DEPARTMENT OF DEFENSE
Uniform Business Office

USER GUIDE

Document Change History

Document Version	PostingDate	Description of Change	Affected Sections
1.0	18 January 2008	Updated section	Cosmetic Surgery
1.1	23 March 2009	Updated sections	Overview Air Evacuation Ambulance Services Claims Form Compliance Radiology Uniformed Services Family Health Plan Glossary
		New sections	Civilian Emergency Billing Third Party Collection Program (DD Form 2570)
1.2	10 July 2009	Updated sections	Accounts Receivable Dental Services Durable Medical Equipment and Supplies Pre-Authorizations/Pre-Certifications Revenue Codes
		New section	DD7/DD7A Process
		Deleted section	Report on Program Results (DD Form 2570). This information is covered in Third Party Collection Program Report.
1.3	1 July 2011	Replaced section	Observation
1.4	13 January 2012	Changed Revision date	Appendix C1
		Replaced Instruction Manual with link to current version	Appendix C3
		Changed UB-92 to UB-04	Throughout User Guide
		Updated section title	Glossary & Definitions

Note: The date in the footer of each page reflects when any part of the guide was last reviewed or changed. The date that each individual guideline was reviewed appears below the title of that guideline. Reviewing and updating these guidelines is a continuous process. Titles of new sections are highlighted in yellow.

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OVERVIEW

Revised: 16 March 2009

1. Purpose. This User Guide provides functional guidance on data collection and billing procedures that influence business practices in military treatment facilities (MTFs).

2. Scope. This guide is intended to be used in conjunction with the references listed below and is designed to provide assistance to the Uniform Business Office (UBO) Staff, System Administrators, and other contractors.

3. References.

3.1. UBO Web site – http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm

3.2. DoD 6010.15-M, Military Treatment Facilities (MTF) UBO Manual, current version – http://www.tricare.mil/ocfo/_docs/New%20Manual%20v1%2020061.pdf

3.3. 32 Code of Federal Regulation (CFR), Part 220 – http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=8860360a3c4578a736fe3af3a528e698&tpl=/ecfrbrowse/Title32/32cfr220_main_02.tpl

3.4. Title 10, United States Code (USC) – http://uscode.house.gov/search/criteria.shtml

3.5. Third Party Outpatient Collection System (TPOCS) Users Guide, current 2005.doc versionhttps://ritpo.satx.disa.mil/skyline/login.asp?useflash=Y

3.6. Military Health System Coding Guidance: Professional Services and Outpatient Coding Guidelines, current version – http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm

3.7. OIB Implementation Update Guide (IUG), 2004 – https://fieldservices.saic.com/reports.asp?myID=34

3.8. Medical and Dental Rates Packages, http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm

3.9. Health Insurance Portability and Accountability Act (HIPAA) reference – http://www.cms.hhs.gov/hipaa, http://www.tricare.osd.mil/hipaa

3.10. DoD 6015.1-M, Glossary of Healthcare Terminology, current version, http://www.dtic.mil/whs/directives/corres/pdf/60151m_011399/p60151m.pdf

3.11. DoD FMR 700.14R (http://www.defenselink.mil/comptroller/fmr/), volumes 4, 5, and 7a

3.12. Medical Expense and Performance Reporting System http://www.meprs.info

4. Background

4.1. The Fiscal Year 2000 National Defense Authorization Act (NDAA) authorized DoD to change the methodology for reimbursement rates from "reasonable costs" to "reasonable charges." MTFs bill third party payers reasonable charges for professional and hospital services in accordance with 32 CFR, Part 220, Section 8(a)(5).

4.2. On 01 October 2002, the billing methodology for MTF reimbursable services and procedures moved from an all-inclusive rate to itemized billing for outpatient services. Each outpatient encounter, service, procedure, or supply provided is billed as a line-item charge.

4.2.1. The CHAMPUS Maximum Allowable Charge (CMAC) fee schedule is the basis for most professional outpatient MHS rates.

4.2.2. Other rates are developed based on Medical Expense & Performance Reporting System (MEPRS) and other government rate tables. These pricing structures affect Third Party Collection (TPC), Medical Service Accounts (MSA), and Medical Affirmative Claims (MAC) programs.

5. Parameters of Outpatient Itemized Billing (OIB)

5.1. Outpatient billable services include clinic encounters, ambulatory procedure visits (APVs), emergency department (ED) visits, observation visits, dental services, occasions of service, and internally and externally ordered ancillary services (laboratory, radiology and pharmacy). These services may be provided by MTF staff or may be purchased from outside the MHS.

5.2. All healthcare providers will document required information, based on current MHS guidelines, pertaining to the patient encounter, including services provided and procedures performed.

5.3. Healthcare services provided by residents and fellows are performed within the parameters of Graduate Medical Education (GME) guidance. For correct billing, the residents and fellows MUST have the correct HIPAA provider taxonomy code.

5.4. Billing an encounter usually requires at least one ICD-9-CM diagnosis code and one HCPCS/CPT code. “Pass-through” Bills most commonly used in billing DoD/VA Joint Venture encounters, may not always have a HCPCS/CPT code.

5.5. In general, CMAC prevailing rates are the basis for the MHS rates. There are some modifications for those services without a CMAC rate and for those procedures that, due to MHS computer system constraints, do not meet the commonly accepted meaning of the code. MHS-adjusted CMAC rates and MHS (or other appropriate agency) standard rate tables for Durable Medical Equipment/Durable Medical Supplies (DME/DMS), Pharmacy, Immunizations/Injectables, Anesthesia, Ambulance and Dental are used to calculate charges for procedures and services performed. Rates change periodically based on the effective date of a rate package.

5.6. HCPCS/CPT codes in the CMAC table are mapped to a CMAC Geographic Locality Rate table based on ZIP Code.

5.7. Modifiers are mapped to specific HCPCS/CPT codes.

5.8. Most providers are mapped to the CMAC Class of providers based on their medical specialty entered into CHCS. The CMAC Class usually only affects billable codes on the “CMAC” and “CMP” rate tables.

5.9. Billable charges are recorded as line items on medical claim forms (e.g.,UB-04, CMS 1500, Universal Claim Form (UCF), and American Dental Association (ADA) Claim Form) and billing forms (e.g., Invoice & Receipt (I&R) and DD7/7A).

5.10. The DD Form 7A, Part B, is used for DD7A billable Patient Categories (PATCAT) without other health insurance (OHI) or to bill the Service directly for the remaining balance after OHI payment is posted.

5.11. Depending on the patient’s category(PATCAT), procedures, and services are billed at 100% of the CMAC or MHS Standard rates (Full Outpatient Reimbursable Rate (FOR)). A government billing calculation factor (percentage discount) for billing outpatient International Military Education and Training (IMET) and Interagency and Other Federal Agency sponsored patients (IAR) rates will be applied to the line item charges calculated for outpatient medical and ancillary services using MHS or anesthesia charges.

HELPFUL LINKS

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*Note: These links may be accessed from this document by pressing CTRL + click (left mouse click over the link until you see the hand).

AHLTA (Armed Forces Health Longitudinal Technology Application): **http://www.ha.osd.mil/ahlta/**

Air Force Medicine: **http://airforcemedicine.afms.mil/**

Army Medicine: **http://www.armymedicine.army.mil/index.html**

Army Publishing Directorate (Army Regulations; DA, DD and SF Forms, etc.): **http://www.apd.army.mil/**

BUMED Instructions: **http://navymedicine.med.navy.mil/default.cfm?selTab=Directives**

DoD Comptroller: **http://www.dod.mil/comptroller/**

DoD Financial Management Regulations (FMR): **http://www.dod.mil/comptroller/fmr/**

DFAS Public Web Site: **http://www.dod.mil/dfas/**

DMIS ID Table: **http://www.dmisid.com/cgi-dmis/default**

Diagnosis Related Group (DRG) Weights: **http://www.tricare.osd.mil/drgrates/**

Embassy Web Sites: **http://embassy.org**

Federal Register: **http://www.gpoaccess.gov/nara/index.html**

Financial Management Service (Treasury): **http://www.fms.treas.gov/**

GSA Forms Library: **http://www.gsa.gov/Portal/gsa/ep/home.do?tabId=0**

Health Care for Foreign Forces and Their Dependents: **http://tricare.osd.mil/foreignforces/**

Navy Medicine: **http://navymedicine.med.navy.mil/**

Office of Management and Budget (OMB): **http://www.whitehouse.gov/omb/**

Reimbursable Rates: **http://www.dod.mil/comptroller/rates/index.html**

Reciprocal Health Care Agreements: **https://fhp.osd.mil/portal/rhas.jsp**

Security Assistance Web Site: **http://www.dsam.dsca.mil**

TRICARE Management Activity: **http://www.tricare.osd.mil/**

Uniform Business Office TMA: **http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm**

United States Code: **http://uscode.house.gov/**

United States Standard General Ledger (USSGL): **http://www.fms.treas.gov/ussgl/**

Veterans Affairs: **http://www.va.gov/**

ACCOUNTS RECEIVABLE

Revised: 01 July 2009

1. Uncollected bills (money owed to an organization by its customers) are called accounts receivable (A/R). In the finance world, accounts receivable are created at the time the service is provided. Because of Military Health System (MHS) billing system limitations and requirements, accounts receivable are created when a bill is generated, which may be up to 17 days after the service was provided.

2. For accounting guidance, refer to DoD Financial Management Regulation 7000.14R.

3. MSA (Medical Service Accounts).

3.1. Three types of bills generate A/R for the MSA.

3.1.1. Non-beneficiary bills, also known as civilian emergencies (CE) or private pay.

3.1.2. Insurance billings on behalf of the non-beneficiary/civilian emergency patient where the Military Treatment Facility (MTF) may bill the patient's insurance company for the care received. The non-beneficiary patient is responsible for all remaining balances; however, the non-beneficiary is ultimately financially responsible for the entire bill if the insurance company does not pay.

3.1.3. Federal agencies and departments, such as Veterans Affairs, Coast Guard, Public Health Service. In theory, other Federal entities should reimburse us at 100% when we bill at the Interagency rate (IAR). In reality, this does not usually occur.

3.1.3.1. Veterans Affairs (VA). Follow-up with the VA must be pursued aggressively to determine why payment has been delayed or reduced. Verify that the care provided was not covered under a separate sharing agreement that may have a different fee schedule.

3.1.3.2. Coast Guard. Verify that the Intra-Governmental Payment and Collection (IPAC) payment was received and posted correctly.

3.1.3.3. Public Health Service (PHS). As of the date of this revision, PHS may be contacted at 301-594-6750.

3.1.3.4. Other Federal entities. Contact the organization directly.

3.1.4. Foreign military, including Foreign Military Sales (FMS) and International Military Education and Training (IMET). No A/R should remain on either of these types of accounts. Bills should be paid in full from either the annual appropriation (IMET) or from the trust fund established for the specific FMS training. Per policy, dependents should arrive in country with medical insurance coverage, but they may also have other or additional instruction included on the invitational travel orders (ITO) to directly bill the country's embassy. If no payment is received, follow your Service-specific guidance on processing the bad debt.

3.1.5. Medicare CE (not a beneficiary of the MHS). If the Medicare fiscal intermediary (FI) is billed for the CE patient, the Medicare Explanation of Benefits (EOB) will indicate the cost shares that are the responsibility of the patient (any co-pay amounts or deductibles that have not been met or are non-covered services). Medicare billing is generated at the interagency rate (IAR). Generally, unpaid balances that are neither the responsibility of the FI nor the patient will be closed in the billing system using the transaction code and sales (source) code identified in your Service-specific guidance.

3.1.6. Medicaid. If the MTF chooses to participate in billing for Medicaid patients, they must have a current, signed agreement with their State. The agreement binds the MTF to accept the Medicaid payment as "payment in full," with no balance billing to the patient for any amounts not covered. State

Medicaid is billed at the full-reimbursable rate (FRR). Generally, unpaid balances that are neither the responsibility of the State nor the patient will be closed in the billing system using the transaction code and sales (source) code identified in your Service-specific guidance.

3.1.7. Elective cosmetic surgery. All elective cosmetic surgery procedures must be paid prior to scheduling the surgery (this includes active duty personnel). However, after the medical record is coded, additional procedures may surface that were not indicated on the initial estimate provided to the patient. If this occurs, a bill is produced, generating an A/R. The patient is billed on an Invoice and Receipt (I&R) statement; if this bill is not paid within 90 days, follow your Service-specific guidance for debt processing.

3.2. For accounting guidance and additional information regarding accounts receivable, refer to various volumes and chapters of the DoD Financial Management Regulation (DoD FMR) 7000.14-R (http://www.defenselink.mil/comptroller/fmr/).

3.3. Planned Changes. In the future, each Service's Enterprise Resource Planning (ERP) system will impact the way A/R is managed at the MTF. Interest and administration fees will be added for delinquent accounts and the debt collection processes will be significantly shortened. For more information, contact the Service MSA Program Manager.

4. Current Third Party Collections (TPC) Accounts.

4.1. Current Inpatient TPC Accounts.

4.1. There is a TPC A/R in CHCS for inpatient TPC accounts. When a hospitalization is coded, it is assigned a Diagnosis Related Group (DRG). The DRG has a relative weighted product that is multiplied by the Adjusted Standardized Amount (ASA) for that specific MTF. When the price is assigned, a UB-04 is produced. As payments come in and are posted (in the MSA module), the A/R is reduced. If the claim is not paid in full but was paid correctly, the account is closed manually using the correct write-off code, which reduces the A/R further. If the claim was not paid in full and was incorrectly discounted, follow Service-specific guidance.

4.1.1. TPC is on a "cash basis," meaning the A/R is not currently included in the Service accounting system. The Service accounting system finds out there was an A/R upon receipt and posting of the funds to the system. This will change in the future when the Standard Financial Information Structure (SFIS) and its associated Business Rules are finalized. SFIS is currently under development.

4.1.2. Usually, there are two line items on an inpatient bill. The bill contains both the professional services (doctor's visits, etc.) and the institutional component. For FY2006, the professional component is 7 percent of the entire bill. The institutional component is 93 percent of the bill. Usually, the revenue code (e.g., for the Blues) is 960, professional fees – general. Usually, for psychiatric professional care, the revenue code for the professional component is 961. Check in the 96x revenue codes to determine if there is a separate code for the specialty involved. For the institutional component, the revenue code is usually 100.

4.2. Current Outpatient TPC Accounts.

4.2.1. TPOCS claims may contain numerous line item charges for services rendered.

4.2.2. Posting and follow-up will require accounting for and reconciliation of multiple service line item charges.

4.2.3. Posting payments, adjustments, and write-offs are performed in an itemized fashion in TPOCS. If the claim is not paid in full but was paid correctly, the account is closed manually using the correct write-off code, which reduces the A/R further. If the claim was not paid in full and was incorrectly discounted, follow Service-specific guidance. Refer to the Itemized Posting section of this Guide for more information.

5. Outstanding Accounts. Any account outstanding past 30 days will be followed up in accordance with procedures prescribed in the DoD MTF UBO Manual, 6010.15-M.

6. Delinquent Accounts. TPC accounts outstanding beyond 180 days and MSA accounts outstanding beyond 90 days are considered delinquent. Refer to the DoD MTF UBO Manual, 6010.15-M, and Service-specific guidance for additional instructions.

AIR EVACUATION

Revised: 16 March 2009

When DoD's air evacuation system is used, the Global Patient Movement Requirements Center (GPMRC) creates the bill. For more information on this, contact HQ US Transcom/GPMRC; 505 Rimkus Drive Room 100; Scott AFB, IL 62225-5049.

2. See "Ambulance Services" for Air Ambulance billing guidance.

ALLERGY TESTING/ALLERGEN IMMUNOTHERAPY

Revised: 6 March 2006

1. Allergen immunotherapy is the administration of allergenic extracts at periodic intervals so individuals can be exposed to an allergen while avoiding an adverse reaction. It is a billable service when performed by a privileged provider. When the service is performed by a technician, it is not currently billable due to the issues associated with technician coding accuracy.

2. CPT codes for allergen immunotherapy include the professional services. There may be an Evaluation and Management (E/M) code for the first encounter as the allergist is obtaining the history and examination necessary to determine how to proceed. Except for the first encounter, the services are usually just the procedure and there is no separately identifiable E/M.

3. Allergy testing is not an ambulatory procedure visit. Patients should remain in the area for at least 20 minutes in case there is an allergic reaction, but this is not a "medically supervised recovery."

4. Allergy Testing CPT codes 95004-95078. These codes are for testing and are billable.

5. Allergen Immunotherapy CPT codes 95115-95199. For billing, there are two basic types of immunotherapy codes, one that includes the provision of the substance, and one that does not include the provision of the substance.

5.1. Allergen Immunotherapy CPT codes 95115-95117. These codes are for the desensitization injection only. They do not include provision of the substance. There are rates associated with these codes and the service should be billed.

5.2. Allergen Immunotherapy with Substance Provided CPT Codes 95120-95170. In the MHS, because patients frequently relocate, Walter Reed Army Medical Center (WRAMC) produces and furnishes allergens/substances. Otherwise, due to the variability in allergens/substances, every time a patient is treated in a new location, the desensitization might have to be repeated. WRAMC furnishes the allergens/substances to the MTFs. WRMC receives separate funding just for this service. WRMC does not bill the patient when furnishing the allergen/substance as it is not dispensing it to the patient, but is sending the allergen/substance to the MTF. The MTF where the allergen/substance is dispensed would use the appropriate code from the 95120-95170 series. The allergen is issued to a specific patient, kept in the clinic only for that patient's use, and administered in the clinic. Then for additional injections from the same vial, the allergy clinic will use the 95115-95117 codes.
NOTE: In the civilian sector, allergens/ substances are coded and billed when dispensed.

5.2.1. Codes 95120-95134. The TMA UBO is working with Walter Reed Army Medical Center to determine the average price of an allergen/substance. Until an average price can be determined, there are no prices for the 95120-95134 codes.

5.2.2. 95144-95170. These codes represent both the substance and the injections. Currently, the price of the substance is not included, but the price of the injection(s) is included.

6. The usual revenue code is 924 for those few codes the may map to the UB-04.

7. <u>Billing Form</u>: The allergy testing as well as the antigen dispensing appears on the CMS 1500.

AMBULANCE SERVICES

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1. Ambulance services are not part of the patient visit and will not be captured or coded on the same encounter as the emergency department (ED) visit or office visit.

2. Ambulance services provided to a patient for transportation to another facility for a service and returned to the hospital are not billed separately. This transport is part of the inpatient institutional encounter.

3. Identifying Billable Ambulance Services. The Billing Office can either check for coded encounters in MEPRS FEA or arrange to receive photocopies of ambulance transport sheets from the emergency department.

3.1. Billing for ambulance transport is applicable to both emergency and non-emergency transports. The next step is to determine whether the ambulance service is billable under the Third Party Collections Program (TPCP), Medical Services Accounts (MSA), or Medical Affirmative Claims (MAC).

3.2. When an ambulance service is determined to be billable, request that a coder determine and document (on the run sheet) the appropriate International Classification of Diseases, Ninth Edition, Clinical Module (ICD-9-CM) diagnosis code, Current Procedural Terminology (CPT) code, and modifiers to use for billing.

4. Generating the Bill. Ambulance service bills must be created manually. In the Third Party Outpatient Collections System (TPOCS), create the bill using Bill Type 4. For MSA, create an account and enter a one-time charge of the manually calculated appropriate rate.

4.1. Only HCPCS code A0999 has a DoD Rate assigned; however, claims with A0999 may be denied. On paper claims, manually change HCPCS code A0999 to the appropriate Ambulance HCPCS code documented on the run sheet.

4.2. The biller can select the appropriate modifier to identify location of onload and offload if the coder did not document it on the run sheet. The most common combination is SH.

D	Diagnostic or therapeutic site other than ‘P’ or ‘H’ when these codes are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician’s office (includes HMO non-hospital facility, clinic, etc)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician’s office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

4.3. MHS Ambulance Billing Units. Currently, MHS ambulance charges are based on hours of service in 15-minute increments. The hourly charge for Ambulance Services is all-inclusive. Supplies and mileage are not billed separately. Billing Offices will calculate the charges based on the number of hours, fractions of an hour, that the ambulance is logged out on a patient run. Fractions of an hour are rounded up to the next 15-minute increment (e.g., 31 minutes are charged as 45 minutes). Refer to the Medical and Dental Services Rate Package for appropriate fiscal year hourly charge. This rate package can be

found on both the TMA UBO Web site and the Comptroller Web site. TPOCS Bill Type 4 form will calculate the charges based on HCPCS Code A0999 and the minutes of service. Manually calculate the charges if creating a one-time charge account in the CHCS MSA billing module.

4.4. Revenue Code. Ambulance Services code A0999 is mapped to revenue code 540 on the revenue code mapping table.

4.5. Occurrence Code. If this transport is related to an injury/accident, use the appropriate occurrence code on the UB-04. Occurrence codes can be found in the Uniform Business Editor or in appendix B-1 of this document.

5. Purchased Services. When a facility purchases ambulance services from a non-DoD source, the cost of the purchased services can be billed instead of the DoD rate. Obtain this information from the Resource Management Division. TPOCS cannot be used to create this type of bill since TPOCS does not allow for changing/adjusting rates. Billing for the actual cost of purchased services requires either creating a “Passthrough” account in MSA or a bill created manually using a typewriter. If the services are purchased or contracted on a flat fee per month/year instead of per run, use the DoD rate.

6. Ambulance Responds but No Transport. When an ambulance is dispatched to an incident, but no patient is transported, there is no appropriate coding or billing for this service.

AMBULATORY DATA MODULE (ADM)

Revised: 7 March 2006

1. The ADM is the data collection module in CHCS for both inpatient and outpatient professional services. Data collected in AHLTA (the CHCS electronic documentation module for some outpatient encounters) flow to ADM. Data may be entered directly in the ADM, which is frequently the case for specialties not currently in AHLTA such as obstetrics, anesthesiology, and emergency medicine.

2. Inpatient Professional Services. Upon admission, transfer to another service and the census hour (i.e., 0015 each morning), an encounter will be generated in the ADM module. These uncoded encounters are not viewable by the provider in his open/uncoded encounter list.

2.1. It is intended that inpatient professional encounters will be coded by the inpatient coders at the same time the inpatient professional coding is entered in CHCS. This is because the documentation is kept in the inpatient record. All professional services where the provider's time is collected his time in the "A***" MEPRS are included in the MHS inpatient composite bill. Therefore, inpatient professional services shall not be billed separately if there is an inpatient institutional bill.

3. ADM data flow to the Coding Compliance Editor (CCE). CCE data flow to TPOCS.

4. Coders may correct coding in the ADM. To correct coding in AHLTA, the provider must amend the encounter in AHLTA.

AMBULATORY PROCEDURE VISITS

Revised: 7 March 2006

1. Overview. MTFs have incorrectly applied the APV to the 20 minute waiting period after an injection. Basically, if at the end of the procedure, the patient can respond to verbal or non-verbal stimuli (e.g., AARGH, the fire alarm, we need to leave) and the patient can exit the building under his own volition (e.g., let me grab my clothes and I'm out of here), it is *not* an APV.
NOTE: In the civilian sector, an ambulatory procedure visit (APV) is the same as a same-day-surgery. It is a procedure requiring post-operative medical care –the patient is not able to care for himself for a period after the procedure.

1.1. Pre- and post-operative appointments are documented in ADM as separate encounters.

1.2.1. For example, if the APV is planned in advance, the encounter when the decision for surgery is made and the encounter where the pre-operative physical is performed will be completed prior to the day of the surgery. These encounters would be coded and billed separately.

1.2.1. If the procedure is emergent (e.g., dislocation of the shoulder), the encounter with the decision for surgery may be the same day as the procedure, but will be coded with a modifier of "57" and will be billed separately from the procedure.

1.2.2. Post-operative care after discharge is also coded separately.

1.2.3. Uncomplicated follow-up is included as part of the procedure bill so there will be no separate bill for uncomplicated follow-up. There should *not* be a bill using 99024, Uncomplicated Follow-Up, since this code has no associated price. It does have relative value units (RVUs) for the MHS prospective payment system.

2. Components. The APV has three major components that are collected in the Ambulatory Data Module (ADM) in the B**5, B**7, C**5 MEPRS. These components are currently collected on the same ADM record. When this flows to TPOCS, the professional and anesthesia components will print out on a single CMS 1500. The institutional component, coded with the 99199, will print out on a UB-04. Depending on the insurer, you may be able to submit the bills as they are and be paid. Some insurers will not permit the surgical procedure and the anesthesia to be on the same CMS 1500. In that case, you will need to cancel the CMS 1500 and generate two separate CMS 1500s.
NOTE: In the civilian sector, components would be collected in three different areas and would generate three different bills.

2.1. Professional Component. This is the surgeon's portion. For non-emergent procedures, this is the review with the patient prior to the procedure (e.g., have there been any changes in your health since we did the pre-operative assessment yesterday), performing the procedure, and assessing/treating the patient until the patient is discharged and leaves.

2.1.1. The ADM record is coded under the name of the primary provider, usually a surgeon. This is the name of the provider which will appear on the CMS 1500. The anesthesia provider will be listed as an additional provider of the ADM record, but additional providers' names do not appear on the CMS 1500.

2.1.2. The provider's HIPAA taxonomy will indicate the provider is a surgeon. The procedure code(s) will usually start with a 1, 2, 3, 4, 5, or 6 because the CPT coding structure uses these numbers for invasive surgical procedures.

2.1.3. If the insurance company accepts both the anesthesia (it will start with the number 0) and the procedure on the same bill, submit the CMS 1500 as it is.

2.1.4. If the insurance company does not accept both the anesthesia and surgical procedure(s) on the same bill, billing personnel will need cancel the combined bill and manually generate separate CMS 1500s for the surgery/surgeon and for the anesthesia/Anesthesia provider.

2.2. Anesthesia Component.

2.2.1. Insurance companies usually look for the following on the CMS 1500 for anesthesia:

2.2.1.1. Name of the anesthesia provider, not the name of the surgeon.

2.2.1.2. A HIPAA taxonomy reflecting an anesthesiologist or Certified Registered Nurse Anesthetist.

2.2.1.3. An anesthesia code in the 00100-01999 range. All anesthesia codes start with "0." The anesthesia code will be related to the principal procedure. For instance, for a closed treatment of a shoulder dislocation, the anesthesia will be related to the shoulder. It is easily identifiable as it will be a CPT 00100-01999.

2.2.1.3.1. There may be a second, add-on anesthesia code in the ADM record if the procedure was a delivery that started as a vaginal delivery and converted to a Cesarean Section or if it is burn care in the ADM, but it will not appear on the bill. Billing personnel will not be aware of any anesthesia add-on codes as they will not appear on the original bill because they have no charge. If there had been a charge, then the patient would have been billed twice for the service.
NOTE: In the civilian sector, there would have been two separate charges.

2.2.1.3.2. There may be codes for qualifying circumstances for anesthesia in the ADM record. Currently, no pricing is associated with these codes, so they will not appear on the bill.

99100 Anesthesia for patient less than 1 yr or older than 70 yrs.
99116 Anesthesia complicated by use of total body hypothermia.
99135 Anesthesia complicated by use of controlled hypotension.
99140 Anesthesia complicated by emergency conditions (specify)

NOTE: In the civilian sector, these codes would be billed on the anesthesia bill.

2.2.1.4. The number of anesthesia minutes. This is not collected in the ADM record. Anesthesia minutes of service include the time before the surgical procedure begins when the patient is "put under" and time after the surgical procedure ends when the patient is in the recovery room. If an insurance company refuses to pay the claim even after you have explained that we currently do not bill based on minutes of services, but rather by flat rate and that the flat rate for anesthesia professional services is based on an average DoD cost of anesthesia services in all MTFs, request your APV coder or coding supervisor to obtain this information for you.

2.2.1.5. The name of the surgical procedure, with its associated code as well as the same post operative diagnosis as used by the surgeon on the surgeon's bill. A charge would be associated with the anesthesia code.

2.2.2. If the insurance company will not accept and pay for the anesthesia on the same CMS 1500 as the surgeon (under the surgeon's name), then billing personnel will need to manually generate a bill for just the anesthesia provider. This bill should reflect the anesthesia provider's name and HIPAA taxonomy code. The bill will reflect the flat rate of the anesthesia.

2.3. Institutional component. In TPOCS, when an APV is coded with the code 99199, a UB-04 will be generated. In the MHS, because each code can only have one rate, we cannot have multiple prices for various levels of institutional services. The UBO has been blocked in its attempts to use non-standard numbers to collect data necessary for billing, so we cannot even collect the standard 8 levels of Ambulatory Surgery Center institutional care. The 99199 is a flat fee to include nursing and technician services until the patient is discharged, the supplies and equipment used, and facility costs.

NOTE: The civilian sector uses the same CPT code as the professional and institutional component, each with its own price.

2.3. There may be additional laboratory or radiology procedures which will also appear on the institutional bill. The name of the surgeon will be the only name on the bill, even if a radiologist reviewed any diagnostic imaging studies or if a pathologist reviewed frozen sections to ensure the margins around a neoplasm contain only healthy cells. The surgeon's name and HIPAA taxonomy will be on the bill because the 99199 is coded on the surgeon's SADR, which generated the bill.

3. An APV patient will remain in APV status until the patient is either released or admitted as an inpatient, regardless of where the patient is physically located within the facility.

4. APV patients cannot be converted to observation. The APV includes all post-surgical services until the patient is discharged, regardless of where the patient is physically located or if the staff belong to an area which is not the operating room. The MTF receives full credit for the entire episode as an APV.

5. If a patient is admitted from an APV (for instance the surgery begins and is converted to a more complicated procedure requiring hospitalization), the ADM record should be closed out with a disposition type of "admitted." The admitting diagnosis should be the same or similar diagnosis as the diagnosis for the APV (e.g., APV pre-operative diagnosis of "mass" and a much larger surgical procedure is identified when the "mass" is exposed).

5.1. Do not generate an APV bill. When the APV becomes a hospitalization, the resources of the APV become accountable in the relative weighted product (RWP) of the DRG. The professional services are included in the adjusted standardized amount (ASA) calculation. The hospital bill is the product of the ASA multiplied by the RWP. *Note: For MSA go into CHCS and exclude these charges.

5.2. If the patient is admitted due to post surgical complications such as extreme nausea, and the admitting diagnosis has nothing to do with the APV pre-operative diagnosis, then the APV is not cancelled, but is billed as the APV. There will be a separate bill for the hospitalization.

6. If a patient presents for an APV, but the APV is not performed and no patient contact or intervention is performed, then the encounter is cancelled and no claim is submitted.

7. If patient intervention is performed and the APV procedure is cancelled, the encounter will include the appropriate V64.X ICD-9-CM diagnosis code for aborted or discontinued procedures, along with the primary ICD-9-CM diagnosis code.

7.1. Modifier -53 (Discontinued Procedure) can be used under certain circumstances when the physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well-being of the patient. When using this modifier, add the modifier -53 to the CPT code reported by the physician for the discontinued procedure (e.g., CPT code 74400-53).

7.1.1. Modifier -53 is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. It can be used when it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued following anesthesia administration.

8. If two or more surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by each creating a separate ADM and coding the component of service he did and using the modifier "62."

8.1. For example, in brain surgery, there may be three surgeons (and three APVs) involved. One surgeon will remove a portion of the skull. The brain surgeon will perform the brain surgery. The third surgeon will close the opening and make it as cosmetically attractive as possible. Since there is only one surgery, the primary surgeon will be the only ADM with the additional anesthesia and institutional codes.

The other two surgeons will only have the professional component that will be able to bill without intervention by billing personnel. There will still only be one anesthesia and one institutional bill.

8.2. Assistant Surgeons. An assistant surgeon will need to be a separate ADM. Currently there is an edit in ADM that will not permit the same code to be entered twice. The assistant surgeon's ADM will not have the anesthesia or institutional codes.

9. Modifier -62 will generate an additional line item charge in MSA on both the I&R and DD7A.

10. The billing office should not see bills with modifier "73" (Discontinued Outpatient Procedure Prior to Anesthesia Administration) and modifier "74" (Discontinued Outpatient After Anesthesia Administration) as these are institutional modifiers and the 99199 is a flat rate code. If there was a procedure, the entire 99199 fee will be charged.

11. Surgery CPT codes: 10021–69990. Many of these procedures use topical anesthesia or conscious sedation, so they will not all be automatically APVs.

12. Revenue Codes. APVs usually will be mapped to:

360 – Operating Room Service – General
361 – Operating Room Service – Minor Surgery
490 – Ambulatory Surgical Care – General
481 – Cardiac Cath Lab.

13. Nourishment during the APV. Check with your Service Representative. As the APV patient is an outpatient, there is no subsistence charge. The APV rate does not include any meals in the dining hall or food trays ordered/delivered to the patient. Just as an outpatient waiting to be seen in a clinic or the Emergency Department would not expect to have a meal served free of charge, the APV patient should not expect free meal service. TPC and MSA billing clerks will not be involved in collecting/billing for meals for APV patients.

ANCILLARY LINKING AND HOLD PERIODS

Revised: 7 March 2006

1. The only time a diagnosis will automatically be linked to a laboratory, radiology or prescription, is when the laboratory test, radiology study, or prescription was ordered in CHCS in conjunction with an outpatient encounter. When the Ordering Provider selects the clinical encounter that relates to the ordered ancillary, both the clinical encounter and the ancillary service are assigned a matching Appointment Internal Entry Number (IEN). This Appointment IEN is then used to match the two encounters once transmitted to TPOCS, during which time the diagnosis code from the clinical encounter is shared with the ancillary service. Note: The LAB, RAD, and PHR sub-systems within CHCS do not have a field to capture the diagnosis code. System Change Requests (SCRs) were submitted requesting this additional field. NOTE: Linking ancillary procedures to diagnoses from the outpatient encounter only applies to TPOCS billing. The diagnosis does not appear on the Invoice and Receipt, the DD7, the DD7A, or the MSA generated UB-04 for inpatient TPC billing.

2. Ancillary services bills are associated with an ADM encounter bills in one of two ways:

2.1. Imposing mandatory Hold Periods after records are transmitted to TPOCS. All encounter and ancillary data is held in a TPOCS suspense file, during which time the system will attempt to match the ancillary to the visit based on Treating DMIS ID, Patient ID, Date of Service, Requesting Location, and Ordering Provider. If all of the criteria match, TPOCS will link the ancillary service to the ADM encounter.

2.1.1. If the ADM encounter is linked, this will result in the ICD-9-CM diagnosis code from the ADM encounter being reported properly. Note: Currently, when the ancillary service is linked with the ADM encounter, the date and provider of the outpatient encounter are reported for all procedures. This could be incorrect when billing a radiology study that was interpreted five days after the outpatient encounter by a radiologist. This could result in an invalid claim, as usually insurers do not expect family practice providers billing for interpretations of CT scans of the cardiovascular system. In addition, sometimes the first listed diagnosis is not the diagnosis which should be linked to the ancillary test/study/prescription. Attention to appropriate diagnosis code and procedure code links is required to ensure that a potentially invalid claim is corrected before submission.

2.1.2. Billing Office personnel may review the associated diagnoses and link a diagnosis to the procedure. Staff may not input a diagnosis which was not in the Ambulatory Data Module (ADM) record. Staff may “unlink” a diagnosis.

2.2. If an ancillary service cannot be linked, the data is processed as a stand-alone service. An ICD-9-CM diagnosis code will NOT be automatically included on the claim. Manual review is required for claims without an associated ICD-9-CM code.

2.2.1. Any identified LAB or RAD claim without an ICD-9 diagnosis should not be billed until the appropriate diagnosis is matched to the service. This usually involves reviewing the documentation that caused the LAB or RAD to be ordered.

2.2.2. An ICD-9 diagnosis code is required on a UB-04. It is not required on a UCF unless the medication dispensed is a controlled substance.

3. Externally Ordered Ancillary Services. Because there is no outpatient encounter at the MTF to link to externally-ordered ancillary services, an ICD-9-CM diagnosis will not automatically be associated with the ancillary service. Therefore, no ICD-9-CM diagnosis code will transmit to TPOCS. An ICD-9-CM diagnosis code must be entered manually into TPOCS in order to complete the claim. Obtaining the correct diagnosis may involve contacting the civilian provider who ordered the service.

4. ADM records are no longer rejected if a linked ancillary comes to TPOCS first. It used to be that if an ancillary service that had been linked in CHCS to an ADM encounter entered TPOCS first (ADM encounter not completed within three days), TPOCS rejected the ADM encounter. This was because TPOCS was programmed to receive ADM encounters prior to ancillary encounters and not in the reverse manner to avoid duplicate billing.

4.1. It is still good practice to ensure that ADM encounters are coded as soon as possible. There is an MHS policy that outpatient encounters should be coded within 72 hours of the encounter. For APVs and excisions of lesions in the office, this may be slightly delayed to ensure the laboratory results are back so the excisions can be correctly coded as benign or malignant.
NOTE: This applies to both TPOCS billing (for patients with OHI) and MSA billing (for patients with PATCATs that generate MSA bills such as civilian emergency and interagency).

5. Hold Periods. Hold periods have nothing to do with diagnoses. Hold periods are the amount of days a bill will remain in "limbo" until it prints out or is sent electronically. Hold periods are in place to consolidate bills.

5.1. In CHCS, a 3-day hold period is standard for all eligible ADM, LAB, RAD, and PHR records. This 3-day hold can be very useful.

5.2. All DD Form 2569s should be collected and entered daily. Because of the 3-day hold, if OHI is identified at an encounter, it permits the MTF to verify and enter the data to have the encounter automatically flow to the billing system.

5.3. Pre-certifications/Pre-authorizations. The 3 days can also be used to obtain pre-certifications and pre-authorizations. Billing personnel should work with radiology, pharmacy, and the operating room. If billing personnel can receive a list of all patients receiving MRIs and CTs, high cost pharmaceuticals and having APVs, the lists can be checked to identify patients with OHI. Pre-certifications can then be obtained prior to the bill flowing to the billing system.

5.4. At the end of the 3-day hold period, MSA encounters are transmitted to the MSA billing module in CHCS. TPC encounters that have been associated with other health insurance (OHI) are transmitted to TPOCS at the end of the 3-day hold period.

6. MSA hold period. An additional 14-day hold period is imposed to allow for the finalization of associated services and to allow for appending and excluding charges as necessary. All MSA services performed on the same date of service for the same patient are printed on the same I&R.

7. TPOCS hold periods.

7.1. ADM, LAB, and RAD Services – The hold period for laboratory and radiology is a site parameter from 7 to 99 days. Usually a 7-day hold (in addition to the 3 days to flow to TPOCS) period is imposed on ADM and LAB/RAD services to: 1) allow for the finalization of associated services; 2) reduce the number of claim forms produced; 3) receive automated updates from the ADM, LAB, and RAD sub-systems in CHCS; and 4) associate an ICD-9-CM diagnosis code from the corresponding ADM encounter to the ancillary service.

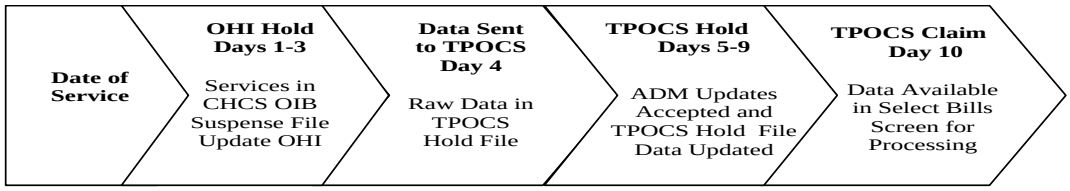
7. 2. ADM and LAB/RAD bills are not usually printed on the same bill as usually ADM encounters (e.g., office visits) are printed on a CMS 1500 and the laboratory and radiology bills are on the UB-04. The laboratory and radiology bills "pull" the diagnosis from the ADM encounter.

7.2. PHR (Pharmacy) Services - An additional 14-day hold period is imposed on PHR services to allow for medications to be picked up by the patient.

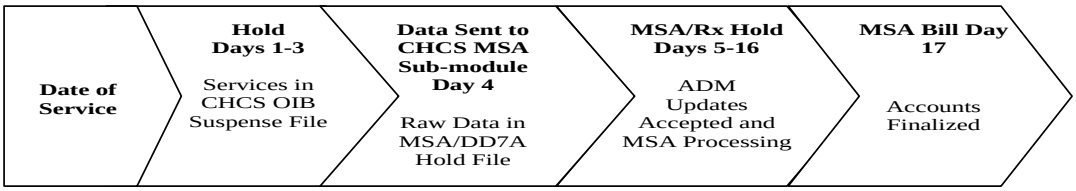
7.2.1. Note: The date of service for pharmacy services is the date the label was printed; however, the transaction cannot be closed until the medication is picked up. Even if PHR services have a

corresponding ADM encounter, all services will default to a Pharmacy Bill Type, and will display the associated ICD-9-CM diagnosis code of the ADM encounter. If the medication is not picked up, it is the responsibility of the MTF pharmacy to re-stock the supply, and clear out the claim in TPOCS prior to the 14th day when the bill will release.

Billing Cycle Timeline for TPC



Billing Cycle Timeline for MSA



ANESTHESIA PROVIDER SERVICES

Revised: 6 March 2006

1. See the APV Section of this Guide for billing anesthesia services in the 0XXXX range associated with an APV. The codes in the 0XXXX range include the initial anesthesia consult prior to the surgical procedure, the anesthesia provided during the surgical procedure, and anesthesia care provided post operatively until care for the patient is transferred to the nurse in the post anesthesia care unit. Separately codable procedures not in the 0XXXX range performed during an APV will be billed on a separate CMS 1500 from the surgeon.

1.1. For outpatient anesthesia services in non-MTFs (e.g., external resource sharing), the anesthesia will be billed on a CMS 1500 at the anesthesia rate.

2. Services provided by anesthesia personnel that are not in the 0xxxx range should be billed on a separate CMS 1500. For instance, when anesthesia personnel are providing outpatient pain management services, the services would be coded in the anesthesia provider's name in the "B" MEPRS.

3. Inpatient Anesthesia Services. Inpatient anesthesia services are part of the Adjusted Standardized Amount and will not be billed separately. Inpatient post-operative pain management is part of the surgeon's responsibility and would not be furnished by anesthesia personnel unless there was a written request in the inpatient record.

3.1. For inpatient anesthesia services in non-MTFs (e.g., if the MHS furnishes anesthesia at a civilian hospital under a external resource sharing agreement), the anesthesia services are included in the professional component percentage (For FY2006, it is 7 percent). The surgeon's and anesthesia provider's services would be itemized on the CMS 1500 without itemized pricing, and a final line indicating "Inpatient Professional Services for DRG ___," and the professional component price.

ANTEPARTUM/OUTPATIENT OBSTETRICAL SERVICES

Revised: 7 March 2006

1. 0500, 0501F, 0502F, and 0503F do not have rates.

2. MHS inpatient obstetrical (OB) services diagnosis related groups (DRGs) do not include antepartum or postpartum care.

3. The MHS does not bill for antepartum care until after the patient has delivered.

4. Work with your systems personnel to generate a monthly ad hoc that reports:

4.1. Patient name;

4.2. All encounters with 0500F – initial prenatal care visit, 0501F – prenatal flow sheet documented in the medical record by first prenatal visit, 0502F – subsequent prenatal care visit, 0503F – postpartum care visit, 59430 – postpartum care only;

4.3. Date of patient's last menstrual period (LMP).

5. When you see a patient with a 0503F or 59430, there is an outcome of pregnancy.

5.1. In those instances where the patient does not deliver at your facility or changes location of antepartum care, you will not see an encounter with 0503F or 59430. Coordinate with coding staff to determine when it would be appropriate to submit the antepartum bill (e.g., nine months after the 0500F or 0501F encounter).

5.2. To produce a bill, identify all encounters for each patient that is coded with 0500F, 0501F, and 0502F.

6. CPT codes 59425, 59426, and 59430 are called "clump codes." The encounter coded with 59430 has a rate and will generate a billable encounter.

6.1. Provide this information to coding staff, requesting that they identify which provider should appear on the bill and which clump code should be billed:

6.1.1. 4-6 encounters, 59425

6.1.2. 7 or more encounters, 59426

6.2. Create a manual bill in either TPOCS or the MSA module of CHCS.

6.3. These clump codes are mapped to the CMS 1500 in TPOCS.

6.4. If the patient was seen for fewer than four encounters, ask coding staff to re-code these encounters based on documentation for regular E&M codes.

6.4.1. Create manual bills in either TPOCS or the MSA module of CHCS based on these E&M codes.

6.4.2. These E&M codes are mapped to the CMS 1500 in TPOCS.

BILLABLE ENCOUNTERS

Revised: 6 March 2006

1. Ability to bill is based on a number of issues ranging from what happened to the patient (documentation), to who performed the service (provider), to whether the patient was eligible to bill (PATCAT), to the patient's status (hospitalized or not hospitalized, MEPRS).

2. Documentation. Documentation must reflect the services performed and by whom.

3. Provider.

3.1. Provider Specialty Code (PSC). The provider specialty code is unique to the Military Health System (MHS). It is similar to the HIPAA Provider Taxonomy. The codes range from 000-999. Codes from 000-901 excluding 900 (technicians) will feed to the TPOCS and MSA billing. Provider specialty code 900 is blocked, since there continue to be significant issues with the correctness of technician coding.

3.1.1. Occasionally, there remain issues with providers incorrectly being assigned a clinic provider specialty code instead of an individual provider specialty code. For instance, 702 is clinical psychologist while 954 is psychology (the clinic). The clinic provider specialty codes are for making appointments, not for individuals. When a prescription is filled, it should be filled against an individual's specialty, such as 001 family practice physician, not against 999 unknown or any of the clinic codes between 910 and 999.

3.2. Health Insurance Portability and Accountability and Accountability Act (HIPAA) Provider Taxonomy. See separate section in this Guide.

3.3. National Provider Identifier (NPI). .

3.4. CMAC Provider Category. In the MHS, the CMAC Provider Category impacts the dollar amount on the bill.
NOTE: In the civilian sector, a grouping similar to this is used to determine the level of billing. For instance, some insurers pay 100% for levels 1 and 2, and 75% or 66% for level 3 and 4.

