
Candidate data 5-125
Clinic profiles 3-4
Current enrollment information 5-136, 5-141
Current MCP enrollment 5-5
Enrollment history 6-11
Expanded provider data 5-62
Family members 5-13, 5-58
Family PCM assignments 5-43
Gaining PCM's assignment preferences and/or place of care information 5-216
Group profile 3-4
Group Provider profiles 3-4
Historical DEERS data 5-118
Hours of service 5-64
List of appointment slots selected 6-21
List of divisions 5-152
Location/preferences 5-125
More DEERS data 7-12
OHI information 5-6
Or print appointment refusal data 6-116
Past and present PCM data 5-44
PCM history 5-45
PCM location data 5-47
Print lists 5-125
Provider information 5-86
Search criteria 3-17, 5-168
View agreement history 2-195
View expired policies 5-67
View search criteria action 5-148

W

Wait List 2-96, 3-18, 5-95, 6-15, 6-24, 6-31, 6-41, 6-42, 6-43, 6-70, 6-71, 6-99, 6-118, 6-119, 6-120, 6-130
Activated 2-96
Automatic wait list processing field 2-97
Max wait list days field 2-96
Print 6-80
Wait list activated field 2-96
Wait list HCP mandatory field 2-96
Wait list hold duration field 2-97
Wait List Requests 2-43, 2-179
Wait list requests 2-175, 2-231
Wait List Requests
Print 6-75
Wild Card(s)
ZIP code(s) 6-51
Zip code(s) 6-112

Z

ZIP 1-10, 2-51, 5-49
Catchment area 2-65
Combinations enter/edit 2-51
DOD ZIP Code Enter Edit Screen 2-56
Location 5-166
Location by 5-220, 5-227
of place of care 6-66
Picklist grouped by 6-86
Provider display on Provider Search screen 6-85
Referral picklist 6-82
Search for gaining PCM 5-220
To enter a new ZIP Code combination 2-52
When entering location 2-72

ZIP (continued)
ZIP code order 6-66
ZIP codes 5-49
Wild card(s) 5-49
ZIP code combination 5-50