3.4.1. Level 1 – Physicians (M.D., or D.O.) and Dentists (D.D.S.)

3.4.2. Level 2 – Psychologists

3.4.3. Level 3 – Other Mental Health Providers (e.g., clinical social workers, mental health nurse practitioners)

3.4.4. Level 4 – Other.

3.4.4.1. Examples of privileged "other" providers: nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), nurse midwives, physician assistants (PAs), optometrists, podiatrists, chiropractors, physical and occupational therapists, speech therapists, dieticians.

3.4.4.2. Examples of non-privileged "other" providers: nurses (not advanced practice nurses who are privileged providers), technicians and medical students.

3.4.4.3. Some individuals have limited privileges in certain circumstances, such as residents, independent duty corpsmen (IDC) and independent duty medical technicians (IDMT).

4. PATCAT. Refer to UBO Web site http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm

5. Medical Expense and Performance Reporting System (MEPRS). MEPRS is unique to the MHS. It is the system used by the MHS to collect resources used, including time, in specific categories. In general, MEPRS is split into five major categories, A*** inpatient, B*** outpatient clinics, C*** outpatient dental, D*** ancillary (both inpatient and outpatient), E*** administrative, F*** special programs (e.g., hearing conservation, immunizations, services performed outside of the MTF to which an individual is assigned) and G*** military related.

5.1. A***. Currently, both professional and institutional as well as laboratory and radiology services are included in the inpatient bill. The inpatient bill is generated based on the diagnosis related group (DRG). A DRG reflects the reason for the hospitalization and procedures done during the hospitalization. Each DRG has a relative weighted product (RWP). The RWP relates to the amount of resources (e.g., nursing and technician time, supplies, facility costs) usually used in providing patient care. In the MHS, an adjusted standardized amount (ASA) is calculated for each specific MTF. The ASA includes the professional as well as the institutional costs. The ASA is the cost of generating one RWP. To determine the bill, the relative weighted product is multiplied by the adjusted standardized amount.

5.1.1. When inpatient professional services are consistently and correctly collected in the ambulatory data module (ADM) in the A*** MEPRS, the MHS will begin to transition to separately billing inpatient professional and inpatient institutional services.

5.2. B***. Most outpatient clinic services, as well as ambulatory procedure visits and observation, are collected in the ADM or AHLTA, which feeds the coded data to the ADM. Most B*** MEPRS are billable when there is documentation, the service is billable and it was performed by a provider with a provider specialty code of 000-901, excluding 900. The billing feed for B*** comes from the ADM.

5.2.1. AHLTA is not a coding program. It is a documentation program. AHLTA is useful to identify a group of symptoms for early identification of a chemical or biological episode. AHLTA coded data flow into the ADM.

5.2.2. Laboratory Tests. There are some Clinical Laboratory Improvement Act (CLIA) waived tests performed and interpreted in the clinics. These will feed to billing in the feed from the ADM.

5.2.3. Ultrasound. There are some ultrasound studies performed and interpreted in a clinic, particularly in an obstetrical clinic. These will feed to billing in the feed from the ADM.

5.3. C***. Some dental procedures are billable.

5.4. D***. Many D*** MEPRS services are billable.

5.4.1. DA**. Pharmacy. The pharmacy feed does not come from the ADM. There is a separate pharmacy feed.

5.4.2. DB**. Laboratory/Pathology. Other than the CLIA waived tests performed and interpreted in a clinic, laboratory and pathology billing data feed from the laboratory module in CHCS.

5.4.2.1. Some larger MTFs have a laboratory system called CO-PATH. This is not the CHCS laboratory module. Most MTFs with CO-PATH need to manually bill for procedures documented in CO-PATH.

5.4.3. DC**. Diagnostic Imaging (Radiology). Other than the few ultrasound studies performed in a clinic, diagnostic imaging billing data feed from the radiology module in CHCS.

5.4.4. Other D*** Activities. There are a number of other billable services performed in D*** activities. Examples include EKGs, EEG, and treadmills. As long as these do not feed to the billing system, they will have to be identified manually and manual bills generated.

5.5. F***. There are many billable activities in the Special Programs, such as immunizations and inpatient professional services furnished to patients in non-MHS hospitals. Ambulance services are collected in FEA* and should be manually billed.

6. Billable *Outpatient* Clinic Work Centers. Remember, not all procedures are billable. Coding is performed for many purposes, not just billing. The following table lists billable Outpatient Work Centers in which billable encounters will automatically flow to TPOCS if all other requirements are met. You will be able to see billable encounters in all of the attached MEPRS. To permit billing, you must ensure the MEPRS is listed in the TPOCS clinic table under "table maintenance." For example, if you want oncology bills to generate, "BAM" must be listed in your TPOCS clinic table. For certain MEPRS, it will be extremely infrequent for a coded encounter to be billable through TPC; however, they could be billable through MAC. The most common example of this is MEPRS "BHGA," Occupational Health. Most MTFs do not have BHGA listed on the MEPRS table, but they want to be able to see it, because it could be billable under MAC. If, for some reason, you do not want the bills to automatically generate for a given MEPRS, do not include the MEPRS in the list of billable MEPRS in your TPOCS.

Billable Outpatient Services

MEPRS Code	Functional Cost Code (Clinical Service) Description	MEPRS Code	Functional Cost Code (Clinical Service) Description
BAA	Internal Medicine	BCA	Family Planning
BAB	Allergy	BCB	Gynecology
BAC	Cardiology	BCC	Obstetrics
BAE	Diabetic	BCD	Breast Cancer
BAF	Endocrinology	BDA	Pediatric
BAG	Gastroenterology	BDB	Adolescent
BAH	Hematology	BDC	Well-Baby
BAI	Hypertension	BEA	Orthopedic
BAJ	Nephrology	BEB	Cast
BAK	Neurology	BEC	Hand Surgery
BAL	Outpatient Nutrition	BEE	Orthotic Laboratory
BAM	Oncology	BEF	Podiatry
BAN	Pulmonary Disease	BEZ	Chiropractic
BAO	Rheumatology	BFA	Psychiatry
BAP	Dermatology	BFB	Psychology
BAQ	Infectious Disease	BFC	Child Guidance
BAR	Physical Medicine	BFD	Mental Health
BAS	Radiation Therapy	BFE	Social Work
BAT	Bone Marrow Transplant	BFF	Substance Abuse
BAU	Genetic	BGA	Family Practice
BAV	Hyperbaric Medicine	BHA	Primary Care
BBA	General Surgery	BHB	Medical Examination
BBB	Cardiovascular and Thoracic Surgery	BHC	Optometry
BBC	Neurosurgery	BHD	Audiology
BBD	Ophthalmology	BHE	Speech Pathology
BBE	Organ Transplant	BHF	Community Health
BBF	Otolaryngology	BHG	Occupational Health
BBG	Plastic Surgery	BHH	TRICARE Outpatient

MEPRS Code	Functional Cost Code (Clinical Service) Description	MEPRS Code	Functional Cost Code (Clinical Service) Description
BBH	Proctology	BHI	Immediate Care
BBI	Urology	BIA	Emergency Medical
BBJ	Pediatric Surgery	BJA	Flight Medicine
BBK	Peripheral Vascular Surgery	BKA	Underseas Medicine
BBL	Pain Management	BLA	Physical Therapy
BBM	Vascular and Interventional Radiology	BLB	Occupational Therapy
BBZ	Burn Clinic		

The following table lists other billable Outpatient Work Centers:

Other Billable Outpatient Work Centers

MEPRS Code	Functional Cost Code (Clinical Service) Description	MEPRS Code	Functional Cost Code (Clinical Service) Description
CAA	Dental Care	CBA	Dental Laboratory
DAA	Pharmacy	DBF	Biochemical Genetic Laboratory
DBA	Clinical Pathology	DCA	Diagnostic Radiology
DBB	Anatomical Pathology	FBI	Immunizations
DBD	Cytogenetic Laboratory	FBN	Hearing Conservation Program (MSA Billing Only)
DBE	Molecular Genetic Laboratory	FEA	Patient Transportation (Ambulance Services)
FC	Healthcare Services Support: Laboratory, Radiology, Pharmacy and Other Services provided or purchased by an MTF in response to requests from an External Civilian healthcare provider, another MTF, or another Federal healthcare provider, except in cases where there is a specific VA/DoD MOU which covers the services. NOTE: Dental Care and Dental Laboratory added for consistency with Business Rules related to Dental Services		

The following table lists billable services which must be manually billed.

MEPRS Code	Clinical Service	MEPRS Code	Clinical Service
DDA	Electrocardiography	DGB	Hemodialysis
DDB	Electroencephalography	DGD	Peritoneal Dialysis
DDC	Electroneuromyography	DGE	Ambulatory Nursing (Chemo)
DDD	Pulmonary Function	DHA	Inhalation and Respiratory Therapy
DDE	Cardiac Catheterization	DIA	Nuclear Medicine

BILLING COMBINED MEDICALLY NECESSARY/COSMETIC PROCEDURE WHEN A PORTION OF THE PROCEDURE IS COVERED BY INSURANCE

Revised: 9 March 2006

1. The total procedure will be composed of:

1.1. Medically necessary professional component

1.2. Cosmetic professional component

1.3. Institutional and anesthesia (I&A) components

NOTE: The patient is totally responsible for the I&A, but the insurer may pay some of the I&A as part of the medically necessary procedure. There are two different types of funds involved, third party and MSA.

2. The MHS is moving from flat rate institutional and anesthesia (I&A) billing for ambulatory procedure visits (APVs) to fee-for-service for institutional and anesthesia for APVs. MHS current cosmetic procedure billing is similar to fee-for-service. The current Third Party Collections is a flat rate for institutional and anesthesia.

3. Professional Components. The medically necessary *professional* component will be paid by the insurance company. The cosmetic *professional* component will be paid by the patient.

4. Institutional and Anesthesia (I&A) Components. Both entities are responsible for the I&A components, but the MTF needs to recover the I&A costs just once. The patient is ultimately responsible for the entire cost of the *cosmetic* procedure (e.g., professional, institutional, anesthesia, implants).

5. Steps to Determine the Institutional and Anesthesia (I&A) Amounts Due From the Insurance Company and the Patient.

5.1. Calculate the I&A cost for both the medically necessary procedure covered by the insurance company and the cosmetic procedure.

5.1.1. Example: A patient is having a bilateral blepharoplasty, *upper* eyelid; with excessive skin (CPT code 15823), which is covered by insurance as it is medically necessary. During the same APV, the patient will also have a cosmetic bilateral blepharoplasty, *lower* eyelid, with excessive skin (CPT code 15821). It will be performed in a bedded MTF in the operating room with general anesthesia.
NOTE: Be sure to obtain a pre-authorization for the medically necessary procedure from the insurance company.

5.1.1.1. The I&A components for the medically necessary (*insurance pays*) procedure in a bedded MTF operating room will be:

Institutional (MHS CPT 99199) flat rate = $819.18
Anesthesia MHS flat rate = $749.00
Insurance I&A Total = $1,568.18

5.1.1.2. The I&A components for the cosmetic (*patient pays*) procedure, in a bedded MTF operating room, will be:

CPT 15821 Institutional in bedded OR = $875.01
CPT 15821 Anesthesia = $236.99
Patient I&A Total = $1,112.00.

5.2. The institutional/anesthesia "MTF I&A Amount to be Collected" will be the higher of the two amounts.

5.2.1. Example: In the above example, the medically necessary procedure has the higher I&A total cost so that will be the MTF I&A *amount to be collected*.

MTF I&A AMOUNT TO BE COLLECTED: $1,568.18.

5.3. The patient must pay for the total cosmetic procedure in advance. Therefore, the patient will pay the professional, I&A and implant fees of the cosmetic procedure in advance.

5.3.1. Example: CPT 15821 Professional fee (first eye $449.73 + bilateral $224.87) = $674.60
CPT 15821 I&A (CPT 15821 Institutional + CPT 15821 Anesthesia) in bedded operating room = $875.01+ $236.99 = $1,112.00
CPT 15821 Implants = $0
Patient Will Pay Total In Advance: $1,786.60

5.4. Insurance will be billed:

5.4.1. Example: CPT15823 Professional fee (first eye 529.37 + bilateral $264.69) = $794.06 on the CMS 1500
Institutional (MHS CPT 99199) flat rate = $819.18 on the UB-04
Anesthesia flat rate= $749.00 on the CMS 1500
Bills to insurance company will total: $2362.24

5.5. Remittance will be received from the insurance company. The professional fee for the surgeon will be posted. The remittance from the institutional and anesthesia (I&A) portions will be added together. Subtract the institutional and anesthesia portions from the MTF I&A Amount to be Collected determined in step 5.2.1.

5.5.5. Example: Because the patient needed to satisfy the annual deductible of $500, the insurance company remitted $768.18 for the institutional component and $300 for the anesthesia component, for a total of $1,068.18. The MTF Amount to be Collected is $1,568.18 from step 5.2.1. The insurance company reimbursement is less than the MTF I&A Amount to be Collected by $500.
NOTE: (Insurance institutional and anesthesia remittance + patient institutional and anesthesia payment) – MTF I&A Amount to be Collected = amount due back to patient.

5.6. Determine if the I&A component paid by the patient for the cosmetic procedure is more than or less than the amount necessary to meet the MTF I&A Amount to be Collected.

5.6.1 When the total of the amounts received for I&A (from both insurance company and patient) exceed the MTF I&A Amount to be Collected, the patient will be refunded the overage.

5.6.1.1. Example: For the institutional and anesthesia, the patient had paid $1,112.00. As the MTF only needs $500 to meet the MTF I&A Amount to be Collected of $1,568.18, the MTF will refund the patient $612.00.

5.6.2. If the I&A payments combined are less than is necessary to meet the MTF I&A Amount to be Collected there will be no refund to the patient.

5.6.2.1. Example: The I&A payments exceed the MTF I&A Amount to be Collected, so this step does not apply.

6. MSA and TPOCS Instructions.

6.1. Generate the patient's bill using the amounts calculated by the Cosmetic Surgery Estimator tool.

6.1.1. Enter the amounts in MSA.

6.1.2. Collect the total amount from the patient.

6.2. TPOCS will generate a bill for the insurance company. Send the bill. Post the funds received.

6.3. If the total I&A received (from insurer and patient combined) exceeds the MTF I&A Amount to be Collected,

6.3.1. Go in to the original MSA account for the surgery.

6.3.2. Generate a One-Time Charge for the new institutional amount ($263.01, see below calculations).

6.3.3. Back out the original amount for the institutional ($875.01).

6.3.4. This should create a credit balance ($612.00). When you get the credit balance you will be given a notify message that a refund is due on the account. And you can produce the SF 1049 Public Voucher for Refund.

6.3.5. Refund the amount to the patient.

7. Calculations for updating the original MSA Bill.

7.1. MTF I&A Amount to be Collected = $1,568.18

7.2. Insurance company I&A remitted $1,068.18 ($ 768.18 for the institutional and $300 for the anesthesia)

7.3. Patient originally I&A paid $1,112.00 ($875.01 for the institutional and $236.99 for the anesthesia)

7.4. New I&A amount owed by patient ($1,568.18 - $1,068.18) = $500.00

7.5. Excess Remittance ($1,068.18 + $1,112.00) - $1,568.18 = $612.00

7.6. New I&A amount owed by patient to be entered in MSA module $875.01 – $612.00 = $263.01 for the institutional.

7.7. Leave the anesthesia bill in MSA as it was originally ($236.99). This is just easier than trying to adjust both the anesthesia and institutional bills.

BUNDLING/UNBUNDLING SERVICES

Revised: 8 March 2006

1. Bundling. Inclusive grouping of codes related to a procedure when submitting a claim. These are generally considered services that are included as an integral part of the procedure or service.

1.1. Bundling is a coding concept originated to simplify billing and decrease the number of claims. For instance, the code for dialysis is for an entire month's services, not each time dialysis is performed. This is because dialysis patients tend to have long-term dialysis, frequently 10-15 times each month. Bundling the services into one bill decreases billing and payer workload.

1.2. There are issues related to bundling in the MHS because the MHS data collection system attempts to provide credit to each provider for each encounter. For instance, there is a global code for the entire professional component for obstetrical services from the time the pregnancy is diagnosed, including the delivery, to the post-partum encounter. One code, one bill. However, in the MHS, you may have different providers performing part of the care. Each provider should have a part of the workload credit. Therefore, in the MHS, coders do not use the global obstetrical code of 59400.

1.3. Bundling involves minor services that are included in a larger service.

1.3.1. Example: If a patient has an office visit and the provider draws blood to send to the lab, the drawing of blood is included in the office visit. However, if the patient reports directly to the laboratory, the laboratory has a separate code for blood drawing.

1.3.2. Example: During a surgery, any incision made must be repaired. The repair is not coded separately, but is part of the surgery. Whereas, if a patient cuts himself with a knife and the emergency room doctor puts in nine stitches, the doctor will code just for the surgical repair.

2. Unbundling. Breaking a single service into its multiple components to increase total billing charges. *Fragmentation* is the same as unbundling.

2.1. It is not unbundling to separately bill antepartum services, delivery, and post partum services in the MHS as it does not increase the total billing charges. This is because the professional component of the delivery is 4% of the institutional component, significantly less than if the delivery was billed as an independent professional component not associated with the delivery.

Example:

Bundled code (correct): 80048 Basic metabolic panel

This is the correct code to use when coding for all of the following: Carbon dioxide (82374), creatinine (82565), chloride (82435), glucose (82947), potassium (84132), sodium (84295), urea nitrogen (BUN) (84520) and calcium (82310).

Unbundled code (incorrect):
80051 Electrolyte Panel
82565 Creatinine, blood
82947 Glucose
84520 Urea Nitrogen (BUN)
82310 Calcium

Note: All listed codes would be included in the Basic Metabolic Panel (80048) code.

CASE MANAGEMENT SERVICES

Revised: 8 March 2006

1. Case management is an important part of comprehensive healthcare. When performed properly, it decreases costs. Case management is performed on an inpatient and outpatient basis.

1.1. Inpatient case management includes activities such as arranging for skilled nursing facility (SNF) availability so when the patient is medically able to transfer out of the hospital, there is a SNF bed available, thereby eliminating the need to stay in the more expensive hospital setting. Arranging for oxygen at a patient's home, or for follow-up home physical therapy is also an inpatient case management activity. This is considered to be part of the hospitalization since it is usually performed by a nurse and is included in the diagnosis related group (DRG).

1.2. Outpatient case management takes many forms. It is frequently performed as part of an encounter, such as the family practice doctor calling to arrange for a surgeon to see a patient later in day because of a cyst that needs immediate surgical intervention. This is coded as part of the evaluation and management (E&M) of the family practice doctor. It is not a separate code or bill from the E&M code.

2. Coordination of care can also occur outside of the E&M encounter. There are separate codes for team conferences, telephone calls, case management (T1016), targeted case management (T1017), and reviewing plans for nursing home patients. It depends upon the documentation as to which services are separately codable. It then depends on the code as to whether it is billable.

2.1. *Documented* coordination of care with a group of at least three *inter*disciplinary providers or agencies without a patient encounter on that day that takes more than 30 minutes may be coded with case management codes (99361-99362) if it meets the requirements of the code. It is *very* seldom in the MHS that this level (e.g., minimum of 30 minutes on a patient) is met and documented. Proper adherence to coding guidelines must be followed because these codes are for the provider with an interdisciplinary team of health professionals of community agencies (e.g., primary care manager/family practice, oncologist, and cardiologist meeting to coordinate the care of a referral patient to that facility).

2.2. Mental Health has "team conferences" that do not meet the requirements of the codes.

2.2.1. Frequently, the meeting is with the active duty member's commander and first sergeant. It would be the same thing as if you worked at McDonalds and you had a problem reporting to work on time, and your supervisor and the store manager had a meeting with your social worker.
NOTE: This would not happen in the civilian sector so it is not a medical issue, but a military personnel issue, which has no applicable code.

2.2.2. The other common "team conference" is when the mental health department meets weekly to spend about five minutes per patient to review goals, note progress during the past week, and determine goals for the next week. This is an *intra*disciplinary meeting and the "team conference" code does not apply.

2.3. Telephone Calls. Because MHS rates are currently related to TRICARE rates, telephone calls are not reimbursable. This does not mean they should not be coded, relative value units are associated with telephone calls at the TRICARE Management Activity level.
NOTE: In the civilian sector, telephone calls may be documented and coded by any provider who meets the requirements in that the call is to coordinate care with another provider or the call impacts medical treatment of the patient. For instance, telephone calls are not coded when they are a continuation of a prior encounter as is the case when the doctor's office calls the patient to notify the patient that the pregnancy test is positive and they set up an appointment.

2.3.1. Some Services have restrictions on coding telephone calls. For instance, one Service limits coding telephone calls to primary care providers.

2.4. T1016/T1017. These codes do not have associated rates; they do not impact billing.

2.5. The billing office is strongly encouraged to request documentation and have it re-coded by a coder to verify any 99361-99362 codes prior to submitting bills.

CHEMOTHERAPY

Revised: 01 October 2003

1. Chemotherapy administration codes 96400 through 96549 are used when the administered drugs are antineoplastic and the diagnosis is cancer.

2. If a significant separately identifiable E/M service is performed in conjunction with the above listed chemotherapy codes, the appropriate E/M service code should be reported with modifier -25.

3. Use revenue code 636 to report HCPCS Level II J codes for drugs administered during chemotherapy for outpatient services.

CIVILIAN EMERGENCY BILLING

Revised: 16 March 2009

1. A civilian emergency (CE) is generally defined as an individual who is not a beneficiary of the Military Healthcare System, and not otherwise entitled to care at a military treatment facility (MTF), but who presents to the MTF for emergency treatment or for acute care.

2. The CE patient is to be treated only during the period of emergency and should be transferred to a civilian facility as soon as the emergency period ends.

3. The CE patient has no entitlement to MTF care and is entirely responsible financially for the cost of any care provided. This includes ambulance run, ancillary services (radiology, pathology, pharmacy) and all medical care provided.

4. The ER or admitting personnel should ensure the CE patient completes and signs a DD Form 2569, "Third Party Collection Program/Medical Services Account/Other Health Insurance," for billing information and also as authorization to release medical records in support of reimbursement. It is highly advisable for the intake personnel to obtain copies of the patient's insurance cards, driver's license, and employment information to provide to the billing office.

5. The Medical Services Account Officer (MSAO) may elect to submit a claim to the patient's medical insurer; however, the non-beneficiary patient is responsible for following-up with their insurance company to ensure timely payment, and the patient is ultimately responsible for all charges incurred during the course of treatment at the MTF.

6. Courtesy insurance billings for the CE patient must be manually produced due to the inability of CHCS to accept other health insurance (OHI) policy information for non-beneficiaries.

7. The Emergency Medical Treatment and Active Labor Act (EMTALA) is the federal law that gives all individuals the right to be treated for an emergency medical condition regardless of their ability to pay.

7.1 EMTALA does not preclude the hospital from billing.

7.2 Although EMTALA requires hospitals to treat emergency cases even if the patient cannot afford to pay, hospitals are still allowed to bill patients and their insurers for care that is provided. Visit this Web site for more information: http://www.emtala.com/.

CLAIM FORMS (Paper)

Revised: 16 March 2009

NOTE: This section does not include information on electronic billing, such as the 837P (professional), 837I (institutional), 837D (dental), and the NCPDP (National Council on Prescription Drug Programs) version 5.1.

1. Multiple claim forms are used in DoD billing. Paper forms used in the MHS include:

- CMS 1500, Health Insurance Claim Form
- DD Form 7, Report of Treatment Furnished Pay Patients Hospitalization Furnished
- DD Form 7A, Report of Treatment Furnished Pay Patients Outpatient Treatment Furnished -
- I&R - Invoice and Receipt
- UB-04 – Uniform Bill form
- UCF – Universal Claim Form, copyrighted by NCPDP (for pharmacy only).

1.1. TPOCS generates bills for third party collection outpatient services. TPOCS generates the UB forms, CMS 1500, and the UCF. TPOCS cannot generate an I&R.

1.2. MSA. The MSA module of CHCS cannot generate a CMS 1500 or a UCF.

1.2.1. Inpatient. MSA generates bills for inpatient third party, interagency and civilian emergencies. The MSA inpatient third party UB form is unique in the MHS as it reflects both the inpatient professional (e.g., doctor's rounds, anesthesia services) *and* the institutional component (e.g., diagnosis related group DRG). These can be on the UB form, the DD 7, and the Invoice and Receipt (I&R).

1.2.2. Outpatient. MSA generates bills for outpatient interagency and civilian emergencies. These can be automatically generated on the DD 7A and the I&R. Generating a UB form must be performed manually.

1.3. MAC. MAC does not have a system to generate claims.

1.3.1. MAC Outpatient. Many sites use the TPOCS module for non-hospitalizations. This is accomplished by using a different site/reporting code (e.g., M for MAC) from the site's actual TPOCS site/reporting code (e.g., M). The site/reporting code is MTF-specific.

1.3.1.1. The other option is to manually generate the bill in TPOCS, print it, go to "select bill" and delete it. This way the bill will not post and will not impact your accounts receivable. Instructions are in the TPOCS manual. Follow Service-specific guidelines.

1.3.2. MAC Inpatient. Since TPOCS only generates outpatient services, all MAC inpatient bills must be generated manually. Usually this involves a typewriter (so make sure you don't let Logistics take it way). Depending on the lawyer working the MAC bills, you may be asked to furnish a UB form for the inpatient bills or plain paper with the information.

1.4. Manual generation. A manual bill can be generated for inpatient professional services furnished at non-MHS MTFs. This is usually performed using a typewriter. Refer to Service-specific guidance.

2. UB Claim Form.

2.1. The UB Claim Form is used for institutional, technical, pharmacy, and ancillary (e.g., laboratory and radiology) services. UB forms for outpatient services can be generated in TPOCS or manually prepared. UB forms for inpatient services can be generated in MSA or manually.

2.2. CPT Codes on the UB form.

2.2.1. Military Health System Bills. In the MHS, there are some differences. Because of the current billing system, each code can only have one price. This is not the case in the civilian sector where if the code appears on the CMS 1500 there can be one price, and on the UB form there is a second price. For instance, in the MHS:

2.2.1.1. Ambulatory Surgery Center: For third party billing, CPT code 99199 is used on the UB form to represent the MHS institutional flat rate fee for APVs. This is because separate codes are not available to bill a separate rate for each level ambulatory surgery center as in the civilian sector.

2.2.1.2. Emergency Room. Currently the MHS cannot assign both a professional price (e.g., $64) for an ED visit and a different institutional price (e.g., $200) to the same CPT code (99282). Therefore, the emergency room bill will have the emergency service CPT code (99281-99285) on the UB form. It is inclusive of both the institutional and professional components of the encounter. This will change with the CY'07 rate release.

2.2.1.3. Observation. Observation also has a professional component, and an institutional component which cannot be done in the provider's office. The observation code for the first day of observation (99218-99220) will appear on the UB form. It includes both the professional component and the institutional component.

NOTE: In the civilian sector, when a CPT (both E/M and procedures) code appears on a UB claim form bill, it represents only the institutional component of the encounter. For example, when 99285 (a high intensity emergency department visit) appears on the UB form, it represents the institutional services only. When the code 11770 Excision of pilondial cyst; simple, appears on the UB form, the insurer thinks "a level 3 ambulatory surgery center bill." When the same CPT 11770 Excision of pilondial cyst, simple, appears on the CMS 1500, the insurer thinks "the doctor's bill for cutting out that slimy cyst."

Doctor's surgery charge:	Ambulatory surgery center charge:
CPT code 11770;	CPT code 99282-5
CMS1500 form: $169	UB form: $510

2.3. In TPOCS and MSA, outpatient hospital and ancillary services (laboratory, radiology, and pharmacy) performed in the MTF are generally billed on the UB Claim Form. When using TPOCS, at payer request, services can be submitted on the CMS 1500 by changing the claim form type in the Table Maintenance function of TPOCS. Refer to the TPOCS User's Manual for more information.

2.4. Submitting UB Claim Forms to Payers.

2.4.1. The UB Claim Form consists of Form Locators (FLs) that pertain to patient, payer, billing, and diagnosis information required when submitting claims to payer organizations.

2.4.2. Outpatient institutional and ancillary services are itemized with revenue codes with their description, CPT/HCPCS codes, and associated charges when submitting the UB Claim Form to payer organizations.

2.5. Multiple UB claim forms on one day. There may be multiple claim forms generated per encounter. For instance, if the patient is treated in the emergency department, the encounter appears on the UB claim form. A separate UB form could be generated for any laboratory tests, radiology studies, and prescriptions ordered during the ED visit, which were completed at a different date.

3. CMS 1500 Health Insurance Claim Form (Versions 12/90 and 08/05; use of the Form CMS 1500 (08-05) became effective 1 June 2007.)

3.1. The CMS 1500 Health Insurance Claim Form is used for professional services. It can only be generated in TPOCS or produced manually. At payer request, professional services can be submitted on

the UB claim form by changing the claim form type in the Table Maintenance function of TPOCS. Refer to the TPOCS User Manual for more information.

3.2. Minor changes have been made to the form to accommodate the National Provider Identifier (NPI) as well as current identifiers for a transition period until the NPI is implemented.

3.3. The CMS 1500 Claim Form consists of 33 items pertaining to patient, payer, billing, and diagnosis information that are required when submitting claims to payer organizations. The CPT/HCPCS code appears on the CMS 1500, representing the professional component of the encounter. Place of service codes are used on the CMS 1500. For MTFs, the place of service code 26 should automatically print in item 24B, except when BIA* indicates Emergency Room and then TPOCS will populate place of service code 23. Revenue codes are not used on the CMS 1500.

3.4. E/M codes are itemized first, if applicable. All other professional services and supplies follow. NOTE: See para 2.2.1. for those few instances when an E/M code will appear on the UB Claim Form for an encounter.

3.5. There may be both a CMS 1500 and UB Claim Form generated for one encounter.

4. Invoice and Receipt. See the Appendix in this Guide for instructions on completing the I&R. Always obliterate (e.g., blacken out) the SSAN on the I&R prior to mailing.

5. DD7/DD7A. See the Appendix E in this Guide for instructions on completing the DD7/DD7A.

6. UCF. See the Appendix D in this Guide for instructions on completing the Uniform Claim Form.

CODING COMPLIANCE EDITOR (CCE)

Revised: 8 March 2006

1. The coding compliance editor (CCE) is a program that performs a logic check on codes assigned to an Ambulatory Data Module encounter. CCE does not edit codes collected in the radiology or laboratory module. It does not perform logic checks on radiology and laboratory codes linked to an ambulatory data module (ADM) encounter.

1.1. CCE flags coded encounters where the programmed logic indicates there may be an issue with the assigned codes. It takes a coder to review every CCE flagged encounter, review it against the documentation, and make a decision. If the coder determines the documentation reflects different codes, the coder can update the ADM record. The updated ADM record feeds back to CHCS and generates an updated Standard Ambulatory Data Record (SADR).
NOTE: Is there a problem with every flagged encounter? No. Can the CCE "fix" the identified issue? No.

1.2. The CCE is to coding as a calculator is to balancing your check book. When you receive your statement from the bank, you take your calculator and enter the balance the bank thinks you have, then you enter what you think you have, make adjustments for outstanding checks and deposits, and hope the answer is "0." Sometimes, when you are entering an amount, the decimal point does not take, so the amount on the calculator scares you beyond belief. You know there is something wrong. This is the same with the CCE. Codes are entered and CCE alerts the coder when there appears to be something illogical occurring.

1.3. There are two ways CCE can be used. It can perform logic checks on codes that flow from the ambulatory data module, or the coder can use the documentation to enter the codes in CCE. Either way, codes that are entered, along with other data about the patient (such as age and gender), flow to CCE.

2. A number of claims that have circulated in the MHS regarding the CCE are incorrect.

2.1. CCE is a coding tool. The CCE walks coders through a series of steps to aid a coder in assigning all the applicable codes based on the documentation. Codes are collected in the ADM, which feeds to the CCE. Based on documentation, codes may be changed in CCE, which feeds back to the ADM and to a SADR, which feeds the clinical data repository (CDR). The CDR is where data are collected and feeds to the MHS Mart (M2). It is from the CDR and M2 where most MHS and Service reports are generated. The reports in the CCE at the MTF level are only MTF data.
NOTE: CCE is not "an enterprise-wide coding, compliance, data collection, and reporting solution for the MHS."

2.2. CCE will identify to the coder where there may be a conflict between codes. It is the coder who will determine the most correct codes based on coding. There are many things that might improve third party collections, such as complete documentation, identifying patients with other health insurance and having correct provider specialty codes. CCE will assist in assuring bills reflect services documented.
NOTE: CCE will not "improve third-party collections."

2.2.1. Some Services plan to have a coder review all documentation as part of implementing CCE. It is having a trained coder review documentation where procedures that have not been coded by the provider will be identified and coded by the coder. CCE will assist in identify incorrectly coded encounters, both those that were upcoded and those that were under-coded.
NOTE: CCE will not "improve revenue generation and collection."

2.3. CCE is not documentation and will not change documentation. Training providers how and what to document to assign the most correct codes to reflect what was done will assist in standardizing documentation.

NOTE: CCE is not "intended to standardize the method for documenting the type and level of care provided in the inpatient and ambulatory care setting."

2.4. CCE is a tool, needing trained coders in excess of what are currently available in the MHS. CCE does not automatically change codes.

2.5. CCE is *not* to "optimize reimbursement" but is to assist a coder in determining the most correct codes.
NOTE: CCE is not a "complete coding solutions for end-to-end processing."

2.6. CCE is *not* a reimbursement system. Codes, after having logic checks, feed to both billing systems, TPOCS and MSA.

3. Availability. CCE is being deployed.

4. Hold Time. There is a significant problem with CCE. The individuals performing the implementation recommended a hold time of greater than three days when the CCE flags an encounter. For instance, a correctly coded encounter edits because an unspecified CPT code (e.g., 28899 unlisted procedure, foot or toes) is used. There was an associated E&M and the diagnosis is correct. An x-ray of the foot was ordered along with a laboratory test to determine if the patient has gout. Because the CCE has a 60-day hold unless an encounter is cleared by a coder, the x-ray and lab tests will flow to billing, but the encounter will not. This means there is no diagnosis associated with the tests. This causes significant billing problems. It is *very* important that any site with CCE ensures the leadership understands the importance of having the encounters for patients with OHI be coded and have the encounter flow to TPOCS within three days of the encounter.

COMPLIANCE

Revised: 23 March 2009

1. Compliance is the strict adherence to established rules and regulations in an effort to reduce fraud, waste, abuse, and mismanagement. An effective compliance program also ensures that the billing office is operating at optimum efficiency. This in turn ensures that employees are working effectively, which increases employee morale as each employee can complete his or her tasks more quickly and more accurately.

2. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to business practices. A compliance program ensures the training is provided and guidance is available so that staff may work efficiently and at optimal levels. It is updated as needed to reflect changes in law and/or procedures. Adhering to a compliance plan will avoid many billing and clinical errors.

3. All billing offices should have a compliance program as stated in the 28 February 2002 OASD(HA) memorandum to the Surgeons General of the Army, Navy, and Air Force (http://www.tricare.mil/ocfo/_docs/Compliance%20Plan%20Implementation%20Policy.pdf)

4. Compliance programs should be developed in accordance with Chapter 2 of DoD 6010.15-M, MTF UBO Manual (http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/manuals.cfm). This chapter is based on the model compliance guidance released by the Department of Health and Human Services Office of Inspector General.

5. Refer to the TMA UBO Web site's "Policy Guidance: Letters" page for additional procedural guidance (http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/letters.cfm).

6. Questions concerning compliance should be directed to the MTF's Compliance Officer or other designated offices in accordance with the procedures outlined in the UBO Manual or by your Service representative.

COORDINATION OF BENEFITS

Revised: 7 March 2006

1. Coordination of Benefits (COB) entails the steps used to determine the obligations of payers when a patient is covered under two or more separate healthcare benefit policies.

2. The MHS follows the standards advocated by the National Association of Insurance Commissioners (NAIC).

3. The primary payer is billed initially and after payment is received, any remaining balance is forwarded to the secondary payer.

3.1. If the patient is a subscriber of an employer's insurance plan, that insurance is considered primary. The coverage obtained through the health plan of a spouse's employer is secondary.

3.2. If a patient is a child of two individuals with insurance through their employers, the parent with the birthday first in the calendar year will be considered the primary payer. For instance, if the mother's birthday is 2 February and the father's birthday is 3 November, the mother's insurance is primary. This is called the "birthday rule."

3.3. Refer to DoD 6010.15-M, UBO Policy Manual, for further information.

> Example:
>
> The spouse of a retiree received treatment at an MTF. The patient is employed and has an insurance policy with his employer. This insurance is considered "primary" Other Health Insurance (OHI). The retired member's policy is secondary. The MTF will submit a claim to the patient's insurance carrier for services rendered to the patient.
>
> The MTF, upon receiving the remittance from the primary insurer, will bill the secondary insurer for the balance.

4. See TPOCS Manual for producing COB (secondary) bill.

COSMETIC SURGERY

Revised: 18 January 2008

1. Elective cosmetic surgery is not a covered medical benefit for DoD beneficiaries. It is also not a TRICARE benefit. It is available to facilitate training requirements and to help maintain DoD providers' skills.

2. Patients undergoing elective cosmetic surgery are responsible for paying all fees associated with the procedure in advance. This would include, but not necessarily be limited to, the surgical fee, plus any institutional and anesthesia (I&A) fees.

2.1. The bill is manually generated in the Medical Services Account (MSA) module based on the fee determined by the Cosmetic Surgery Estimator Tool and agreed to by the patient.

2.2. Patient has Other Health Insurance (OHI)

2.2.1. If the patient has OHI, the patient may submit a claim to his or her insurance company as long as there is no medically necessary procedure at the same session.

2.2.2. If the patient has OHI and there is a medically necessary procedure at the same session, the OHI will be billed in the Third Party Collection Program (TPCP). See DoD UBO User Guide, Billing Combined Medically Necessary/Cosmetic Procedure When a Portion of the Procedure Is Covered by Insurance.

3. Reconstructive or Cosmetic Procedures

3.1 Some procedures can be considered reconstructive or cosmetic. The provider determines if the service is medically necessary or cosmetic.

3.2. If the provider determines the procedure is cosmetic, then the first diagnosis code will be from the V50.x series.

3.3 If the provider determines the procedure to be reconstructive, then the first diagnosis code will not be from the V50.x series and the procedure is considered a medical benefit.

4. List of Cosmetic Procedures – Inclusion and Exclusion

4.1. Inclusions to the Cosmetic Surgery Program

4.1.1. Only the cosmetic surgery procedures listed in the current year Cosmetic Surgery Estimator (CSE), which is part of the Outpatient Medical and Dental Rate Package, are billable.

4.2. Exclusions to the Cosmetic Surgery Program

4.2.1. Medically Indicated Procedures That Are Not a TRICARE Covered Benefit.

4.2.1.1. Refractive Eye Surgery. Refractive eye surgery is a medically indicated service in that it improves the function of the eye. It is <u>not</u> cosmetic even though there are less resource-intensive methods of addressing this problem, such as glasses.

4.2.2. Not Medically Indicated, Not Cosmetic

4.2.2.1. Elective Caesarian Section with no medical indication. This is not a cosmetic issue; it is usually a matter of convenience for the patient or provider.

4.2.3. Societal/Religious. Some procedures are not medically necessary, but are done electively for religious reasons, such as circumcision. As these procedures are not cosmetic, they are not included in the cosmetic program.

5. Billable Elements of the Cosmetic Surgery

5.1. Elective cosmetic surgery procedures are billed at the Full Reimbursable Rate (FRR), regardless of the Patient Category. The median geographical location is used to develop the standard fees, no matter where the service is furnished. Services furnished in Alaska, Washington, DC, and San Antonio, Texas, are priced the same.

5.2. Professional Component. The professional fee is based on the CPT codes, which describe the type of procedure that is being performed. These procedures and rates are derived from the CHAMPUS Maximum Allowable Charge (CMAC) rate table, when available.

5.3. Institutional Component. The institutional fee is based on the location (e.g., inpatient, outpatient operating room, outpatient doctor's office/clinic procedure room) where the procedure is performed.

5.3.1. If the procedure is performed in the provider's office, the location costs are included in the CPT with the professional component.

5.3.2. If the procedure is furnished in an operating room, a separate institutional fee is charged.

5.3.3. If the patient is an inpatient, a DRG rate is charged.

5.4. Additional Procedures

5.4.1. Anesthesia. If only topical anesthesia is used, there is no separate anesthesia charge. If anesthesia is administered by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA), or if Monitored Anesthesia Care (MAC) or Moderate Sedation is provided, there is a separate fee based on the type of anesthesia and the average length of anesthesia care time.

5.4.1.1. The "type of anesthesia" does not refer to the anesthetic agent but to the location of the surgical procedure (e.g., "rhinoplasty" is anesthesia for the nose, "abdominoplasty" is anesthesia for the abdomen).

5.4.2. Additional Procedure by the Surgeon During the Same Session. Additional procedures are paid at the CMAC rate, which may be discounted using industry standard discounting methods.

5.5. Implants. If implants are used, the patient usually arranges for the implants to be drop-shipped to the MTF. If the MTF buys the implant, the patient shall reimburse the cost.

5.6. Additional Providers. When an additional provider assists the primary provider, an additional percentage of the professional fee is charged. This includes residents assisting the primary provider.

6. Reconstructive Surgery. Medically necessary cosmetic surgery may be processed under the Third Party Collections Program (TPCP) if the DoD beneficiary has a valid OHI and the required documentation is presented to justify medical necessity. Be sure to obtain a pre-certification or pre-authorization number prior to the treatment.

7. Botox for Cosmetic Surgery. (This section does not apply to the special rates in para13).

7.1. For Botox, a "unit" is the calculated median intraperitoneal lethal dose (LD50) in mice. The Botox vial from the pharmacy contains 100 units in a sterile, vacuum-dried form without a preservative.

7.2. To use the Botox, it must be reconstituted by adding sterile fluid. Depending on the provider's

preference, location, etc., the vial may be reconstituted with various amounts of fluid. This makes it necessary to always know the dilution amount as well as the actual amount injected. The provider must document in the medical record the amount of dilution and the actual number of "units" in diluted form that were actually administered.

For example, if 10 cc were added to the bottle to reconstitute the dried Botox, then every 0.1 cc administered would be one unit (there were 100 units in the vial, and 0. 1cc is 1/100 of 10 cc).

7.3. Botox does not have a preservative; therefore, it has a short shelf life when reconstituted. To make the most effective use of the Botox, which costs approximately $500/vial, providers usually arrange "Botox Buddies" to administer the full vial of Botox on the same day.

7.4. Billing for Cosmetic Botox and fillers (e.g., Restylane). When billing for Botox or cosmetic fillers, there are two costs associated with the procedure;

7.4.1. A $200 flat rate per session is charged for administering the substance. The appropriate CPT/MSA codes for this service are 17999-Y1950 thru Y1954. Please refer to the most recent Cosmetic Surgery Superbill for the correct code. The codes are specific for each substance administered (e.g., Botox Administration is 17999-Y1950).

7.4.2. A separate cost for the substance (e.g., Botox, Restylane, Zyderm, Zplast) will be charged by unit/cc.

7.5. Botox for cosmetic use should be ordered by the clinic and paid for with clinic funds. Only code the Botox if the vial is paid for out of clinic funds. For instance, there were reports that providers were prescribing a vial for an individual patient. The clinic technician was picking up the vial from the pharmacy to take back to the clinic. This is a suspect method of obtaining Botox, as administration of an entire vial to one patient, would cause severe medical consequences. Using the Botox prescribed to one patient for multiple patients would also be incorrect use.

7.6. There are separate procedure codes for Botox used for medical neurolytic indications, such as eye muscle problems.

8. Bill Calculation. Use the Cosmetic Surgery Estimator Tool. Information about the tool is available from your UBO Service Representative.

9. MSA Bill Generation and Letter of Acknowledgement. The MSA Office must collect the projected cost of the procedure in advance of treatment. The MSA Office **must** have the patient sign a letter of acknowledgment indicating that these charges are not final and additional charges for related services (e.g., radiology, anesthesia, laboratory, prescriptions, and supplies) are pending. Payment for additional services is due no later than 30 days from the date of final billing.

9.1. Billing elective cosmetic surgery procedures in MSA is a manual process. The MSA bill must be created in the CHCS/MSA billing module. ***The initial procedure charge is posted and paid prior to treatment with additional charges billed once all services are complete.***

9.2. Post Surgical Billing Adjustment. Until coding for the surgical procedure is complete, the full charges for the medical service, including all ancillary services, will not be available. Consequently, the MSA Office may not be able to collect full payment in advance of services performed.

9.3. Letter of Acknowledgement (see attachment following this section). Patients must sign a letter acknowledging their financial responsibility for costs associated with the surgery. Do not provide a receipt until the letter is signed and in the file. Surgeries are not to be scheduled until a receipt is available. (See para14 regarding Cosmetic Surgery file requirements).

10. Procedure Cancelled. If the procedure was prepaid, and the procedure was cancelled:

10.1. If the implants have not been opened and can be returned, the cost of the implants less the restocking fee will be refunded if the MTF paid for the implants (which should not be the case). If implants cannot be returned, the cost of the implants will not be refunded.

10.2. If the procedure is cancelled prior to administration of anesthesia, funds will be refunded for the procedure, facility, and anesthesia.

10.3. If anesthesia administration begins, but there is no incision, funds will be refunded minus the costs of the implants and the anesthesia costs.

10.4. If anesthesia is administered and surgery begins, funds will not be refunded.

11. Patient Has Other Health Insurance (OHI) or is an Intergovernmental Patient (MSA).

11.1. When the patient has valid OHI and the procedure involves both a cosmetic and medically necessary procedure, it may be necessary for the MSA office to coordinate with the TPCP Office to cancel any cosmetically related TPCP charges to ensure the correct TPCP bill.

11.2. The MSA Office must also ensure that all charges associated with the cosmetic procedure are excluded from the DD7A billing menu for DD7A billable patients.

12. Cosmetic and Medically Necessary Procedures Performed During the Same Session. The components of the service include the medically necessary professional component, the cosmetic professional component, and the institutional and anesthesia components.

12.1. The patient will pay for the entire cosmetic portion of the procedure prior to scheduling.

12.2. The medically necessary portion of the procedure should be billed to the patient's OHI.

12.3. If the insurance payment and the payment for the cosmetic portion of the procedure is greater than the cost for the entire procedure, then the credit amount would be refunded to the cosmetic surgery payment up to the amount of the total cost of the cosmetic procedure.

For example, if the total procedure = $10,000 (Cosmetic and Medically Necessary Portion)
The Patient would pay the entire cosmetic portion = $7500, Insurance pays = $6000 for the medically necessary portion of the procedure. Total payment received $13,500
<u>Total Payment</u> ($13,500) **minus** <u>Total Cost</u> of ($10,000) = a patient refund of $3,500

13. Cosmetic Surgery Complications. Complications of cosmetic surgery procedures are excluded from coverage under TRICARE. Reference; TRICARE Policy Manual (TPM) dated August 2002, Chapter 4, Section 1.1.

13.1. The patient is responsible for all charges related to the complications.

13.1.2. The patient must acknowledge this disclosure and a copy of the signed acknowledgement letter must be filed in the patient's medical record. See Acknowledgement Letter below.

13.2. Medical services may be provided by the MHS for cosmetic surgery complications when the complication represents a medical condition separate from the condition that the non-covered surgery was directed towards.

13.2.1. A complication may be considered a separate medical condition when it causes a systemic effect or occurs in a different body system from the non-covered treatment or is an unexpected complication. *For example: Treatment for toxic shock syndrome (a systemic effect) following breast augmentation would be a covered benefit.*

13.3. Benefit Exclusions. The patient is responsible for all costs associated with complications that occur in the same body system or the same anatomical area of the non-covered treatment and when the complication is one that commonly occurs.

13.3.1. For example, in a breast augmentation procedure, a localized wound infection would be excluded and non-covered.

14. Cosmetic Surgery Provider Advisory Panel. The purpose of the workgroup is to provide guidance and functional expertise in the ongoing clarification and refinement of the Cosmetic Surgery Billing Package.

14.1. To capture provider representation, a workgroup was formed consisting of Service specialty leaders and provider representatives.

14.2. This will ensure consistent policies and procedures with current and future packages as well as an efficient means of distribution of relevant information amongst the Services.

14.3. If you are interested in volunteering, please submit your name, email address, and telephone number to the UBO helpdesk at ubo.helpdesk@altarum.org.

15. Special Pricing. Special pricing will be considered for residency programs whose professional organization requires or strongly recommends experience in certain cosmetic procedures, and, due to pricing, patients are not available.

15.1. Special pricing consideration will be given case by case. The Specialty must show an adverse impact (e.g., limited training opportunities) on General Medical Education (GME) requirements and board eligibility.

15.1.2. Requests must be coordinated with TMA/UBO Support at ubo.helpdesk@altarum.org.

15.2. The Dermatology Residency Program requires specific experience with cosmetic Botox injections. The Accreditation Council for General Medical Education (ACGME) competencies for patient care states:

> Significant exposure to other procedures either through direct observation or as an assistant at surgery is required. Examples in this category include Mohs micrographic surgery and reconstruction of these defect, the application of a wide range of lasers and other energy sources, sclerotherapy, **Botox injections**, soft tissue augmentation and chemical peels.

15.3. To meet requirements for Dermatology, the following billing procedures are implemented.

15.3.1. If the service is performed by a Dermatology Resident and the patient is under the age of 65:

15.3.1.1. Bill and report Botox injections by using the following CPT codes
- 64612, Chemodenervation, facial muscle
- 64613, Chemodenervation, neck muscle or
- 64614, Chemodenervation, extremity
- Append modifier 50 to the CPT code for bilateral procedures

15.3.1.2. Charge a discounted rate (institutional component only), CPT code 64612, Chemodenervation, facial muscle
- $84.00 for a unilateral procedure
- $126.00 for a left and right (bilateral) procedure

15.3.1.3. Charge a discounted rate (institutional component only), CPT code 64613, Chemodenervation, neck muscle

- $92.00 for a unilateral procedure
- $138.00 for a left and right (bilateral) procedure

15.3.1.4. Charge a discounted rate (institutional component only), CPT code 64614, Chemodenervation, extremity

- $ 92.00 for a unilateral procedure
- $138.00 for a left and right (bilateral) procedure

15.4. The Botox drug is included in the procedure and should not be billed separately.

15.5. This will be a manual calculation until the Cosmetic Surgery Estimator Tool (CSET) is updated (approximately July 2008).

15.6. If the service is performed by any provider who is not a Dermatology Resident or the patient is over the age of 65:

15.6.1. Charge the full price based on the current rate structure.

15.7. Patients receiving benefits under Medicare Eligible Retiree Health Care Fund (MERHCF) are not eligible for a discount.

15.8. If the service is performed by a physician and not the Dermatology Resident, regardless of the patient's age, charge the full price, based on the current rate structure.

15.9. The new rate structure for Dermatology Residents is based on the following methodology:

15.9.1. Must have a provider specialty code of 081 (Dermatology Resident w/license) or 082 (Dermatology Resident w/o license)

- CHAMPUS Maximum Allowable Charge (CMAC) rate table based on the current FY07 median location (303, Arizona) $157.35 (example, based on code 64612)
- Divide $157.35 by the Total RVUs 4.25
- Multiply Practice Expense RVUs for Non-Facility 2.27

16. Cosmetic Surgery Documentation. At a minimum, the patient's cosmetic surgery file must contain the following documentation prior to closing out the case.

16.1. Cosmetic Surgery Superbill, original copy completed by the provider.

16.2. Estimator Report from CSET completed by the MSA office.

16.3. Letter of Acknowledgment, signed by the patient acknowledging his financial responsibility for costs associated with the surgery, which may include additional fees associated with complications. These fees are due no later than 30 days after the final bill is presented.

16.4. Coding from the surgical encounter. If different from the initial invoice, a copy of the rebilling and payment/refund.

SAMPLE LETTER OF ACKNOWLEDGEMENT
COSMETIC SURGERY

- I, _____, have elected to
  PATIENT'S NAME

undergo _____ at
NAME OF PROCEDURE

_____.
NAME OF MEDICAL TREATMENT FACILITY

1. Since this surgery is not a TRICARE or DoD benefit, I agree to pay in advance for the procedure(s) at the rate(s) listed in the attached estimate. I acknowledge that the initial amount paid by me may not constitute payment in full since there maybe additional charges for services such as laboratory, radiology, and pharmacy, as well as any unforeseen necessary procedures undertaken during the surgery. I understand that these charges are not factored into the initial estimate, but will be added upon computation of the final bill. I agree that these charges must be paid within 30 calendar days after presentation of the final bill or, pursuant to the 1982 Debt Collection Act, I will incur additional interest and/or administrative charges.

2. I have read and understand the refund policy (printed on the back of this form) in the event I change my mind and decide not to have the surgery.

3. I have been counseled that follow-up care after my surgery is NOT guaranteed in a military medical treatment facilities because the care may exceed the ability of the facility and/or there may not be appointments available when I need to be seen. I understand that follow-up care, including care for complications, is not a covered benefit under TRICARE, which means that I may be financially responsible for that care if I am not treated at a military treatment facility. I have reviewed Chapter 4, Section 1.1, of the TRICARE Handbook (August 2002 edition)) and understand what type of follow-up care I will be financially responsible for if I am not treated at military facility.

- I fully understand these conditions and agree to proceed.

_____	_____
SIGNATURE OF COUNSELING OFFICIAL	SIGNATURE OF PATIENT
DATE SIGNED: _____	DATE SIGNED: _____

DD7/DD7A PROCESS

Added: 01 July 2009

1. This report identifies non-DoD beneficiaries (i.e., Coast Guard, National Oceanic and Atmospheric Administration (NOAA), and United States Public Health Service (USPHS)) who receive inpatient care at a military treatment facility.

1.1. This report should be run monthly; the charges generate when the admission is coded; there is no mechanism for UBO staff to make changes/corrections to this report. The Composite Health Care System (CHCS) menu path is as follows:

MSA
MRM
DD7 and print

1.2. The Commander, or designated representative, should sign each page of the report.

2. DD Form 7A: The Monthly Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished Part B.

2.1. DD Form 7A is used to bill outpatient medical charges for patients who are employees of certain non-DoD federal agencies and foreign governments based on the DD7A Pay Mode within the Patient Category (PATCAT) BillingTable.

2.1.1. The menu path to print the preview listing for review prior to finalization is:

MSA
D7A
PRE Select Detail or Summary based on your needs.

2.1.2. Review the listing and exclude/deselect accounts with a $0.00 balance; this is normally due to a telephone consult or the patient is Medicare eligible.

2.1.3. The menu path for that is

MSA
D7A
MBP

2.2. The primary difference between Medical Services Account (MSA) and DD7A processing is that an individual account is created for MSA billable patients, whereas the DD7A is a monthly report of services aggregated by PATCAT (e.g., all Active Duty Coast Guard (C11) visits are printed on one report and all Family Members of Coast Guard (C41) are printed on another).

2.3. All encounter procedures, ancillary support services, and issued supplies are calculated as line item charges, but are summarized per treating DMIS ID, patient, and date of service on the monthly DD7A billing report.

2.4. A system option exists to print an itemized DD7A preview list per Treating DMIS ID, Patient, and Date of Service.

2.5. DD7A charges can be appended and excluded in the same manner as Medical Services Accounts (MSAs). Charges billed on the DD7A do not establish an accounts receivable (A/R). Accounting for these charges is performed manually.

2.6. The DD7A must be finalized and printed monthly. Services for the current month's DD7A cannot be displayed until the previous month's report has been finalized. Once the report has been finalized, no further changes can be made to that month.

2.6.1. DD7A reports are maintained in CHCS for the current and one previous month. It is necessary to maintain a hard copy of the report for MSA records.

2.6.2. These reports are submitted along with the SF1080 to the responsible agency* for payment.

Commandant, U.S. Coast Guard
Attn: DoD Invoice Processing
2100 2nd Street, Room:JR-08-0223
Washington DC 20593

NOAA
8403 Colesville Road
Suite 500, Room 5505
Silver Spring MD 20910

USPHS
Medical Affairs Branch
5600 Fishers lane Room 4C04
Rockville MD 20857

*These addresses are subject to change. Verify them before submitting forms.

2.7. Refer to the Appendix E of this guide for more information on the DD7A form instructions.

DENTAL SERVICES

Revised: 01 July 2009

1. If the Ambulatory Data Module (ADM) is used to capture dental encounters associated with the Medical Expense and Performance Reporting System (MEPRS) Code C***, accounts are generated in Third Party Outpatient Collection system (TPOCS) and Medical Services Accounts (MSA) in the same manner as B level MEPRS codes.

1.1. If ADM is not used, entries are hand-keyed into MSA and TPOCS from the supplied dental superbill.

2. Rates for dental procedures are calculated based on the DoD Dental Rate Table that originates from the American Dental Association Code on Dental Procedures and Nomenclature (CDT) codes.

2.1. CDT codes are alpha-numeric Healthcare Common Procedural Coding System (HCPCS) Level II codes ranging from D0100 to D9999.

2.2. The dental rate table in TPOCS is maintained for three years (current year and two prior years).

2.3. The Dental Rate Table contains billing rates for Interagency rates (IAR), International Military Education and Training (IMET), and full reimbursement rate (FRR).

3. Dental Ambulatory Patient Visit (APV) Services.

3.1. All dental procedures are billable with a CDT code or a Current Procedural Terminology (CPT) code along with any ancillary service as a line-item charge representing procedures that were performed, regardless of the location where the procedure was performed.

3.2. CPT codes are used when billing for oral and maxillofacial surgery (OMS) such as surgical procedures or oral implants reconstruction.

3.3. A series of dental CDT (ADA) codes are located on the CHAMPUS Maximum Allowable Charge (CMAC) Rate Table with rates for billing dental and oral surgeries and procedures.

4. Modifier ET. This code is used only for emergency dental procedures. It is not available at this time for the D-HCPCS codes, but it will be added at the next release.

DIAGNOSIS POINTERS

Revised: 7 March 2006

1. TPOCS Diagnosis Pointers. Only TPOCS can generate the CMS 1500. Diagnoses are collected in the Ambulatory Data Module

1.1. Diagnosis and other ICD-9-CM codes are listed in block 21 of the CMS 1500. These are fed from the Ambulatory Data Module to TPOCS.

1.2. Billing personnel must be familiar with HCPCS/CPT codes displayed on the CMS 1500 that are associated with a valid diagnosis and the Diagnosis Code (pointer) listed on the CMS 1500 Claim Form block 24E.

2. The CMS 1500 block 24E diagnosis code pointer (Diagnosis Code) must contain “1”, “2”, “3,” and/or “4”. Diagnosis pointers must also be in sequential order on the claim.

3. The diagnosis code is indicated by an ICD-9-CM code, which is displayed on a CMS 1500 Claim Form in Item 21.

4. The HCPCS/CPT codes are displayed in Item 24D on the CMS 1500 Claim Form and as line items on the MSA I&R.

5. The DD7A will provide the ability to display all line item charges for a specific patient; however, the monthly report will list only summary charges per Patient and Date of Service.

6. Refer to the CMS 1500 Claim Form Instructions in the Appendix for more information.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. *388. 70* 3. *482*

2. *380. 4* 4. *478. 1*

24 A DATE(S) OF SERVICE From MM	DD	YYYY	To MM	DD	YYYY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
10	10	2001	10	10	2001	26		*99212*		*1,2,3,4*	75	00	1				
10	10	2001	10	10	2001	26		*69210*		*2*	250	00	1				

POS 26 = Military Treatment Facility

DIALYSIS

Revised: 8 March 2006

1. Dialysis is usually billed on a per month basis, at the beginning of the month following the services.

2. There are separate codes to be used to represent less than monthly dialysis treatments. These are used when the patient first begins dialysis treatments, when a patient is hospitalized during the month, the patient is not in the area and receives treatment elsewhere during the month (e.g., two week vacation in Florida), or the patient dies.

3. Dialysis is performed by a nurse under the written orders of a physician.

4. Dialysis is an ancillary service. The encounters are collected in the ambulatory data module (ADM) in the DGB* or DGD* MEPRS. As the D*** MEPRS currently do not flow automatically to TPOCS these bills will need to be generated manually.

5. To monitor the effectiveness of the dialysis services, with each monthly bill, a separate line must be added to the bill. The code will be 90999. The description will be "Unlisted dialysis procedure, inpatient or outpatient." Billing personnel will need to review the latest blood urea nitrogen (BUN) test dialysis unit documentation and determine the result. Based on the result, the appropriate modifier will be appended to 90999. The blood urea nitrogen tests are laboratory codes 84520-84525. The URR is determined using the pre- and post dialysis BUN samples.

G1 – Most recent Urea Reduction Ratio (URR) reading of less than 60
G2 – Most recent URR reading of 60-64.9
G3 – Most recent URR reading of 65-69.9
G4 – Most recent URR reading of 70-74.9
G5 – Most recent URR reading of 75 or greater
G6 – End Stage Renal Disease patient for whom fewer than 6 dialysis sessions have been provided in a month

5.1. The Revenue code will be 820, 821, or 829.

5.2. The code 90999 is a no charge code.

5.3. CMS will profile your MTF based on the pre- and post- dialysis blood urea nitrogen (BUN) samples.

6. Other data that may be needed will be identified on the explanation of benefits with codes such as:

211 – date(s) of dialysis training provided to patient
212 – date of last routine dialysis
213 – date of first routine dialysis.

DoD REIMBURSABLE DISASTER VICTIM

Revised: 8 March 2006

NOTE: This section of the User Guide only applies to large disasters that are declared disasters by FEMA, and for which the MHS receives a Mission Assignment. This section does not apply to local disasters (e.g., a tornado, localized flooding) that are not declared a disaster by FEMA. See also, National Disaster Medical System (NDMS) Billing, in this Guide.

1. Under the Stafford Act (Public law 93-288, Robert T. Stafford Disaster Relief and Emergency Assistance Act), regular labor of permanent federal agency personnel and overhead costs are not eligible for reimbursement except when costs incurred would normally be paid from a trust, revolving, or other fund. This means that if an MTF hires someone specifically to provide services for the disaster, or if the MTF pays someone overtime for the services provided, and the services were provided in the MTF, the services *may* be billable. If the MTF paid travel, per diem, or transportation, those costs *may* be billable, but not through the UBO.

2. The Federal Emergency Management Agency (FEMA) is responsible for implementing the Stafford Act.

3. In general, the only money available to cover charges for non-beneficiary emergency services is the patient's insurance (or Medicare/Medicaid). Otherwise, the patient is responsible for the charges.

4. There are two special instances, both involving disasters. For emergency non-beneficiary patients regulated to an MTF by the National Disaster Medical System (NDMS), see the NDMS section. The other possible source of reimbursement is through FEMA Mission Assignment.

4.1. Actions required for FEMA reimbursement for services permissible to be reimbursed under the Stafford Act:

4.1.1. FEMA requests DoD support, using a Mission Assignment (MA) [each mission assignment has its own number]→DoD Concurs →Northern Command issues an Execution Order (EXORD) →Military Services perform tasks.

5.1. Federal agencies providing disaster assistance under their own authorities independent of the Stafford Act *are not* eligible for Federal Emergency Management Agency (FEMA) reimbursement.

5.2. FEMA will not reimburse for regular labor of permanent federal agency personnel and overhead costs unless costs would normally be paid for from a trust, revolving, or other fund. 1. In general, the only money available to cover charges for non-beneficiary emergency services is the patient's insurance (or Medicare/Medicaid). Otherwise, the patient is responsible for the charges.

6. For the UBO to bill, the patient must be treated in an MTF. If the MTF responded to a Mission Assignment by sending a bus load of staff and supplies to the disaster area, and the MTF staff worked out of a tent, the costs would be forwarded to TMA RMO through the appropriate Service channels. For UBO to bill FEMA, the following must be met/available:

6.1. The patient is not a DoD beneficiary.

6.2. The patient is not an NDMS regulated non-beneficiary inpatient. NDMS reimbursable disaster victims are non-beneficiary inpatients regulated to an MTF by the National Disaster Medical System. For NDMS regulated non-beneficiaries, see the separate NDMS section of this Guide.

6.3. The MTF must have and submit patient demographics to specifically identify the patient. Examples of demographic information the MTF must have are the patient's SSAN, full name, date of birth, address prior to disaster, temporary address, and the name and address of next of kin.

6.4. The documentation maintained at the MTF must reflect the clinical course of the services.

6.5. Cause of Injury/Illness. The patient must have been treated for injuries or illnesses (a) caused by or compounded by the disaster, (b) the evacuation due to the disaster, or (c) received due to assisting with recovery from the disaster.

6.6. The patient must have been treated for an emergency condition (i.e., threat to life, limb or sense; or permanent disfigurement) or non-deferrable care. This would not include preventive services such as vaccinations. It would also not include many emergent (i.e., arising unexpectedly) or urgent, non-emergency conditions.

6.7. The services were furnished within 30 days of the disaster.

6.8. There is administrative patient documentation reflecting:

6.8.1. The date, time, county, and state where the work was actually performed.

6.8.2. A complete, DD Form 2569, signed by the patient (or the patient's representative if the patient was unable to sign, such as the patient never regained consciousness), and

6.8.2.1. If there is insurance, that co-pays, deductibles and the insurance remittance combined do not cover billed charges; or

6.8.2.2. If the patient is covered by Medicare, that co-pays, deductibles, insurance remittance (if applicable) and the Medicare remittance combined do not cover billed charges.

6.8.3. If the patient has insurance or is covered by Medicare, the patient is responsible for paying co-pays and deductibles.

6.8.3.1. Note: Medicaid (a state program) pays after FEMA (a federal program). Example: If a patient is treated for a service which is not usually available in the area except at the MTF, such as hyperbaric medicine, even if the patient met the other conditions to be a disaster patient, the patient is not a disaster patient. In this case, the patient would probably be a civilian emergency.

6.9. Certification that emergency services were temporarily not available, at the time the MTF furnished the services, in the local area for the condition treated.

7. Business Office Actions During Emergency Situations.

7.1. Be safe. Avoid becoming another casualty.

7.2. Emergency patient care takes priority over business office activities. Example: If a patient was relocated from the disaster area to an unfamiliar area, and comes to a MTF for emergency care because he did not know where else to get care, he is not a disaster patient if care for his condition was available elsewhere in the new area.

7.3. Collect other health insurance information (OHI) on all non-active duty patients. This is the same as during non-emergency situations. Do not interfere with patient care while collecting OHI information. Remind MTF staff not to discharge/release patients until OHI information is collected. A good way to remind staff of the need to collect OHI information is to include a DD Form 2569 on the clipboard used by the patient affairs/PAD emergency reception team. If your MTF has "emergency admissions packages" the DD Form 2569 should be included in these packages.

7.4. Contact your Service UBO representative to determine if there is a FEMA Mission Assignment. The mission assignment number is on the actual mission assignment document.

8. Business Office Actions Post Emergency.

8.1. Keep your Service UBO representative updated as to the number of possible FEMA reimbursable patients by inpatient/outpatient category, with/without insurance, with/without Medicare, and approximate costs.

8.2. Collect necessary documentation to support FEMA billing. Since it will be very rare for the services to have been furnished by staff hired specifically for the emergency or by staff being paid overtime while furnishing the services, it will be very rare for an MTF to submit a FEMA package.

8.3. When requested, forward copies of the required documentation and bills to your Service representative. Documentation includes a copy of the signed DD Form 2569 and applicable UB- 92 and CMS 1500 for each patient. The Standard Form (SF) 1080, Voucher For Transfers Between Appropriations and /or Funds, will be used to consolidate the bills. The SF 1080 will have your MTF UBO point of contact information in the block “Department, establishment, bureau, or office receiving funds.” In the “Article or Services” block will be the MA number, FEMA disaster number, the state where services were furnished, and the type of bill (e.g., UB-04 or CMS 1500). Each bill will be listed separately. Quantity will be “1” for each bill. “Unit Price” will not be used. Amount will be the amount of the bill. Total will be the total of all the bills attached. For instance, if there were two qualifying patients treated by providers being paid for overtime or who were hired just for the disaster work, and each had a CMS 1500 and UB 92, there would be four listed services.

8.4. Source documents must be kept by the MTF for 6 years and 3 months after final payment.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES AND DME/DMS RATE TABLE

Revised: 8 June 2009

1. Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS; formerly referred to as Durable Medical Equipment and Durable Medical Supplies (DME/DMS)).

1.1. DMEPOS primarily and customarily refers to equipment and supplies used to serve a medical purpose and is appropriate for use in the home. DMEPOS must be prescribed by a physician.

1.2. DMEPOS will only be coded if the equipment or supply item is issued to the patient without the expectation that the patient will return the item when no longer needed.

1.2.1. Medical and Surgical Supplies A4000-A8999: Covers a wide variety of medical, surgical, and some durable medical equipment (DME)-related supplies and accessories.

1.2.2. Durable Medical Equipment E0100-E9999: E codes include durable medical equipment such as canes, crutches, walkers, commodes, decubitus care, bath and toilet aids, hospital beds, oxygen and related respiratory equipment, monitoring equipment, pacemakers, patient lifts, safety equipment, restraints, traction equipment, fracture frames, wheelchairs, and artificial kidney machines.

1.2.3. Temporary Codes K0000-K0899: K codes were established for DME Medicare Administrative Contractors (DME MACs). The K codes are developed when the currently existing permanent national codes for supplies and certain product categories do not include the codes needed to implement a DME MAC medical review policy.

1.2.4. Orthotic and Prosthetic Procedures and Devices L0000-L4999, L5000-L9999: Include orthotic and prosthetic procedures and devices, as well as scoliosis equipment, orthopedic shoes, and prosthetic implants.

1.2.5. Temporary Codes Q0000-Q9999. Q codes cover a wide range of procedures, tests, injections, infusions, cast supplies, etc. Q Code rates can be found on the CMAC, Immunization and DME/DMS Rate Tables.

1.2.6. Vision Services V0000-V2999: These V codes include vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.

1.3. Coded DMEPOS is billable when TMA UBO has established a rate.

1.4. Codes listed on the DME/DMS Rate Table will populate the UB-04.

1.5. Revenues codes most commonly used are: 0271, 0272, 0274, 0291, 0292, 0293, 0294 and 510.

2. DME/DMS Rate Table:

2.1. The DME/DMS Rate Table includes rates for DMEPOS and radiopharmaceuticals.

2.1.1. Radiopharmaceuticals are not DMEPOS.

2.1.1.1. The revenue code for radiopharmaceuticals is 0343.

EDUCATION SERVICES

Revised: 9 March 2006

1. Education can be performed one-on-one or in a group setting and is billable if it meets the requirements of an Evaluation and Management visit. Refer to the Evaluation and Management Services section of this Guide.

2. Counseling and/or risk factor reduction intervention services are provided by other appropriate sources for the purpose of promoting health and preventing illness or injury. These services include issues such as family problems, diet and exercise, or injury prevention.

3. Diabetic education is now billable in the MHS when provided by a privileged provider and properly coded.

ELECTROCARDIOGRAM SERVICES

Revised: 01 October 2003

1. Electrocardiograms (EKGs) are only billable with a defined diagnosis supported by valid documentation.

2. If an EKG is performed as a “D” level MEPRS code, it is not billable; however, when performed in association with a clinic visit a “B” level MEPRS code it is billable. Note: Please refer to the Future Enhancements/Current Changes section for future billable services.

3. Electrocardiogram CPT codes: 93000–93278, 93799

EMERGENCY DEPARTMENT SERVICES

Revised: 8 March 2006

1. Emergency Department (ED) Service codes are only used when three criteria are met:

1.1. The department is open 24 hours each day, 7 days each week.

1.2. Unscheduled, services are furnished to patients presenting for immediate care.

1.3. The department is affiliated (e.g., located) with a hospital.

NOTE: In the civilian sector: The ED is not part of the physician's practice (e.g., the doctor has a "Doctor's office" separate from the hospital). Therefore, there are usually two bills: 1) the professional (doctor's) component is on the CMS1500; 2) the institutional component is on the UB-04.

The same code sets are used by both the professional and institutional component, but the codes mean different things based on which billing form is used.

- When 99281 is used on the CMS1500, it is the doctor's charges for a minor, self limiting problem.
- When 99281 is used on the UB-04, it is the facility charges for the technician screening the patient, the high cost emergency equipment, the nurses, the cable television in the waiting room, the air conditioning, the exam tables, and waiting room furniture and all the other building expenses such as paving the parking spaces.

Keeping the 24-hour highly trained support staff open is expensive. Therefore, the facility bill is a significant part of the emergency services encounter.

3. The current MHS billing system is unable to assign two prices to one code. Therefore, the charges for both the professional (doctor) and institutional (facility) components of a visit (the evaluation and management) are added together to form the price. Since the institutional component is the larger cost component, the emergency bill is generated on the UB-04.

4. There are basically two kinds of emergency visits: 1) a visit involving only an evaluation and management (E&M); and 2) a visit involving an E&M and a separately codable procedure.

5.1. E&M Only. A patient could come in for a rash, or sun burn or an ear infection. These are considered medical services. These services are totally reflected in the E&M code (e.g., 99281-99285). There are no separately codable procedures.

5.2. E&M with Separately Codable Service. The other kind of service would involve both an E&M as well as a separately codable procedure.

5.2.1. Example: A child presents with broken Crayolas in both ears and one nostril. The provider would look over the child to determine if there were any other problems such as eating Crayolas. The provider would remove the foreign bodies. He would then assess to determine if there were any residual breathing or hearing problems. The initial overall assessment and the post removal breathing and hearing assessments would be coded as the E&M. The foreign body removal of the nose would be coded with 30300 and the bilateral removal of foreign bodies of the ear would be coded with 69200-50

6. Charges for services other than the visit (the E&M) will be generated on the appropriate form.

6.1. Example: If the patient was treated for a broken arm and there was extensive debridement from the "road rash" from riding his bicycle into drainage ditch, both the treatment of broken arm and debridement would be on the CMS 1500. The x-ray of the arm and tetanus toxoid would be on the UB-04.

6.2. Radiology and Laboratory. Radiology and laboratory services ordered during the ED services will be billed as well as the E&M component of the encounter and any other separately codable procedures.

7. Admission. If the patient is admitted as an inpatient directly from the ED (e.g., the patient does not leave the ED), either by the emergency services provider or by a referring provider, the discharge type from the ED should be “admitted.” The institutional component of the encounter will then become part of the institutional component of the hospitalization.

7.1. Radiology and Laboratory with ED Admission. All radiology and laboratory services ordered during an encounter where the discharge status is “admitted” become part of the institutional component of the hospitalization. If these services generate a bill, the bill should be cancelled.

7.2. E&M Coding when the Emergency Services Provider Admits. The Emergency Services provider should use an admission code when coding an encounter where the patient is admitted. The E&M codes would be 99221-99223.

7.3. E&M Coding for Emergency Services Provider When Referring Provider Admits. If the emergency services provider does not perform the admission (the referring provider who was called in does the admission), the emergency services provider should use an encounter code other than admission (e.g., do not use 99221-99223). For example, it would be expected to see a visit code of 99281-99285. Unfortunately, this may generate a bill that will have to be cancelled as the institutional component becomes part of the inpatient institutional component bill that will be generated later. At this time, there is no method available to send only a bill for the professional component of the emergency encounter.

7.4. E&M Coding for Admitting Provider. If the referring provider admits the patient, the referring provider must ensure the encounter is coded in the A*** MEPRS as a RNDS type appointment. This is because when a patient is admitted, the E&M services leading to the admission become part of the E&M services of the admission.
NOTE: There should be no bills sent for emergency services when the patient is admitted. There should be no bills for inpatient rounds as they are part of the current inpatient bill.

8. Ambulance Transport. Ambulance transport should not be coded on the emergency doctor’s encounter. See the separate guidance on coding and billing ambulance services in this Guide.

9. Critical Care Services. Critical Care Services provided in the ED are billed using CPT codes 99291 and 99292. Critical Care is considered an E&M service. Critical Care services may be coded along with other E&M and procedures.

10. The Chief Complaint should be listed in Form Locator (76) on the UB-04 Claim Form.

11. Revenue code for the UB-04 is 450.

EVALUATION AND MANAGEMENT SERVICES

Revised: 8 March 2006

1. Evaluation and Management (E&M) codes are a subset of the American Medical Association's CPT codes. The MHS does not use the term E&M in the same manner as the civilian sector. The MHS limits E&M to mean the CPT codes 99201-99499. Basically, an E&M code represents that component of an encounter which is not a separately codable procedure.
NOTE: The civilian sector also includes the mental health, physical/occupational therapy and optometry/ophthalmology E&M codes when using the term "E&M."

2. E&M codes are used to classify the nature of the physician's work, type of service, place of service and patient's status. The E&M code includes services such as obtaining the patient's history, performing an exam and making a medical decision. There are separate specific codes for most resource intensive procedures.

3. E&M codes are used for physicians and non-physician providers for clinic and rounds encounters. The charges associated with E&M codes consist of professional charges. For those E&M services usually performed in a doctor's office, a small dollar amount of the bill is for the office use. For rounds, observation and emergency department E&M, the cost of the facility is not included. The institutional cost is billed separately.

4. 99211. Non-privileged providers with provider specialty codes 074 – 818, may use the E&M 99211, which is billable. 99211, when used by technicians (provider specialty code 900, 902, 905) and when assigned to clinics (e.g., provider specialty codes greater than 905) is not billable. This separation of billable/non-billable, based on provider specialty code (000-816 and 901 billable; 900 and 902-999 not billable) applies as well to all other codes.

5. 99499. Prior to the Ambulatory Data Module (ADM) P1P2 update, all encounters required an E&M code, even if there was no applicable E&M performed. The code "99499" was used as a "holding code" in the E&M field. There was no price associated with 99499 and it did not appear on TPOCS bills. With the ADM P1P2 update, encounters either must have an E&M or a CPT/HCPCS Procedure, but do not need both. APV encounters must have a CPT/HCPCS procedure.

6. Each E&M code associated with an encounter requires a Diagnosis Code Pointer assigned to Block 24E of the CMS 1500 Claim Form.

7. At least one, and up to three E&Ms can be associated with an encounter.

8. In the MHS, as in the civilian sector, E&M codes appear in the same field as all other CPT/HCPCS codes. There is no separate field for E&M codes on the CMS 1500.

9. E&M codes have a specific subset of modifiers. At this time, the MHS only applies the E&M to the professional component except for the emergency and observation E&M. Because the institutional component is not considered, the modifier -27 (an institutional modifier) would be inappropriate to use in the MHS. Common MHS E&M modifiers are:

Modifier	Descriptor
-21	Prolonged evaluation and management services
-24	Unrelated evaluation and management service by the same physician during a post-operative period
-25	Significant, separately identifiable evaluation and management services by the same physician on the same day of procedure or other service
-32	Mandated services

Modifier	Descriptor
-52	Reduced services
-57	Decision for surgery
-GC	Service by resident under direction of a teaching physician
-SM	2nd surgical opinion
-SN	3rd surgical opinion

FILE AND TABLE MAINTENANCE

Revised: 8 March 2006

1. Files and tables are system components that are essential for accurate, up-to-date billing.

2. There are many files and tables that must be correctly entered in CHCS to cause the correct data to be collected so the data will flow to TPOCS and MSA. Frequently, having the incorrect PATCAT or provider specialty code will cause billable encounters not to flow to the billing system.

3. Non-UBO Tables. There are many tables that impact billing that do not belong to the Uniform Business Office (UBO). The Patient Category (PATCAT), Provider Specialty Code (PSC), ICD-9-CM, and CPT/HCPCS tables belong to the Unified Biostatistical Utility (UBU), but the UBO provides input to these tables. The MEPRS tables belong to the MEPRS Management Improvement Group (MMIG).

4. Every fall, there is an ICD-9-CM coding table update. To ensure the most correct codes are available, many bedded facilities delay coding discharges after 1 October of that year when the updated ICD-9-CM table is loaded. This may cause a hiccup in billing inpatient services from 1 October until the table load every autumn.

5. UBO Tables. Files and tables contain the rates and costs associated with procedures performed and supplies used.

CPT-to-Modifier Mapping (one table for TPOCS, three tables for CHCS)
CPT-to-Revenue Code Mapping
CMAC rate (for outpatient services)
DMIS ID/CMAC Locality Mapping (to match each MTF to the correct geographic location)
Pharmacy Dispensing fee
Immunization Rate
Anesthesia Rate
Dental Rate
Ambulance Rate
DME/DMS Rate
IMET/IAR Rate
National Drug Code (NDC) (usually 4 times annually, in FY2006 there will probably be 2 updates)
HIPAA Provider Taxonomy.

5.1. Pharmacy Issues. There are a number of issues associated with pharmacy billing.

5.1.1. Managed Care Pricing File. This is a file that lists the lowest generic cost at which the Defense Logistics Agency can purchase drugs with the same active ingredient, dosage form, and strength from vendors, regardless of brand name or generic distinction. The current CHCS Pharmacy module reports the National Stock Number (NSN), not the National Drug Code (NDC), of the dispensed substance, to TPOCS. The newly purchased, soon-to-be integrated, Pharmacy Module will transmit the NDC of the substance dispensed. This will permit separate pricing based on NDCs instead of the NSN.

5.1.2. New Pharmaceutical Items. Over the past few years, there have been fewer than the planned four releases of the NDC rates. New pharmaceuticals that are priced after an NDC table goes to testing are not billable until the next NDC table is released. In CY2006, there will be two NDC rate releases.

5.1.3. Obsolete National Drug Codes. NDCs tend to stay on the NDC rate table for two years after the pharmaceutical has stopped production because it can take a few years for all of the product to be dispensed. After two years, the product may be dropped from the NDC rate table. In most cases, when an MTF has an issue with this, it is because the pharmacy at the MTF did not update its tables to reflect the new NDC for the product. MTFs need to work with their pharmacies when obsolete NDCs edit.

5.2. Cosmetic Surgery. In the past, there was a “Non-CMAC” table with cosmetic surgery rates. In the CY2005 release, cosmetic surgery transitioned to a computerized cosmetic surgery estimator tool to more accurately reflect costs.

5.3. Standard Insurance Table. This table was updated prior to the transition to a central DEERS SIT/OHI table. Now, standard insurance table data are updated centrally in DEERS.

5.4. The MTF UBO staff must ensure that the system administrator has received and downloaded the most current and updated version of the rate tables.

6. TPOCS. The following files are used to transmit patient data through the CHCS/TPOCS interface:

CHCS Daily SIT
CHCS Daily Provider File
CHCS Daily OHI
ADM Encounter Data
CHCS Lab/Rad Extract
CHCS Pharmacy Extract

6.1. The files must be maintained regularly by the MTFs assigned staff to ensure that updates have been incorporated. Files and tables that are not maintained regularly can affect reimbursement and possibly result in a non-compliant bill or claim.

6.2. Safeguards must be in place to prevent unauthorized creation, disclosure, modification, or destruction of these files.

6.3. The interface must be safeguarded to ensure that the data is accurate, complete, and readily available. Back-up files should be inspected periodically to ensure they are correct. Many MTFs have thought they were backing up data only to find the back-ups were not working.

6.4. These data files transmitted across the interface fall under the provisions of the Privacy Act of 1974 and the DoD Privacy Program.

6.5. The systems administrator must verify that they have been sent to TPOCS and that proper synchronization has taken place.

GRADUATE MEDICAL EDUCATION

Revised: 8 March 2006

1. Residents are individuals who have completed medical school, but are in an additional training program. Residents have provider specialty codes that are different than those physicians who have successfully completed the residency.
NOTE: The correct CHCS Provider Specialty Code assignment and the correct HIPAA Health Care Provider Taxonomy for each encounter are essential to correct billing.

1.2. The term "intern" is sometimes used for residents in their first year of residency. In this section, interns are included in the term resident.
NOTE: "Internist" is an internal medicine physician. An "internist" is NOT the same thing as an "intern."

1.3. A "fellow" is used in this section for physicians who have successfully completed a residency and have stayed to continue specialized training. Sometimes you will hear fellows referred to as residents.

1.3. Medical Students are individuals participating in, but not yet graduated from, a medical school.

2. Provider Specialty Code (PSC). PSCs are entered in the provider's profile, usually created in the Credentials Section at the MTF. A provider usually has one PSC, but if the provider has multiple specialties, the provider may have multiple provider specialty codes. For example, an OB/GYN physician who enters a Flight Medicine Residency would have a provider specialty codes of 150 (OB/GYN physician) *and* 301 (Aerospace Medicine Resident).

2.1. Adding a Provider to a CHCS "Clinic." The data in the CHCS provider profile are used when a provider is added to a "Clinic." A "Clinic" in CHCS is how the computer system knows the appointment availability of providers in the physical walls of the clinic. For example, there may be five aerospace medicine physicians, one medical student and two residents working in an Aerospace Medicine Clinic. To be able to make appointments for these individuals in CHCS, a "Clinic" is established in the CHCS, indicating the available hours, if the encounters will all be non-count or if there will be count encounters, etc. Then, when a new aerospace medicine resident arrives at the MTF, the CHCS systems people add the provider's name, PSC, etc., to the CHCS "Clinic."

2.1.1. In the example above describing an OB/GYN becoming an Aerospace Medicine resident, if the OB/GYN physician still pulled call and delivered babies, the OB/GYN physician would be entered in the OB Clinic using the 150 PSC and would be added to the Aerospace Medicine Clinic using the 301 PSC for Aerospace Medicine resident.

2.2. Medical Students. Medical students are entered as generic technicians using the 900 PSC.

2.3. Residents With or Without Licenses. When performing duties associated with their residency, residents will use the resident provider specialty codes.

2.4. Fellows have successfully completed the residency. Fellows use the specialist PSCs.

3. HIPAA Health Care Provider Taxonomy.

3.1. Medical students will be assigned a HIPAA Health Care Provider Taxonomy of: Student, Health Care 390200000x.
NOTE: 390200000x was new as of 1 January 2005. It was not yet in the CHCS HIPAA table. The HIPAA table was released in November 2005. A message was sent to the Services when the new HIPAA table is loaded.

3.2. Residency does not confer a HIPAA Health Care Provider Taxonomy. Each resident must be assessed to determine if the resident has a license to practice medicine.

3.2.1. Resident With or Without License. If the resident has, or does not have a license, and is performing duties associated with the residency, the resident will be assigned the HIPAA Health Care Provider Taxonomy: Student, Health Care 390200000x.

3.2.2. Residents performing services outside of the residency program, qualifying for another HIPAA taxonomy and performing services associated with the other HIPAA taxonomy, will be assigned the other HIPAA taxonomy. For instance, if a resident also happens to be a physician assistant and is seeing patients in the Emergency Room without supervision of the supervising provider of the residency program, will have that workload associated with the HIPAA taxonomy for a physician assistant which is:

Physician Assistant, Medical: 363AM0700X
Physician Assistant, Surgical: 363AS0400X

3.3. Fellows have medical licenses and have successfully completed a residency. When performing duties in that specialty, the fellow will use the appropriate specialty HIPAA Health Care Provider Taxonomy.

HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) CODES

Revised: 8 March 2006

1. HCPCS codes are grouped into three levels.

1.1. Level I: Current Procedural Terminology (CPT). The CPT codes are primarily services by privileged providers, commonly called professional services. The codes matched to the nomenclature are copyrighted by the American Medical Association. TMA buys a site license for each MTF annually.

1.2. Level II: HCPCS. These codes are listed in a book of the same name, HCPCS. They are not copyrighted. The list is maintained by the Centers for Medicaid and Medicare Services (CMS). National codes primarily cover services by individuals other than physicians (e.g., dentists, mental health/substance abuse services) and supplies. It also includes provider services, such as screenings, that will be reimbursed by CMS. For instance, if a physician performs an annual woman's exam, the CPT code 99395 would be coded. However, because CMS only pays for the screening and not the entire physical, there is a code just for the screening.

1.2.1. When both CPT and HCPCS Level II codes have virtually identical narratives for a procedure or service, the CPT code is used. If, however, the narratives are not identical (e.g., the CPT code narrative is generic, whereas the HCPCS Level II code is specific) the Level II code is used.

1.2.2. HCPCS Level II codes begin with a single letter (A through V) followed by four numeric digits. They are grouped by the type of service or supply they represent. HCPCS Level II codes listed on the CMAC Rate Table (J, G, P and Q) and are billable.

1.2.3. Durable Medical Equipment and Durable Medical Supplies (DME/DMS) are billed based on the DME/DMS Rate Table. This is automated by systems to apply the correct rate.

HEALTH INSURANCE

Revised: 8 March 2006

1. Standard Insurance Table (SIT). The SIT serves to centralize claim address information across the MHS resulting in use of up-to-date and accurate payer information.

1.1. Users assigned the SIT Security Key in CHCS may add Temporary (Temp) entries to their local SIT.

1.2. Users should avoid adding a duplicate entry to the SIT by "looking up" insurance companies by their street address (instead of the Insurance Company Name or Short Name fields) before adding a Temp entry.

1.3. Prior to adding a Temp entry to the SIT, the insurance company's claims address and contact information should be verified by calling the insurance company before being entered.

1.4. Data for the Temp entries should be entered as accurately and completely as possible.

1.5. "Local Comment" Fields may be used as a free text field, allowing users to include important, site specific notes on each SIT entry. Example: "Ask for Tammy in Medical Claims Department."

1.6. The "Standard Comment" field is used to share information that may be useful to all sites in submitting claims to a certain payer. This field is only populated by the DoD Verification Point of Contact (VPOC).

2. Adding Temp Entries. All temp entries added to the local CHCS SIT, should also be submitted to the VPOC so that the centrally managed SIT database can be updated.

2.1. Use the SIT Request spreadsheet posted on the TMA UBO website to submit the new entry to the VPOC.

2.2. Make sure you complete the MTF name, your name, and contact number at the top of the form. All requests must be verified.

2.3. Required data elements include the following:

Insurance Company Name
Street Address
City, State, Zip Code
At least one valid telephone number

2.4. E-mail SIT requests to ubo@tma.osd.mil and include in the subject line: SIT ADD REQUEST

2.4. Refer to the Future Enhancements/Current Changes section of this Guide for additional information on adding new Temp entries with the CHCS/New DEERS Interface.

3. Other Health Insurance (OHI). Section 1095 of USC Title 10 established the right of the United States to bill and collect reasonable charges from third party payers for healthcare services provided by facilities of the Uniformed Services to covered beneficiaries who are also covered by the third party payer's insurance. This includes workers' compensation and Medical Affirmative Claims (MAC).

3.1. The law mandates that the operation of the Third Party Collection Program is not dependent upon a participation agreement, or any similar contractual relationship, between MTFs and third party payers. This includes PPOs and any third party liability insurances.

3.2. The Code of Federal Regulations implements the law. Title 32, Section 220.2(d) of the code states that an assignment of benefits or other submission by the beneficiary is not necessary for MTFs to bill third party payers.

3.3. Admissions personnel must collect information pertaining to other health insurance (OHI) for al DoD beneficiaries, except active duty members. OHI is defined as the existence of insurance coverage, excluding TRICARE and Medicare.

3.3.1. Ideally, this information should be collected at the time of registration, appointment, and/or check-in.

3.4. OHI information will be reviewed annually and verified with the beneficiary at every visit. Additionally, insurance information should be verified with the insurance carrier before entering in CHCS.

3.5. OHI will be collected on Third Party Collection Program - Record of Other Health Insurance, DD Form 2569.

3.6. The original (complete, signed, and dated) DD Form 2569 will be placed in the patient's medical record. Another form may be used to collect the data, as long as the form is attached to the DD Form 2569 (on which is written "See attached"). A copy of the documentation (DD 2569 and/or the other form) is forwarded to Billing. Billing personnel will verity the documentation, and then enter it in CHCS. A completed, original, current DD Form 2569 must be in the inpatient record, the outpatient record and all ambulatory procedure visit records.

3.7. MTF-specific OHI collection forms may not be maintained in the medical record.

3.7.1. Ancillary OHI Form, Negative Response. A common practice for the ancillary "no, I don't have any other insurance" forms is to keep them in a file in Billing by month. At the end of 12 months, the documents are shredded and the new month's forms are placed in the file. Another practice is to file the "ancillary OHI no" forms alphabetically by patient's last name.

3.7.2. Ancillary OHI Form, Affirmative Response. For OHI collected by ancillary departments, the ancillary OHI forms are kept in Billing, filed by patient name.

3.8. CHCS is the repository for all OHI data and transmitted to TPOCS. Modifications to OHI must be made in CHCS.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Revised: 9 March 2006

1. Background. The 1996 Health Insurance Portability and Accountability Act (HIPAA), established new standards and requirements for health plans, clearinghouses, and healthcare providers that transmit health information electronically. Implementing regulations issued by the Department of Health and Human Services established requirements for standard code sets to be used when transmitting HIPAA compliant transactions, information security guidance, as well as rules to protect patient confidentiality.

2. HIPAA Provider Taxonomy – Military Unique Codes. These codes are used only by the Military Health System (MHS) and the US Coast Guard. Except for the IDCs and IDMTs, the appropriate individual taxonomies, such as radiologist, psychologist, certified registered nurse anesthetist, and optometrist are listed in the Health Care Provider Taxonomy list available on the UBO website. The non-individual (organizational) HIPAA codes listed in paragraph 2.2., below, will probably be the only HIPAA organizational codes used by a military treatment facility (MTF).

2.1. Individuals

1710I1002X Independent Duty Corpsman – A Navy Independent Duty Corpsman (IDC) is an active duty Sailor who has successfully completed one of the Navy's specific IDC training programs. IDCs are formally trained and educated to perform primary medical care and minor surgical services in a variety of health care and non-health care settings worldwide under indirect physician supervision. IDCs provide care to Department of Defense operational forces and other supporting forces, such as contractors and foreign nations.

1710I1003X Independent Duty Medical Technicians – an Independent Duty Medical Technician (IDMT) is specially trained and educated to perform primary medical care, minor surgical services, and treatment of dental disorders for active duty military members in a variety of health care and non-health care settings worldwide under direct and indirect physician supervision. An IDMT may take medical histories, perform physical exams, order lab tests and x-rays, prescribe medications, and give immunizations. IDMTs work under the direct supervision of a physician preceptor when at home station and indirectly when assigned to a Mobile Aid Station, Mobile Medical Unit, remote site, or otherwise deployed specifically as an IDMT.

An IDMT may be an experienced Aerospace Medical Service Technician who meets special qualifications and is recommended for training by the Aerospace Medical Service Functional Manager at their Medical Treatment Facility.

IDMTs maintain certification as Nationally Registered Emergency Medical Technicians and as Immunization Back-up Technicians.

2.2. Agency

261QM1101X – Military and U.S. Coast Guard Ambulatory Procedure – That part of a "fixed" (non-temporary, non-deployed) DoD or Coast Guard entity furnishing surgical procedures requiring medically supervised recovery. This is similar to a civilian ambulatory surgical center. It may be in shared resources with a DoD or Coast Guard Clinic or a DoD Hospital. It does not include items issued directly to a patient from an outpatient pharmacy or patient transport. It includes initial "take home" pharmaceuticals.

261QM1103X – Military Ambulatory Procedure Visits Operational (Transportable) – "Non-fixed" facilities or distinct parts of a "non-fixed" facility, providing outpatient surgical procedures requiring medically supervised recovery. It does not include items issued directly to a patient from an outpatient pharmacy or patient transport. It includes initial "take home" pharmaceuticals.

261QM1100X – Military/U.S. Coast Guard Outpatient – The Defense Health Program or U.S. Coast Guard funded "fixed" facilities or distinct parts of a facility, providing outpatient medical and dental services, primarily for Uniformed Services beneficiaries. A "fixed" facility is a non-temporary, non-deployed facility. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the "fixed" facility. It includes, as examples, the institutional portion of outpatient encounters (except Ambulatory Procedure Visits), supplies issued (e.g., glasses, ostomy supplies, crutches), and radiology and laboratory studies. It does not include items issued directly to a patient from an outpatient pharmacy or patient transport.

286500000X – Military Hospital

2865M2000X – Military General Acute Care Hospital – A Department of Defense (DoD) healthcare organization furnishing inpatient care 24 hours per day in "fixed" facilities, primarily for DoD beneficiaries. The entity is Defense Health Program (DHP) funded. A "fixed" facility is a non-temporary, non-deployed facility usually used for healthcare services. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the "fixed" facility. It includes those services and institutional costs usually included in a Diagnosis Related Group as well as "pass-through" items.

2865X1600X – Military General Acute Care Hospital; Operational (Transportable) – A DoD healthcare organization furnishing inpatient care 24 hours per day in "non-fixed" or deployed facilities. The entity is not DHP funded. Services are primarily intended for DoD active duty although some services may be furnished for non-DoD active duty. "Non-fixed" facilities are generally deployed DoD healthcare activities that do not provide services on or in association with a DoD fort or base. "Non-fixed" facilities include hospital ships.

291900000X – Military Clinical Medical Laboratory – A DoD medical clinical reference laboratory not associated with a DoD Hospital or DoD Clinic. An example is the Armed Forces Institute of Pathology.

332000000X – Military/U.S. Coast Guard Pharmacy – A DoD or U.S. Coast Guard entity whose primary function is to store, prepare, and dispense pharmaceuticals and other associated items to Uniformed Services beneficiaries. These pharmacies may be associated with a DoD or U.S. Coast Guard clinic, DoD Hospital or may be freestanding. This is usually associated with outpatient services,

2.3. Transportation

341800000X – Military/U.S. Coast Guard Transportation – Definitions to come …. (1/1/2005: new)

3418M1120X – Military or U.S. Coast Guard Ambulance, Air Transport – Vehicle and staff for patient emergency or non-emergency air transport. (1/1/2005: new)

3418M1110X – Military or U.S. Coast Guard Ambulance, Ground Transport – Vehicle and staff for patient emergency or non-emergency ground transport. This includes traditional ambulances as well as ambulance buses. (1/1/2005: new)

3418M1130X – Military or U.S. Coast Guard Ambulance, Water Transport
Vehicle and staff for patient emergency or non-emergency sea/water transport. (1/1/2005: new)

3. HIPAA Electronic Billing Function Business Rules Overview

3.1. The HIPAA "837" refers to the electronic health care claim transaction. It refers to both professional (837p) and institutional (837i) transactions. Within the scope of the Military Treatment Facilities (MTF)

business office operations, the electronic 837 transaction currently applies only to the Third Party Collections Program (TPCP) Outpatient Itemized Billing (OIB) program. It is not anticipated that the MSA module in CHCS will ever generate electronic bills. The Charge Master Based Billing (CMBB) software billing system will generate electronic bills.

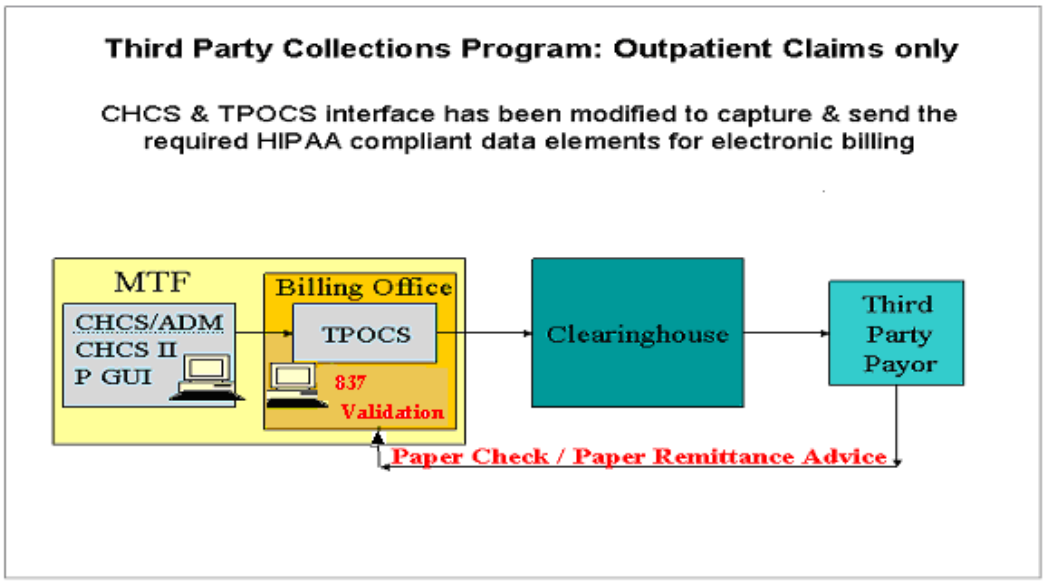
3.2. The HIPAA compliant format mandates specific data elements. The interface between CHCS and TPOCS captures and sends the required HIPAA compliant data elements for electronic billing. Data required for electronic billing cannot be entered in TPOCS. TPOCS performs a HIPAA edit check prior to the transmission of all electronic claims. If the claim does not meet the HIPAA electronic transmission requirements, it will result in a paper claim. Outpatient visits and pharmacy claims are the primary types of services currently being electronically billed.

3.3. Only bills flowing to TPOCS are currently able to generate an electronic bill. Bills that are manually entered in TPOCS cannot be electronically billed.

3.3.1. The following claims submissions will require paper format: ambulance, dental, inpatient TPC, MSA, MAC, and ancillary services, to include laboratory and radiology.

3.4. Currently, remittances sent to the MTF by the Third Party Payer (e.g., Explanation of Benefits [EOBs] and payments), continue to be in the paper format.

4. Process Flow Diagram of the MTF HIPAA 837 Electronic Billing Process



5. MTF Revenue Cycle Front

5.1. CHCS/ADM: Data Element Collection Requirements

5.1.1. Capture of Other Health Insurance (OHI)
Subscriber's gender and date of birth (DOB): HIPAA required fields.
Data Source: CHCS.

5.2. The patient is NOT always the OHI policy holder/subscriber: Patient is defined as the beneficiary covered by the subscriber's insurance policy; Subscriber is defined as the name listed in the health insurance policy.

5.3. The HIPAA software conversion will automatically populate these fields *if* the subscriber has been previously entered into CHCS. If the subscriber information is not contained in CHCS and/or is not authorized to receive care in an MTF, the MTF will need to establish procedures to obtain this information (subscriber's gender and date of birth) and input the data into CHCS (Other Health Insurance – Enter/Edit Continuation Screen).

5.3.1. Additional insurances have been added. Legacy insurance selections in CHCS have been mapped to the new HIPAA Insurance Type Table. Below is a list of additional HIPAA insurance types that have been added to the CHCS table for HIPAA compliance.

Insurance Type Code

- AP Auto Insurance Policy, e.g. GEICO policy
- C1 Commercial, e.g. BC/BS fee for service or 80/20 policy
- CP Medicare Conditionally Primary – primary for a particular condition, e.g. conditionally, Medicare benefits may be paid while a workers compensation claim is pending payment
- GP Group Policy – risk sharing, group policy through place of employment
- HM Health Maintenance Organization, network of providers, need referrals, e.g. CIGNA Healthcare
- IP Individual Policy – no risk sharing, e.g. individual that is self-employed and owns policy
- LD Long Term Policy – policy for long term care, e.g. assisted living/nursing home
- LT Litigation – MAC or tort claim, liability may lie elsewhere rather than healthcare coverage
- MB Medicare Part B
- MI Medigap Part B – supplement to Medicare Part B
- MP Medicare Primary – Medicare Part A, Medicare is patient's primary insurance
- OT Other
- PP Personal Payment – self-pay, no insurance
- SP Supplemental Policy – any policy that is not patient's primary insurance

5.4. Pregnancy Related Claims

NOTES: (1) HIPAA alpha test site recommended MTF business practice: Include the patient's LMP and estimated date of birth data field in the new OB orientation paperwork. If data are entered into an OB clinic database, provide access to other MTF clinics, to include outpatient coding staff. (2) HIPAA alpha test site recommended MTF business practice: Include the patient's LMP and estimated date of birth on all OB consults/ referrals to other MTF clinics/specialty providers. If this information is not available, the dates are estimates based on information provided by the patient.

5.4.1. Pregnancy Related Indicator: new data field;
Situational HIPAA requirement for clinical encounters that are pregnancy related.
Data source: ADM (P-GUI & CHCS II fields will be available by May 2004).

5.4.2. If the Health Care Provider (HCP) enters "Yes" in the Pregnancy Related Field, the last menstrual period (LMP) and estimated date of birth required fields are triggered for data entry. Data entry will require the MM/DD/Year format.

5.4.3. Specialty care: when a pregnant patient receives treatment in a specialty clinic the following guidance is provided:

5.4.3.1. Pregnancy related conditions: HCP should enter "Yes" in the Pregnancy Related Field. This will trigger the LMP and estimated date of birth fields, which will require data entry to complete the ADM encounter.

5.4.3.2. NOTE: pregnancy related conditions pertain to treatment received during the prenatal timeframe and not during the post-partum period.

Non-pregnancy related conditions: HCP enters “No” in the Pregnancy Related Field. MTF staff responsible for coding the encounter should use ICD-9-CM V22 (V22.0, V22.1, V22.2) diagnosis codes.

5.5. Injury Related Claims
NOTE: This HIPAA requirement pertains to the initial treatment of an injury, not the subsequent after-care. Pursuant to national and MHS ADM Coding Guidelines, E-Codes are used to code the treatment for an initial injury. The ADM record will require an E-Code in order to complete the record.

5.5.1. Injury Related Field: new data field;
Situational HIPAA requirement based on the reason for the encounter and the Common Procedural Treatment (CPT) codes used.
Data source: ADM/PGUI/AHLTA.

5.5.2. If the HCP/MTF staff enters “Yes” in the Injury Related Field, the date and cause code (reason for injury) fields are triggered. The Injury Related Field will automatically trigger to “Yes” with the use of an E-code by the HCP/MTF coding staff.

5.5.3. Cause Codes: (*Note*: User can select up to 3 Cause Codes)

AA- Automobile- the injury involved an automobile
AP- Another Party Responsible- liability lies with another individual or entity
EM- Employment- Occurred while on the job
OA- Other Accident- All other injuries

5.5.3.1. The AA cause code will trigger an additional field, geographical location, which requires data input. HIPAA mandates the use of [ISO)] standard state/country codes to identify the place where the injury occurred.

5.5.3.2. CONUS: Pick-list available from FIPS state codes (TPOCS will convert to ISO standard)

5.5.3.3. OCONUS: Pick-list available for OCONUS sites and ship locations

5.5.4. Previous Record Entry/Current Functionality in ADM – This is an existing ADM functionality that may impact new HIPAA-related data. It pulls over ICD-9-CM codes from the patient’s last encounter. It is clinic specific.

5.5.4.1. Implication of this functionality is the possibility of auto populating an E-code from the prior initial injury related encounter. Injury related information is collected for initial injury only. In this instance, user must switch “Yes” to “No” for “Injury Related” and edit the E-code. The MTF CHCS administrator has the capability to turn this function “on or off,” as directed by the clinic manager/supervisor.”

5.6. Ancillary Services

5.6.1. Laboratory: MTFs will be required to use the paper format to submit all laboratory claims.

5.6.1.1. Future functionality – if an MTF has the CHCS lab interoperability in use, a new data field is required: the Clinical Laboratory Improvement Amendment (CLIA) number. The CLIA will be required for all external labs. The CLIA number will require a one-time entry into the MTF’s laboratory file and table fields.

5.6.2. Radiology: MTFs will be required to use the paper format to submit all radiology claims.

5.6.3. Pharmacy: Pharmacy can be billed electronically or using paper forms.

5.6.4. Ambulatory Procedure Visits (APV) – Database administrators should ensure that the MTF location file is set up appropriately to identify APV appointments.

5.6.4.1. User adds prior authorization number to an APV, as required. It is recommended that current business process of acquiring prior authorization numbers be evaluated. An APV prior authorization number MUST be entered in CHCS to be pushed to TPOCS to result in a HIPAA compliant electronic bill.

5.6.4.2. During an APV, the user is prompted to identify additional providers associated with the encounter. Name, order and role of providers are entered. The provider in the first position is always the Appointment Provider.

5.6.4.3. "Operating Provider" has been added to the drop down list available for Appointment Provider for an APV. Operating Provider is the default role for APVs.

6. Provider Taxonomy

6.1. Provider taxonomy is a required HIPAA electronic billing field. Providers are mapped to a CMAC provider class and a HIPAA provider taxonomy code based on their medical specialty in CHCS. This occurs when a provider profile is created for the provider in CHCS. This table is maintained in CHCS and the appropriate provider taxonomy code is automatically pushed to TPOCS for billing purposes.

6.2. Provider specialties/taxonomy for outside providers: at least one provider specialty is required for all new outside providers if they meet the following criteria:

Provider flag is "PROVIDER"
Provider has a DEA#
Provider class is "OUTSIDE PROVIDER"

6.2.1. If a user attempts to enter a new outside provider without a provider specialty, the following message is generated:

> "At least one provider specialty is required for external providers. If you do not know which specialty to enter, enter 000 for GENERAL MEDICAL OFFICER if the external provider is a physician. (CMAC Provider Class = 01)"

7. Claims in Paper Form

7.1. Currently, ambulance, dental, inpatient TPC, MSA, MAC, laboratory, radiology, and manual bills will print on a paper claim.

8. MTF Revenue Cycle Third Party Collections Office (in TPOCS, not in CHCS)

8.1. Condition Codes (to be entered by billing personnel with drop down menu availability) – These are two-digit number codes entered on the UB-04 to indicate that a condition applies to a claim, coverage exists under another insurance, whether the injury or illness is related to employment, or identifies conditions that may affect payment processing

8.2. Payer specific – Billing personnel should contact payers and determine what condition codes payers require. Up to four codes may be listed. Below is a list of condition codes used in the outpatient setting. Please refer to this list when talking with payers.

Code #	Condition Code	Applicability
03	Patient Covered by Insurance Not Reflected Here	Applicable for outpatient services (commercial billing)

Code #	Condition Code	Applicability
04	Patient is HMO Enrollee	Applicable for outpatient services (commercial billing)
06	ESRD Patient in First 18 Months of Entitlement covered by Employer Group Health Insurance	Applicable for outpatient services (commercial billing)
18	Maiden Name Retained	Applicable for outpatient services (commercial billing)
19	Child Retains Mother's Name	Applicable for outpatient services (commercial billing)
28	Patient and/or Spouse's Employer Group Health Plan is Secondary to Medicare	May be applicable to Medicare electronic billing
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	May be applicable to Medicare electronic billing
30	Non-Research Services Provided to Patients Enrolled in a Qualified Clinical Trial	Applicable for outpatient services (commercial billing)
31	Patient is Student (Full-Time Day)	Applicable for commercial billing
32	Patient is Student (Cooperative/Work Study Program)	Applicable for commercial billing
33	Patient is a Student (Full-Time Night)	Applicable for commercial billing
34	Patient is Student (Part-Time)	Applicable for commercial billing
78	New Coverage Not Implemented by HMO	For Medicare billing (when HMO does not cover)
B3	**Pregnancy Indicator**	**Required by HIPAA**
G0	Distinct Medical Visit	Applicable for Medicare electronic billing when multiple medical visits occurred on the same day in the same revenue center with different chief complaints

8.3. New Tables, Reports, and Data Capture in TPOCS

8.3.1. Provider Taxonomy Descriptions and Codes Table – non-editable by billing personnel. HIPAA requires Provider Taxonomy to be sent on an electronic claim.

8.3.2. Person Relationship Description and Code Table – non-editable by billing personnel. Relationship table has been remapped from CHCS to HIPAA relationship codes and sent to TPOCS.

8.3.3. Insurance Type Description and Code Table – non-editable by billing personnel. Additional insurances are added and remapped to HIPAA insurance table.

8.3.4. HIPAA Validation Error Report – Report to show claims that were tagged for electronic billing, but did not meet new HIPAA requirements and defaulted to a paper bill (Refer to Table A below). New message to show why a claim was tagged for electronic billing but did not meet the new HIPAA requirements and defaulted to a paper bill (Refer to Table B below).

Table A.

(1.0) TPOCS 3.1 - Itemized Billing - [(5.6.1) - Preview Report: HIPAA Validation Errors]

File Edit Data Patients Billing Accounting Reports Tools Window Help

For Official Use Only

*** Third Party Outpatient Collection System ***

21-Oct-2003

HIPAA Validation Error Report

Note: Bills that cannot be transmitted electronically are missing data required for HIPAA compliance

Error Date	Control No	Missing Data
09/10/2003	A03-59	Policy Holder Gender,
08/04/2003	A03-61	Policy Holder Gender,
09/10/2003	A03-61	Policy Holder Gender,
09/29/2003	A03-61	Policy Holder Gender,
08/12/2003	A03-63	Policy Holder Gender,
09/16/2003	A03-64	Policy Holder Gender,
09/10/2003	A03-70	Policy Holder Gender,
09/10/2003	A03-72	Policy Holder Gender,
09/16/2003	A03-9	Policy Holder Gender,
09/11/2003	A03-90	Policy Holder Gender,
09/11/2003	A03-91	Policy Holder Gender,

Table B.

HIPAA E-Billing

E010-0009: Required columns for HIPAA Electronic Billing is missing

Print

OK

More >>

Detailed Message:

The following errors were found for HIPAA Compliance:
-Policy Holder Gender is missing.

8.4. Country Code - geographical location of an accident is required in CHCS for automobile accident related injury only. The code in CHCS feeds to TPOCS. It is viewable by billing personnel and is non-editable. When available, valid state codes are viewable. Default of ZZ will appear for unknown states and OCONUS locations.

8.4.1. In instances where manual bills are created in TPOCS, electronic billing will not occur. Currently, remittances and EOBs will continue to be in paper form. The EOBs may appear different.

IMMUNIZATION/INJECTION/INFUSION SERVICES

Revised: 8 March 2006

1. When an immunization or injection is the only service provided, the appropriate immunization/injection code is used to bill for this service. There will be a code for the actual injection and a separate code to reflect the vaccine product. There is no applicable Evaluation & Management Code (E&M), but to have data flow to TPOCS, the E&M code 99499 needs to be entered in the E&M field.

2. For data collection purposes, when a patient is seen in a clinic setting and then referred to an immunization clinic for injections, two encounters are generated. One encounter relates to the clinic visit, and the other relates to the immunization visit. This will generate two claim forms, one for the injection (UB-04) and one for E&M (CMS 1500).

3. If the injection is given during the initial clinic visit, the visit will have a minimum of three codes, one E&M code, one injection code (e.g., 90471), and the vaccine code. It will also have multiple diagnosis codes, one for the reason for the visit, and a V-code to explain the need for the vaccination, such as V04.81 Need for prophylactic vaccination for influenza.

4. Vaccines/Toxoids

4.1. Immunization administration CPT codes 90471-90472 and 90473-90474 must be billed in addition to one of the appropriate vaccine/toxoid CPT codes 90476-90749.

4.2. Payers now require specific prophylactic diagnosis codes (ICD-9-CM V-codes) for immunization(s). They generally no longer accept V07.8 (other specified prophylactic measure) when billed with an immunization.

5. Therapeutic/Prophylactic/Diagnostic Injections

5.1. CPT codes 90782-90799 are used for the *administration* of therapeutic, prophylactic, or diagnostic injections. These administration codes do not include the substance(s) injected.

5.2. The appropriate HCPCS Level II J-code *must* be used in addition to the administration codes(s) to bill for the substance(s) *injected if it was specially ordered by the clinic for the patient*. If the substrate is from clinic stock, or issued to the patient by the pharmacy, the J-code should not be used. If it is from routine clinic stock, the cost is included in the institutional component of the clinic visit. If it is issued to the patient by the pharmacy, the pharmacy will show the substance was dispensed.

6. Therapeutic or Diagnostic Infusion (Excluding Chemotherapy)

6.1. Time-based codes 90780-90781 are used to bill infusion *administration*. A physician's presence is required for these infusion services. Ringers or other solutions that are transfused are part of the institutional component of the administration code when the solution was clinic stock or issued to the patient by the pharmacy.

6.2. The appropriate HCPCS Level II J-code *must* be used in addition to the administration codes(s) to bill for the substance(s) infused if the infused diagnostic or therapeutic substance was ordered for the patient and paid for with clinic funds.

7. Billing Vaccinations.

INPATIENT FISCAL YEAR RATES

Revised: 8 March 2006

1. Every year, the Adjusted Standardized Amount (ASA) is calculated for bedded facilities. This is the multiplier that is used with the diagnosis related group's relative weighted product to generate the inpatient bill. The rate reflects both the inpatient institutional and inpatient professional components.

2. To change the rates, the CHCS user must update the rate table. To do this:

2.1. Log into CHCS.

2.2. Go to the MSA module.

2.3. Go under Office Function Menu then Edit Rate Table.

2.4. Update the rates according to the attached charts.

2.5. Make sure the effective date is the date you are loading plus one day.

ITEMIZED POSTING OF RECEIPTS

Revised: 8 March 2006

1. As Explanations of Benefits (EOB) are remitted reflecting a full or partial payment to the MTF, the user must post payments to the General Ledger on a line-item basis.

2. Because many payers submit payments for multiple claims and multiple beneficiaries, all line-items on the EOB should be reconciled with Accounts Receivable (A/R) prior to posting payments and depositing funds.

3. Prior to posting payments, the A/R clerk should at a minimum:

   3.1. Obtain the Control Number for each payment.

   3.2. Verify the amount paid against the amount billed.

   3.3. Determine amounts to be written off by applying DoD approved closure reasons.

4. Upon entering the control number in TPOCS, the General Ledger screen populates with each line item billed for that claim. Each line item must be processed separately.

5. For each line item displayed in the Detail Posting Tab, the following will not be editable:

   5.1. Procedure Code (CPT, HCPCS, NDC) and associated modifier(s),

   5.2. Original Amount (this amount changes as payments, write-offs or adjustments are made and saved),

   5.3. Either the Credit or Debit field; depending upon the transaction code selected,

   5.4. Current Balance,

   5.5. Percent Paid.

6. If payment is received in full, a “Pay in Full” button is available for instant posting to all line items.

7. If appropriate, the user must write off the balance of the line item with the “Write Off” button.

8. Any adjustments to be made to the account can be accomplished at the “Adjustment” tab or by choosing Adjustment from the General Ledger drop down menu.

9. Any patient having a secondary OHI policy is identified in the Itemized posting screen by an alert prompting the user to indicate whether or not secondary billing is desired.

> *Reviewers: Which one is it?*
> *Option A. After you have input and save with a write-off transaction code, you will be permitted to bill secondary insurance.*
> *Option B. If secondary insurance exists and the user proceeds with secondary billing, the account for the primary payer is automatically closed and the remaining balance is billed to the secondary insurer.*

The secondary claim is reported with the same control number followed by an “a” (e.g., A12345a).

10. The UBO will migrate to HIPAA denial/adjustment reason codes in the future when the DD Form 2570 is revised to accommodate itemized posting.

11. Please refer to the TPOCS Users' Guide for instructions on posting payments and other General Ledger transactions.

12. A manual process must be put into place by the MTF for the acceptance *of payments* that do not belong to the MTF. It is recommended that MTFs create a log to track manual deposits and refunds and a separate customer number to deposit these collections into.

12.1. Payments received in error by TPP. There will be time that you receive a payment on a patient that does not belong to you. Since you do not have a bill in either TPOCS or CHCS recommended action would be:

12.1.1. If the check only includes this payment error, return check and make a note on your check log that the check was returned.

12.1.2. If the check includes payments that belong to you, post those payments where they belong.

12.1.3. Create a separate DD1131 to deposit into a separate customer number for that portion of the check that could not be posted.

12.1.3.1. Note on the DD1131 the patient, payer, check number, date of check, reason for manual deposit, etc.

12.1.4. Log in manual deposit information on a manual deposit tracking log.

12.4.1.1. Forward manual deposit information to the person responsible for approving refund actions.

13. TPOCS is not programmed to accept posting of payments or adjustments larger than the amount of the original bill for that line item. Most common reasons are TPP keyed in the wrong amount billed causing an overpayment, interest payment, TPP allowed more than the amount billed. You could either deposit the payment in to the appropriate TPCP customer number or you could establish a separate customer to deposit overpayments into.

14. It is imperative that the user reconciles all payments prior to posting and before depositing funds.

15. The Itemized posting process involves a significant number of steps to process payments and close claims. The A/R clerk should allow adequate time for the posting process.

Examples:

Line item overpaid due to processing error by TPP.
You billed BCBS $50.00 for an office visit. BCBS incorrectly keyed in amount billed as $500.00 and paid $480.00 (office visit copay of $20.00)
You would post $30.00 to the line item.
Manually deposit $450.00.
Refund $450.00 due to TPP processing error.

Line item overpaid due to TPP allowed more than billed.
You billed AARP $113.57 for CPT 90371, AARP allowed $571.40 and paid 20% - $116.28.
You would post $113.57 to the line item.
Manually deposit $2.71.
Refund $2.71 due to overpayment.

LABORATORY SERVICES (Codes 80048-89356)

Revised: 6 March 2006

1. Laboratory Services are billed based on the CPT code assigned. TMA UBO assigns rates to the CPT codes.

1.1. Only TMA UBO assigned rates can be used unless the tests were performed under supplemental care (the MTF paid another entity, and the fee is a "pass-through″) .

2. Billing For Tests Performed External to the MTF and Billed to the MTF by the External Laboratory. The MTF bills the insurance company for the laboratory service using the modifier -90, Reference (Outside) Laboratory. The fee will be the price paid by the MTF to the external laboratory. Billing personnel will need to work closely with Resource Management to obtain the prices paid by the MTF to the entity which did the test.

3. Billing For Tests Performed External to the MTF, but NOT Billed to the MTF. The MHS has reference laboratories, such as Armed Forces Institute of Pathology (AFIP) and the reference laboratory at Brooks City Base. There are also instances when a small MTF collects specimen that are tested at a larger MTF, and the results returned to the MTF so that the patient can receive the results from his provider.

3.1. Use the TMA UBO rates when samples are collected at the MTF, sent to an external laboratory, but the external laboratory does not bill the MTF. These tests should have the modifier -90, Reference (Outside) Laboratory to indicate they were not done by the MTF.

4. Modifiers.

4.1. Technical Component – Modifier "tc". The CHCS laboratory module makes a non-standard use of the modifier "32" to mean "technical component. When looking directly at data from the CHCS laboratory module, the modifier "32" will appear; interpret it as if it was modifier "tc." The technical component is used to indicate a procedure could be split into two separate parts. This is the component reflecting the cost of the building, supplies, equipment and technicians.

4.2. Reference Laboratory – Modifier 90.

4.3. Repeat Clinical Diagnostic Laboratory Test – Modifier 91. This modifier is used when a laboratory test is medically necessary multiple times in the same day, but is not usually done as a series of tests. It is used when the initial test has abnormal results, immediate action is taken to bring the results closer to normal, and then the test is repeated to see the amount of change.

4.4. Clinical Laboratory Improvement Act (CLIA) Waived Test – Modifier QW. There are certain laboratory tests that may be performed in the provider's office. These tests tend to be relatively simple. Check with your MTF laboratory to determine if any CLIA waived tests are being used in your MTF, and if so, obtain a list by clinic. These laboratory tests will appear on the CMS 1500 along with the other services/procedures performed in the provider's office. The laboratory tests must have a modifier "QW." Other than the CLIA waived tests, there should not be any laboratory tests appearing on provider's office visit bills.

5. Component Laboratory Tests. There are three possible methods of billing a laboratory test. A professional component may be billed separately, usually with a modifier of -26. A technical component may be billed separately, usually with a modifier of –tc. A test may have both professional and technical components, and when both are done at the same time there is no modifier. When a test has only a professional component (e.g., autopsy), there would be no modifier. When a test has only an institutional component (e.g., blood typing), there would be no modifier. Most laboratory tests only have a technical component.

5.1. Composite laboratory studies have both a technical and a professional component. For example, 88173, Cytopathology, evaluation of fine needle aspirate: interpretation and report. The rates for these codes are on the "CMP" table of the "CMAC" file.

CPT	Class#	Professional Rate	Technical Rate	Global
88173	1	$128.47	$99.37	$227.84

5.1.1. Professional Component Only. When the professional component is billed separately, modifier -26 (professional component) is appended to the HCPCS/CPT code. In the above case, if 88173-26 feed to TPOCS, the bill would appear on the CMS 1500 with a charge of $128.47.

5.1.2. Technical Component Only. If only the technical component was performed at your MTF, the code would be 88173-32 in the CHCS laboratory module. When TPOCS receives the feed, TPOCS changes -32 to –tc . 88173-tc would appear on the UB-04. There would be a charge of $88.37 associated with the 88173-tc.

5.1.3. Both Professional and Technical Component Performed. If the total procedure is performed, there is no modifier appended to the 88173 so the bill will be $227.84 and appear on the UB-04.

6. Billing – In General. A service that has a professional component in which the physician reads and interprets the result of a test performed by a technician, is designated by a CPT/HCPCS code and modifier "26" on the CMS 1500 Claim Form. The technical component is recorded on the UB-04 Claim Form with the modifier "tc." In the CHCS Laboratory module, (for some reason unknown to us) modifier "32" is used to indicate the technical component. When this modifier flows to TPOCS and MSA, it is automatically changed to "tc," which will appear on the bill. For those procedures that could be split (e.g., a professional and technician component) but aren't (meaning the entire procedure is performed at that time), there is no modifier. In this case, if the procedure would normally go on the CMS 1500 (e.g., some urology procedures), the procedure will appear on the CMS 1500. If the procedure usually mapped to the UB-04 (as with most laboratory and radiology studies), it will map to the UB-04.

6. Forms. In general, laboratory services without modifier and laboratory service with modifier tc will print on the UB-04. When only a professional component of a laboratory services is performed, the CPT with modifier -26 will print on the CMS 1500.

6.1. UB-04. Verify the assigned revenue code in FL 42 for each HCPCS/CPT code submitted. The number of outpatient laboratory tests is entered in FL 46 (Unit of Service) on the UB-04 Claim Form for each CPT code. Refer to the section for Linking Ancillaries to Encounters for additional information.

7. Laboratory Panel Codes. 80048-80076. It is illegal to bill for separate laboratory tests when there is a code which consolidates them as a panel. It is called unbundling. When panels are unbundled, the individual charges will be greater than if the panel code is used. The panel codes must be billed if all the components of the panel were performed, even if the provider ordered each test individually, or if the provider ordered the panel and the laboratory reported the tests individually. The laboratory MUST submit tests as panel codes electronically to billing if there is an applicable panel code.
NOTE: This differs from civilian practice, where Medicare has a rule that certain outpatient services furnished within 3 days of an inpatient admission must be bundled into the diagnostic related group (DRG).

7.1. To use a panel code, all the tests in the panel must have been performed.

8. Diagnostic services performed for pre-admission are billed separately from the inpatient bill and itemized. Pre-admission services are not included in the Adjusted Standardized Amount (ASA) which is used to calculate the cost for inpatient billing.

9. Specimen Collection and Handling.

9.1. Venipuncture. Routine venipuncture or finger/heel/ear stick is used for specimen collection. If the venipuncture and the analysis of the blood are performed at the same location, the venipuncture is not billed separately. If a venipuncture is performed that is not part of an office visit/consult at one location, and laboratory analysis is performed at another location, both procedures are billed. It is infrequent in the MHS when a venipuncture is performed in the clinic and it is not associated with an office visit/consult.

9.2. Specimen Handling Fee Codes (99000-99001). The only clinic of which the UBO is currently aware which provides this is the Luke AFB OB/GYN clinic at Del Webb Hospital in Phoenix, AZ. Usually, when a specimen is collected, it is transported to the laboratory associated with the clinic, and the laboratory accessions and packages the specimen for shipment to a reference laboratory. It is rare to see 99000-99001 used appropriately in the MHS.
NOTE: 99000 – 99001 is used in the civilian sector when specimen is collected in a doctor's office, packaged and assigned an accession number by the doctor's office, and posted or driven to a reference laboratory.

9.3. Biopsies and Surgical Specimen. Laboratory samples can be obtained by biopsy. The provider performing the biopsy/surgical procedure codes the procedure with a CPT code. The specimen will be properly processed at the collection site and forwarded to the laboratory. Examples of proper processing is labeling the bottle and placing the specimen in a bottle of preservative or placing the specimen on a slide, adding the proper solution and covering the specimen with a cover slip. The biopsy/surgical procedure code includes the initial processing and transport to the laboratory.

10. Payers may require a line item date of service to be reported in FL-45 for outpatient laboratory services covering two or more dates.

11. There are two terms for laboratory tests that billing personnel should understand: accession and certification. A provider inputs a laboratory order. When the lab acknowledges the order, the specimen receives an accession number. The laboratory calls the patient in and collects the specimen, which is labeled with the accession number. The test is then conducted. Laboratories are certified either by the medical technician performing the test or the test can go to a supervisor/pathologist for certification. The laboratory accessioning the specimen is the MTF which bills the laboratory test.

MANUAL BILLING

Revised: 7 March 2006

NOTE: This section is about many of the reasons bills do not automatically generate and need manual feed.

1. There are two reasons for manual billing: 1) Some bills, such as ambulance billing, are always manual; 2) something is lacking at the time the encounter would have automatically fed to create a bill and the feed did not occur.

2. CHCS is not programmed to retroactively transmit past data even when the missing or incorrect data has been added or amended. A manual bill must be produced for any encounter that has not been automatically billed by the system.

3. Incorrect PATCAT. Examples of incorrect PATCATs are numerous, from Coast Guard personnel being entered as Navy, to active duty retiring, and the PATCAT not being updated. Appointment and admission personnel must be reminded to inquire as to the reason for eligibility, asking "Are you still Active Duty?" or "Is this an OSHA encounter?" All incorrect PATCATs must be forwarded to patient administration for correction. The billing office must review all possible applicable encounters and update them. All prior encounters will not automatically feed and claims/invoices must be generated manually.

> 3.1. For example: The MSA Officer of an OCONUS site learns that a former active duty member is now a DoD employee. The patient's PATCAT has not previously been modified to indicate the patient's new status. The patient has been treated in the OCONUS site for the last three months. Because of the patient's civilian status, treatment should have been rendered on a space available, reimbursable basis. The MSA Officer must create manual bills for all of the past visits.

4. Incorrect Provider Specialty Class. Periodically the billing office personnel should request a list of all SADRs for the past month with the MEPRS, 1st Diagnosis, 1/2/3 E&M, 1/2/3/4 CPT, provider name, and provider specialty code. SADRs with a provider specialty code of 910-999 need to be reviewed; a SADR should *never* have one of these codes. This list should be given to the department responsible for the provider file maintenance.

5. OHI not current. If OHI is not documented in the Patient Insurance Information (PII) file in CHCS within three days from date of service, the encounter will not flow appropriately into the billing systems.

> 5.1. For example: MTF personnel learn in June that a spouse of an active duty member has third-party insurance that has been in effect since January. The billing office would like to bill for all patient care episodes between January and June. The insurance information has been added to the Patient Insurance Information file in CHCS and transmitted to TPOCS. The billing office must create manual bills for all of the past visits.

6. Users must gather all of the encounter information, such as the ADM encounter and all billable ancillary services (e.g., laboratory, radiology, and pharmacy), to create a claim.

6.1. The data gathered must include at a minimum, one ICD-9-CM diagnosis code and one E/M code. HCPCS/CPT and NDC codes assigned to the ancillary services must also be obtained, if applicable.

6.2. Manual claims generated in TPOCS cannot be electronically transmitted.

MEDICAL AFFIRMATIVE CLAIMS

Revised: 8 March 2006

1. Medical affirmative claim (MAC) bills are itemized for outpatient care, and generated using the adjusted standardized amount (ASA) multiplied by the relative weighted product for inpatient bills.

2. MAC claims are billed at the Full Reimbursable Rate (FRR).

3. There are a number of very helpful MAC reports available in CHCS. These reports identify all encounters.

3.1. It is the billing personnel's responsibility, working with the provider, a coder, or other knowledgeable individual, to identify those services related to the accident/injury.

3.2. Detailed encounter information for a potential MAC bill is retrieved from the inpatient, ambulatory data module, Laboratory, Radiology, and Pharmacy modules within CHCS.

4. The menu path is:

MAC Enhancement Report

1. CHCS Menu path: ADM Ambulatory Data Module - >2 Ambulatory Data Reports - >MAC Medical Affirmative Claims Services Report

2. Security Key: KG ADS MAC

If a user does not currently have access to the ADM menu, this person can gain access through assignment of the new secondary menu option:

Secondary menu: KG ADS RPT INJURY REPORT

Medical Affirmative Claims Ser KG ADS RPT INJURY REPORT

Medical Affirmative Claims Services Report

You may need to obtain the security key from your System Administrator.

4. Follow Service specific guidance to generate the actual form

4.1. The user has the capability of manually keying data into TPOCS for the purpose of generating a UB-04 or CMS 1500 Claim Form. Data for MAC claims can be entered under a separate reporting ID in TPOCS for tracking and reporting purposes.

4.1. Refer to the UBO website for instructions on how to perform manual billing through CHCS.

4.2. Some Services will continue to manually generate the bills (e.g., using a typewriter).

5. Refer to the DoD 6010.15-M, MTF UBO Manual for more information on the MAC Program.

MEDICAL SERVICES ACCOUNT (MSA) BILLING FORMS

Revised: 8 March 2006

1. Invoice & Receipt

1.1 The Invoice & Receipt (I&R) form is used for billing MSA patients with a pay rate of Inter-Agency Rate (IAR) or Full Reimbursement Rate (FRR) established within the CHCS Patient Category (PATCAT) Billing Table.

1.2. The I&R form is also used as a receipt for funds collected.

1.3. I&R forms are controlled, numbered DoD standard billing forms. They must be secured and accounted for in the same manner as all controlled forms. Paper forms are used by MTFs that do not use CHCS. The MSA sub-system within CHCS generates an automated numbered form for sites that use CHCS.
NOTE: MTFs that use CHCS should retain paper forms in case CHCS is down for an extended period of time.

1.4. All charges for services performed on the same date of service, at the same treating DMIS ID, and for the same patient, are billed on one I&R form and are displayed as line items. Refer to the Appendix for the I&R billing form instructions.

2. DD Form 7A

2.1. The Monthly Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished Part B. DD Form 7A is used to bill outpatient medical charges for patients who are employees of certain non-DoD federal agencies and foreign governments based on the DD7A Pay Mode within the PATCAT Billing Table.

2.2. The primary difference between MSA and DD7A processing is that an individual account is created for MSA billable patients, whereas, the DD7A is a monthly report of services aggregated by PATCAT (e.g., all Active Duty Coast Guard (C11) visits are printed on one report and all Family Members of Coast Guard (C41) are printed on another).

2.3. All encounter procedures, ancillary support services, and issued supplies are calculated as line item charges, but are summarized per treating DMIS ID, patient, and date of service on the monthly DD7A billing report.

2.4. A system option exists to print an itemized DD7A per Treating DMIS ID, Patient, and Date of Service.

2.5. DD7A charges can be appended and excluded in the same manner as MSA accounts. Charges billed on the DD7A do not establish an accounts receivable (A/R). Accounting for these charges is performed manually. Refer to the Future Enhancements/Current Changes section of this Guide for proposed updates.

2.6. The DD7A must be finalized and printed monthly. Services for the current month's DD7A cannot be displayed until the previous month's report has been finalized.

2.6.1. DD7A reports are maintained in CHCS for the current and one previous month. It is necessary to maintain a hard copy of the report for MSA records.

2.7. Refer to the Appendix of this Guide for more information on the DD7A form instructions.

3. SF 1080

3.1. The Voucher for Transfers between Appropriations and/or Funds (SF1080) is used to bill inpatient and outpatient medical charges for patients with a Pay Mode of SF 1080 on the PATCAT Billing Table.

3.2. Currently, CHCS does not itemize outpatient charges on the SF 1080. A work-around process must be developed to ensure that all patients are appropriately charged for services rendered (e.g., choosing an alternate PATCAT that will produce charges). See the Future Enhancements/Current Changes section of this Guide for further information on SF 1080 billed patients.

MENTAL HEALTH SERVICES

Revised: 9 March 2006

1. Mental health services have many components. In some places, they are called “Life Skills.” Some services that may appear to be mental health are not funded by the Defense Health Program (DHP) and should not be coded; therefore there should be no billing. Common examples are many Family Advocacy and Substance Abuse activities in the Air Force. For instance, a family advocacy officer, who happens to be a clinical social worker, is seeing a parent who has a child in the exceptional family member program prior to the active duty member being transferred to an overseas appointment. This is not a codable encounter and there should be no bill.

2. Psychotherapy CPT codes are based on the place of service (office/outpatient or inpatient); the type of therapy (interactive or insight-oriented); time spent in the encounter (minutes of service); and whether an Evaluation and Management (E&M) service is performed.

3. E&M services should not be billed separately when using billing codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829.

3.1. Use codes 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, or 90828 when medical E&M services are provided in addition to mental health services.

3.1.1. However, since there is a CHCS systems requirement for an E&M code, use 99499 as the place holder.

4. Psychotherapy services are based on rates from the CMAC rate table for provider classes 02 and 03. Refer to Provider section of this Guide.

5. Psychotherapy CPT codes are mapped to the UB-04 in TPOCS.

6. The usual revenue codes are 91X, 90X and 94X.

MODIFIERS

Revised: 8 March 2006

1. Modifiers are important as many of them impact billing. Modifiers are used with CPT and HCPCS codes. There are no ICD-9-CM modifiers (there are DoD extenders, unique to the DoD, but they do not impact billing and do not flow to any of the billing systems). As with any code, modifiers must be supported by medical documentation.

2. Modifiers are two-character descriptors. Modifiers are added after the CPT/HCPCS code, such as 27780-RT for treatment of a closed fracture of the right proximal fibula, without manipulation. Modifiers impact billing by indicating that a service was altered from the stated CPT/HCPCS description. Common examples directly impacting billing are:

2.1. -24. Modifier -24 is used when a provider sees a patient for an unrelated issue during a postoperative period. For instance, if a family practice provider performed a vasectomy on Monday (vasectomies have a 10-day postoperative period), then treated the patient as a walk-in for a sore throat on Friday, the provider would need to append modifier -24 to the office visit code. Without the modifier, the insurance company may not pay as the insurance company would think the office visit was part of the global follow-up for the procedure. Yes, you would think that the diagnosis would make it obvious, but many insurance edit systems do not take the diagnosis into account as the edits would be very difficult to keep updated. It is easier to send the incorrectly coded encounter back to be fixed.

2.2. -25. Separate E&M on the same day as another E&M or procedure. For instance, a pediatrician performs a well-baby exam and also treats the child's conjunctivitis (pink eye) at the same visit. The pediatrician would code the physical (e.g., 99392) without a modifier and would code the office visit for the conjunctivitis with a modifier (e.g., 99212 -25). When the insurance company pays, it may slightly decrement the payment for the code with the modifier (in this example, the 99212).

2.3. -26. Professional Component. This is usually used with modifier –tc for the technical component. Other than urology, pathology and laboratory, the most common time this would be seen would be fetal stress tests. If a nurse on the OB unit did the technical component of the fetal contraction stress test (59020) or the fetal non-stress test (59025), and the OB/GYN provider only interpreted the results, the provider would code the procedure as 59020-26, or 59025-26. This will cause the rate from the "Cmp" (component) CMAC rate table to appear on the CMS 1500.

2.4. -50. Bilateral. For instance, a patient has cataracts removed from both eyes during the same surgical session. The rate will be multiplied by 2. Insurance companies may decrement payment for the second procedure, sometimes up to 50%.

2.5. -51. Multiple Procedures. The procedures on the bill will all be listed at the standard rate. Many insurers pay only 50% of the professional fee for multiple procedures. For instance, a patient has a colonoscopy with biopsies and stopping bleeding. The insurer will pay 100% for stopping the bleeding, but only 50% of the fee for the biopsy.

2.6. -52. Reduced Services. The bill will generate at 100% of the rate. Typically insurers will request documentation of how the procedure was reduces and may reimburse less than 100% of the bill.

2.7. -54. Surgical Care Only. For instance, a fracture is set in the Emergency Department, but after care will be done in Orthopedics. The bill will generate at 100% of the rate, but many insurers will discount the procedure 20-40 % depending on the amount of the total global procedure which is the actual surgery.

2.8. -55. Postoperative Management Only. For instance, the orthopedic clinic does only the after care for a fracture treated in the Emergency Room at the downtown hospital. The bill will generate at 100% of

the rate, but many insurers will discount the procedure 60-80% depending on the amount of the total global procedure is for the postoperative follow-up.

2.9. -56. Preoperative Management Only. For instance, an emergency room may do the preoperative component of the care for an open fracture reduction, with the orthopedic surgeon coming in to actually perform the procedure. The bill will generate at 100% of the rate, but many insurers will discount the procedure up to 90% depending on the amount of the total global procedure is for the intraoperative and the postoperative follow-up.

2.10. Modifiers -62, -80, -81 and -82. In ADM, the same code cannot be entered multiple times on the same encounter. This is an issue when using modifiers -62, -80, -81 and -82 (indicating multiple surgeons and assistants at surgery). In ADM, when there are two surgeons or a surgeon and an assistant surgeon, each surgeon/assistant surgeon will need to generate a separate ADM. This is because the principle surgeon will code the procedure code without a modifier, e.g., 58660, laparoscopy, surgical; with lysis of adhesions. The assistant surgeon would code the procedure as 58660-80. Because ADM will only allow the code to be entered once, there is no way to show both surgeons doing the work. Remember, only the principle surgeon will have the 99199 code for the institutional component and the anesthesia services. The second surgeon (modifier -62) and the assistant surgeons (modifier -80, -81, -82) will not have the 99199 and will not have the anesthesia services. One CMS 1500 will be generated for the principle surgeon. One CMS 1500 will be generated for the assistant surgeon or the second surgeon.

2.10.1. For assistant surgeons, remember to use the modifier "– AS" if the assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist. Technicians and operating room nurses will not be coded as assistant surgeons.

3. Modifiers Which Don't Directly Impact Billing. There are many codes which need a location modifier. For instance, a modifier is needed for a fracture of an arm to tell if it is the right (-RT) or left (-LT) arm. Some bills will be returned if the location modifier is not on the bill. Look out for eyelids, fingers, toes, arms, and legs which all need modifiers.

3.1. Specialty Modifiers. Modifiers can indicate the provider's specialty, such as an anesthesiologist, certified registered nurse anesthetist (CRNA), psychologist, clinical social worker or nurse midwife. Some insurers will pay 100% for physicians, psychologists and dentists and pay a reduced rate for physician extenders. These modifiers will become less important when the HIPAA taxonomies become mandatory.

4. The ADM currently accepts up to three modifiers of a CPT/HCPCS code.

5. Some modifiers affect the amount of reimbursement for a particular procedure while others provide additional information only. The following logic works for both TPOCS and MSA/DD7A:

5.1. When the first listed modifier is informational, the rate is multiplied by 1.

5.2. When the first listed modifier is calculable, the rate is multiplied by the number listed in the Baseline Modifier Mapping Table.

5.3. If the modifier is in the 2nd or 3rd position, a rate is applied if the modifier is calculable.

6. In the MHS, because most of the coding is professional, and outpatient institutional coding is limited to the code 99199 (representing the institutional flat rate of an ambulatory procedure visit), modifiers which are only for institutional use are not used. Specifically, modifier -27 is not appropriate for MHS use at this time.
NOTE: In the civilian sector, not all payers accept modifiers.

7. When coding professional services, there are three different computer systems. These computer systems may have less than complete sets of modifiers available. For instance, the preoperative,

intraoperative, and postoperative modifiers are not currently available for the S-HCPCS codes when coding in the ambulatory data module (ADM). The Coding Compliance Editor (CCE) may have a new modifier (such as the out-of-cycle CMS disaster patient modifier) which is not yet available in ADM or AHLTA.

7.1. TPOCS and MSA have the same modifiers that are available in the ADM. AHLTA is very responsive and should have all the appropriate modifiers. If a modifier is not appropriate for the code, the modifier may not appear. Even if the modifier is not in AHLTA, but when reviewed by the CCE, a modifier is appropriate, the modifier can be added in CCE, which flows to ADM, which flows to TPOCS, MSA and the SADR. Modifiers do not currently flow in the SADR to the Clinical Data Repository (which feeds the M2).

NATIONAL DISASTER MEDICAL SYSTEM (NDMS) BILLING

Revised: 7 March 2006

National Disaster Medical System (NDMS) billing was discussed at the 6 January 2006 NDMS Executive Secretariat Meeting. This meeting, held at the Department of Health and Human Services (HHS), included representatives from the Department of Veterans Affairs, Military Health System, Federal Emergency Management Agency (FEMA), HHS, including the Centers for Medicare and Medicaid Services (CMS).

NOTE: See also DoD Reimbursable Disaster Victim, in this Guide.

1. Reimbursable FEMA Costs. During the meeting, it was verified that it is not legal to include billing medical fee-for-service charges in a Mission Assignment. The Mission Assignment is only for reimbursement of costs incurred above and beyond normal healthcare operations. Mission assignment does not include funds for salaried individuals, or those hourly individuals who would normally be working the hours worked. Reimbursable costs in a Mission Assignment would include items such as per diem (e.g., TDY/TAD expenses), overtime, and medical supplies.

1.1. The Services were asked to identify the cost of health care provided to non-beneficiaries as the result of Hurricanes Katrina and Rita. Total costs identified by the Services were $78,101 in outpatient fee-for-services and $142,786 for inpatient billable services. For the MHS, using MEPRS data, the average cost of medical supplies for outpatient services is 5.81 percent of the total cost. The Services identified $78,101 as the cost of outpatient services provided. The MEPRS inpatient factor for medical supplies is 9.75 percent with the Services identifying $142,786 as the cost of inpatient services provided.

Outpatient: Total $78,101 x .0581 = $4,537.67

Inpatient ($230,761-$87,975 NDMS): Total non-NDMS $142,786 x .0975 = $14,064.42

NOTE: The total inpatient amount reported was $230,761. Of that total, $87,975 was for NDMS inpatient billable services, which is separate from FEMA billing.

1.2. TMA UBO reported the $18,602 ($4,537.67+$14,064.42) for medical supply costs to Lt Col Julian, TMA Resource Management, for inclusion in the Mission Assignment bill sent to FEMA.

2. Reimbursable NDMS Costs. NDMS may only be billed for definitive care which is interpreted to mean "inpatient hospitalizations." NDMS may only be billed for patients regulated by FEMA through a Federal Coordination Center (FCC) to the inpatient facility. NDMS may only be billed after other payers (except TRICARE and Medicaid) have paid their obligations. NDMS may not be billed for patient deductibles or co-pays; the patient will always be responsible for these obligations.

2.1. The Services reported seven NDMS patients as having been regulated by an FCC to an MHS facility (two at Brooks Army Medical Center for Katrina and five at William Beaumont Medical Center for Rita).

2.2. NDMS may only be billed for up to 110 percent of the CMS rate for charges for which others do not have an obligation to pay. For instance, if there is a third party payer (insurance), be it medical insurance or some other kind of insurance (e.g., homeowners if a ceiling fell on a patient, or automobile if a person lost control of his car in rapidly flowing flood water), the third party's obligation may not be included in the amount billed to NDMS. Additionally, any co-pays or deductibles owed by the patient should be excluded from the amount billed to NDMS.

2.3. Generating Bills for NDMS Reimbursable Services. TMA provided guidance to the Services a number of times prior to and after the disasters directing that third party payers must be identified and billed first before any claims were submitted to NDMS for reimbursement.

2.3.1. When There Are No Third Party Payers. NDMS is part of FEMA which is part of the Department of Homeland Security. As such, the bills will be generated using the Intra Agency rate.

2.4. Usually, the total MHS inpatient bill is submitted on a single UB-04. This UB-04 is a consolidated bill that contains both inpatient professional and institutional charges.

2.4.1. For NDMS, the bill must be split so that the inpatient institutional component is on the UB-04, and the professional component is on the CMS 1500. This is because unless each of the professional services is listed, the claims processor will have no way of determining what professional services were furnished. NDMS will reimburse up to 110 percent of the CMS rates. CMS has separate rates for professional bills and institutional bills.

3. Institutional Component. The UB-04 must be adjusted to reflect the removal of the professional component. For discharges after 1 October 2005, 7 percent of the Adjusted Standardized Amount is the professional component, and 93 percent is the institutional component. One UB-04 will be submitted indicating the Diagnosis Related Group (DRG) and the NDMS claims processor will reimburse up to 110 percent of what CMS would have paid for the inpatient institutional component for that DRG.

4. Professional Services. CMS 1500s will be submitted for the professional services, and the NDMS claims processor will reimburse up to 110 percent of what CMS would have paid for the inpatient professional services.

4.1. Example: A patient was discharged with a DRG with a relative weighted product (RWP) of 1. The Adjusted Standardized Amount (ASA) for the MTF was $10,712.34, with 7 percent of that being professional services. The MTF will generate a UB-04 for $10,712.34 x .93 = $9,962.48 for the institutional component (this includes radiology, laboratory, and inpatient pharmacy). The MTF will also generate applicable CMS 1500 for the professional services, such a CMS 1500 for E&M 99222 for $120.96, one for four subsequent hospital days using 99231 for $36.48 per day, and one for 99238 hospital discharge day for $76.15. NDMS will pay up to 110 percent of the CMS allowable rate for that service for that location.
NOTE: This example is only applicable if there is a signed DD Form 2569 in the medical record indicating that the patient has no insurance and is not Medicare beneficiary.

4.2. When reimbursement payments received from a payer(s) and the patient (for deductibles or co-pays) equal or exceed the MTF's inpatient bills, no bill will be submitted to NDMS.

4.2.1. A patient was discharged with a DRG with a relative weighted product (RWP) of 1. The ASA for the MTF was $10,712.34. The insurer was billed, at the Full Reimbursement Rate (FRR), $10,712.34. The patient had a deductible of $500 and a co-pay amount of $212.34. The insurance company paid $10,000. Total amount paid, plus deductible and co-pays covered the amount due to the MHS, so there is no need to separate professional encounters from the total inpatient bill as there will be no bill submitted to NDMS.

4.3. When a bill is not totally satisfied by the payer's reimbursement, and patient deductible and co-pay costs, the MTF will submit a bill to NDMS for the remaining balance using the appropriate forms (CMS 1500 and UB-04).

4.3.1. The MTF will calculate the interagency bill. The MTF will subtract the applicable percentage (for discharges after 1 October 2006, 7 percent) from the interagency rate to determine the amount of the inpatient institutional bill. The MTF will code the applicable professional services and determine the prices using the interagency rate. This includes separate CMS 1500 for anesthesia services, if applicable.

4.3.2. When a third party payer pays a portion of the bill, and/or the patient pays a deductible/co-pay, these payments will be made against the professional component of the bill.

4.3.3. A patient was discharged with a DRG with a relative weighted product (RWP) of 1. The ASA for the MTF was $10,712.34 (FRR), with 7 percent of that being professional services. So the MTF will generate a UB-04 for $10,712.34 x .93 = $9,962.48 for the institutional component (this includes radiology, laboratory, and inpatient pharmacy). The MTF will also generate an applicable CMS 1500 for the professional services, such as E&M 99222 for $120.96, one for four subsequent hospital days using 99231 for $36.48 per day, and one for 99238 hospital discharge day for $76.15.

- A third party payer paid $500, the deductible was $500, and the co-pay was $500.
- The MTF would determine the interagency rate for the original services, in this case, $10,150.54.
- The MTF would subtract 7 percent from the interagency bill to determine the UB-04 bill to be $9,440.01.
- The MTF would determine all the CMS 1500 services at the interagency rate.
- This would be approximately $343.03 x .9475 (interagency multiplier) or $325.00.
- $1,500 in payments - $325 (the professional fees) = $1,175.
- $9440.01 (UB-04 Interagency bill) - $1,175 (amount already paid not posted against the professional fees) = $8,265.01
- The MTF would not send to NDMS the CMS 1500s. It would send the UB-04 with a charge of $8,265.01.
- NDMS will pay up to 110 percent of the CMS allowable rate for that service for that location.

4.4. Submitting NDMS Bills. Prior to submitting claims, the MTF must determine the amount of any deductibles, co-pays, and obligations by third party payers, to include Medicare obligations. In the most recent cases, since most patients were discharged prior to 1 November 2005, this coordination with third party payers and Medicare should be complete. As discussed on a19 January 2006 teleconference, claims may be submitted beginning 24 January 2006 to TrailBlazer, the NDMS claims processor. All NDMS claims must be submitted to TrailBlazer by 31 March 2006. See attached files for more instructions regarding billing NDMS.

5. Usual Billing Steps for NDMS.

5.1. Physician determines a patient, regulated to the MTF by an FCC, needs to be admitted.

5.2. Billing office personnel collects Other Health Insurance (OHI) information on the DD Form 2569. This includes information on Medicare and Medicaid coverage. Patient signs the DD Form 2569.

5.3. Billing office personnel assigns the appropriate patient category (PATCAT). As eligible beneficiaries would not be NDMS patients, the PATCATs in A, B, C, F, M, N, P, and R would not be applicable. The most likely PATCATs would be K92A Civilian Emergency Care and K92C Civilian Emergency - Social Security Beneficiary.

5.4. If there was OHI or the patient was a Social Security beneficiary, the applicable organization(s) would be contacted to obtain a pre-certification.

5.5. The patient hospitalization would occur. The patient would be discharged. The record would be coded. A diagnosis related group (DRG) would be assigned.

5.6. The MTF would generate a bill and provide it to the patient. If the patient had OHI or Medicare, and the patient assigned his benefits to the MTF, the MTF could bill the OHI. Upon receipt of the OHI payment, or if there was no OHI, the appropriate bill would be submitted to Medicare.

5.7. The patient would pay any applicable patient deductibles/co-pays.

5.8. Upon resolution of payments from OHI, Medicare, patient's deductible/co-pay, the appropriate bill will be generated for NDMS claims processor.

OBSERVATION SERVICES

Revised: 01 July 2011

1. General Background.

1.1. Observation (OBS) is an outpatient billable service. The Assistant Secretary of Defense for Health Affairs issued a memorandum titled "Policy for Billing for Observation Services in Fixed Military Treatment Facilities." This memorandum cancels policy titled "Policy for the Reporting and Billing of Observation Services," dated August 11, 2010, and implements new policy for billing for observation services in fixed MTFs. This section of the User Guide has been prepared to ensure correct billing for both TPC and MSA functions. prepared to ensure correct billing for both TPC and MSA functions.

1.1. Under the policy referenced above, the use of functional cost code B**0 is no longer authorized.

1.2. Observation services shall only be provided in two locations: the hospital's Emergency Department (ED) or in a nursing unit/ward of the hospital.

1.2.1. Current MTF information systems can only support outpatient observation services for patients in the ED. Current systems allow capture the required billing data including ED MEPRS code and procedure codes for services rendered in the ED, including OBS.

1.2.1.1 Observation services (professional and facility) that are initiated in the ED following an ED evaluation, and result in the patient being discharged home (or to an external location outside the MTF) are captured in the Ambulatory Data Module (ADM) on the "B***" ED SADR.

1.2.2. For continuity of care reasons, patients placed on a nursing unit/ward that require observation care will be "admitted" to the hospital via the CHCS.

2. Coding and Documentation Background to Billing.

2.1. There must be a separate medical observation record with proper documentation of the admitting orders, nursing notes and progress notes while in observation status. This record will be referenced by coders and billers as source validation of documentation to ensure correct coding and subsequent billing.

2.2. Coding and documentation guidance specific to observation services was updated and published with an effective date of 1 January 2011. Appendix H - Observation Services, of the MHS Coding Guidelines can be found at: http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm

2.3. Clinical "pathways" are outlined in the coding guidance define the typical scenarios for episodes of observation care that originate on the nursing unit/ward, in the ED, or when a patient is subsequently converted to inpatient status (from ward or ED).

2.4. MTFs have the ability to code facility HCPCS codes (G0378 and if applicable, G0379) for each hour in observation status. This is in addition to the provider's professional E/M services and any other appropriate services reflecting all care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) during observation care, provided the patient is not subsequently converted to an inpatient.

2.5. A coding methodology was developed to identify or flag patients on the nursing unit/ward in OBS status who were discharged home (or to an external location outside the MTF) rather than converted to an inpatient status. These episodes of care are identified based on diagnosis code V71.9 will be the first-listed code on the SIDR and an MS-DRG assignment of 951.

2.6. For patients originally placed in observation status in the nursing unit/ward and subsequently converted to inpatient status, coding of the inpatient SIDR will be accomplished by sequencing V71.9 in the last-listed code on the SIDR. This allows for tracking of episodes of care where OBS status originated in the nursing unit/ward and converted to an acute care hospital admission.

2.7. All observation services rendered on the nursing unit/ward, both facility and professional, will be captured on the associated "A" SADR/CAPER in the Rounds module in the CHCS.

3. Billing when the Patient is Not Converted to Inpatient Status

3.1. MTFs have the ability to bill facility, provider professional services, and other services reflecting all care provided during observation care, provided the patient is not subsequently converted to an inpatient.

3.2. Billing staff will review all inpatient claims/invoices to identify patients on the nursing unit/ward in OBS status, and who were discharged home (or to an external location outside the MTF) based on diagnosis code V71.9 will be the first-listed code on the SIDR and an MS-DRG assignment of 951 to identify incorrect inpatient claims/invoices.

3.2.1. For TPCP inpatient claim: The insurance claim appears in print queue in CHCS; claim is printed and reviewed by the biller.

3.2.2. For inpatient MSA: Invoicing for inpatient admissions appears on the DD7 report in CHCS.

3.2.3. Does V71.9 and DRG 951 appear on the CHCS-generated insurance claim form? If yes, flag claim/invoice as Observation.

3.3. For those incorrect inpatient claims/invoices, billing staff will cancel the incorrect claim/invoice and manually generate appropriate outpatient claims\invoices for all services rendered during the OBS episode of care.
Cancel the claim or write off charges in CHCS to the appropriate closure code (as determined by each Service)
Write off I&R charges generated in CHCS(as determined by each Service)
Pass information to outpatient or other designated billing staff

3.4. Facility HCPCS codes (G0378 and if applicable, G0379), provider professional services and any other services reflecting care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) during observation care should be billed based on the patient category and outpatient itemized billing rates.

3.5. Refer to the Patient Summary Report in CHCS. Do admission and discharge date, or start and end times, etc., indicate less than a 24 hr. stay? If yes, flag claim/invoice as a possible Observation or other non-inpatient episode of care (e.g., post APV overnight stay).

Confer with HIM staff/Coding Guidelines for assistance in admission status determination
Proceed with claim cancelation/invoice write-off followed by outpatient billing or inpatient billing as appropriate

4. Billing when the Patient is Converted to Inpatient Status.

4.1. Facility HCPCS codes (G0378 and if applicable, G0379), provider professional services and any other services reflecting care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) are not billable when a subsequent "true" admission occurs.

4.2. Likewise, the attending provider's professional services on the A*** Rounds SADR are not billable when a subsequent "true" admission occurs.

4.3. When a “true” admission occurs, MTFs will bill based on normal inpatient billing procedures computing charges based on the patient category and approved adjusted standardized amount (ASA) rates, MS-DRG assignment, and MS-DRG relative weighed products and length of stay outlier criteria.

OPHTHALMOLOGY, OPTOMETRY & VISION SERVICES

Revised: 9 March 2006

1. Medical issues such as conjunctivitis (pink eye), detached retinas, scratched corneas, removal of foreign bodies and glaucoma are usually covered services in insurance policies.

1.1. Medical issues are usually coded using the office visit codes in the CPT 99201-99215 and 99241-99245.

2. Frequently, vision services are not covered. Vision services would include screening eye exams and glasses/contacts.

2.1. Vision services are usually coded with codes in the CPT 92002- 92396 and the V2020-V2799. Therefore, frequently vision service bills are denied as an uncovered/excluded service.

3. With few exceptions, CPT codes 92002-92004, 92012-92014, and 92015-99195 are mapped to print on the CMS 1500.

OTORHINOLARYNGOLOGY SERVICES

Revised: 01 October 2003

1. Special otorhinolaryngologic services are diagnostic and treatment services that are not included in a comprehensive otorhinolaryngologic evaluation or office visit and are reported separately.

2. Speech therapy is included as part of the special otorhinolaryngologic services.

3. Hearing tests such as whisper voice or tuning fork are considered part of the general otorhinolaryngologic service and are not reported separately.

4. Hearing test codes are inherently bilateral. If testing is applied to just one ear, use modifier -52.

5. Otorhinolaryngology CPT codes: 92502-92526, 92531-92534, 92541-92548, 92551-92597, and 92601-92617.

OUTPATIENT SERVICES NOT RELATED TO INPATIENT ADMISSIONS

Revised: 01 October 2003

1. Clinical outpatient services that are not related to the patient's hospital admission and are rendered prior to inpatient admission are billed as outpatient services.

2. Clinical outpatient services that are not related to the patient's hospital admission and are rendered during the inpatient stay are billed as outpatient services.

PAIN MANAGEMENT SERVICES

Revised: 01 October 2003

1. Pain management services are evaluated using the 8 to 10-point McGill pain pattern scale. If the patient's level of pain is below the 8 to 10 point scale, then the services will fall below the stipulated guidelines for billing. Pain management reimbursement policies are carrier-specific.

2. Pain Management Consultations

2.1 Pain management consultations are carefully watched for abuse. Medicare has targeted office codes 99241–99245 and hospital codes 99251–99255 for careful scrutiny.

2.2 When a surgeon requests a post-operative pain consultation for a patient immediately following surgery (24 hours), documentation is required in the surgical medical record.

3. Epidural Catheter Placement

3.1 Physicians place epidural catheters for post-operative pain management at any of four sites along the spine.

3.2 Placement of a cervical or thoracic catheter should be coded using CPT code 62318.

3.3 Placement of a lumbar or sacral catheter should be coded using CPT code 62319.

3.4 Post-operative pain management with epidural or subarachnoid drug administration is coded with CPT code 01996. Presently, this is a flat rate.

4. Trigger Point Injections

4.1 Trigger Point Injections should be coded according to the muscle groups targeted, not according to the number of injections administered.

4.2 When multiple injections are administered at the same site, only a single injection should be coded.

4.3 Complete documentation is critical in establishing medical necessity for a trigger point injection. An injection (CPT code 20550) is covered when the following criteria are met: the patient's clinical condition is marked by substantial pain and/or significant functional disability; appropriate conservative treatment has not provided acceptable relief; and there is a reasonable likelihood that the injection will significantly improve the patient's pain and/or functional disability.

4.4 For subsequent trigger point injections received in a series, the patient's medical record must state the degree of relief the patient experienced from the previous injection.

PATIENT ADMINISTRATION

Revised: 7 March 2006

1. It is strongly recommended that a coding professional verify coding prior to generating a bill. Follow Service-specific guidelines (e.g., for the Navy, you *shall* have 100% of documented billable encounters reviewed by a coder). It ensures the documentation is in the facility and did not walk out to the patient's car along with the patient. It also ensures the coding is accurate.

2. Billing personnel cannot do it all. To paraphrase Senator Clinton, "It takes an MTF." To have an effective billing program, the billing department needs MTF support in the form of appointment, check-in, and admissions personnel. The following information needs to be collected: MTF leadership must support clerks collecting:

2.1. Other Health Insurance (OHI) information – collected on the DD Form 2569 – to be forwarded to the billing department for verification and entry into CHCS,

2.2. Assignment to a patient category (PATCAT) for *every* encounter. The MTF will not earn all possible workload credit if a patient is assigned an incorrect PATCAT. This can also lead to incorrect billing. For example, if a retiree comes in for an FAA physical, for that encounter, the patient should be assigned K53. If the patient is assigned the retiree PATCAT and that patient had OHI, the MTF would incorrectly bill OHI instead of Interagency. Always coding the patient as a retiree will "loose" the MTF credit. Occupational health services are not included in MTF funding for empanelled patients. See the PATCAT Section of this Guide for additional information.
NOTE: The PATCAT is dynamic. A patient may be a retiree for one encounter and an occupational health patient for the next encounter.

2.3. "Cause of injury" data. MTF personnel need to use the free text fields in the appointment module to document the cause of injuries. This will aid in the identification of potentially recoverable services through the Medical Affirmative Claims (MAC) program.

PHARMACY SERVICES

Revised: 8 March 2006

1. There are many issues associated with pharmacy billing. These include internal versus external prescriptions; initial fills, refills, the number of units which will be reimbursed; types of coverage; which form to use; over-the-counter; and Third Party and Medical Services Accounts.

2. Internal prescriptions. An "internal prescription" is one prescribed by a provider who saw the patient at the MTF. This means that both the appointment and intake personnel should have checked if the patient had other health insurance (OHI). Check with your Service representative to determine if it is necessary for pharmacy technicians to do OHI checks for internal prescriptions.

2.1. Internally ordered prescriptions that are ordered and linked to a B*** MEPRS (outpatient clinic) and C*** MEPRS (dental clinic) encounter feed to TPOCS via the pharmacy feed. If the prescription is filled and dispensed within the holding time established at the MTF, the prescription bills will have the same diagnosis as on the encounter and will appear on a UB-04 with a diagnosis from the encounter. This is important, as the diagnosis needs to be on the UB-04 for the payer.

2.1.1. For outpatient prescriptions associated with D*** MEPRS encounters, the pharmacy TPOCS feed does not automatically link the prescription to the encounter because the encounter coding does not feed automatically to TPOCS. The diagnosis from the D*** MEPRS encounter should be used on the pharmacy bill. If your MTF is manually billing D*** MEPRS, you can cancel the separate pharmacy bill and manually generate the D*** MEPRS encounter along with the prescription.

2.2. Internal to the server, but external to the MTF. Guidance will be forthcoming. An example of where this is an issue is when a prescription is written at one MTF on the CHCS server and filled at a different MTF on the same CHCS server. It is the pharmacy's responsibility to ensure the correct MEPRS is assigned to these prescriptions.

3. External prescriptions. An "external prescription" is one prescribed by a civilian provider external to an MTF. Since the patient did not have an appointment and was not checked in by MTF personnel at a clinic, pharmacy personnel must query all patients with external prescriptions regarding OHI.

3.1. Abbreviated OHI form. There is an abbreviated OHI form for all external ancillaries (e.g., pharmacy, laboratory, radiology) that may be used by the MTF. This will ensure the technician collects enough data for the billing office to generate a bill. The abbreviated form, along with a photocopy of the external prescription or order, should be sent to the billing office. Depending upon the MTF, the abbreviated form will be scanned into an MTF-designated program or filed in the billing office. See the Appendix of this Guide for a copy of the abbreviated OHI Form.

3.2. TPOCS. TPOCS should receive all prescriptions for OHI patients. Evidently, there is a problem when the prescription is modified prior to dispensing. Many of these prescriptions when filled, do not feed to TPOCS. Sites are encouraged to use the CHCS Pharmacy Cost Report, which is reported alphabetically. If the CHCS Pharmacy Cost Report only reports external prescriptions (FCC* MEPRS) an ad hoc report may be available from your Service representative. This report can be split alphabetically to the billing personnel to review against their patients with OHI. Billing personnel will need to generate manual bills for these missed prescriptions.

3.3. Required Data Elements for External Providers.

3.3.1. The Drug Enforcement Agency (DEA) Number, Provider Specialty Code and CMAC Provider Class, HIPAA Taxonomy, and National Provider Identifier (NPI) Type 1 are all needed to create a correct provider profile. The first time a prescription is received from an external provider, a number of data elements are required to establish a provider file. The DEA# is critical to have for all external

civilian providers. These extra data elements are on the abbreviated OHI Form.

3.3.2. CMAC Provider Class. This is still used by the Uniform Business Office for billing. Physicians and Dentists are CMAC provider class 01. Psychologists are provider class 02. Other mental health privileged providers are 03, such as advanced practice mental health nurse practitioners and clinical social workers. All others, including physician assistants, other nurse practitioners, optometrists, podiatrists, physical and occupational therapists, nurses and technicians are CMAC class 04.

3.3.3. If the provider has a DEA# and a non-billable Medical Specialty code such as OB/GYN/942, then this will not generate a bill, but go on the TPOCS Load Error Report. By working the TPOCS Load Error Report, the billing office can easily identify those providers needing additional or corrected information.

3.4. Diagnosis. To be paid, the diagnosis must be populated. When the diagnosis is unavailable and you are using the UB-04, depending on the payer's preference, possible options include using the ICD code V68.1, or 799.89, or contacting the provider who prescribed the medication to obtain the applicable diagnosis.

4. Initial fills/Refills.

4.1. Quantity Limits. Many insurance plans have dispensing limitations as a cost containment measure and the insurer's way of avoiding waste when a patient begins a new medication. The patient may have unacceptable medication compliance issues such as an adverse reaction. For example, if a patient begins a drug and develops hives. Because of the adverse effect, the provider instructs the patient to discontinue the medication and prescribes another. Insurers may also limit refills and limit quantities on certain drugs for patient safety and FDA guidelines. Certain drugs, such as narcotics, may have additional FDA limits on the quantities that a pharmacy may dispense. Billing clerks must not split the bill into multiple bills of a quantity less than the quantity actually dispensed. Generally, refills will not be approved and paid until 75% of the drug has been used.

4.1.2.1. Refills. Frequently there are no visits associated with refills. When the pharmacy refill bill feeds to TPOCS or MSA, there will be no associated diagnosis. A diagnosis associated with the initial issue may be researched and used on the UB-04 or, depending on the payer, the codes V68.1 or 799.89 may be used (see paragraph 3.4., above).

4.1.3. Differences between civilian sector and DoD practices contribute to a relatively high degree of rejects of claims for refill prescriptions:

4.1.3.1. Refills are generally not covered until 75% of the original script has been used. Not all DoD pharmacies enforce a 75% restriction on refills.

4.1.3.2. In the case of a paper claim, the appropriate fill number is entered on the standard pharmacy UCF claim form. The UB-04 claim form, since it is not a standard pharmacy claim form, does not have a place or box to enter the refill information. MTFs are encouraged to enter the term "refill" next to the script number when the UB-04 is used for a pharmacy claim.

4.2. Pre-authorization/pre-certification of prescription drugs. Many insurers require pre-authorization of certain drugs as part of their Patient Safety and Quality Monitoring program. High cost/frequently incorrectly prescribed drugs or "specialty" drugs have been identified by various insurers as needing pre-authorization. This list is not consistent among insurers and is subject to change. See attached list of drugs that commonly require pre-authorization. Some plans have a list of drugs requiring pre-authorization on their website.
NOTE: Specialty drugs include, but are not limited to, drugs that require special handling and close monitoring, and are used to treat chronic conditions such as hemophilia, immune deficiency, and rheumatoid arthritis.

4.2.1. Certain classes of drugs, including growth hormones, replacement enzymes, drugs used to treat Attention Deficit Disorder, and narcolepsyoncologic agents generally require pre-authorization. In some instances, the approval can be extended to cover refills over a certain time period or for a certain quantity. Example: Nexium may require prior authorization but the authorization or approval may extend to refills over a period of a year before another approval must be obtained. There is currently no way of flagging medications requiring pre-authorization. When an initial prescription bill is denied due to lack of pre-authorization, the billing clerk must check to see if there are refills. If so, the billing office should work with the insurer and provider to obtain a pre-authorization prior to any refills being dispensed.

5. Coverage Types. There are three principle types of insurance which will pay for prescriptions; medical, drug plan, and comprehensive. Prior to billing for pharmacy items, the billing office should verify the patient has *pharmacy* coverage initially and every year thereafter. Medical or comprehensive coverage does not necessarily include pharmaceutical coverage.

5.1. Insurers expect pharmacy bills from commercial pharmacies (e.g., Rite-Aid) or mail order pharmacies. The MHS pharmacy bills are somewhat unusual and insurers may not have standard procedures for paying this type of bill. Many, if not all, commercial pharmacies and mail-order pharmacies have transitioned to electronic billing. See the “Coverage Type” section for more information.

5.2. In general, when a patient is covered for medical care that includes pharmaceuticals, the insurer requests the UB-04 form be used and that there be a diagnosis associated with the prescription to explain why the pharmaceutical was prescribed.

6. Forms. The bill types that may be generated in the TPOCS are the UB-04 and the Universal Claim Form (UCF). Prescriptions default to the form selected by the MTF. When both forms are needed, the TPOCS defaults can be carrier-specific. In MSA, the bill type is determined by the PATCAT of the patient.

6.1. The UCF is the National Council for Prescription Drugs Program (NCPDP) standard paper claim form used for billing pharmacy claims. The UCF does not require the use of a diagnosis code (it is strictly for the pharmacy benefit, not medical). For controlled substances, a diagnosis is needed in field 16. For external prescriptions, many sites try to contact the civilian provider for the diagnosis for which the controlled substance was ordered.

6.2. UB-04. Use of the UB-04 is encouraged unless otherwise requested by a payer because you can enter more prescriptions on one form than can be entered on one UCF. When the diagnosis is unavailable, and you are using the UB-04, depending on the payer’s preference, use the ICD code V68.1 or 799.89.

7. Over-The-Counter (OTC) Medications. Some MTF pharmacies will dispense OTCs. OTCs are normally not a covered benefit. If it is not covered in the policy, by law, the insurer cannot be required to pay. At this time, the MHS system cannot be programmed to bill for one insurance policy and not bill for another insurance policy. If OTCs are a covered benefit, they should be included on the bill, even if they cost more (in labor) to bill and post then will be recovered. This is because the cost may be applied to the patient’s deductible.

7.1. Deleting OTCs from TPOCS Bills When the Insurer Does Not Pay For OTCs. To generate a bill without OTCs, go to select bills. Click on the specific line you will be deleting. Click on the “eraser button,” which is a menu button on the tool bar. Save your changes. The bill should print with a new total. This will keep your accounts receivable more accurate and save time by not having to delete the entire claim to create a manual claim without the OTCs.

7.2. It is anticipated that with the July 2006 Pharmacy Rate Table update, OTCs will no longer be on the rate table and this will no longer be an issue.

8. NCPDP Number. Each dispensing location in the MHS has its own NCPDP. Be sure to use the

correct facility NCPDP number on the prescription.

9. Documentation Requirements. For some prescriptions, there are payer-specific requirements and supportive medical record documentation must be submitted with the claim.

10. Prescribing Cost. TPOCS and MSA automatically calculate the prescription cost multiplying the Number of Units by the Unit Cost and adding a Pharmacy Dispensing Fee for all prescriptions both new and refills. These rates are developed using the Managed Care Pricing File from Defense Support Center Philadelphia (DSCP). For some medications, this price is significantly lower than what your MTF may be paying to obtain the medication. This is because DSCP has pricing agreements for large quantities. Your MTF may not be buying large quantities using the DSCP agreements.

11. Dispensing Fee. A dispensing fee is established annually and loaded with the other outpatient pricing tables.

12. Medicare Supplemental. MTFs can bill Medicare supplemental policies for prescription drugs if a beneficiary maintains Medicare supplemental policies H, J, or I.

13. Revenue Codes. Revenue codes will be populated if the pharmacy services are billed on the UB-04 Claim Form. The revenue code (250) for internal and external pharmacy bills can be edited in TPOCS.

14. Non-Issued Prescriptions. The bill is created and flows to TPOCS when a prescription label is printed, not when the prescription is actually issued to the patient. When a patient does not pick up the prescription within 10 days, the pharmacy must appropriately update the pharmacy module in CHCS so the cancellation flows to TPOCS before the bill is printed/e-billed.

SAMPLE SAMPLE SAMPLE SAMPLE SAMPLE SAMPLE SAMPLE SAMPLE

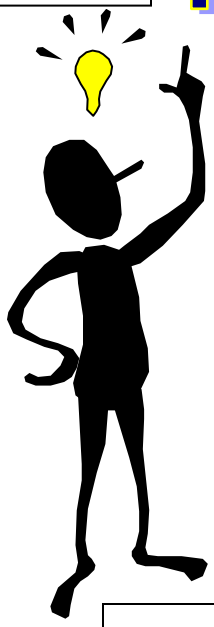
FOR EXTERNALLY ORDERED ANCILLARY SERVICES

$$$$ Let your health insurance premiums work for YOU! $$$$

Do you pay for other health insurance beside TRICARE?

PHARMA___
RAD _____
LAB _____

Third Party Collection Program



- Participation in this program can help you meet your annual deductibles with **no out-of-pocket expense**!!!
- Funds received will allow us to continue to provide superb service and enhance the quality of care you receive at this facility!!!
- Update your insurance information (DD Form 2569) annually - at the clinic or in the Business Office.

Patient Name/SSN:_____

SPONSOR/SSN:_____

Policy Holder's Name:_____

Policy Holder's Employer:_____

Insurance Company:_____

Policy #:_____Group #:_____

Ins. Co. Address:_____

Ins. Co. Phone #:_____

Family Members Covered by Plan? **Yes / No** (please circle) (list names below)

_____

_____

Authority: Title 10 USC Sect. 1095; EO 9397

PRE-AUTHORIZATIONS/PRE-CERTIFICATIONS

Revised: 01 July 2009

1. Pre-authorizations: Some insurers require approval of an admission, a procedure, a drug, or supply before furnishing it or at the time of service so they can receive full reimbursement.
NOTE: For this section, the terms pre-authorization and pre-certification are used interchangeably as are the terms insurer and insurance company.

1.1. Obtaining pre-authorizations is a Uniform Business Office (UBO) task. Without a pre-authorization, a Military Treatment Facility (MTF) may not recover a significant amount of funds. Insurance companies are usually looking at high-cost items.

1.2. Every insurance company has different criteria, and the criteria may change annually. A third party is sometimes used to review and authorize services.

2. Admissions: A process must be in place for Admission personnel to notify UBO staff when a patient with Other Health Insurance (OHI) is admitted. UBO staff or Utilization Review (UR) nurse will call the insurance company's pre-authorization phone number or use a secure on-line process to contact them.

2.1. Admissions personnel need to notify UBO staff when a patient is admitted for care; it may be done via e-mail group, by providing Admission sheet and DD2569 form, or by phone call.

2.2. All admissions, ambulatory procedure visits (APV), and some outpatient encounters require calling the insurance company for pre-authorization. An authorization number may be given after providing a reason for admission. A "Clinical Review" may be required. In some cases, no authorization is needed for a diagnosis (e.g., pregnancy) or where Medicare is considered the primary payer. Failing to call may require additional clinical review and be subject to a reduction in reimbursement (e.g., a $500 penalty).

2.3. "Clinical Review" may be done by UBO staff, or sent to a Utilization Review nurse or a staff nurse.

2.4. The authorization number needs to be on UB-04 in field locator 63; number may be added to Composite Health Care System (CHCS) "PII [Patient Insurance Information] Pre-authorization field." This field will be overwritten with the next authorization. Keep detailed documentation of authorization for each admission with its billing file.

3. Outpatient Surgery and Diagnostic Imaging/Radiology Therapy: A process must be in place to obtain a copy of future appointment schedules. Look for patients with insurance to see if there are any schedules, procedures, or visits that require pre-authorization.

3.1. Schedules usually do not have insurance information listed; every site may have a different method of tracking and obtaining a schedule; this makes the process difficult for UBO.

3.2. Calling for pre-authorization. Authorization may be given after providing a reason for procedure; however, additional information may be required from the medical record and a 'Clinical Review' may be necessary.

3.3. The authorization number needs to be on the UB-04 in field locator 63 or on the CMS 1500 in item number 23.

4. Pharmacy Scripts: A process must be in place for UBO staff to identify scripts that require prior authorization; scripts differ per insurance company.

4.1. Create tracking lists of scripts by payer requiring Prior Authorization (PA). Often this is not known until a denial is received.

4.2. Request from the payer or print from a Web site a blank pharmacy authorization form. UBO staff may only need to partially complete the form prior to sending to the provider.

4.3. Fax completed forms to the payer for authorization. Authorizations are usually good for one year.

4.4. For payers who deny a script requiring “step-care”; obtain list of patient scripts and information which then may be provided over the phone to the payer.

5. Post-authorization: If a denial is received for not obtaining prior-authorization after service is billed, start authorization steps at once. Service may not always be authorized after billing, but many times, they are authorized and paid.

6. Common Services: Following is a non-inclusive list from various insurance companies of services that may require pre-authorization; every insurance policy may be different.

Genetic Testing

Mental Health * Substance Abuse

Morbid Obesity/Bariatric Surgery

Nuclear Stress Tests/Nuclear Cardiac Imaging Studies

Durable Medical Equipment (Orthotics/Prosthetics/CPAP)

Physical Therapy * Occupational Therapy * Speech Therapy * Chelation Therapy

Spinal Surgery * Transplants * Sleep Apnea Surgery * Reconstructive Surgery

CT (Computerized Axial Tomography) Scans * MRI (Magnetic Resonance Imaging)

MRA (Magnetic Resonance Angiography) * PET (Positron Emission Tomography)

PROLONGED SERVICES

Revised: 01 October 2003

1. Direct (Face-to-Face) Patient Contact

1.1 Codes +99354 and +99355 are add-on codes and are used to report the total duration of face-to-face time spent by the physician involved in direct patient contact beyond the usual service. These codes should be listed separately in addition to the E/M service.

1.2 Time does not have to be continuous but must be documented.

Example:

A patient is seen in the Urgent Care Clinic as a result of a fall down the escalator. The patient had multiple trauma and was examined by an Orthopedic physician for a suspected hip fracture. The physician communicated to the patient the extent of the injuries and the treatment plan. The history and examination were detailed with moderate complexity decision making. The examination time was 55 minutes. The threshold was met and the visit is coded with 99214 E/M (25 minutes) and 99354 (30 minutes) for the extra time.

2. Without Direct (Face-to-Face) Patient Contact

2.1 Codes +99358 and +99359 are used to report the total duration of non-face-to-face time spent by the physician.

2.2 Time does not have to be continuous but must be documented.

2.3 These codes may include review of extensive records and tests, communication with other professionals (excludes telephone calls) and/or communication with the patient or family.

Example:

Given the above scenario, if the physician communicated with other professionals concerning the proposed treatment plan and conducted review of extensive records and tests, then the applicable prolonged services without direct face-to-face contact can be coded. Note: In order to use codes 99358 and 99359 the physician would have seen the patient prior (direct face-to-face).

PROVIDERS

Revised: 01 October 2003

1. Providers (e.g., physicians, nurse practitioners, nurses, medical technicians, etc) are mapped to a CMAC Provider Class and a HIPAA Provider Taxonomy Code for billing purposes, based on their medical specialty code in CHCS. Not all providers map to a CMAC Provider Class and corresponding HIPAA Provider Taxonomy Code.

2. Within the MHS, providers are classified as either privileged or non-privileged. See the Professional Services and Outpatient Coding Guidelines (1 October 2002) for a complete definition of each.

3. Currently in the MHS, services provided by non-privileged providers (registered nurses, licensed practical nurses, independent duty corpsmen, and technicians) are billed using E/M code 99211 and/or 99499 as a place holder for capturing workload only. The ADM requirement to use an E/M on each encounter is being addressed with an SCR. E/M 99211 informs the payer that "the presenting problem may not require the presence of a physician."[1] The actual procedure is not billed under a supervising physician and the payer may or may not reimburse for these services.

NOTE: Changing business and system processes to bill for these non-privileged providers' services under a supervising physician as "incident to" services is being reviewed. Please refer to the Future Enhancements/Current Changes section of this document for details.

4. In cases where there is a requirement for physician supervision (e.g., GME programs), the services are billable, and the documentation requirements are met, the ADM encounter is completed under the supervising physician's name. The MTF may also choose to change their business practices and follow civilian "incident to" guidance[2] and bill for services rendered by non-privileged providers under the supervising physician's name. The charges are then pulled from the CMAC Rate Table based on the supervising physician's CMAC Provider Class.

5. CMAC Provider Classes:
   - 01 is the physician class (MD and DO)
   - 02 is the psychologist class (PhD and psychologist)
   - 03 is other mental health provider class (Certified Social Worker)
   - 04 is other non-mental health provider class (Nurse Practitioner)

6. Refer to the Appendix for a mapping of CHCS Provider Type to CMAC Provider Class to HIPAA Provider Taxonomy.

7. For licensure and education requirements refer to 32 CFR §199.6.(c)(3)(iii).

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[1] AMA, CPT 2003

[2] ingenix, Complete Guide to Part B Billing Compliance

PULMONARY FUNCTION

Revised: 8 March 2006

1. Pulmonary function testing is a determination of the effectiveness of the pulmonary system (e.g., the lungs). These tests usually require special equipment, but some tests will be coded with the office visit such as pulse oximetry for patients with possible oxygenation problems such as asthma or chronic obstructive pulmonary disease (COPD).

2. Outpatient Clinic Services.

2.1. Pulse Oximetry. When a test, such as 94760 pulse oximetry, is performed in the outpatient clinic, it needs to be linked to a diagnosis reflecting the possible oxygenation problem. If the procedure is done as a vital sign, with no symptoms to indicate a problem, and it is coded as a separate procedure, do not expect insurance companies to pay.

2.2. Spirometry. During some physicals, particularly for pilots, total lung capacity is measured. In some cases it meets the requirements for 94010, spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation. It is not usually performed for other physicals. Since active duty care is not billable, spirometry would not appear frequently on bills for physicals.

3. Pulmonary Function Clinic. These services are usually furnished in the DD** MEPRS Functional Cost Code (FCC). Because they are performed and coded in the DD** MEPRS, they would have to be identified and billed manually.

3.1. Many of these codes have both a technical component (the technician performs the hook up and records the test) and a professional component (the doctor reviews the tracing, does an interpretation, and writes a report). With the 17 day hold, both the technical and professional components *should* be available to bill at one time. In that case, they would be manually billed on the CMS 1500, using the code for the total procedure (tracing and interpretation) in the privileged provider's name, on the day the interpretation and report was performed.

RADIOLOGY

Revised: 14 January 2009

1. Radiology CPT codes are in the 70010-79999 range. Radiology services coded with no modifier or appropriate modifiers except for -26 should be billed on the UB-04. Radiology services coded with modifier -26 reflects only professional services and should be billed on the CMS 1500.

2. Most radiology work is collected in the radiology module of CHCS and feeds directly to TPOCS or MSA. The Correct Coding Editor (CCE) does not review coding from the Radiology module.

2.1. Billing personnel should be aware that some of the modifiers used in the radiology module are inconsistent with general coding principles.
These modifiers are being used to calculate radiology workload values. If you have any questions about whether or not you should use the modifier on a bill, please contact a member of you facilities' coding staff The modifier meanings within the radiology module are as follows.

- 32 modifier (Exam weight for procedure)
- 26 modifier (Reporting weight of the procedure)
- 00 modifier (Total weight value for the procedure)
- 50 modifier (Bilateral / weight is doubled)
- 51 modifier (Exam only - bilateral)
- 22 modifier (Portable/ weight is doubled)
- 99 modifier (Bilateral and portable)

3. Revenue Codes. There are several different categories of revenue codes that can be used, based on the procedure code. The general categories are: 032X-Radiology; 035X-CT Scan; 040X-Other Imaging Services; 0483-Cardiology; 061X-Magnetic Resonance Technology (MRT); and 0750-Gastrointestinal Services.

4. TPOCS Bill Type 3.

RATE TABLES

Revised: 01 October 2003

1. DoD uses rates tables to apply charges to services rendered and supplies provided in an outpatient setting. Each service and supply is identified with a HCPCS/CPT code.

2. UBO has adopted the use of the CHAMPUS Maximum Allowable Charge (CMAC) table as its primary rate table.

3. The CMAC table is used by DoD to reimburse providers in its Managed Care Support Contract Network. Because not all services rendered by a civilian provider are reimbursable by TRICARE, UBO has developed DoD Average Cost Rate Tables to assign charges to other services rendered inside the MTF.

4. CMAC Table

4.1. CMAC rates are calculated based on guidance provided in the TRICARE Reimbursement Manual 6010.53-M and 32 CFR 199.14.

4.2. Each billable provider is mapped to a CMAC Provider Class of 1-4. The CMAC table contains rates for each CMAC Provider Class applicable for that service. Please refer to the Provider section for more information on CMAC Provider Class and mapping information.

4.3. The CMAC table is divided into 90 different locality codes. Localities account for differences in geographic regions based on demographics, cost of living, and population.

4.4. CMAC Localities correspond to zip codes of treating facility DMIS ID codes.

4.5. For each locality code, the CMAC table is composed of three sub-tables; the CMAC Rate Table, the Component Rate Table, and the Non-CMAC Rate Table.

4.6. Listed below is the order in which the CMAC Tables are utilized to obtain rates:

4.6.1. CMAC Rate Table

The CMAC Rate Table will determine the rate for individual professional services and procedures identified by HCPCS and CPT codes, which are used for outpatient services. The majority of the codes are contained in this table.

4.6.2. CMAC Component Rate Table

4.6.2.1. The Component Rate Table is based on components that are comprised of professional, technical, and global reimbursement rates.

4.6.2.2. The professional component rates are for services that are normally performed by a physician to interpret a diagnostic test. Modifier -26 designates these services.

4.6.2.3. The technical component rates are institutional charges that are not normally billed separately (e.g., charges for equipment, technician services, supplies and materials used during test). Modifier -TC designates these services.

4.6.2.4. The global rate is equal to the sum of professional and technical charges.

4.6.3. Non-CMAC Rate Table

4.6.3.1. This table captures pricing for procedure codes at the local or state level.

4.6.3.2. Each state/locality does not have the same set of prevailing fees. In other words, there may be a difference in the HCPCS/CPT codes with prevailing fees for each locality.

4.6.3.3. When rates are pulled from the Non-CMAC Rate Table, the prevailing local fee is used in all cases. Note: Although some Non-CMAC Rate Tables contain a rate for anesthesia services, UBO uses the flat rate contained in the Anesthesia Rate Table.

4.6.4. The CMAC Tables are maintained for three years (current year and two prior years).

5. DoD Average Cost Tables

5.1. Ambulance Rate Table. The Ambulance Rate Table is used to calculate charges for ambulance services, based on an all-inclusive hourly rate and date of service for MEPRS code FEA*. Charges are calculated for each 15-minute increment of service.

5.2. Anesthesia Rate Table. The Anesthesia Rate Table is used to calculate charges for the professional portion of anesthesia services, based on a flat rate per anesthesia CPT code and date of service. The anesthetic agent is also billed based on the appropriate HCPCS “J” code.

5.3. Dental Rate Table. The Dental Rate Table is used to calculate charges for dental services based on American Dental Association (ADA) Current Dental Terminology (CDT) Codes (HCPCS Level II "D" Codes).

5.4. DME/DMS Rate Table. The Durable Medical Equipment/Durable Medical Supplies (DME/DMS) Rate Table is used to calculate charges for DME/DMS based on HCPCS Level II Codes and date of service.

If a prevailing rate is not available from the Non-CMAC Rate Table, the rate is provided from the DME/DMS Rate Table. Note: Please refer to the Future Enhancements/Current Changes section for more information.

5.5. Immunizations/Injectibles Rate Table. The Immunization/Injectibles Rate Table is used to calculate charges for vaccines and therapeutic medications (injections) administered other than by mouth as part of a clinic encounter, as identified by HCPCS Level II "J" Codes and date of service.

5.6. NDC Rate Table. The National Drug Code (NDC) Rate Table is used to calculate charges for pharmacy issued prescriptions, based on NDC Code, Order Quantity (as established within the MTF Pharmacy file) and date of service.

Scheduled Rate Table Updates	
CMAC	Annually
Ambulance	Annually
Anesthesia	Annually
DME/DMS	Annually
Immunizations/Injectibles	Annually
NDC	Quarterly
Dental	Annually

6. Government Billing Calculation Factor

6.1. A government billing calculation factor (percentage discount) for billing outpatient International Military Education and Training (IMET) and Interagency and Other Federal Agency Sponsored Patients

(IAR) rates, will be applied to the line item charges calculated for outpatient medical and ancillary services using CMAC or anesthesia charges if the Patient Category indicates that the patient is to be charged at the IMET or IAR rate.

6.2. No Charge Calculations

6.2.1. CHCS sends HCPCS/CPT codes, for all coded billable services, to TPOCS and MSA for processing.

6.2.2. CHCS and/or TPOCS will provide notification to the designated Outpatient Itemized Billing Administrator of conditions that may require manual intervention, changes to CHCS files, or validation of calculated charges.

6.2.3. Error notifications are provided when data elements critical to rate calculations are null or missing. Examples of error messages are provided below:

Treating DMIS ID is null or missing from the encounter or ancillary record for CMAC billable charges
CMAC Locality is null or missing from the encounter ancillary record for CMAC billable charges
CMAC Rate could not be calculated due to missing CMAC Locality Rate Table
CMAC Rate could not be calculated due to an inactive HCPCS/CPT Code
CMAC Rate could not be calculated due to a null or missing HCPCS/CPT Code
CMAC Rate could not be calculated due to a null or missing CMAC Provider Class
Pharmacy charges could not be calculated due to an inactive NDC Code
Dental procedure charges could not be calculated due to missing ADA procedure codes, for encounters assigned to C*** (MSA Only)

6.2.4. MTFs are not authorized to add charges for HCPCS/CPT codes, which do not have a rate; instead they should troubleshoot the cause of the non-calculation and fix the problem at the source.

7. Unlisted Procedures

7.1. Unlisted procedure codes (primarily CPT codes ending in ’99,’ though other codes usually ending in “9” are sometimes unlisted procedures) are not billable and do not produce a rate.

7.2. MTFs are not authorized to add a charge for unlisted procedures.

7.3. Efforts should be made to minimize use of unlisted procedures; except in the case of CPT code 99499, which is used to indicate Evaluation and Management services did not take place during an encounter.

7.4. If no rate can be found on any DoD approved existing rate tables, then no fee is produced.

REFUNDS FROM TPOCS & CHCS FOR OHI PAYMENTS (ARMY/NAVY[3])

Revised: 9 March 2006

When an overpayment is received for claims billed out of TPOCS, the following actions must be taken:

1. Post all monies received to the applicable TPOCS accounts and to CHCS Account "Outpatient Insurance."

2. After determining the amount to be refunded, an SF 1034 and SF 1080 must be completed and mailed to the applicable DFAS address. A separate SF 1034 and SF1080 must be completed for each insurance company to be refunded.

3. After completing the above actions there must be a refund out of CHCS. This is accomplished by going to the last outpatient CHCS business posted and backing out the amount(s) to be refunded.

4. After backing out the amount(s) from CHCS, go to each respective account in TPOCS and refund the amount(s) accordingly. Note: In the itemized side of TPOCS only the full amount posted can be refunded; the system will not allow partial refunds.

5. If additional monies are received that are not due the MTF and the check cannot be returned, post the additional money in CHCS, then go back to steps 2-3.

[3] This does not pertain to Air Force billing operations.

REHABILITATION SERVICES

Revised: 01 October 2003

1. For all encounters, the ADM Record should be coded listing the appropriate V-code first (V57.1 for PT, V57.21 for OT), followed by the diagnosis code (frequently a symptom) if available.

2. For Rehabilitation Technicians rendering treatment ordered by a privileged provider (P.T., O.T., SLT), the privileged provider supervising the procedures should have the first provider position in ADM, and the technician the second provider position.

3. Rehabilitation technician services are coded using a 99499, along with appropriate modalities and therapeutic procedures.

4. Physical Therapy CPT codes: 97001 for evaluations and 97002 for re-evaluations

5. Occupational Therapy CPT codes: 97003 for evaluations and 97004 for re-evaluations

6. Athletic Training Evaluation CPT codes: 97005 for evaluations and 97006 for re-evaluations

REVENUE CODES

Revised: 08 June 2009

1. Revenue codes (RCs) are used on the paper Uniform Bill 04 (UB-04) claims form in FL42 to identify specific accommodations (inpatient) and ancillary services (outpatient).

1.1. A revenue code must be assigned for each line item charge billed in FL47.

1.2. Revenue codes affect reimbursement.

1.2.1. A revenue code must be valid for the type of claim being billed. For example, Accommodation RC 010X is valid for inpatient TOB (FL4) 011X only; it is not valid for outpatient claims TOB 013X.

2. Billing guidelines, including revenue codes, are extensive, so having current reference materials is important. One source is the Ingenix® Uniform Billing Editor. It provides information about the correlation of Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT) coding, revenue codes, type of bill, etc.

3. The Revenue Code to CPT Code Mapping table is loaded in both the Composite Health Care System (CHCS) and the Third Party Outpatient Collection System (TPOCS).

3.1. This mapping table generally lists RCs in numeric order, not by order of frequency. Changes to the order of the RCs listed on this mapping table will be considered upon request. Send requests to your Service UBO Representative(s).

3.2. The CHCS Inpatient Claims Module will only accept one RC for the all-inclusive hospital charges and one RC for the professional fees. Payer-specific requirements must be addressed by manually changing the RC on the paper UB-04.

3.3. In TPOCS, you can change an RC by using the drop-down option.

4. Following is a list of the most common RCs for your UB-04s.

RC	Description
0001	Total charge (paper only)
010X	All-Inclusive Rate
024X	All-Inclusive Ancillary
025X	Pharmacy
026X	IV Therapy
027X	Medical/Surgical Supplies and Devices
028X	Oncology
029X	Durable Medical Equipment (Other than Renal)
030X	Laboratory
031X	Laboratory Pathology
032X	Radiology—Diagnostic
033X	Radiology—Therapeutic and/or Chemotherapy Administration
034X	Nuclear Medicine
035X	CT Scan
036X	Operating Room Services
037X	Anesthesia
038X	Blood and Blood Products
040X	Other Imaging Services
041X	Respiratory Services
042X	Physical Therapy

RC	Description
043X	Occupational Therapy
044X	Speech Therapy-Language Pathology
045X	Emergency Room
046X	Pulmonary Function
047X	Audiology
048X	Cardiology
049X	Ambulatory Surgical Care
051X	Clinic
053X	Osteopathic Services
054X	Ambulance
061X	Magnetic Resonance Technology (MRT)
062X	Medical/Surgical Supplies
063X	Pharmacy
073X	EKG/ECG (Electrocardiogram)
074X	EEG (Electroencephalogram)
075X	Gastrointestinal Services
076X	Treatment or Observation Room
077X	Preventive Care Services
081X	Acquisition of Body Components
082X	Hemodialysis—Outpatient or Home
090X	Behavioral Health Treatments/Services

RC	Description
091X	Behavioral Health Treatments/Services
092X	Other Diagnostic Services
093X	Medical Rehabilitation Day Program
094X	Other Therapeutic Services
095X	Other Therapeutic Services

RC	Description
096X	Professional Fees
097X	Professional Fees
098X	Professional Fees

SYSTEM CHANGE REQUESTS/SYSTEM INCIDENT REPORTS

Revised: 01 October 2003

1. TMA UBO Developed Functional Change Requirements

1.1. Functional requirements are gathered from various sources, such as meetings. These requirements often need to be translated into system change requests and system incident reports (SCRs/SIRs).

1.2. The SCR/SIR form is completed.

1.3. The SCR/SIR is entered into a matrix (Word format) for the TMA UBO Program and UBO Service Managers.

1.4. Once approved, the SCR/SIR is sent either directly by the TMA UBO Program Manager or by the SCR/SIR support person on behalf of the TMA UBO Program Manager to Information Management (IM).

1.5. IM will put the SCR/SIR into Dynamic Object Oriented Reporting System (DOORS) and then add it to the UBO SCR Tracking Matrix (Excel format). Updated matrices will be sent to the SCR support person periodically for review and concurrence. The matrix will be sent to the TMA UBO Program Manager for his/her information.

1.6. Once in DOORS, the SCR will go through the budgeting process by IM.

1.7. Monthly meetings will be held to go over the status of SCRs/SIRs.

2. Service-Level Developed Functional Change Requirements

2.1 The Services and MTFs are allowed to directly submit SCRs/SIRs to report system issues or errors.

2.2 An SCR/SIR template can be obtained from the UBO website.

2.3 The requesting individual should submit the SCR/SIR to their UBO Service Manager and refer to the SCR/SIR process stated above in paragraph 3.

TECHNICIANS, NURSES, AND "INCIDENT TO"

Revised: 8 March 2006

1. Technician services are not currently billed. Presently, independent technician services furnished in the clinic and collected in the ambulatory data module (ADM) and Armed Forces Healthcare Longitudinal Tracking Application (AHLTA) are not generally billed. This is because there continue to be obvious coding problems with technician coding. For instance, there are still technician encounters with evaluation and management (E&M) codes of 99205, 99212, 99213, 99214, and 99215, as well as the various physical codes (e.g., 99385). These are obviously incorrect.

1.1. To avoid fraudulent billing, the MHS will not bill for technician services coded in the B*** MEPRS functional cost codes (FCC) until the coded data more accurately reflect documentation, services, and Uniform Biostatistical Utility (UBU) Coding Guidelines.

2. Provider specialty codes. In CHCS, there are MHS defined "Provider Specialty Codes." For instance, the code for a family practice physician is 001. The provider specialty code for a technician is 900. At the present time, encounters with the provider specialty code of 900 are blocked from appearing on the bill except for the FBI* MEPRS (Immunization Clinic) and BLA* MEPRS (Physical Therapy). The provider specialty code for a physician assistant is 901. This is the only code above 900 that will generate a bill. The codes 902 and 905 are also technician codes and do not generate bills.

2.1. Provider specialty codes 910-972 (for instance 954, psychology) tend to represent services furnished by a clinic. Since it is not possible to determine if a privileged or a non-privileged provider furnished the service when it is collected in a clinic provider specialty code, bills will not be generated.

2.1. Technician Services. Technicians have a provider specialty code of 900 with a provider specialty description of "Corpsman/Technician." When PSC 900 is entered, it generates a taxonomy code with CMAC Provider Class of 04, additional medical provider. The HIPAA Provider Taxonomy Code is 246Z00000X. The HIPAA Provider Taxonomy Description is "TECHNOLOGISTS, TECHNICIANS & OTHER TECHNICAL SERVICE PROVIDERS/SPECIALIST/TECHNOLOGIST/OTHER."

2.1.1. PSC 900 is blocked so technician services do not feed to TPOCS. It is not the CMAC Provider Class of 04, as many other 04s, such as physical therapist and nurse practitioner bills are generated in TPOCS.

2.1.2. There are new HIPAA taxonomies for Independent Duty Corpsmen (IDCs) and Independent Duty Medical Technicians (IDMTs). These new HIPAA taxonomies will be added to the HIPAA table when the table is updated in CHCS. When IDCs and IDMTs apply for an NPI type 1, they should use the following HIPAA taxonomies:

1710I1002X Independent Duty Corpsman.
1710I1003X Independent Duty Medical Technicians.

3. Radiology Technician Services. Radiology services are collected in the radiology module, not in the ADM. In diagnostic imaging/radiology, there are frequently two components to a service. There is the technician component of actually performing the procedure and the professional component when the radiologist interprets the study results and prepares a report. At MTFs without a radiologist, a technician will conduct the study and the diagnostic imaging code will appear on the bill with a 7xxxx-tc. The "tc" is a modifier indicating only the technical component was provided, which must be manually entered into CHCS by the technician unless the radiology program has this pre-coded. The professional component is furnished at another MTF (the study is available at the other MTF using teleradiology). At the radiologist's MTF, bills will generate with a 7xxxx-26. The "26" modifier indicates that only the professional component is being billed. The radiologist must manually enter modifier "26" into CHCS unless the radiology program has this pre-coded.

3.1. The rates for the radiology components are in the CMAC table. Each CMAC rate table has two sub-tables, one with "cmac…" and one with "comp…" When a procedure has different prices for the 'tc" and the "26," it will be in the "comp" table. The 7xxxx-tc will have a rate just for the technical component. The 7xxxx-26 has a rate just for the professional component.

4. Laboratory/Pathology Technician Services. Laboratory/pathology services are collected in the laboratory module of CHCS, not the ADM. Many laboratory services contain only technician services. These services, coded with codes in the 80048-89356, will generate bills.

5. Physical/Occupational Therapy. When a technician furnishes the services, the entry in the ADM *must* reflect the technician's provider specialty code of 900 (HIPAA 247200000X for all non-certified technicians).

5.1. Physical/Occupational Therapy services, furnished in the PT/OT Clinic, to outpatients, are collected in the CHCS ambulatory data module in the BLA*/BLB* MEPRS FCC. When a Physical/Occupational therapist furnishes the services, the provider should be identified with the provider specialty code of 705/706. This will generate a bill displaying the HIPAA taxonomy for a Physical/Occupational Therapist (225100000X for PT/225X00000X for OT).

5.1. Supervising Provider in Immediate Area and Able to Respond. The documentation must indicate the privileged provider who was in the immediate area for the entire procedure/therapy and could have been contacted verbally. This does not mean the therapist was available via the telephone while he was at the Medical Records Review Committee. This means the physical therapist was in the same room or a room off of the main room, and was available to respond immediately.

5.2. Billing Options for PT/OT Technician Services.

5.2.1. Bill Using Technician's Name. Generate bills for services automatically (i.e., without manual intervention in the TPOCS module) with the technician as the provider. Some insurance plans do not cover physical therapy performed by someone other than a physical therapist. In these cases, the bills will be denied.

5.2.2. Bill Using Supervising Provider's Name - "Incident to" Bills.

5.2.2.1. Written Orders. To generate "incident to" bills, the documentation *must* demonstrate that the services were furnished under orders written by a privileged provider (e.g., physical therapist).
NOTE: "Incident To" is a commonly accepted concept in the civilian sector. It is applied when a non-privileged provider furnishes services pursuant to a privileged provider's written orders, with a supervising provider immediately available during the service. Many insurance plans reimburse "incident to" at the physician rate (e.g., 100%) while they reimburse physician extenders (e.g., advanced practice nurses, physician assistants [PAs], clinical social workers) at a discounted rate (e.g., 75% or 66%).

5.2.2.2. Proper Coding. The technician's documentation must meet the requirements for the code. For instance, most physical therapy codes are time based. Therefore, the time started and time ended must be documented.

6. Physician Extender Services and Data Collection. While physician assistants (PAs) may not practice independently in some areas and advanced practice nurses may be limited in some states, the MHS is not governed by state limits when the provider is furnishing services on a federal reservation. Therefore physician extenders furnish services in accordance with the privileges granted by that facility. The MHS does not collect "incident to" work differently than work furnished under privileges. Work is collected in the name of the individual doing the work. If there is a supervising provider, this individual is an additional provider assigned a provider type of supervising.

6.2.1. Billing Physician Extender Work as “Under Privileges” or “Incident To.” No physician extender services will be billed under a supervising provider’s name. There is no method in the ADM to collect that the service was “incident to” or if the service was in accordance with granted privileges. We know all services were performed in accordance with granted privileges. All billing for physician extenders will be performed in the physician extender’s name.

6.2.2. MHS Does Not Use “Incident To” With Physician Extenders. Because the ADM does not indicate when PAs and other physician extenders are furnishing services under their own privileges or as “incident to,” a decision had to be made regarding billing. Physician extender services could all be billed as incident to; however, this would be incorrect when treating new patients or new problems. Physician extender services could be billed as independent providers. The decision was made to bill physician extenders under their own privileges, not as “incident to.”

6.3. “Incident To” for Non-Physician Extenders. Some nurses who are not advanced practice nurses (e.g., not nurse midwives, nurse practitioners, nor certified registered nurse anesthetists) perform “incident to” services. These services are usually found in the Internal Medicine Clinic. An example is a nurse who, using medical staff approved protocols, with a physician in verbal (not telephonic) contact, monitors patients on long term anticoagulant therapy. The nurse follows written physician orders and immediately confers with the physician when there are any issues. In this case, the nurse would code the encounter with a 99211. This could be manually billed if all “incident to” requirements are verified prior to billing. These “incident to” bills would need to meet the same requirements as billing “incident to” for physical therapy technicians (see above).

THIRD PARTY COLLECTION PROGRAM REPORT ON PROGRAM RESULTS (DD FORM 2570) and UBO METRICS REPORTING SYSTEM

Revised: 30 December 2008

1. Third Party Collection Program Report on Program Results, DD Form 2570

1.1. The Third Party Collection Program (TPCP) Report of Program Results (DD Form 2570) must be generated by each TPCP billing location. The report(s) should be generated on the last business day of the reporting quarter or the first business day of the new quarter. (1st Quarter = October – December, 2nd Quarter = January – March, 3rd Quarter = April – June, 4th Quarter = July – September)

1.1.1 No transactions should be completed in the new quarter prior to generating the prior quarter's report or the data will be incorrect.

1.1.2 In TPOCS, the default beginning date of the report is 10/01/1991. Do not change this date or the data will be incorrect.

1.1.3. Report data is cumulative. PY1 and PY2 will always be full cumulative fiscal year data. CFY will be cumulative through the quarter that is being reported.

1.1.3.1. The DD 2570 reports count claim and adjustment transactions based on the date-of-service fiscal year, not on the transaction-date fiscal year. Amounts collected are counted based on the date-of-service fiscal year and the collection-transaction-date fiscal year. Follow Service-specific guidelines for validating report data.

1.1.3.2. If a DD 2570 report does not balance, run the Positive and Negative Balance Reports in TPOCS and run the Negative Balance report in CHCS. These reports will help you find data errors that could be affecting the totals on the DD 2570. Fix the errors and re-run the reports. If this still does not work, submit an MHS problem ticket and notify your Service POC.

1.1.4. Non-Active Duty Outpatient visits are not captured in TPOCS and therefore are not reported on the TPOCS Outpatient TPCP Report of Program Results, DD 2570. MTFs should follow Service-specific guidance to obtain non-active duty outpatient visit counts.

2. UBO Metrics Reporting System

2.1. MTFs will enter DD 2570 data into the UBO Metrics Reporting System (MRS) at http://ubometrics.org/ .

2.2. Reporting is not complete until each report is validated by the Service and/or Region POCs. Internal due dates for MTFs and validation requirements are set by the Services.

2.3. The UBO Metrics Reporting System (MRS) Suite Administrator will roll up all reports four weeks after the end of each reporting quarter. (This deadline may be extended by the discretion of the TMA UBO Program Office Manager.)

2.4. Any requests for corrections or additions after the roll-up must be sent through the Service POC to the UBO MRS Administrator. The MRS Administrator will forward the request to the TMA UBO Program Office for review and approval prior to implementing any changes.

3. UBO Metrics Reporting System Account Access Requests

3.1. Requests for access to the Metrics Reporting System (MRS) and Web Intelligence must be approved by the UBO Program Office for non-service-affiliated users or the applicable Service POC and

forwarded to the UBO MRS Administrator. Account Access Requests should include: User's First/Last Name, e-mail address, commercial phone number, DMIS ID and type/level of access (User, Region POC, Service POC, Read Only). For Region POC access, requests should include the above information and specified Region (in lieu of DMIS ID).

3.2. Service POCs are responsible for informing the UBO MRS Administrator of any account changes, including deactivation.

UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

Revised: 25 November 2008

1. USFHP is a TRICARE Prime option that is available to family members of active duty military, retirees, and their eligible family members through not-for-profit health care systems in six areas of the country. TRICARE pays a capitated fee to the USFHP for each enrolled patient.

1.1. The six facilities are:

a. Martin's Point Health Care, Portland, ME
b. Johns Hopkins Community Physicians, Baltimore, MD
c. Brighton Marine Health Center, Boston, MA
d. St Vincent Catholic Medical Centers, New York City, NY
e. CHRISTUS Health, Galveston, TX
f. PacMed Clinics, Seattle, WA

2. The USFHP is similar to a Health Maintenance Organization. When DoD beneficiaries enroll, they agree to receive all their care, including prescriptions, laboratory, radiology, and office visits with the USFHP facility.

2.1. USFHP enrollees are no longer entitled to receive services at a military treatment facility.

2.2. USFHP enrollees are not authorized to use military treatment facilities to obtain routine or urgent care.

2.2.1. The only exceptions to this limitation are acute medical emergencies and a military treatment facility is closest facility, or if care is not available through US Family Health Plan and the patient is properly referred to an MTF by TRICARE Prime.

2.2.1.1. The USFHP enrollee must notify the USFHP of medical emergency care within 24 hours.

2.2.1.2. USFHP patients are considered civilian emergencies.

2.2.1.3. A DEERS check will indicate the patient is not eligible for care.

2.2.2 If the patient presents for emergency care, they must be registered under PATCAT K92B – USFHP ENROLLEE – EMERGENCY.

2.3. The MSA bill for emergency care and TRICARE-referred care will be submitted to the USFHP where the patient is enrolled.

2.3.1. If the patient presents for routine, non-emergent care, then the patient should be registered under PATCAT K92A – CIVILIAN EMERGENCY CARE.

2.3.2. The MSA bill will be sent to the patient.

3. USFHP is not other health insurance (OHI) under the Third Party Collection Program. Do not request a HIC ID or input USFHP into OHI/PII.

UNITS OF SERVICE

Revised: 01 October 2003

1. A unit of service is the number of times a procedures is performed (e.g., multiple biopsies), amount of time (e.g., 15 minute intervals for most physical therapy procedures), supplies (e.g., number of shoe inserts) or days that a particular HCPCS/CPT code is performed or supplied.

2. Units of Service are captured in ADM.

3. The Unit of Service field is 24G on the CMS 1500 Claim Form and Form Locator (FL) 46 on the UB-04 claim form. This field accommodates three characters and a whole number.

4. The Unit of Service field is multiplied by the rate (Units * Rate) to calculate the total charges for the line item.

5. For anesthesia services (CPT Codes 00100–01999), the Unit of Service field defaults to a value of “1.” This is the method until anesthesia is calculated using minutes of service rather than a flat rate.

6. For modifier -50, bilateral procedures, the Unit of Service defaults to “1” and the rate is multiplied by “2” because the modifier indicates that the procedure was performed twice.

7. For HCPCS/CPT codes that are time-based, ensure the correct Units of Service are captured based on the range of time noted in the description of the HCPCS/CPT code.

APPENDIX A – HELPDESK & HOTLINE SUPPORT

Helpdesk and Hotline Support

MHS Helpdesk	UBO Help Desk
(CHCS/TPOCS Issues)	(Functional Issues)
MHS-helpdesk.com	UBO.helpdesk@altarum.org
(800) 600-9332	(703) 575-5385

APPENDIX B – UB Claim Form Instructions for Outpatient Services***

Note: The Uniform Billing Claim Form has been updated. The boxes explain the transition schedule. Instructions for the UB-04 are found in Appendix B1; a quick guide to the UB-04 is found in Appendix B2.

1 March 2007 – 22 May 2007	*Providers can use either the current UB-04 or the revised UB-04 version.*
23 May 2007	*The UB-04 claim form is discontinued; only the revised UB-04 is to be used.* ***Note:*** *All rebilling of claims should use the revised UB-04, even though earlier submissions may have been on UB-04.*

Uniform Billing Form Transition Schedule

Dates	***UB Form to Use***
Prior to 1 Mar 2007	*UB-04 only*
1 Mar 2007 – 22 May 2007	*UB-04 or UB-04*
23 May 2007	*UB-04 only*

Note: These dates are in accordance with the Centers for Medicare and Medicaid Services (CMS). Consult your Service UBO Manager for specific implementation guidance for your Service.

APPENDIX B1 – UB-04 Claim Form Instructions

Revised: 22 May 2007

Form Locators (FL) are automatically populated by TPOCS.

FL 1: Provider Name, Address and Telephone Number
Required – Inpatient
Required – Outpatient
This information is used in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2: Pay-to Name, address, and Secondary Identification Fields
Situational – For MHS, FL 2 will mirror FL 1.
Required when the pay-to name and address information is different than the Billing Provider information in FL1.

FL 3a: Patient Control Number
Required – Inpatient
Required – Outpatient
The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.

FL 3b: Medical/Health Record Number
Situational – Inpatient
Situational – Outpatient
Required when the provider needs to identify for future inquiries, the actual medical record of the patient
The number assigned to the patient's medical/health record by the provider -

FL 4: Type of Bill
Required – Inpatient
Required – Outpatient
This four-digit alphanumeric code gives three specific pieces of information after a leading zero.

Digit 1: Leading Zero

Digit 2: Type of Facility
- 1 = Hospital
- 2 = Skilled Nursing Facility
- 3 = Home Health
- 7 = Clinic
- 8 = Special Facility

Digit 3: Bill Classification
- 1 = Inpatient
- 3 = Outpatient
- 4 = Other

Digit 4: Frequency
- 1 = Admit through Discharge claim
- 2 = Interim-First Claim
- 3 = Interim-Continuing Claim
- 4 = Interim-Last Claim
- 5 = Late Charge

**For further explanation on Type of Bill, please refer to the NUBC UB04 Official Data Specifications Manual

FL 5: Federal Tax ID Number
Required – Inpatient
Required – Outpatient
The format is NN-NNNNNNN. The hospital/MTF's Federal Tax number is assigned by the federal government for tax reporting purposes.

FL 6: Statement Covers Period (From-Through
Required – Inpatient
Required – Outpatient
The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY).

FL 7: Not Used

FL 8: Patient's Name
Required – Inpatient
Required – Outpatient
The provider enters the patient's last name, first name, and if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).

FL 9: Patient's Address
Required
The provider enters the patient's full mailing address, including street number and name, post office box number or Rural Free Delivery, City, State, and Zip code.

FL 10: Patient's Birth Date
Required
The provider enters the month, day and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.

FL 11: Patient's Sex
Required
The provider enters an "M" (male) or an "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.

FL 12: The Admission or Start of Care Date
Situational – Outpatient
Required – Inpatient
This field contains the date the patient was admitted to the provider for inpatient care, outpatient services or other start of care.
The hospital enters the date the patient was admitted for inpatient care (MMDDYY).

FL 13: Admission Hour
Situational – Outpatient
Required – Inpatient
This FL contains the hour during which the patient was admitted for inpatient or outpatient care.

00	12:00 (midnight) – 12:59 a.m.
01	01:00 – 01:59
02	02:00 – 02:59
03	03:00 – 03:59

04	04:00 – 04:59
05	05:00 – 05:59
06	06:00 – 06:59
07	07:00 – 07:59

08	08:00 - 08:59
09	09:00 – 09:59
10	10:00 – 10:59
11	11:00 – 11:59
12	12:00 (noon) – 12:59 p.m.
13	01:00 – 01:59
14	02:00 – 02:59
15	03:00 – 03:59
16	04:00 – 04:59

17	05:00 – 05:59
18	06:00 – 06:59
19	07:00 – 07:59
20	08:00 – 08:59
21	09:00 – 09:59
22	10:00 – 10:59
23	11:00 – 11:59

FL 14: Type of Admission/Visit
Required – Inpatient bills only
This is the code indicating priority of this admission.

Code Structure	
1	**Emergency** – The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	**Urgent –** The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	**Elective** – The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	**Newborn** – Use of this code necessitates the use of a Special Source of Admission codes.
5	**Trauma Center** – This code is for a visit to a trauma center/hospital as licensed or designated with authority and authorized.

FL 15: Source of Admission
Required – Inpatient
Situational – Outpatient
The provider enters the code indicating the source of the referral for this admission or visit.

Code Structure	
1	Physician Referral
2	Clinic Referral
3	Managed Care Plan Referral
4	Transfer from a Hospital (Different Facility)
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
Note – If type of admission code is 4, then this additional FL coding structure is used for newborn:	
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

FL 16: Discharge Hour

Required – Inpatient
Situational – Outpatient
Required only for inpatient commercial claims. Hours are indicated in military time using two-character numbers.

FL 17: Patient Status
Required for Inpatient Claims
This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to SNF with Medicare Certification in Anticipation of Covered Skilled Care
04	Discharged/Transferred to an Intermediate Care Facility
05	Discharged/Transferred to Another Type of Institution Not Defined Elsewhere in this Code List
06	Discharged/Transferred to Home Under Care of Organized Home Health Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advise or Discontinued Care
08	Reserved for National Assignment
09	Admitted As an Inpatient to This Hospital
10-19	Reserved for National Assignment
20	Expired
21-29	Reserved for National Assignment
30	Still a Patient
31-39	Reserved for National Assignment
40	Expired at Home
41	Expired in a Medical Facility Such as a Hospital, SNF, ICF or Freestanding Hospice
42	Expired, Place Unknown
43	Discharged/Transferred to a Federal Health Care Facility
44-49	Reserved for National Assignment
50	Discharged to Hospice – Home
51	Discharged to Hospice – Medical Facility
52-60	Reserved for National Assignment
61	Discharged/Transferred Within This Institution to a Hospital-Based Medicare Approved Swing Bed
62	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharges/Transfers to a Critical Access Hospital
67-70	Reserved for National Assignment
71-99	Reserved for National Assignment

FLs 18-28: Condition Codes
Situational – Inpatient

Situational – Outpatient
Required when there is a Condition Code that applies to this claim.
The provider enters the corresponding code to describe any of the following conditions or events that apply to this billing period.

Code Structure	
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered by Insurance Not Reflected Here
04	Information Only Bill
05	Lien Has Been Filed
06	ESRD Patient in First 18 Months of Entitlement Covered by Employer Group Health Insurance
07	Treatment of Non-terminal Condition for Hospice Patient
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage
09	Neither Patient Nor Spouse is Employed
10	Patient and/or Spouse is Employed by No EGHP Coverage Exists
11	Disabled Beneficiary, but No Large Group Health Plan Coverage
12	Coders are for Payer Use Only
Special Conditions	
17	Patient is Homeless
18	Maiden Name Retained
19	Child Retains Mother's Name
20	Beneficiary Requested Billing
21	Billing for Denial Notice
22	Patient on Multiple Drug Regimen
23	Home Care Giver Available
24	Home IV Patient Also Receiving HHA Services
25	Patient is a Non-U.S. Resident
26	VA-Eligible Patient Chooses to Receive Services in Medicare-Certified Facility
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test
28	Patient and/or Spouse's EGHP is Secondary to Medicare
29	Disabled Beneficiary and/or Family Member's LGHP Is Secondary to Medicare
30	Non-Research Services Provided to Patients Enrolled in a Qualified Clinical Trial
Student Status	
31	Patient is Student (Full-Time Day)
32	Patient is Student (Cooperative/Work Study Program)
33	Patient is a Student (Full-time Night)
34	Patient is Student (Part-Time)
35	Reserved for National Assignment
Accommodations	
36	General Care Patient in a Special Unit
37	Ward Accommodation at Patient's Request
38	Semiprivate Room Not Available
39	Private Room Medically Necessary
40	Same-Day Transfer
41	Partial Hospitalization

42	Continuing Care Not Related to Inpatient Admission
43	Continuing Care Not Provided Within Prescribed Post-discharge Window
44	Inpatient Admission Changed to Outpatient
45	Reserved for National Assignment
CHAMPUS/TRICARE Information	
46	Non-availability Statement on File
47	Reserved for CHAMPUS/TRICARE
48	Psychiatric Residential Treatment Centers (RTCs) for Children and Adolescents
49	Product Replacement Within Product Lifecycle
50	Product Replacement for Known Recall of a Product
51-54	Reserved for National Assignment
55-59	Skilled Nursing Facility Related
Prospective Payment	
60	Day Outlier
61	Cost Outlier
62	Payer Code
63	Incarcerated Beneficiaries
64-65	Payer Only Codes
66	Provider Does Not Wish Cost Outlier Payment
67	Beneficiary Elects Not to Use Lifetime Reserve Days (LTR)
68	Patient Elects to Use LTR Days
69	IME/DGME/N&AH Payment Only
Renal Dialysis Setting	
70-76	
Other Codes	
77	Provider Accepts or Is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full
78	New Coverage Not Implemented by HMO
79	CORF Services Provided Off-Site
80	Home Dialysis – Nursing Facility
81-99	Reserved for National Assignment
Special Program Indicator Codes	
A0	CHAMPUS/TRICARE External Partnership Program
A1	EPSDT/CHAP
A2	Physically Handicapped Children's Program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A6	Vaccines/Medicare 100% Payment
A7	Reserved for National Assignment
A8	Reserved for National Assignment
A9	Second Opinion Surgery
AA	Abortion Performed Due to Rape
AB	Abortion Performed Due to Incest
AC	Abortion Performed Due to Serious Fetal Genetic Defect, Deformity, or Abnormality
AD	Abortion Performed Due to a Life Endangering Physical Condition Caused by, Arising

	From, or Exacerbated by the Pregnancy Itself
AE	Abortion Performed Due to Physical Health of Mother That is Not Life Endangering
AF	Abortion Performed Due to Emotional/Psychological Health of the Mother
AG	Abortion Performed Due to Social or Economic Reasons
AH	Elective Abortion
AI	Sterilization
AJ	Payer Responsible for Co-payment
AK	Air Ambulance Required
AL	Specialized Treatment/Bed Unavailable
AM	Non-Emergency Medically Necessary Stretcher Transport Required
AN	Preadmission Screening Not Required
AO-AZ	Reserved for National Assignment
BO	Medicare Coordinated Care Demonstration Claim
B1	Beneficiary Ineligible for Demonstration Program
B2	Critical Access Hospital Ambulance Attestation
B3	Pregnancy Indicator
B4	Admission Unrelated to Discharge on Same Day
B5-BZ	Reserved for National Assignment
C0-CZ	PRO Related Codes
Claim Change Reasons	
D0	Changes to Services Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS/Rate Codes
D3	Second or Subsequent Interim PPS Bill
D4	Changes in ICD-9-CM Diagnosis and/or Procedure Codes
D5	Cancel to Correct HICN or Provider Identification Number
D6	Cancel Only to Repay a Duplicate or OIG Payment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
DR	Disaster Related
E0	Change in Patient Status
E1-FZ	Reserved for National Assignment
G0	Distinct Medical Visit
G1-GZ	Reserved for National Assignment
H0	Delayed Filing, Statement of Intent Submitted
H1-LZ	Reserved for National Assignment
M0-MZ	Reserved for Payer Assignment
N-OZ	Reserved for National Assignment
P0	Reserved for National Assignment for Public Health Reporting Only
P1	Do Not Resuscitate Order (DNR) for Public Health Reporting Only
P2-PZ	Reserved for National Assignment for Public Health Reporting Only
Q0-VZ	Reserved for National Assignment
W0	United Mine Workers of America (UMWA) Demonstration Indicator
W1-ZZ	Reserved for National Assignment

FL 29: Accident State
Situational
Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code.
A two-digit code to identify the state where the accident occurred.

FL 30: Not Used

FLs 31-34: Occurrence Codes and Dates
Situational
Required when there is a Condition Code that applies to this claim.
Codes and associated dates defining a significant event relating to this bill that may affect payer processing.

Accident Related Codes	
01	Auto Accident
02	No-Fault Insurance Involved—Including Auto Accident/Other
03	Accident—Tort Liability
04	Accident—Employment Related
05	Other Accident
06	Crime Victim
07-08	Reserved for National Assignment
Medical Condition Codes	
09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset for a Chronically Dependent Individual (CDI)
13-16	Reserved for National Assignment
Insurance Related Codes	
17	Date Outpatient Occupational Therapy Plan Established or Last Reviewed
18	Date of Retirement of Patient/Beneficiary
19	Date of Retirement of Spouse
20	Guarantee of Payment Began
21	UR Notice Received
22	Date Active Care Ended
23	Reserved for National Assignment
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
26	Date SNF Bed Became Available
27	Date of Hospice Certification or Recertification
28	Date CORF Plan Established or Last Reviewed
29	Date Outpatient Physical Therapy Plan Established or Last Reviewed
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed
31	Date Beneficiary Notified of Intent to Bill (Accommodations)
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP
34	Therapy Date of Election of Extended Care Services

35	Date Treatment Started for Physical
36	Date of Inpatient Hospital Discharge for Covered Transplant Patient
37	Date of Inpatient Hospital Discharge for Non-covered Transplant Patient
38	Date Treatment Started for Home IV Therapy
39	Date Discharged on a Continuous Course of IV Therapy
Service Related Codes	
40	Scheduled Date of Admission
41	Date of First Test for Pre-admission Testing
42	Date of Discharge (Hospice Only)
43	Scheduled Date of Cancelled Surgery
44	Date Treatment Started for Occupational Therapy
45	Date Treatment Started for Speech Therapy
46	Date Treatment Started for Cardiac Rehabilitation
47-49	Payer Codes
50-69	Reserved for State Assignment
70-99	Reserved for Occurrence Span Codes
A0	Reserved for National Assignment
A1	Birth Date—Insured A
A2	Effective Date—Insured A Policy
A3	Benefits Exhausted
A4-A9	Reserved for National Assignment
B0	Reserved for National Assignment
B1	Birth Date—Insured B
B2	Effective Date—Insured B Policy
B3	Benefits Exhausted
B4-B9	Reserved for National Assignment
C0	Reserved for National Assignment
C1	Birth Date—Insured C
C2	Effective Date—Insured C Policy
C3	Benefits Exhausted
C4-C9	Reserved for National Assignment
D0-D9	Reserved for National Assignment
E0	Reserved for National Assignment
E1	Birth Date—Insured D
E2	Effective Date—Insured D Policy
E3	Benefits Exhausted
E4-E9	Reserved for National Assignment
F0	Reserved for National Assignment
F1	Birth Date—Insured E
F2	Effective Date—Insured E Policy
F3	Benefits Exhausted
F4-F9	Reserved for National Assignment
G0	Reserved for National Assignment
G1	Birth Date—Insured F
G2	Effective Date—Insured F Policy
G3	Benefits Exhausted

G4-G9	Reserved for National Assignment
H0-I9	Reserved for National Assignment
J0-L9	Reserved for State Assignment
M0-Z9	See Definitions Under Occurrence Span Codes (FL 36)

FLs 35-36: Occurrence Span Code and Dates
Situational – Inpatient and Outpatient
Required when there is an Occurrence Span Code that applies to the claim.
The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.Code and the related date that identify an event that relates to the payment of the claim.

70	Qualifying Stay Dates (For SNF Use Only) or Non-utilization Dates (For Payer Use Only on Hospital Bills)
71	Prior Stay Dates
72	First/Last Visit
73	Benefit Eligibility Period
74	Non-covered Level of Care/LOA
75	SNF Level of Care
76	Patient Liability
77	Provider Liability Period
78	SNF Prior Stay Dates
79	Payer Code
80-99	Reserved for State Assignment
M0	PRO/UR Approved Stay Dates
M1	Provider Liability—No Utilization
M2-W9	Reserved for National Assignment
X0-Z9	Reserved for State Assignment

FL 37: Untitled
Currently Not Used

FL 38: Responsible Party Name and Address
Situational – Inpatient and Outpatient
Use to print the name and mailing address of the party responsible for the bill if a window envelope is utilized.

FLs 39-41: Value Codes and Amounts
Situational – Inpatient and Outpatient
Required when there is a Value Code that applies to this claim.
Codes and related dollar or unit amount(s) identify data of a monetary nature that is necessary for the processing of this claim.

01	Most Common Semiprivate Room Rate
02	Hospital Has No Semiprivate Rooms
03	Reserved for National Assignment
04	Inpatient Professional Component Charges that Are Combined Billed
05	Professional Component Included in Charges and Also Billed Separately to Carrier
06	Medicare Blood Deductible
07	Reserved for National Assignment

08	Medicare Lifetime Reserve Amount in the First Calendar Year
09	Medicare Coinsurance Amount in the First Calendar Year
10	Medicare Lifetime Reserve Amount in the Second Calendar Year
11	Medicare Coinsurance Amount for Second Calendar Year
12	Working Aged Beneficiary/Spouse with EGHP
13	ESRD Beneficiary in a Medicare Coordination Period with an EGHP
14	No-Fault, Including Auto/Other
15	Workers Compensation
16	Public Health Service (PHS) or Other Federal Agency
17	Outlier Amount
18	Disproportionate Share Amount
19	Indirect Medical Education Amount
20	Total PPS Capital Payment Amount
21	Catastrophic
22	Surplus
23	Recurring Monthly Income
24	Medicaid Rate Code
25-29	Reserved for National Assignment—Medicaid
30	Preadmission Testing
31	Patient Liability Amount
32-36	Reserved for National Assignment
37	Pints of Blood Furnished
38	Blood Deductible Pints
39	Pints of Blood Replaced
40	New Coverage Not Implemented by HMO (for Inpatient Claims Only)
41	Black Lung
42	Veterans Affairs
43	Disabled Beneficiary Under Age 65 with LGHP
44	Amount Provider Agreed to Accept from the Primary Insurer When this Amount Is Less than Total Charges, but Greater than the Primary Insurer's Payment
45	Accident Hour
46	Number of Grace Days
47	Any Liability Insurance
48	Hemoglobin Reading
49	Hematocrit Reading
50	Physical Therapy Visits
51	Occupational Therapy Visits
52	Speech Therapy Visits
53	Cardiac Rehabilitation Visits
54-55	Reserved for National Assignment
Home-Health-Specific	
56	Skilled Nurse—Home Visit Hours (HHA Only)
57	Home Health Aide—Home Visit Hours (HHA Only)
58	Arterial Blood Gas (PO2/PA2)
59	Oxygen Saturation (O2 Sat/Oximetry)
60	HHA Branch MSA

61	Location Where Service Is Furnished (HHA and Hospice)
62-66	Reserved for National Assignment
67	Peritoneal Dialysis
68	EPO—Drug
70	Interest Amount
71	Funding of ESRD Networks
72	Flat Rate Surgery Charge
73	Drug Deductible
74	Drug Coinsurance
75	Gramm–Rudman–Hollings
76	Providers Interim Rate
77-79	Payer Codes
80-99	Reserved for State Assignment
A0	Reserved for National Assignment
A1	Deductible Payer A
A2	Coinsurance Payer A
A3	Estimated Responsibility Payer A
A4	Covered Self-Administrable Drugs—Emergency
A5	Covered Self-Administrable Drugs—Not Self-Administrable in Form and Situation Furnished to Patient
A6	Covered Self-Administrable Drugs—Diagnostic Study and Other
A7-AZ	Reserved for National Assignment
B0	Reserved for National Assignment
B1	Deductible Payer B
B2	Coinsurance Payer B
B3	Estimated Responsibility Payer B
B4-BZ	Reserved for National Assignment
C0	Reserved for National Assignment
C1	Deductible Payer C
C2	Coinsurance Payer C
C3	Estimated Responsibility Payer C
C4-CZ	Reserved for National Assignment
D0–D2	Reserved for National Assignment
D3	Estimated Responsibility Patient
D4-DZ	Reserved for National Assignment
E0	Reserved for National Assignment
E1	Deductible Payer D
E2	Coinsurance Payer D
E3	Estimated Responsibility Payer D
E4-EZ	Reserved for National Assignment
F0	Reserved for National Assignment
F1	Deductible Payer E
F2	Coinsurance Payer E
F3	Estimated Responsibility Payer E
F4-FZ	Reserved for National Assignment
G0	Reserved for National Assignment

G1	Deductible Payer F
G2	Coinsurance Payer F
G3	Estimated Responsibility Payer F
G4-GZ	Reserved for National Assignment
H0-YZ	Reserved for National Assignment
X0-ZZ	Reserved for National Assignment

FL 42: Revenue Code
Required – Inpatient
Required – Outpatient
Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.

FL 43: Revenue Description
Not Required for electronic billing
Required for Inpatient Paper Claim
Required for Outpatient Paper Claim
The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43... Descriptions or abbreviations correspond to the revenue codes This description must be shown in HCPCS coding.

FL 44: HCPCS/Rates/HIPPS Rate Codes
Situational except when required for outpatient claims when an appropriate HCPCS code exists for this service line item. The provider enters the HCPCS code describing the procedure here.
Required – Inpatient
Not required – Outpatient
Used when room and board revenue code is reported

HCPCS Modifiers
Situational except when required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. (See: Appendix A – HCPCS Modifiers Section)

FL 45: Service Date
Required – Outpatient
Not Required – Inpatient
The date (MMDDYY) the outpatient service was provided.

FL 46: Units of Service
Required – Inpatient
Required – Outpatient
A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.

FL 47: Total Charges
Required – Inpatient
Required – Outpatient
The total charges reflected on this claim for the statement covers period (FL 6). This field is automatically calculated and populated.

FL 48: Non-Covered Charges
Situational except required if needed to report line specific non-covered charge.
The total non-covered charges pertaining to the related revenue code in FL42.

FL 49: Untitled
Not Used

FL 50A, B, and C: Payer Identification
Required – Line A (Primary Payer) – Inpatient & Outpatient
Situational – Lines B and C
Enter the name of the primary payer on line A.
Secondary Payer is listed on line B.
Tertiary Payer is listed on line C.

FL 51A: Health Plan ID
Required – Line A (Primary Payer) – Inpatient & Outpatient
FL 51B (Situational), and C (Situational)
The number used by the health plan to identify itself.
Report the national health plan identifier when one is established.

FLs 52A, B, and C: Release of Information Certification Indicator
Required – Inpatient
Required – Outpatient
A "Y" code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim.
I is used when the provider has not collected a signature.

FL 53A, B, and C: Assignment of Benefits Certification Indicator
Required – Inpatient
Required – Outpatient
Code indicates provider has a signed form authorizing the third-party payer to remit payment directly to the provider

FLs 54A, B, and C: Prior Payments
Situational except required when the indicated payer has paid an amount to the provider towards this bill.
The amount the provider has received (to date) by the health plan toward payment of this bill.

FL 55A, B, and C: Estimated Amount Due From Patient
Not Required

FL 56: National Provider Identifier (NPI) Type 2 (Facility)
Required, effective May 23, 2007
For Pharmacy billing, TPOCS will insert the NPI Type 2 of the Dispensing Pharmacy.
The unique identification number assigned to the provider submitting the bill.

FL 57: Other Provider ID (primary, secondary, and/or tertiary)
Situational
Use this field to report other provider identifiers as assigned by a health plan (as indicated in FL 50 lines 1-3) **prior** to May 23, 2007.

For Pharmacy Billing, upon request, TPOCS will allow the user to select the appropriate provider identifier; DEA# or NCPDP# or UPIN# to populate in this form locator.

FLs 58A, B, and C: Insured's Name
Required for both inpatient and outpatient
That corresponds to lettered lines (A – primary B – secondary C – tertiary) payer shown in FLs 50-54. The provider must enter the name of the individual in whose name the insurance is carried.

FL 59A, B, and C: Patient's Relationship to Insured
Required – line A for inpatient and outpatient

Situational – line B and C
If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured:

01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

FLs 60A, B, and C: Insured's Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN))
Required

FL 61A, B, and C: Insurance Group Name
Situational (required if known)
Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C: Insurance Group Number
Situational (required if known)

FL 63: Treatment Authorization Code
Situational unless required by payer
Required when an authorization or referral number is assigned by the payer.

FL 64: Document Control Number (DCN)
Situational
The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65: Employer Name
Situational unless required
The name of the employer that provides health care coverage for the individual identified on the same line in FL 58.
FL 66: Diagnosis and Procedure Code Qualifier (ICD Version Indicator)
Required
Qualifier Code "9" required.

FL 67: Principal Diagnosis Code
Required – Inpatient Claims
Required – Outpatient Claims
The hospital enters the ICD-9 code for the principal diagnosis. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

FLs 67A-67Q: Other Diagnosis Codes and POA (Present on Admission Indicator*)
Inpatient Required
Outpatient - Required
The hospital enters the full ICD-9 codes for up to eight additional conditions if they co-existed at the time

of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.
*(Note: MHS does not require Present on Admission (POA) Indicator at this time)

FL 68:
Not Used

FL 69: Admitting Diagnosis
Required for inpatient claims
Not required for outpatient claims
Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL70A – 70C: Patient's Reason for Visit
Situational except required for unscheduled outpatient visits or upon the patient's admission to the hospital. This information may be any documented reason for the service provided, including patients stated reason for seeking care or the reason provided by the physician as part of the order for the service. This information is not required for all scheduled outpatient encounters.
Patient's Reason for Visit is required for all unscheduled outpatient visits for outpatient bills.

FL71: Prospective Payment System (PPS) Code
Not Used

FL72: External Cause of Injury Codes
Situational unless required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment.

FL 73:
Not Used

FL 74: Principal Procedure Code and Date
Situational except when required for inpatient claims
Used when a procedure was performed.
Note: Not used on outpatient claims.

FL 74A – 74E: Other Procedure Codes and Dates
Situational except when required for inpatient claims
Used when additional procedures were performed.
Note: Not used on outpatient claims.

FL 75:
Not Used

FL 76: Attending Provider Name and Identifiers (including NPI Type 1)
Situational except when required after the HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider OR required on/after the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.
For pharmacy billing, NPI type 1 of the Dispensing provider will be reported if available or NPI type 2 of the Dispensing Facility.

Secondary Identifier Qualifiers	
0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number

FL 77: Operating Provider Name and Identifiers (including NPI)
Situational except required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Secondary Identifier Qualifiers	
0B	State License Number
1G	Provider UPIN Number
EI	Employer's Identification Number
SY	Social Security Number

FLs 78 and 79: Other Provider Name and Identifiers (including NPI)
Situational except required when the claim involves another provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.

The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim; i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Provider Type Qualifier Codes	Definition	Situational Usage Notes
DN	**Referring Provider**	The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.
ZZ	**Other Operating Physician**	An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send the name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.
82	**Rendering Provider**	The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim; i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Secondary Identifier Qualifiers:	
0B	State License Number
1G	Provider UPIN Number
EI	Employer's Identification Number
SY	Social Security Number

FL 80: Remarks
Situational

FL 81: Code-Code Field
Situational
To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

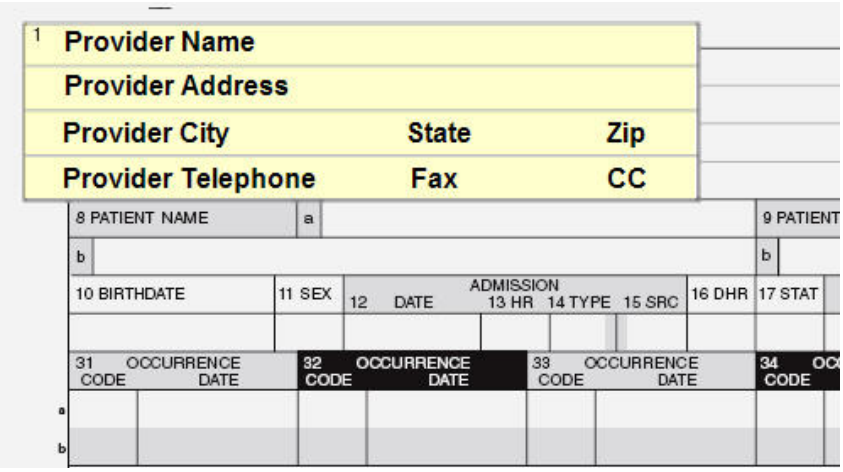
Code List Qualifiers	
01-A0	Reserved for National Assignment
A1	National Uniform Billing Committee Condition Codes
A2	National Uniform Billing Committee Occurrence Codes
A3	National Uniform Billing Committee Occurrence Span Codes
A4	National Uniform Billing Committee Value Codes – not used for Medicare
A5-B0	Reserved for National Assignment
B3	Health Care Provider Taxonomy Code
Code Source: ASC X12 External Code Source 682 (National Uniform Claim Committee)	
B4-ZZ	Reserved National Assignment

APPENDIX B2 – UB-04 Claim Form Quick Guide

KEY CHANGES TO THE FORM

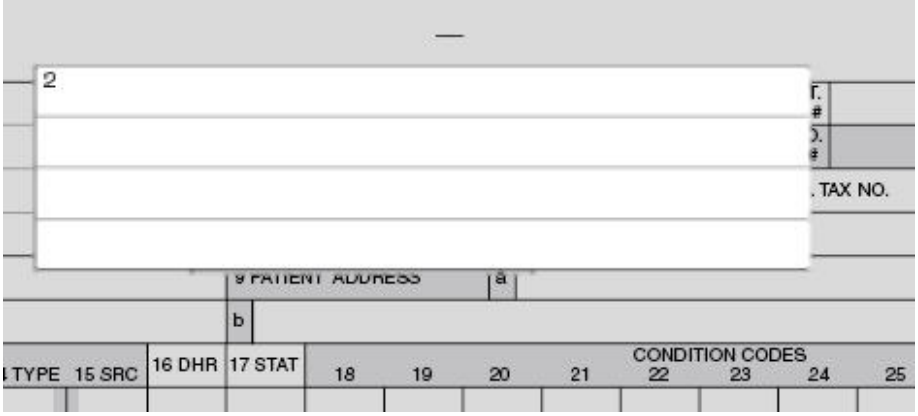
FL1: Required

Billing Provider Name, Address and Telephone
Number and Country Code – (Required when the address is out of the United States of America)

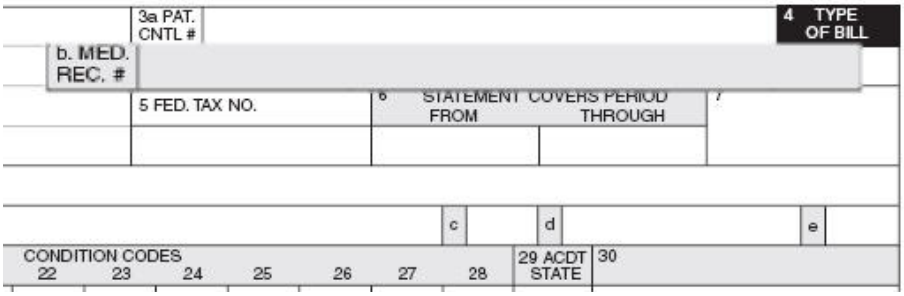


FL 2: Situational

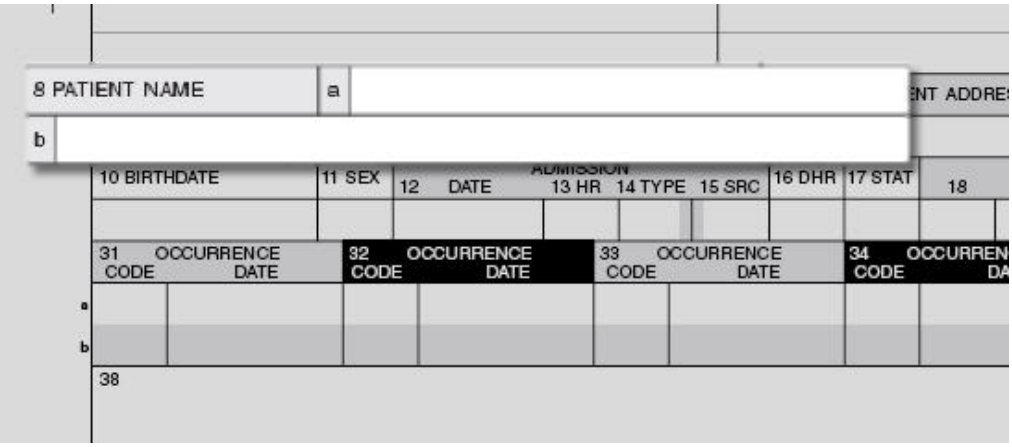
Pay-to Name, address, and Secondary Identification Fields
Note: For MHS will contain same information as in FL 1



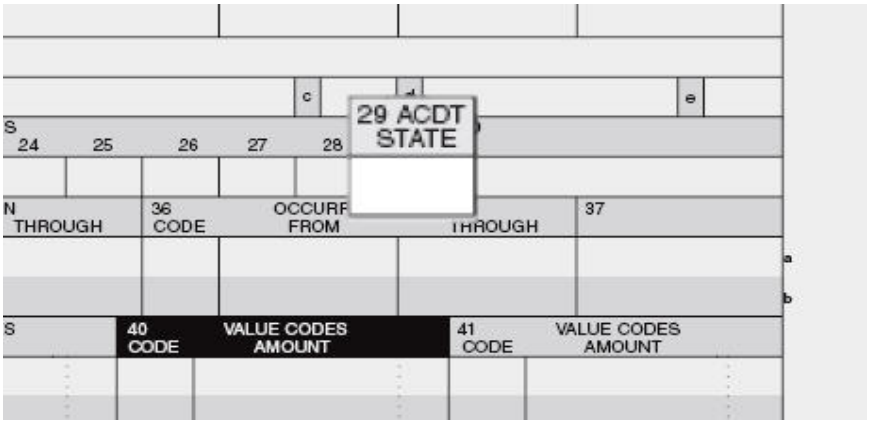
FL 3b: Situational
Medical/Health Record Number
The number assigned to the patient's medical/health record by the provider (not FL3a).



FL 8: Required
Patient's Name
The provider enters the patient's last name, first name, and if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).



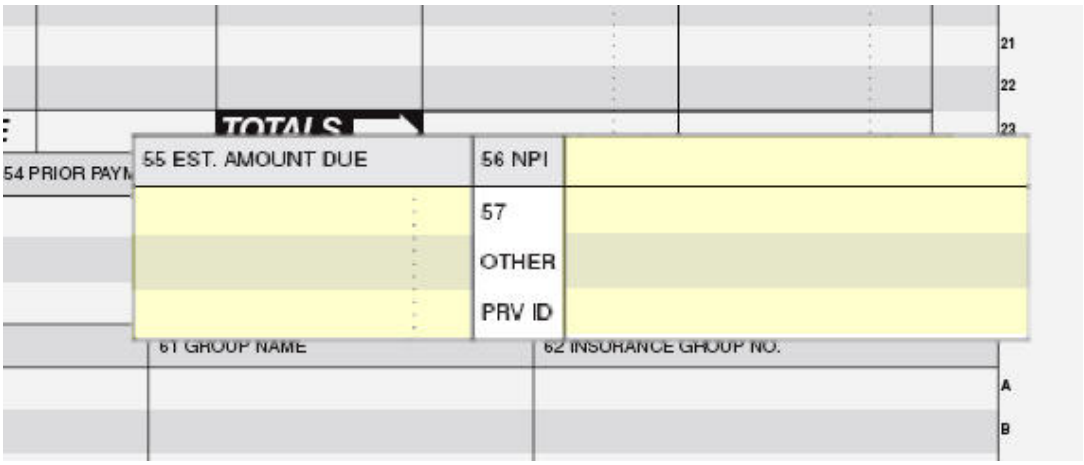
FL 29: Situational
Accident State
The accident state field contains the two-digit state abbreviation where the accident occurred. Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code.



FL 45: Required
Service Date

The date (MMDDYY) the outpatient service was provided (applies to lines 1 through 22; line 23 refers to the Creation Date (MMDDYY) of the bill (the date the bill was created/printed)).

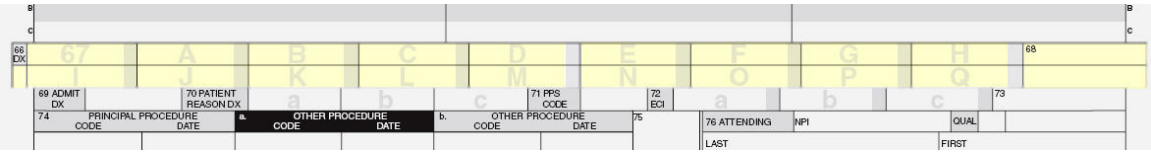
FL 56: Required
National Provider Identifier – Billing Provider Type 2 (Facility)
The unique identification number assigned to the provider submitting the bill; NPI is the National Provider Identifier.



FL 67: Required
Principal Diagnosis Code
The hospital enters the ICD-9 code for the principal diagnosis. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

FLs 67A-67Q: Inpatient Required
Other Diagnosis Codes (Note: MHS does not require Present on Admission (POA) Indicator)
The hospital enters the full ICD-9 codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

Outpatient - Required
The hospital enters the full ICD-9 codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

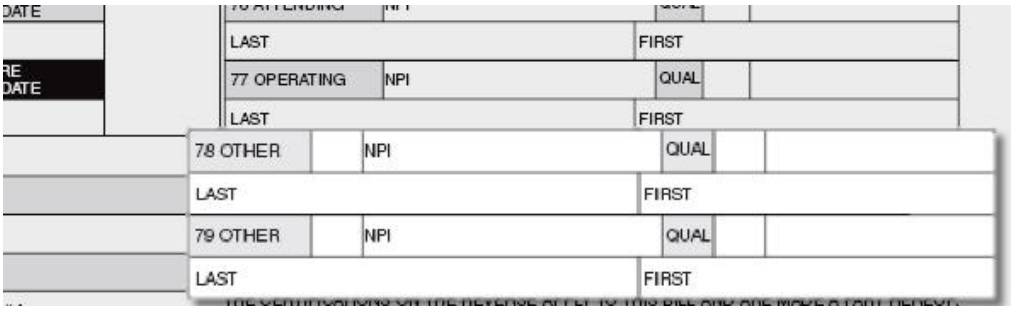


FLs 78 and 79: Situational
Other Provider Name and Identifiers (including NPI).

The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

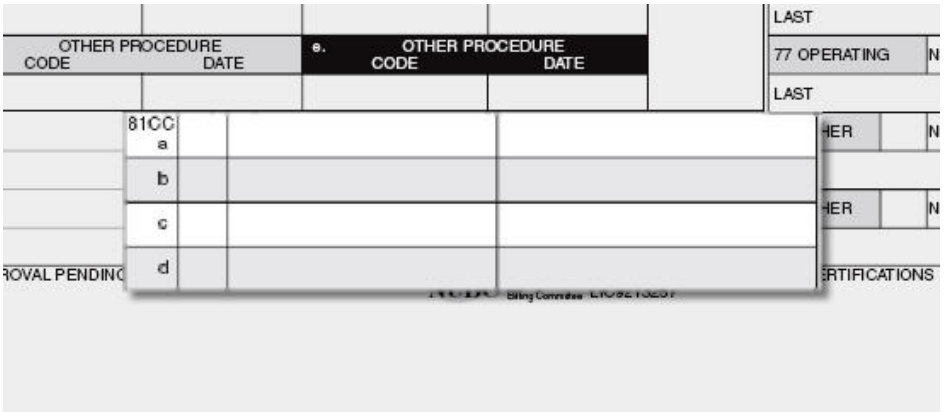
<u>DN - Referring Provider</u>: The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician

<u>ZZ - Other Operating Physician</u>: An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved.



FL 81: Situational
Code-Code Field
To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

<u>Code List Qualifiers</u>:
01-A0 Reserved for National Assignment
A1 National Uniform Billing Committee Condition Codes
A National Uniform Billing Committee Occurrence Codes
A3 National Uniform Billing Committee Occurrence Span Codes
A4 National Uniform Billing Committee Value Codes – not used for Medicare
A5-B0 Reserved for National Assignment
B3 Health Care Provider Taxonomy Code
B4-ZZ Reserved for National A



<u>82 - Rendering Provider</u>: The health care professional who delivers or completes a particular medical service or non-surgical procedure.

<u>Secondary Identifier Qualifiers</u>:
0B - State License Number
1G - Provider UPIN Number
EI - Employer's Identification Number
SY - Social Security Number

APPENDIX C – CMS 1500 Claim Form Instructions

Revised: 7 May 2007

Note: The CMS 1500 form has been updated. The boxes below provide the transition schedule. Instructions for the CMS 1500 (08-05) are found in Appendix C1; a quick guide to key changes in the form are found in Appendix C2; and a link to the National Uniform Claim Committee's 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version appears in Appendix C3 (the manual appears elsewhere on the UBO Web site).

2 January 2007 – 31 May 2007	*Providers can use either the current Form CMS 1500 (12-90) version or the revised Form CMS 1500 (08-05) version. Note: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS 1500 (08-05) by January 2, 2007.*
1 June 2007	*The current Form CMS 1500 (12-90) version of the claim form is discontinued; only the revised Form CMS 1500 (08-05) is to be used.* ***Note:*** *All rebilling of claims should use the revised Form CMS 1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS 1500 (12-90).*

Note: These dates are in accordance with the Centers for Medicare and Medicaid Services (CMS). Consult your Service UBO Manager for specific implementation guidance for your Service.

APPENDIX C1 – CMS 1500 (08-05) Claim Form Instructions

Revised: 1 July 2011

Detailed information regarding each Item Number can be found in the "National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for (08/05) Version, version 1.3 7/06". Please note that the 1500 Reference Instruction Manual is intended to provide general instructions on how to complete the claim form and not definitive billing instructions for the Department of Defense, Military Health System (DoD, MHS) purposes.

CMS 1500 Transition Schedule[4]

Dates	***CMS 1500 Form to Use***
Prior to 2 Jan 2007	*12/90 only*
2 Jan 2007 – 31 May 2007	*12/90 or 08/05*
1 June 2007	*08/05 only*

Items are automatically populated by TPOCS.

Item 1: Type of Health Insurance Coverage – Required
Insurance coverage. System defaults to "Other".

Item 1a: Insured's ID Number – Required
Insured's social security number.

Item 2: Patient's Name (Last Name, First Name, Middle Initial) – Required
Insured's last name, first name, and middle initial.

Item 3: Patient's Birth Date and Sex – Required
Eight-digit birth date (MM|DD|CCYY) of the patient; patient's sex.

Item 4: Insured's Name (Last Name, First Name, Middle Initial) – Required
Insured's last name, first name, and middle initial.

Item 5: Patient's Address – Required
Mailing address and telephone number of the patient in the corresponding boxes.

Item 6: Patient's Relationship to Insured – Required
Relationship of the patient listed in Item 2 to insured listed in Item 4.

Item 7: Insured's Address – Required, if applicable
Mailing address and telephone number of the insured in the corresponding box. If item number 4 is completed then this field should be completed.

Item 8: Patient Status – Required
Marital status and full- or part-time student. NOTE: Patient Status does not exist in the electronic 837 Professional 41010A1.

Item 9: Other Insured's Name – Required, if applicable
If the yes box is checked in Item 11D, then this section (Items 9–9D) must be filled out. Name of the insured person (last, first, middle initial).

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[4] **Note: These dates are in accordance with the Centers for Medicare and Medicaid Services (CMS). Consult your Service UBO Manager for specific implementation guidance for your Service.**

Item 9a: Other Insured's Policy or Group Number – Required, if applicable
Other insured's insurance policy or group number.

Item 9b: Other Insured's Date of Birth/Sex – Required, if applicable
Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box indicating the sex of this person.

Item 9c: Employer's Name or School Name – Required, if applicable
Employer's name or school name of the other insured person. NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1.

Item 9d: Insurance Plan Name or Program Name – Required, if applicable
Name of the insurance plan or program related to the other insured person.

Item 10a-10c: Is Patient's Condition Related To: (Auto Accident/Other Accident) – Required, if applicable
Check the appropriate box if the patient's condition is related to any of the following: employment (MAC), auto accident, or other accident.

Item 10d: Reserved For Local Use-Blank – Not Required

Item 11: Insured's Policy Group or FECA Number- Conditional
Insured's Policy Group or FECA Number Insured's policy group or FECA number.

Item 11a: Required Insured's Date of Birth/Sex – Required
Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box indicating the sex of the insured.

Item 11b: Employer's Name or School Name – Conditional
Employer's name or school name of the insured. NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1.

Item 11c: Insurance Plan Name or Program Name – Required
Name of the insurance plan or program of the insured.

Item 11d: Is There Another Health Plan Benefit? – Required, if applicable
If "Y'" is checked, Items 9–9d must be completed. Check the appropriate box to indicate whether or not there is another health insurance benefit. System defaults to "No."

Item 12: Patient's or Authorized Person's Signature – Required with a default ("Signature on file" is acceptable) AOB statement
This item is automatically populated with the following statement, "Assignment Authorization of Benefits is assumed under 10 U.S.C. 1095."

Item 13: Insured's or Authorized Person's Signature – Required with a default ("Signature on file" is acceptable)
The MTF has the option of selecting one of the following statements: "Assignment of Benefits is assumed under Title 10 U.S.C. 1095" or "Signature on file."

Item 14: Date of Current Illness, Injury, or Pregnancy – Required, if applicable
Current date of illness, injury or pregnancy (MM|DD|CCYY).

Item 15: If Patient Has Had Same or Similar Illness – Required, if applicable
Past occurrence date (MM|DD|CCYY) of illness or injury if it is the same or similar illness or injury.

Item 16: Dates Patient Unable to Work in Current Occupation – Not Required
Blank

▶Item 17: Referring Provider – Conditional
(Revised – Title was changed from Referring Physician to Referring Provider)
Name of the Provider who referred or ordered the service.

▶Item 17a: Other ID Number of Referring or Ordering Provider, Qualifier – Conditional
(Revised – This area was shaded and a new field was added to hold the two-digit qualifier for other ID Number)
The Provider Taxonomy code of the referring provider or ordering provider should be reported in the shaded area. The qualifier (ZZ – Provider Taxonomy) identifies the type of Other ID being reported in the shaded area.

●Item 17b: Provider NPI # – Required, if applicable
NPI Type 1 of the referring or ordering provider will appear in this field, if available. If there isn't a referring or ordering provider, leave blank.

Item 18: Hospitalization Dates Related to Current Services – Required, if applicable
Eight-digit date (MM|DD|CCYY) if the services were provided subsequent to a related hospitalization.

Item 19: Reserved for Local Use – Not Required
Blank

Item 20: Outside Lab – Not Required
Blank

Item 21: Diagnosis or nature of illness or injury – Required
ICD-9-CM diagnosis code for the patient's diagnosis/condition. The ICD-9-CM diagnosis code must be coded to the highest specificity and sequenced in order of priority (e.g., primary or secondary condition).

Item 22: Medicaid Resubmission – Not Required
Blank

Item 23: Prior Authorization Number – Required, if applicable
Prior authorization number for those procedures requiring prior authorization.

▶Section 24 (Revised – To accommodate submission of both the NPI and other Provider Identifier during the NPI transition)

Item 24a: Dates of Service – Required
Eight-digit date (MM|DD|CCYY) of the time period in which the services were performed.

Item 24b: Place of Service – Required
Code "26" represents an MTF. This code should automatically print on all CMS 1500s. However for an emergency room visit, the place of service will be coded as "23" Emergency Room. TPOCS will provide the biller the option to determine if the encounter is related to ER services. When saving the bill TPOCS will assign the place of service based on MEPRS code BIA* and default to "Y" (yes) for Item 24c – EMG.

▶Item 24c: EMG – Required, if applicable
(Revised – This was originally titled "Type of Service". This field is now titled "EMG".
EMG represents Emergency Indicator. The indicator states whether or not a service(s) is related to an emergency. If MEPRS code is BIA* and services are emergency related, then Y for "Yes" will appear in the box or if "No" the field will be left blank.

Item 24d: Procedures, Services, or Supplies – Required
HCPCS/CPT code, including modifiers when applicable, for the procedures, services, or supplies furnished to the patient.

Item 24e: Diagnosis Pointer – Required
(Revised – Title changed from Diagnosis Code to Diagnosis Pointer)
Pointer number (1– 4) from Item 21 that is applicable to that specific procedure, service or supply furnished.

Item 24f: Charges – Required
Charge for each listed service.

Item 24g: Days or Units – Required
Number of days or units that were supplied for that particular HCPCS/CPT code listed in that line. If only one service was provided, the numeral 1 must be entered. This field will default to 1.

Item 24h: EPSDT Family Plan – Not Required
EPSDT Family Plan
Blank

Item 24i: ID Qualifier – Required
(Revised – This field was originally titled "EMG", which is now in Item 24c. This field is now titled "ID Qualifier")
The ID qualifier will default to (**ZZ – Provider Taxonomy**) and will be used to report the type of non-NPI number of the rendering provider. The Provider Taxonomy code of the rendering provider will be reported in the shaded area of Item 24j.

Item 24J: Rendering Provider ID# – Required
(Revised - This field was originally title "COB". The original fields 24j and 24k were combined and renumbered and now titled "Rendering Provider ID#".)
The Provider Taxonomy code of the rendering provider will be reported in the shaded area. NPI Type 1 of the rendering provider will be reported in the unshaded area.

Item 24k: This field was deleted and combined with 24j.
Deleted

Item 25: Federal Tax ID Number – Required
Federal Tax ID number for the facility.

Item 26: Patient's Account Number – Required
Patient's account number that is assigned by the MTF's accounting system to identify that particular patient.

Item 27: Accept Assignment – Required
TPOCS defaults to "X" in the Yes box indicating assignment of benefits is accepted pursuant to Title 10 U.S.C. 1095.

Item 28: Total Charge – Required
Total Charge
Total charges for the services provided (e.g., sum of charges in Item 24F).

Item 29: Amount Paid – Conditional
Amount Paid
$0.00 indicates no up-front monies were paid. DoD does not collect co-payments for services rendered.

Item 30: Balance Due – Conditional
Total amount of the charges. This should match Item 28.

Item 31: Signature of Physician or Supplier – Required
Signature of the provider of service or supplier, or his representative, and the date the form was signed. A signature or stamp is required here. Some MTFs use this area to indicate who, the biller was and that the bill has been reviewed.

Item 32: Name and Address of Treating Service Facility – Required
Name, address, and telephone number of the MTF.

- **Item 32a: NPI # – Required (New field)**
NPI type 2 of the treating MTF will be reported in this field.

- **Item 32b: Other ID qualifier and Other ID# – Required (New field)**
The qualifier will be reported followed by the HIPAA Taxonomy code or Treating Facility Tax ID.

Item 33: Billing Provider Information – Required
Physician, Supplier Billing Name, Address, Zip Code, Phone, PIN#, and Group#
Name of the physician who rendered the services. It is now required that the provider be identified with their credentials (e.g., MD, NP, PA, RN, LPN). The system should include the provider's credentials following the name.

- **Item 33a: NPI # – Required (New field)**
NPI type 2 of the billing facility will be reported.

- **Item 33b: Other ID# – Required (New field)**
The qualifier followed by the HIPAA Taxonomy code.

APPENDIX C2 – Quick Guide to Key Changes in Revised Form CMS 1500 (08-05)

Claim Form Version

When submitting a paper claim, use the form that has the following: carrier block located in the upper right margin, the 1500 symbol and the approval date located in the upper left margin. The version with the four black alignment bars forms in the upper left corner has been eliminated.

Items 17, 17a and 17b (split field)

Item 17: Name of Referring Provider or Other Service
TPOCS will populate the referring provider information in Items 17, 17a and/or 17b.

Item 17a: Other ID#
Current Provider ID and/or Tax ID will be used until the NPI # is used. Once NPI is implemented, the primary HIPAA taxonomy code associated with the provider specialty table will be reported for the referring provider, ordering or other source and will populate from TPOCS.

Item 17b: NPI
The NPI number of the referring provider will populate from TPOCS.

17a.		
17b.	NPI	

Section 24

The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI, and another provider identifier and the submission of supplemental information. An example of supplemental information would be a narrative description of an unlisted code. Note: See Instructions and Examples of Supplemental Information in 1500 Reference Instruction Manual.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1															PX	
							23	Y							NPI	1123568999
2																
															NPI	
3																
															NPI	
4																
															NPI	
5																
															NPI	
6																
															NPI	

Items 24B and 24C

Item 24B – Place of Service
The place of service code identifies the location of where the service occurred. For DoD, the place of service code 26-Military Treatment Facility is hard coded in TPOCS for all 1500 claims with the exception of emergency room services.
If the MEPRS code is BIA*, then place of service code will be **Item 23 – Emergency Room.**

Note: TPOCS will provide the user the option to determine if the encounter is related to ER services. When saving the bill TPOCS will assign the place of service code based on MEPRS code BIA*.

Item 24C – EMG
This item was originally labeled "Type of Service" and is now the Emergency indicator "EMG". The indicator states whether the services rendered due to an emergency. For DoD, If the MEPRS code is BIA*, the indicator will default to "Y", if not, then the field will be blank.

> If MEPRS code BIA*, then place of service code will default to 23 – Emergency room and default to "Y" for item 24c EMG

B. PLACE OF SERVICE	C. EMG
23	Y

Item 24I – ID Qualifier

I. ID. QUAL.
PX
NPI
NPI
NPI
NPI
NPI
NPI

ID Qualifier = PX - Taxonomy code

Previously this field was labeled as "EMG" and is now located in Item 24C. It has been replaced with a new item, ID Qualifier. The qualifier is used to identify the type of non-NPI number used to represent the provider. For DoD, the non-NPI number used will be the HIPAA Taxonomy code thus the ID Qualifier-PX will be assigned.

Item 24J – Rendering Provider

J. RENDERING PROVIDER ID. #

Item 24J will contain the HIPAA Taxonomy code in the shaded area and NPI Type 1 for the Rendering Provider in the designated block for NPI.

Items 32, 32a, and 32b

32. SERVICE FACILITY LOCATION INFORMATION	
USAFA 10Th Medical Group/SGSBR 4102 PINION DR STE 100 USAF ACADEMY, CO 80840	
a. NPI	b.

Item 32- Service Facility Location
Address for the Treating/Service Facility will appear in this block. Block 32 will be limited to 78 characters with a three-line template, 26 characters each for address. NOTE: On the print forms, there will now be a limitation of how small you can print on the forms. Therefore, item 32 and 33 will be restricted to three lines for the facility and provider address.

Item 32a - NPI number
The NPI number of the Treating facility - NPI Type 2 will populate from TPOCS. This field allows for 10 characters.

Item 32b - Other ID#
The non-NPI number will be either the Treating Facility Tax ID or HIPAA Taxonomy code preceded by the two-digit qualifier identifying the type of non-NPI number.

APPENDIX C3 – National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version

Revised: 13 January 2012

Follow this link to the latest version of the NUCC manual.

www.**nucc**.org/content/view/33/42/

APPENDIX D – Prescription Drug Uniform Claim Form (UCF)

Note: The Uniform Claim Form has been updated. The changes are described and illustrated below. Instructions for the revised form are found in Appendix D1; the instructions for the current, expiring form are found in Appendix D2.

The Prescription Drug Universal Claim Form (UCF) is used for the paper submission of third party pharmacy claims. However, at the payer's request, pharmacy services can be submitted on a UB claim form by changing the claim form type in the Table Maintenance function of TPOCS. Refer to the TPOCS User's Manual for more information.

The UCF captures up to two prescriptions per form, unless a controlled substance is prescribed (one prescription per form). The diagnosis code is not a required field on the UCF when billing for a prescription, except for controlled substances.

Revisions – Universal Claim Form

Although the Universal Claim Form was revised, provider data elements were changed to accommodate HIPAA and the National Provider Identifier (NPI) requirements (e.g., Data for the Service Provider ID will change from reporting the NCPDP# to using NPI Type 2 for the dispensing pharmacy).

Key Changes to the Universal Claim Form

Service Provider ID

[Example needed]

Prescriber ID

PRESCRIBER I.D.	QUAL (12)

Provider ID

PROVIDER I.D.	QUAL (16)

APPENDIX D1 – Revised Universal Claim Form Instructions

Revised: 23 February 2007

Changes to the provider data elements were made to the Universal Claim Form (UCF) to accommodate the reporting of the National Provider Identifier (NPI). The revisions to the data elements in the Service Provider, Prescriber and Provider ID sections will be noted within this document.

NOTE: All Pharmacy/Bill Type-2's generated in TPOCS should include; NPI Type 2 for the facility and NPI Type 1 for the Dispensing provider (data elements for the Prescriber ID will be based on payer requirements).

For your convenience, symbols will be used to denote (●) New Item or (▶) Revision of an existing Item.

Fields will be automatically populated by TPOCS.

Patient Information – This section of the Universal Claim Form provides patient and cardholder information.

Cardholder I.D., Required
Cardholder's I.D.

Group I.D., Conditional
Group I.D.

Cardholder Name, Required
Cardholder's name (last, first, middle initial)

Plan Name, Required
Plan name

Patient Name, Required
Patient's name (last, first, middle initial)

(1) - Qualifier Code, Other Coverage Code, Required
Other coverage codes, as applicable
0 - Not Specified (Default)
1 - No other coverage identified
2 - Other coverage exists-payment collected
3 - Other coverage exists-this claim not covered
4 - Other coverage exists-payment not collected
5 - Managed care plan-denial
6 - Other coverage denied-not a participating provider
7 - Other coverage exists-not in effect at this time
8 - Claim is billing for co-pay

(2) - Qualifier Code, Person Code, Required
Code assigned to specific person in the family

Patient Date of Birth, Required
Patient's DOB three spaces MMDDCCYY

(3) - Qualifier Code, Patient Gender Code, Required
0 - Not Specified
1 - Male
2 - Female

(4) - Qualifier Code, Patient Relationship Code, Required
Relationship code of patient to cardholder. (Drop down box)
0 - Not specified
1 - Cardholder
2 - Spouse
3 - Child
4 - Other

Pharmacy Information - This section of the UCF provides pharmacy information required for processing the claim. Note: NPI Type 2 of the treatment/dispensing MTF will be used for all pharmacy claims generated in TPOCS.

Pharmacy Name, Required
Name of Pharmacy
For DoD, the name of the MTF that filled the prescription.

(5) – Qualifier Code, Service Provider I.D., Required
ID of the service provider/ followed by the following qualifier code
TPOCS will now assign qualifier **01-NPI Type 2** based on the **Dispensing DMIS ID.**

Blank - Not Specified
01 - National Provider Identifier (NPI)
02 - Blue Cross
03 - Blue Shield
04 - Medicare
05 - Medicaid
06 - UPIN
07 - NCPDP Provider ID
08 - State License
09 - CHAMPUS
10 - Health Industry Number
11 - Federal Tax ID
12 - DEA

Address, Required
Pharmacy street address
For DoD, the address of the MTF that filled the prescription.

Phone Number, Required
Pharmacy phone number
For DoD, enter the phone number of the MTF that filled the prescription.

City, Required
City for pharmacy address
For DoD, the city of the MTF that filled the prescription.

Fax No., Required
Fax # for the pharmacy.
For DoD, the fax number of the MTF that filled the prescription.

State and Zip Code, Required
State and Zip code for pharmacy
For DoD, the state and zip code of the MTF that filled the prescription.

Workers Compensation Information – This section provides information related to Worker Compensation claims.

Employer Name, Conditional
Employer's name for the patient

Address, Conditional
Employer's street address

City, Conditional
Employer's city

State, Conditional
Employer's state

Zip Code, Required
Employer's zip code

Authorized Signature, Required
Authorized signature of patient or legal guardian (handwritten)

(6) – Qualifier Code, Carrier I.D., Required
ID of the carrier
Code assigned to Worker's Compensation Program
Worker's Comp information is conditional and should be reported only for Workers Comp claims.

Employer Phone Number, Required
Employer's phone number

Date of Injury, Required
Date of injury

(7) – Qualifier Code, Claim Reference I.D., Required
Reference ID for the claim
Claim number assigned by Workers Compensation Program

Prescription/Service Information – Sections 1 and 2 of the Universal Claim Form require the same data. The form allows for two separate prescriptions to be filed on one claim form.

Prescription/Service Reference Number, Required
Prescription or service reference #

(8) – Qualifier Code, Prescription/Service Reference Number Qualifier, Required
Blank - Not specified
1 - Rx Billing (Default)
2 - Service Billing

Date Written, Required
Date prescription or service written

Date of Service, Required
Dispensed date

Fill Number, Required, if applicable
Fill number for the prescription

(9) – Qualifier Code, Quantity Dispensed, Required, if applicable
Quantity of prescription dispensed; expressed in metric decimal units

Days Supply, Required, if applicable
Number of days supplied in prescription

Product Service ID, Required, if applicable
Product/service ID number
Currently, will default to the NDC number

(10) – Qualifier, Product Service ID Qualifier, Required
Appropriate qualifier code
Blank - Not specified
00 - Not Specified
01 - Universal Product Code (UPC)
02 - Health Related Item (HRI)
03 - National Drug Code (NDC) (Default)
04 - Universal Product Number (UPN)
05 - Department of Defense (DoD)
06 - Drug Use Review/Professional Pharmacy Service (DUR/PPS)
07 - CPT4
08 - CPT5
09 - HCPCS
10 - Pharmacy Practice Activity Classification (PPAC)
11 - National Pharmaceutical Product Interface Code (NAPPI)
12 - International Article Numbering System (EAN)
13 - Drug Identification Number (DIN)
99 - Other

Dispensed As Written (DAW) Code, Not Required (Blank)
DAW code

Prior Authorization Number Submitted, Conditional
Prior authorization # submitted

(11) – Qualifier Code, Prior Authorization Type, Conditional
Enter the Prior Authorization Code
0 - Not Specified (Default)
1 - Prior Authorization
2 - Medical Certification
3 - EPSDT (Early Periodic Screening Diagnosis Treatment)
4 - Exemption from Co-pay
5 - Exemption from RX limit
6 - Family Planning Indicator
7 - Aid to Families with Dependent Children (AFDC)
8 - Payer Defined Exemption

Prescriber ID, Required
Identification of the provider that prescribed the drug

(12) – Qualifier Code, Prescriber ID Qualifier, Required
Enter the appropriate billing qualifier based on payer requirements (dropdown box)

Blank - Not specified
00 - Not specified
01 - DEA
02 - State License
03 - SSN
04 - Name (Default)
05 - National Provider ID (NPI)
06 - Health Industry Number (HIN)
07 - State Issued
99 - Other

(13) – Qualifier Code, DUR/PPS Codes, Conditional
PPS codes—(Limit 1 set of DUR/PPS codes per claim)
A - Reason for Service
B - Professional Service Code
C - Result of Service

(14) – Qualifier Code, Basis Cost, Required
Basis Cost
Blank - Not specified
00 - Not specified
01 - Average Wholesale Price (AWP)
02 - Local Wholesale
03 - Direct (Default)
04 - Estimated Acquisition Cost (EAC)
05 - Acquisition
06 - MAC (Maximum Allowable Cost)
07 - Usual and Customary
09 - Other

Provider ID (Registered Pharmacist, R.P.H.), Required
Provider's ID- NPI Type 1 of the dispensing Provider

(15) – Qualifier Code, Provider ID Qualifier, Required
Use qualifier 05-National Provider ID
Blank - Not specified
00 - Not specified
01 - DEA
02 - State License
03 - SSN
04 - Name
*05 - National Provider ID (NPI)
06 - Health Industry Number (HIN)
07 - State Issued
99 - Other (Default)

Diagnosis Code, Conditional
ICD9-CM diagnosis code

(16) Qualifier Code, Diagnosis Code Qualifier, Conditional
Report diagnosis code and qualifier related to prescription-limit: one per prescription
Blank - Not Specified
00 - Not Specified
01 - ICD-9 (Default)
02 - ICD-10

03 - National Criteria Care Institute (NDCC)
04 - Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05 - Common Dental Terminology
06 - Medi-Span Diagnosis Code
07 - American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)
99 - Other

Other Payer Date, Conditional
Other payer date

Other Payer ID, Conditional
ID for other payer

(17) – Qualifier Code, Other Payer ID Qualifier, Conditional
Blank - Not Specified
01 - National Payer ID (Default)
02 - Health Industry Number (HIN)
03 - Bank Information Number (BIN)
04 - National Association of Insurance Commissioners (NAIC)
05 - Coupon
99 - Other

Other Payer Reject Codes, Conditional
Reject codes from other payer

Usual and Customary Charge, Required
Usual and Customary Rate

Ingredient Cost Submitted, Required
Ingredient cost per unit
Total cost of the drug not including the dispensing fee

Dispensing Fee Submitted, Required
Dispensing is added into Basis Cost and not listed in field

Incentive Amount Submitted, Conditional
Incentive charges (Default = 0.00)

Other Amount Submitted, Conditional
Other charges submitted

Gross Amount Due Submitted, Required
Total due
Equals sum of Usual & Customary Charge, Ingredient Cost Submitted, Dispensing Fee Submitted, Incentive Amount Submitted, and Other Amount Submitted.

Patient Paid Amount, Conditional
Cost paid by the patient (Default =0.00)

Other Payer Amount Paid, Conditional
Total paid by the other payer

Net Amount Due, Required
Remaining balance due
Equals Gross amount due subtracted by sum of Patient Amount Paid and Other Payer Amount Paid.

Compound Prescriptions, Not required
Limit 1 compound prescription per claim if compound prescription used
Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area on the reverse side at the bottom of claim form. Use a separate claim form for each compound prescription.

I.D. _____ GROUP I.D. _____

NAME _____ PLAN NAME _____

PATIENT NAME: _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ___ ___ ___ (MM DD CCYY) PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ / _____ QUAL (5)

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION

EMPLOYER NAME _____

ADDRESS _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT/ AUTHORIZED REPRESENTATIVE _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____

DATE OF INJURY ___ ___ ___ (MM DD CCYY) **CLAIM (7) REFERENCE I.D.** _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM	DD	CCYY	DATE OF SERVICE MM	DD	CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM	DD	CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM	DD	CCYY	DATE OF SERVICE MM	DD	CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM	DD	CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

SAMPLE

APPENDIX D1 – Universal Claim Form Instructions

Revised: 01 October 2003

Fields will be automatically populated by TPOCS.

Patient Information – This section of the Universal Claim Form provides patient and cardholder information.

Cardholder I.D., Required
Cardholder's I.D.

Group I.D., Conditional
Group I.D.

Cardholder Name, Required
Cardholder's name (last, first, middle initial)

Plan Name, Required
Plan name

Patient Name, Required
Patient's name (last, first, middle initial)

(1) - Qualifier Code, Other Coverage Code, Required
Other coverage codes, as applicable
0 - Not Specified (Default)
1 - No other coverage identified
2 - Other coverage exists-payment collected
3 - Other coverage exists-this claim not covered
4 - Other coverage exists-payment not collected
5 - Managed care plan-denial
6 - Other coverage denied-not a participating provider
7 - Other coverage exists-not in effect at this time
8 - Claim is billing for co-pay

(2) - Qualifier Code, Person Code, Required
Code assigned to specific person in the family

Patient Date of Birth, Required
Patient's DOB three spaces MMDDCCYY

(3) - Qualifier Code, Patient Gender Code, Required
0 - Not Specified
1 - Male
2 - Female

(4) - Qualifier Code, Patient Relationship Code, Required
Relationship code of patient to cardholder. (Drop down box)
0 - Not specified
1 - Cardholder
2 - Spouse
3 - Child
4 - Other

Pharmacy Information - This section of the UCF provides pharmacy information required for processing the claim.

Pharmacy Name, Required
Name of Pharmacy
For DoD, the name of the MTF that filled the prescription.

(5) – Qualifier Code, Service Provider I.D., Required
ID of the service provider/ followed by the following qualifier code
Blank - Not Specified
01 - National Provider Identifier (NPI)
02 - Blue Cross
03 - Blue Shield
04 - Medicare
05 - Medicaid
06 - UPIN
07 - NCPDP Provider ID
08 - State License
09 - CHAMPUS
10 - Health Industry Number
11 - Federal Tax ID
12 - DEA

Address, Required
Pharmacy street address
For DoD, the address of the MTF that filled the prescription.

Phone Number, Required
Pharmacy phone number
For DoD, enter the phone number of the MTF that filled the prescription.

City, Required
City for pharmacy address
For DoD, the city of the MTF that filled the prescription.

Fax No., Required
Fax # for the pharmacy.
For DoD, the fax number of the MTF that filled the prescription.

State and Zip Code, Required
State and Zip code for pharmacy
For DoD, the state and zip code of the MTF that filled the prescription.

Workers Compensation Information - This section provides information related to Worker Compensation claims.

Employer Name, Conditional
Employer's name for the patient

Address, Conditional
Employer's street address

City, Conditional
Employer's city

State, Conditional

Employer's state

Zip Code, Required
Employer's zip code

Authorized Signature, Required
Authorized signature of patient or legal guardian (handwritten)

(6) – Qualifier Code, Carrier I.D., Required
ID of the carrier
Code assigned to Worker's Compensation Program
Worker's Comp information is conditional and should be reported only for Workers Comp claims.

Employer Phone Number, Required
Employer's phone number

Date of Injury, Required
Date of injury

(7) – Qualifier Code, Claim Reference I.D., Required
Reference ID for the claim
Claim number assigned by Workers Compensation Program

Prescription/Service Information - Sections 1 and 2 of the Universal Claim Form require the same data. The form allows for two separate prescriptions to be filed on one claim form.

Prescription/Service Reference Number, Required
Prescription or service reference #

(8) – Qualifier Code, Prescription/Service Reference Number Qualifier, Required
Blank - Not specified
1 - Rx Billing (Default)
2 - Service Billing

Date Written, Required
Date prescription or service written

Date of Service, Required
Dispensed date

Fill Number, Required, if applicable
Fill number for the prescription

(9) – Qualifier Code, Quantity Dispensed, Required, if applicable
Quantity of prescription dispensed; expressed in metric decimal units

Days Supply, Required, if applicable
Number of days supplied in prescription

Product Service ID, Required, if applicable
Product/service ID number
Currently, will default to the NDC number

(10) – Qualifier, Product Service ID Qualifier, Required
Appropriate qualifier code
Blank - Not specified

00 - Not Specified
01 - Universal Product Code (UPC)
02 - Health Related Item (HRI)
03 - National Drug Code (NDC) (Default)
04 - Universal Product Number (UPN)
05 - Department of Defense (DoD)
06 - Drug Use Review/Professional Pharmacy Service (DUR/PPS)
07 - CPT4
08 - CPT5
09 - HCPCS
10 - Pharmacy Practice Activity Classification (PPAC)
11 - National Pharmaceutical Product Interface Code (NAPPI)
12 - International Article Numbering System (EAN)
13 - Drug Identification Number (DIN)
99 - Other

Dispensed As Written (DAW) Code, Not Required (Blank)
DAW code

Prior Authorization Number Submitted, Conditional
Prior authorization # submitted

(11) – Qualifier Code, Prior Authorization Type, Conditional
Enter the Prior Authorization Code
0 - Not Specified (Default)
1 - Prior Authorization
2 - Medical Certification
3 - EPSDT (Early Periodic Screening Diagnosis Treatment)
4 - Exemption from Co-pay
5 - Exemption from RX limit
6 - Family Planning Indicator
7 - Aid to Families with Dependent Children (AFDC)
8 - Payer Defined Exemption

Prescriber ID, Required
Name of the provider that prescribed the drug

(12) – Qualifier Code, Prescriber ID Qualifier, Required
Blank - Not specified
00 - Not specified
01 - DEA
02 - State License
03 - SSN
04 - Name (Default)
05 - National Provider ID (NPI)
06 - Health Industry Number (HIN)
07 - State Issued
99 - Other

(13) – Qualifier Code, DUR/PPS Codes, Conditional
PPS codes—(Limit 1 set of DUR/PPS codes per claim)
A - Reason for Service
B - Professional Service Code
C - Result of Service

(14) – Qualifier Code, Basis Cost, Required

Basis Cost
Blank - Not specified
00 - Not specified
01 - Average Wholesale Price (AWP)
02 - Local Wholesale
03 - Direct (Default)
04 - Estimated Acquisition Cost (EAC)
05 - Acquisition
06 - MAC (Maximum Allowable Cost)
07 - Usual and Customary
09 - Other

Provider ID (Registered Pharmacist, R.P.H.), Required
Provider's ID

(15) – Qualifier Code, Provider ID Qualifier, Required
Blank - Not specified
00 - Not specified
01 - DEA
02 - State License
03 - SSN
04 - Name
05 - National Provider ID (NPI)
06 - Health Industry Number (HIN)
07 - State Issued
99 - Other (Default)

Diagnosis Code, Conditional
ICD9-CM diagnosis code

(16) Qualifier Code, Diagnosis Code Qualifier, Conditional
Report diagnosis code and qualifier related to prescription-limit: one per prescription
Blank - Not Specified
00 - Not Specified
01 - ICD-9 (Default)
02 - ICD-10
03 - National Criteria Care Institute (NDCC)
04 - Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05 - Common Dental Terminology
06 - Medi-Span Diagnosis Code
07 - American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)
99 - Other

Other Payer Date, Conditional
Other payer date

Other Payer ID, Conditional
ID for other payer

(17) – Qualifier Code, Other Payer ID Qualifier, Conditional
Blank - Not Specified
01 - National Payer ID (Default)
02 - Health Industry Number (HIN)
03 - Bank Information Number (BIN)
04 - National Association of Insurance Commissioners (NAIC)
05 - Coupon

99 - Other

Other Payer Reject Codes, Conditional
Reject codes from other payer

Usual and Customary Charge, Required
Usual and Customary Rate

Ingredient Cost Submitted, Required
Ingredient cost per unit
Total cost of the drug not including the dispensing fee

Dispensing Fee Submitted, Required
Dispensing is added into Basis Cost and not listed in field

Incentive Amount Submitted, Conditional
Incentive charges (Default = 0.00)

Other Amount Submitted, Conditional
Other charges submitted

Gross Amount Due Submitted, Required
Total due
Equals sum of Usual & Customary Charge, Ingredient Cost Submitted, Dispensing Fee Submitted, Incentive Amount Submitted, and Other Amount Submitted.

Patient Paid Amount, Conditional
Cost paid by the patient (Default =0.00)

Other Payer Amount Paid, Conditional
Total paid by the other payer

Net Amount Due, Required
Remaining balance due
Equals Gross amount due subtracted by sum of Patient Amount Paid and Other Payer Amount Paid.

Compound Prescriptions, Not required
Limit 1 compound prescription per claim if compound prescription used
Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area on the reverse side at the bottom of claim form. Use a separate claim form for each compound prescription.

APPENDIX E – DD7A Instructions

Revised: 01 October 2003

Sections are automatically populated by CHCS.

Section 1: Required
Installation Providing Hospitalization (name and address)
Name of medical activity, base and/or post, and Major Command as applicable providing medical care in continental United States. Name of medical activity, APO and Major Command outside continental United States (OCONUS).

Section 2: Required
Month and Year Covered By This Report
Month and year covered by this report (9 character alpha month, 4-digit year).

Section 3: Required
Category of Patients
Category of the patients.

Section 4: Required
Authority for Treatment
Authority for the treatment.

Section 5: Required
Name and SSN
Name (Last, First, Middle Initial) and SSN (9 digit numeric)

Section 6: Required
Military Grade
Military grade or status of the individual (e.g., civilian, eligible family member).

Section 7: Requirement Not Available
Organization

Section 8: Required
Clinic associated with the Encounter
Clinic associated with the Encounter or Requesting MEPRS Code Location of service for each patient.

Section 9: Required
Dates
List day, month and year (DDMMYYYY) as the Date of Service of the services/supplies furnished.

Section 10: Required
Description of Services
Description of services provided, such as Encounter, Lab, Rad, Immunization, Pharmacy, etc., and corresponding dollar amount, for the Date of Service.

Section 11: Required
Date of certification of report
Date of certification

Section 12: Required
Authentication (signature, military grade, and organization of Commanding Officer)
Obtain the required signature of the MTF commander or authorized representative (on original only) including grade and organization.

Section 13: Required, if applicable
Total Amount per Patient Category and Total Billed To Date
Total amount for all patients listed for each Patient Category, Total Amount Billed this Fiscal Year, and any applicable adjustments for the period.

Section 14: Required
Date of Service
Date of Service

Section 15 (New): Required
CPT codes
This will only be available on the Detail per Patient.
HCPCS/CPT code for procedure.

Section 16 (New): Required
Description
This will only be available on the Detail per Patient.
30 Character AMA Short Name description for CPT/ HCPCS code.

Section 17 (New): Required
Cost
This will only be available on the Detail per Patient.
Cost of corresponding procedure.

Section 18 (New): Required
Total (Per Patient and Date of Service)
Total of all costs in section 18.

APPENDIX F – I&R Instructions

Revised: 01 October 2003

Sections are automatically populated by CHCS.

Provider Name, Address: Required
Medical activity, base and/or post, and Major Command as applicable providing medical care in continental United States. Name of medical activity, APO and Major Command outside continental United States.

Organization: Required
Military branch

Sponsor Name: Required
Name of the patient's sponsor (Last, First, MI)

Service: Required
Service code

Duty Address: Required
Duty address of sponsor

Grade: Required
Military grade or status of the individual (e.g. civilian, eligible family member).

Billing Name: Required
Name of person to be billed (Last, First)

FMP/SSN: Required
FMP and SSN of person to be billed

Billing Address: Required, if applicable
Address of person to be billed

Patient Name: Required
Name of patient (Last, First)

Account Number: Required
Account number for bill

Date of Service: Required
Date of admission or outpatient visit (DDMMMYYYY).

Discharge Date: Required for inpatient services only
Date of discharge. Inpatient services only (DDMMMYYYY).

Total Charge: Required
Sum of total inpatient or outpatient charges

Details of Service for Inpatient Invoice & Receipts

Beg Date: Required
Date of admission

End Date: Required
Description of service

Chg Days: Required
Number of chargeable days

Chg. Days: Required
Number of non-chargeable days

Rate: Required
Per Diem rate charged per day for service (if a DRG calculated bill, system divides totals charges by number of chargeable days).

Charge: Required
Sum of total charges

Details of Service for Outpatient Invoice & Receipts

Svc: Required
Service charge category (e.g., OPE, LAB, RAD)

Code: Required
Procedure or product code (e.g., CPT, NDC)

Description: Required
Description of service

Qty: Required
Quantity of service rendered

Svc Date: Required
Date service provided

Charges: Required
Charge for service

Date: Required
Date of last transaction (e.g., date account generated, date of last payment)

Payment: Required
Payments made on account by date

Type Pay: Required
Form of payment (e.g., cash (C), check (K), credit card (E))

Check No.: Required, if applicable
Check number of payment

Ctrl No.: Required
Control number of transaction (auto assigned by CHCS)

Balance: Required
Balance calculated by subtracting Payment from Total Charges or previous balance.

GLOSSARY & DEFINITIONS

Revised: 01 January 2009

The following information has been excerpted from the "Department of Defense Glossary of Healthcare Terminology" (DoD 6015.1-M), with additions.

ADA. American Dental Association.

ADDITIONAL DIAGNOSIS. Any diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the physician considers of sufficient significance to warrant inclusion for investigative medical studies.

ADMISSION. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day when the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. When reporting admission data, always exclude: total absent–sick patients, carded-for-record only (CRO) cases, and transient patients.

ADMISSION CERTIFICATION. Approval by a case manager or insurance company representative for a member to be admitted to a hospital or in-patient facility. Method of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under a certification program. The goal of pre-admission certification is to ensure appropriateness and medical necessity of hospitalization or other medical treatment. (Also called Pre-admission Certification).

ADM. Ambulatory Data Module.

AIS. Automated Information System. Computer hardware, computer software, telecommunications, information technology, personnel, and other resources that collect, record, process, store, communicate, retrieve, and display information. An AIS can include computer software only, computer hardware only, or a combination of the above.

ALLOWED AMOUNT. Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a Maximum Allowable.

AMBULATORY CARE. Health services provided without the patient being admitted. Also called Outpatient Care. The services of ambulatory care centers, hospital outpatient departments, physicians' offices, and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours.

ANCILLARY. Tests and procedures ordered by healthcare providers to assist in patient diagnosis or treatment (radiology, laboratory, pathology).

APV. Ambulatory Patient Visit. An APV provides pre-procedure and post-procedure care, observation, and assistance for patients requiring short-term care (less than 24 hours).

A/R. Accounts Receivable.

ASO (Administrative Services Only). An arrangement in which an employer hires a third party to deliver administrative services to the employer, such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans.

ASSIGNMENT OF BENEFITS. The payment of medical benefits directly to a provider of care rather than to a member. Generally requires either a contract between the health plan and the provider, or a written release from the subscriber to the provider allowing the provider to bill the health plan.

ATTENDING PHYSICIAN. The physician with defined clinical privileges that has the primary responsibility for diagnosis and treatment of the patient. A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case. There will always be only one primary physician; however, under very extraordinary circumstances, because of the presence of complex, serious and multiple, but related, medical conditions, a patient may have more than one attending physician providing treatment at the same time.

BALANCE BILLING. The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copays, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).

BENEFIT. Amount payable by the insurance company for covered medical expenses as specified by the plan to a claimant, assignee, or beneficiary.

BENEFIT LIMITATIONS. Any provision, other than an exclusion, which restricts coverage coverage, regardless of medical necessity. Limitations are often expressed in terms of dollar amounts, length of stay, diagnosis or treatment descriptions.

BPR. Business Process Reengineering. MHS Business Process Reengineering is a radical improvement approach that critically rethinks and redesigns product and service processes within a political environment to achieve dramatic MHS mission performance gains.

BRAND-NAME DRUG. Prescription drugs marketed with a specific brand name by the company that manufactures it. May cost insured individuals a higher co-pay than generic drugs on some health plans.

BUNDLING. Combining into one payment the charges for various medical services rendered during one health care encounter. Bundling often combines the payment from physician and hospital services into one reimbursement. Also called "package pricing."

CARRIER. An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health or other insurance programs.

CASE MANAGEMENT. A system embraced by employers and insurance companies to ensure that individuals receive appropriate, reasonable health care services.

CATASTROPHIC HEALTH INSURANCE. Policy that provides protection primarily against the higher costs of treating severe or lengthy illnesses or disabilities. Normally these are "add on" benefits that begin coverage once the primary insurance policy reaches its maximum.

CERTIFICATE BOOKLET. A printed description of the benefits and coverage provisions intended to explain the contractual arrangement between the carrier and the insured group or individual. May also be referred to as a policy booklet.

CERTIFICATE OF COVERAGE (COC). Outlines the terms of coverage and benefits available in a carrier's health plan.

CHAMPUS. Civilian Health and Medical Program of the Uniformed Services. An indemnity-like program called TRICARE Standard that is available as an option under DoD's TRICARE Program. There are deductibles and cost shares for care delivered by civilian health care providers to active duty family

members, retirees and their family members, certain survivors of deceased members, and certain former spouses of members of the seven Uniformed Services of the U.S.

CHCS. Composite Health Care System. Medical AIS that provides patient facility data management and communications capabilities. Specific areas supported include MTF health care (administration and care delivery), patient care process (integrates support--data collections and one-time entry at source), ad hoc reporting, patient registration, admission, disposition, and transfer, inpatient activity documentation, outpatient administrative data, appointment scheduling and coordination (clinics, providers, nurses and patients), laboratory orders (verifies and processes), drug and lab test interaction, quality control and test reports, radiology orders (verifies and processes), radiology test result identification, medication order processing (inpatient and outpatient), medicine inventory, inpatient diet orders, patient nutritional status data, clinical dietetics administration, nursing, order-entry, eligibility verification, provider registration, and the Managed Care Program.

CLAIM. A request by an individual (or provider) to an individual's insurance company for the insurance company to pay for services obtained from a health care professional. Types of claims and/or data records include Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug and Dental, and Program for the Handicapped.

CLAIM REIMBURSEMENT. The payment of the expenses actually incurred as a result of an accident or sickness, but not to exceed any amount specified in the policy.

CLAIMS REVIEW. The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

CLAIM STATUS CODES. A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction, and is maintained by the Health Care Code Maintenance Committee.

“CLEAN” CLAIM. A claim that is free of defect and impropriety, containing required substantiating documentation and also free of circumstances that require special treatment that may prevent timely payment.

CLINIC. A health treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and ambulatory services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, preventive medicine services, and health promotion activities to support a primary military mission. In some instances, a clinic may also routinely provide therapeutic services to hospitalized patients to achieve rehabilitation goals, (e.g., occupational therapy and physical therapy). A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital and for the care of cases that cannot be cared for on an outpatient status, but that do not require hospitalization. Such beds may not be considered when calculating occupied-bed days by MTFs.

CLINIC SERVICE. A functional division of a department of a Military Treatment Facility identified by a three-digit MEPRS code.

CLOSED ACCESS. Gatekeeper model health plan that requires covered persons to receive care from providers within the plan's coverage. Except for emergencies, the patient may only be referred to and treated by providers within the plan. A managed health care arrangement in which covered persons are required to select providers only from the plan's participating providers.

CMAC. CHAMPUS Maximum Allowable Charge.

CMS. Centers for Medicare & Medicaid Services (CMS). Formerly the Health Care Financing Administration (HCFA).

CMS 1450. Also known as UB-04 or UB-04. The common claim form used by hospitals to bill for services.

CMS 1500. A claim form used to bill for professional services. Required by Medicare and generally used by private insurance companies and managed care plans.

CODE SET. Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions.

CODING. A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "upcoded" which is considered fraud. A national certification exists for coding professionals and many compliance programs are raising standards of quality for their coding procedures.

COINSURANCE. A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. ¨ Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges. The individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary and reasonable. Coinsurance rates may differ if services are received from an network or non-network provider. In addition to overall coinsurance rates, rates may also differ for different types of services. Co-insurance is only required up to the plan's stop loss amount.

COMPLIANCE. Accurately following the government's rules on Medicare billing system requirements and other federal or state regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities.

COMPREHENSIVE COVERAGE. Insurance is either comprehensive or limited. Comprehensive means broader coverage and/or higher indemnity payments than limited coverage.

COMPREHENSIVE MAJOR MEDICAL INSURANCE. A policy designed to provide the protection offered by both a basic and major medical health insurance policy. It is generally characterized by a low deductible, a co-insurance feature, and high maximum benefits.

CONCURRENT REVIEW. Review of a procedure or hospital admission done by a health care professional, other than the one providing the care, during the same time frame that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) - Federal law that continues health care benefits for employees whose employment has been terminated. Employers are required to notify employees of these benefit continuation options, and, failure to do so can result in penalties and fines for the employer. An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment. COBRA imposes different restrictions on individuals who leave their jobs voluntarily versus involuntarily (Department of Labor, 2002).

CONSULTATION. A deliberation with a specialist concerning the diagnosis or treatment of a patient. To qualify as a consultation (for statistical measure) a written report to the requesting health care professional is required.

CONTINUED STAY REVIEW. A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

CONTRACT. A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation, and less formal agreements may be made.

CONTRACT PROVIDER. Any hospital, physician, skilled nursing facility, extended care facility, individual, organization, or agency licensed that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

CONVENTIONAL INDEMNITY PLAN. An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

CONUS. Continental United States. United States territory, including the adjacent territorial waters located within the North American continent between Canada and Mexico. Alaska and Hawaii are not part of the CONUS.

COORDINATION OF BENEFITS (COB). Provision regulating payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage. A coordination of benefits, or "nonduplication," clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pays its benefits in full and which becomes the supplementary payer on a claim.

COPAYMENT. A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. There may be separate copayments for different services.

COVERED SERVICE. This term refers to all of the medical services the enrollee may receive at no additional charge or with incidental co-payments under the terms of the prepaid health care contract.

COVERED BENEFIT. A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

CPT – CURRENT PROCEDURAL TERMINOLOGY. A systematic listing and coding of procedures and services performed by a physician. Each procedure or service is identified with a five-digit code that simplifies the reporting of services.

CPT MODIFIER. A modifier is an addendum to procedure codes which indicates that a procedure has been altered by some specific circumstance but not changed in its definition.

CREDIT FOR PRIOR COVERAGE. Any pre-existing condition waiting period met under an employer's prior (qualifying) coverage will be credited to the current plan, if any interruption of coverage between the new and prior plans meets state guidelines.

DEDUCTIBLE. A fixed dollar amount during the benefit period, usually a year, that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For

example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from a network provider or if received from a non-network provider.

DEDUCTIBLE CARRY OVER CREDIT. Charge incurred during the last three months of a year that may be applied to the deductible and which may be carried over into the next year.

DENIAL OF CLAIM. Refusal by an insurance company to honor a request by an individual (or provider) to pay for health care services obtained from a health care professional.

DIAGNOSIS. A term used to identify a disease or problem from which an individual patient suffers or a condition for which the patient needs, seeks, or receives health care.

DISALLOWANCE. When a payer declines to pay for all or part of a claim submitted for payment.

DME. Durable Medical Equipment. Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. An area of increasing expense, particularly in conjunction with case management.

DMIS ID. Defense Medical Information System Identification Code. The Defense Medical Information System identification code for fixed medical and dental treatment facilities for the Tri-Services, and the U.S. Coast Guard. In addition, DMIS IDs are given for non-catchment areas, administrative units such as the Surgeon General's Office of each of the Tri-Services, and other miscellaneous entities.

DRG. Diagnosis Related Group. Patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed. It provides a framework for specifying hospital case mix and identifies classifications of illnesses and injuries for which payment is made under prospective pricing programs. It is used to determine the payment the hospital will receive for the admission of that type of patient. E/M. Evaluation and Management.

ED. Emergency Department.

EDI - ELECTRONIC DATA INTERCHANGE. The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization. Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

EDI TRANSLATOR. Used in electronic claims and medical record transmissions, this is a software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

EFFECTIVE DATE. The date on which a policy's coverage of a risk goes into effect.

ELECTIVE CARE. Medical, surgical, or dental care that, in the opinion of professional authority, could be performed at another time or place without jeopardizing the patient's life, limb, health, or well-being. Examples are surgery for cosmetic purposes, vitamins without a therapeutic basis, sterilization procedures, elective abortions, procedures for dental prosthesis, prosthetic appliances, and so on.

ELECTRONIC CLAIM. A digital representation of a medical bill generated by a provider or by the provider's billing agent for submission using telecommunications to a health insurance payer.

ELECTRONIC MEDIA CLAIMS. A flat file format used to transmit or transport claims.

ELECTRONIC REMITTANCE ADVICE. Any of several electronic formats for explaining the payments of health care claims.

EMERGENCY. Situation that requires immediate intervention to prevent the loss of life, limb, sight or body tissue or to prevent undue suffering.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. ERISA exempts most large self-funded plans from State regulation.

ENCOUNTER. A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment.

ENROLLED GROUP. Persons with the same employer or with membership in an organization in common, who are enrolled collectively in a health plan.

EXCLUSIONS. Specified illnesses, injuries, or conditions listed in the policy that are not covered. Experimental therapies, cosmetic surgery, and eyeglasses are common exclusions.

EXCLUSIVE PROVIDER ARRANGEMENT (EPA). An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN. A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

EXPLANATION OF BENEFITS (EOB). A carrier's written response to a claim for benefits. Sometimes accompanied by a benefits check.

FAMILY MEMBER PREFIX (FMP). A two-digit number used to identify a sponsor or prime beneficiary or the relationship of the patient to the sponsor.

FEE-FOR-SERVICE PLAN. Fee-for-service health insurance plans typically allow patients to obtain care from doctors or hospitals of their choosing, but in return for this flexibility they may pay higher copayments or deductibles.

FISCAL INTERMEDIARY. The agent that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs. This entity may also be referred to as TPA or third party administrator.

FLEXIBLE BENEFITS PLAN (CAFETERIA PLAN) (IRS 125 PLAN). A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

FLEXIBLE SPENDING ACCOUNTS OR ARRANGEMENTS (FSA). Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee’s share of insurance premiums or medical expenses not covered by the employer’s health

plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. See also Medical Spending Account.

FORMULARY. An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care.

FRR. Full Reimbursable Rate.

FY. Fiscal Year.

GME. Graduate Medical Education. Full-time, structured medically related training, accredited by a national body (e.g., the Accreditation Council for Graduate Medical Education) approved by the commissioner of education and obtained after receipt of the appropriate doctoral degree.

GATEKEEPER. A primary care physician, utilization review, case management, local agency or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for. An arrangement in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone that makes the decision of where a patient will receive services.

GENERIC DRUG. The chemical equivalent to a "brand name drug."

GLOBAL FEE. A total charge for a specific set of services, such as obstetrical services that encompass prenatal, delivery and post-natal care.

GROUP INSURANCE. Any insurance policy or health services contract by which groups of employees (and their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

HCPCS. CMS's Healthcare Common Procedural Coding System. A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes, but also has codes for services not included in CPT, such as ambulance. While HCPCS is nationally defined, there is provision for local use of certain codes.

HEALTHCARE PROVIDER. A healthcare professional who provides health services to patients; examples include a physician, dentist, nurse, or allied health professional.

HEALTHCARE PROVIDER TAXONOMY CODES. An administrative code set that classifies health care providers by type and area of specialization. A provider may have more than one Healthcare Provider Taxonomy Code.

HEALTH INSURANCE. Financial protection against the health care costs of the insured person. May be obtained in a group or individual policy.

HEALTH MAINTENANCE ORGANIZATION (HMO). An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The members of an HMO are required to use participating or approved providers for all health services except for emergencies and generally all services need approval by the HMO through its utilization program.

I&R. Invoice & Receipt.

IAR. Interagency Rate.

ICD-9-CM. International Classification of Diseases, 9th Revision, Clinical Modification. A coding system for classifying diseases and operations to facilitate collection of uniform and comparable health information.

IMET. International Military Education and Training.

IMMUNIZATION. Protection of susceptible individuals from communicable diseases by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.

IMMUNIZATION PROCEDURE. The process of injecting a single dose of an immunizing substance. For a detailed discussion on counting immunization procedures, see DoD 6010.13-M (reference (a)).

INDEMNITY INSURANCE/PLAN. Traditional insurance that reimburses the patient and/or provider as expenses are incurred.

INDIVIDUAL HEALTH INSURANCE PLAN. A type of insurance plan for individuals and their dependents who are not eligible for coverage through employer group coverage.

IN-NETWORK. Describes a provider or health care facility which is part of a health plan's network. When applicable, insured individuals usually pay less when using an in-network provider.

INSOLVENCY. A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

J-CODES. A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items.

LIFETIME MAXIMUM BENEFIT. The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

LIMITATIONS. A restriction on the amount of benefits paid out for a particular covered expense.

LONG-TERM CARE POLICY. Insurance policies that cover specified services for a specified period of time. Covered services usually include nursing care, home health care services, and custodial care.

LONG-TERM DISABILITY (LTD). Insurance which pays employees a percentage of monthly earnings in the event of disability.

LOS – LENGTH OF STAY. A term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

MAC. Medical Affirmative Claims.

MAJOR MEDICAL EXPENSE INSURANCE. Policies designed to offset medical expenses resulting from catastrophic or prolonged illness or injury. They generally provide benefits payments for 75 to 80 percent of most types of medical expenses above a deductible paid by the insured.

MANAGED BEHAVIORAL HEALTH PROGRAM. A program of managed care specific to psychiatric or behavioral health care.

MANAGED CARE. The coordination of health care services in the attempt to produce high quality health care for the lowest possible cost. Examples are the use of primary care physicians as gatekeepers in HMO plans and pre-certification of care.

MANAGED CARE PLANS. Managed care plans generally provide comprehensive health

services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), and Point of Service Plans (POS).

MANAGED CARE PROVISIONS. Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

- Preadmission certification – An authorization for hospital admission given by a case manager or insurer prior to a member's hospitalization. Failure to obtain a preadmission certification in non-emergency situations may reduce or eliminate the insurer's obligation to pay for services rendered.
- Utilization review – The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
- Preadmission testing – A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- Non-emergency weekend admission restriction – A requirement that imposes limits on reimbursement for non-emergency weekend hospital admissions.
- Second surgical opinion -–A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed.

MAXIMUM OUT-OF-POCKET EXPENSE. See Out-of-Pocket Maximum.

MAXIMUM PLAN DOLLAR LIMIT. The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. Plans can have a yearly and/or a lifetime maximum dollar limit. The most typical of maximums is a lifetime amount of $1 million per individual.

MEDICAL CODE SETS. Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations.

MEDICALLY NECESSITY SERVICES. Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and They are the most appropriate level or supply of service which can safely be provided.

MEDICAL SAVINGS ACCOUNTS (MSA). Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

MEDICARE PART A. Inpatient portion of benefits under the Medicare Program. Covers inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and co-payments.

MEDICARE PART B. Outpatient portion of benefits under the Medicare Program. Covers physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, co-payments, deductibles, and balance billing.

MEDICARE PART C (MEDICARE ADVANTAGE PLAN/MEDICARE REPLACEMENT). Medicare Advantage plans are private health plans that generally provide all the coverage of Original Medicare and more. Many Medicare Advantage plans provide benefits and services not covered by Original Medicare. Some plans may also include Part D, or prescription drug coverage. These plans are referred to as Medicare Advantage with Prescription Drug (MAPD) coverage. Types of Medicare Advantage Plans include: Medicare Health Maintenance Organization (HMOs), Preferred Provider Organizations (PPO), Private Fee-for-Service Plans, Medicare Special Needs Plans. Patient must have Medicare Part A and Part B to enroll in Medicare Part C. SecureHorizons is an example of an insurer that offers Medicare Advantage Plans.

MEDICARE PART D. Medicare Part D plans prescription drug coverage plans offered by private companies. Everyone with Medicare can get this optional coverage. Medicare Part D covers both brand-name and generic prescription drugs at participating pharmacies. There are two types of Medicare Part D coverage: Stand-alone plans, also referred to as Prescription Drug Plans (or PDP plans), which solely offer prescription drug coverage. Medicare Advantage plus Prescription Drug (or MAPD) plans that offer prescription drug coverage as well as medical coverage for doctor visits and hospital expenses.

MEDICARE REMITTANCE ADVICE REMARK CODES. A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transactions.

MEDICARE SUPPLEMENTAL POLICY/MEDIGAP. Private health insurance plans that pay for the cost of services not covered by Medicare, such as coinsurance and deductibles. Insurance companies are allowed to sell patients only one Medigap policy. Different standardized plans are referred to as A, B, C, D, E, F, F+, G, H, I, J, J+, K and L. Because the policies are standardized, the benefits for a particular plan are the same for each insurance company that offers this type of coverage.

MEPRS. Medical Expense and Performance Reporting System. A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions and requirements for accounting and reporting of expense, manpower, and performance data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.

MSA. Medical Services Account.

MTF. Military Treatment Facility. A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

NATIONAL DRUG CODE (NDC). A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. This code set was adopted as the standard for reporting drugs and biologics on standard transactions.

NATIONAL PROVIDER IDENTIFIER. A system for uniquely identifying all providers of health care services, supplies, and equipment.

NETWORK. A group of doctors, hospitals and other health care providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

NON-PARTICIPATING/NON-PLAN PROVIDER. See Out-of-Network Provider.

OCCASION OF SERVICE. A specific identifiable act or service involved in the medical care of a patient that does not require the assessment of the patient's condition nor the exercising of independent judgment as to the patient's care, such as a technician drawing blood, taking an x-ray, administering an immunization, issuance of medical supplies and equipment; i.e., colostomy bags, hearing aid batteries, wheel chairs or hemodialysis supplies, applying or removing a cast and issuing orthotics. Pharmacy, pathology, radiology and special procedures services are also occasion of service and not counted as visits.

OCONUS. Outside the Continental United States.

OPEN ACCESS. A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor.

OPEN-ENDED HMOS. HMOs which allow enrolled individuals to use out-of-plan providers and still receive partial or full coverage and payment for the professional's services under a traditional indemnity plan.
OUT-OF-AREA BENEFITS. Benefits supplied to a patient by a payer or managed care organization when the patient needs services while outside the geographic area of the network.

OUT-OF-NETWORK BENEFITS. Typically, HMOs will not reimburse for services provided by a hospital or doctor who is not in their network, except for emergencies or if the HMO offers Out-of-Plan/Open ended benefits. With PPOs and other managed care plan, there may exist a provision to reimbursement at out-of-network/out-of-plan benefits. Usually this will involve higher copay or a lower reimbursement. Also referred to as opt-out benefits.

OUT-OF-NETWORK PROVIDER. A provider, doctor or hospital that does not have a contract to participate in a health plan network. Out-of-Network providers are also called non-participating, non-plan, or out-of-plan providers/physicians.

OUT-OF-PLAN/OUT-OF-PLAN PROVIDER. See Out-of-Network Benefits/Out-of-Network Provider.

OUT-OF-POCKET EXPENSES. Costs borne by the member that are not covered by health care plan. Portion of health services or health costs that must be paid for by the plan member, including deductibles, co-payments and co-insurance.

OUT-OF-POCKET MAXIMUM/LIMIT. The maximum dollar amount a member is required to pay out of pocket during a year. Until this maximum is met, the plan and member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. Also referred to as Stop Loss.

OUTPATIENT. An individual receiving health care services for an actual or potential disease, injury or life style related problem that does not require admission to a medical treatment facility for inpatient care.

OUTPATIENT PROFESSIONAL SERVICES. Ambulatory professional services. See discussion on Inpatient Professional Services.

OUTPATIENT SERVICE. Care center providing treatment to patients who do not require admission as inpatients.

PARTICIPATING PROVIDER. A provider contracted with an insurer. Usually refers to providers who are part of a network.

PATIENT. A sick, injured, wounded, or other person requiring medical or dental care or treatment.

PATIENT LIABILITY. The dollar amount that an insured is legally obligated to pay for services rendered by a provider. These may include co-payments, deductibles and payments for uncovered services.

PCM. Primary Care Manager. An individual (military or civilian) primary care provider, a group of providers, or an institution (clinic, hospital, or other site) who or which is responsible for assessing the health needs of a patient, and scheduling the patient for appropriate appointments (example: pediatric, family practice, ob-gyn) with a primary health care provider within the local MHS network.

PCP. Primary Care Physician. Generally applies to internists, pediatricians, family physicians and general practitioners and occasionally to obstetrician/gynecologists.

PCP - PRIMARY CARE PROVIDER. A health care professional who serves as a member's primary contact within a health plan. In a managed care plan, the primary care provider provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals. Sometimes referred to as the gatekeeper. Some plans will pay out-of-network benefits if services are not provided by or referred by the member's PCP.

PHARMACY BENEFIT MANAGER (PBM). Third party administrators of prescription drug benefits.

PLAN SPONSOR. An entity that sponsors a health plan. This can be an employer, a union, or some other entity.

POINT-OF-SERVICE (POS) PLANS. Managed care plans that give the insured the option of seeing providers within the plan's network and paying the co-payment amount only, or seeing providers out of the network and getting reimbursed as you would under an conventional indemnity policy.

PRE-ADMISSION CERTIFICATION. See Admission Certification.

PRE-ADMISSION TESTING. Medical tests that are completed for an individual prior to being admitted to a hospital or inpatient health care facility.

PRE-EXISTING CONDITION. A medical condition that is excluded from coverage by an insurance company, because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company.

PREFERRED PROVIDER ORGANIZATION (PPO). PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans, in that they will pay a higher percentage for care provided by providers in the network.

PRIMARY COVERAGE. Plan that pays its expenses without consideration of other plans, under coordination of benefits rules.

PRINCIPAL DIAGNOSIS. The condition established after study to be chiefly responsible for the patient's admission. This should be coded as the first diagnosis in the completed record.

PRINCIPAL PROCEDURE. The procedure that was therapeutic rather than diagnostic, most related to the principal diagnosis, or necessary to take care of a complication. This should be coded as the first procedure in the completed record.

PRIVILEGED PROVIDER. Independent practitioners who are granted permission to provide medical, dental and other patient care in the granting facility within defined limits based on the individual's education, professional license, experience, competence, ability, health and judgment. The provider has his/her qualifications reviewed by the credentialing review board, a scope of practice defined and a request for privileges approved by the privileging authority.

PROFESSIONAL SERVICES. Any service or care rendered to an individual to include an office visit, X-ray, laboratory services, physical or occupational therapy, medical transportation, etc. Also, any

procedure or service that is definable as an authorized procedure from the CPT coding system or the CHAMPUS manuals.

PROVIDER. Person or entity, such as physicians, nurse practitioners, chiropractors, physical therapists, hospitals, home health agencies, nursing homes, providing health care services to patients.

RATE. Regular fee charged to all persons of the same patient category for the same service or care.

REFERRAL. Transfer of patient's care to specialty physician or specialty care by a primary care provider/physician.

REVENUE CODE. Identifies a specific accommodation and/or ancillary service performed.

RETROSPECTIVE REVIEW PROCESS. A review that is conducted after services are provided to a patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of health care services provided.

SECONDARY COVERAGE. Health plan that pays costs not covered by primary coverage under coordination of benefits rules.

SELF-FUNDED/SELF-INSURED PLAN. Employer or organization assumes complete responsibility for health care losses of its covered employees. Funds are set up against which claim payments are drawn. Claims processing is typically handled by a third party administrator or through an insurance carrier who acts as a third party administrator rather than an insurer.

SUBROGATION. Procedure where insurance company recovers from a third party when the action resulting in medical expense (e.g. auto accident) was the fault of another person. The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable.

SUBSCRIBER. Employment group or individual that contracts with an insurer for medical services. Usually synonymous with enrollee, covered individual or member.

SHORT-TERM DISABILITY. An injury or illness that keeps a person from working for a short time. Short-term disability insurance coverage is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working.

SMALL EMPLOYER GROUP. Generally means groups with 1 - 99 employees. The definition may vary between states.

TRIPLE-OPTION. Insurance plans that offer three options from which an individual may choose. Usually, the three options are traditional indemnity, an HMO, and a PPO.

THIRD PARTY ADMINISTRATOR (TPA). An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

TPCP. Third Party Collection Program.

TPOCS. Third Party Outpatient Collection System. Compiles outpatient visit information from Ambulatory Data System (ADM), and ancillary testing or services information from the Composite Health Care System (CHCS). Using rate tables for billing services from DoD Comptroller, the system generates a billing for accounts receivable, refunds or other health care insurance purposes.

TELEHEALTH, TELEMEDICINE, E-HEALTH. The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education and/or medical learning.

TERMINATION DATE. Date that a group contract expires or an individual is no longer eligible for benefits.

THIRD PARTY PAYMENT. Payment by a financial agent, rather than direct payment by a patient, for medical care services.

THIRD PARTY PAYER. Any organization, public or private that pays or insures health or medical expenses on behalf of beneficiaries or recipients. The payer organization pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

UBU. Unified Biostatistical Utility. The part of CEIS responsible for capturing and standardizing biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses and algorithms across the MHS.

UCF. Universal Claim Form. A paper claim form used to bill pharmacy claims only.

UNBUNDLING. The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES. The average fee charged by a particular type of health care provider within a geographic area for a particular medical procedure. The term is often used by medical plans as the amount they will approve for a specific test or procedure. Also referred to as Reasonable and Customary Fees.

VISIT. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.

WORKLOAD. An expression of the amount of work, identified by the number of work units or volume of a workload factor that a work center has on hand at any given time or performs during a specified period of time.

WAITING PERIODS. The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

WORKERS COMPENSATION INSURANCE. Insurance coverage for work-related illness and injury. All states require employers to carry this insurance.