



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 106
6010.51-M
SEPTEMBER 13, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: NATIONAL DEFENSE AUTHORIZATION ACT (NDAA), FISCAL YEAR (FY)
2009, SECTION 732, FINAL IMPLEMENTATION OF EXTENDED CARE
HEALTH OPTION (ECHO) CAP

CONREQ: 15032

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change package eliminates the \$2,500 per month limit for the following ECHO benefits; diagnostic services, treatment, respite care, assistive services, and durable equipment.

EFFECTIVE DATE: August 9, 2010.

IMPLEMENTATION DATE: November 1, 2010.

This change is made in conjunction with Aug 2002 TPM, Change No. 130, Aug 2002 TRM, Change No. 120, and Aug 2002 TSM, Change No. 86.


Reta M. Michak
Director, Operations Division

ATTACHMENT(S): 10 PAGES
DISTRIBUTION: 6010.51-M

CHANGE 106
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REMOVE PAGE(S)

CHAPTER 9

Addendum B, pages 3 - 6

CHAPTER 10

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CHAPTER 20

Section 10, pages 11 and 12

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Addendum B, pages 3 - 6

Section 10, pages 11 and 12

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 9, ADDENDUM B

REASON CODES

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (CONTINUED)			
<i>D400</i>	<i>TFL - Paid Primary in Error</i>		<i>No</i>
<i>D401</i>	<i>TFL - Dup logic failed to ID</i>		<i>No</i>
D900	Other		Yes

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CHAPTER 9, ADDENDUM B

REASON CODES

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES			
This claim is not a duplicate because it involves:			
N100	Twins	This is not a duplicate payment since the claim involves a patient who is a twin of the patient on the other claim(s).	No
N101	Ambulance services - separate transport.	This is not a duplicate payment since the claim involves ambulance services for a separate transport from that paid on the other claim(s).	No
N102	Same procedure(s)/ service(s) but different encounters (dates of service).	This is not a duplicate payment since the claim involves different dates of service from those paid on the other claim(s).	No
N103	Same condition but different equipment/ supplies.	This is not duplicate payment since the claim involves different equipment/ supplies than those paid on the other claim(s) for the same condition.	No
N104	Different psychological tests billed under same procedure code(s).	This is not a duplicate payment since the claim involves different psychological tests billed under the same procedure code than those paid on the other claim(s).	No
N105	Additional services not previously billed.	This is not a duplicate payment since the claim involves additional services not paid on the other claim(s).	No
N106	Same procedure codes/ different provider types (e.g., surgeon/assistant surgeon).	This is not a duplicate payment since the services paid on this claim are for assistant surgeon services were rendered by a different type of provider than the type of provider paid on the other claim(s).	No
N107	ECHO prorated Durable Equipment (DE)	This is not a duplicate payment since the services paid on this claim are for different ECHO prorated DE than that paid on the other claim(s). <i>This code is obsolete as of the implementation date of elimination of prorating ECHO DE but will be retained for historical purposes only.</i>	No

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 9, ADDENDUM B

REASON CODES

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (CONTINUED)			
N108	Technical or facility component/ professional component.	This is not duplicate payment since the services paid on this claim involve the technical or facility/professional services not paid on the other claim(s).	No
N109	Same procedure codes but different procedure code modifiers.	This is not a duplicate payment since the services paid on this claim have different procedure code modifiers than those on the other claim(s).	No
N110	Resubmission (Tracer Claim) of previously denied line item(s).	This is not a duplicate payment since these services had been previously denied but were resubmitted with corrected procedure codes.	No
N111	Multi-page claim entered separately.	This is not a duplicate payment since this claim contained more than one page which were entered separately as two or more claims.	No
N112	Multiple services rendered on the same date or within the same date range.	This is not a duplicate payment since the multiple services rendered on the same date were legitimate and acceptable or the multiple services billed were rendered on different dates within the date range of the other claim(s).	Yes
N113	Incorrect DEERS Dependent Suffix.	This is not a duplicate payment since the services were rendered to two different patients however the DEERS Dependant Suffix is incorrect creating the appearance of duplicate claims for a single patient.	No
N200	Data conversion errors.	This is not a duplicate payment since the services paid on this claim are different from those paid on the other claim(s), but due to data conversion errors they appear to be the same.	Yes
BASE	Initial submission		No

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 9, ADDENDUM B

REASON CODES

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (CONTINUED)			
N201	Multi-suffix claim.	This is not a duplicate payment since the services paid on this claim suffix are different from those paid on the other suffix(es). NOTE: To use this reason code, the additional suffix listed cannot contain any payments contained in a previous suffix. If the additional suffix was issued to pay a different provider, or it reflects a payment issued under a previous suffix and a cancellation of the previous suffix has been issued or will be issued for the previous suffix, it is still a duplicate payment and the claim should be assigned "Y" Dupe? and an "Actual Duplicate Reason Code" used.	Yes
N300	Claim belongs to FI 99	The claim belongs to FI 99. This non-duplicate reason code may be used to enable resolution of a set where the FI 99 claim is <u>not</u> the BASE claim. If the FI 99 claim is the BASE claim, the other claim(s) may be flagged with "Y" or "N" Dupe? and reason codes, recoupment amounts entered, and corresponding adjustments flagged as usual. If the FI 99 claim is <u>not</u> the BASE claim, it should be flagged with an "N" Dupe? and an N300 reason code. In either case, no FI 99 adjustments should be flagged.	No
N900	Other		Yes

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002
 CHAPTER 10, ADDENDUM B
 REASON CODES

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (CONTINUED)			
<i>D400</i>	<i>TFL - Paid Primary in error.</i>	<i>Claim was erroneously processed and paid by MCSC instead of TDEFIC contractor</i>	<i>No</i>
<i>D401</i>	<i>TFL - Dupe logic failed to ID.</i>	<i>Claim processing dupe logic failed to ID as TFL claim</i>	<i>No</i>
D900	Other		Yes

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 10, ADDENDUM B

REASON CODES

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CHAPTER 10, ADDENDUM B

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NON-DUPLICATE REASON CODES (CONTINUED)			
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N109	Same procedure codes but different procedure code modifiers.	This is not a duplicate payment since the services paid on this claim have different procedure code modifiers than those on the other claim(s).	No
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N900	Other		Yes

9.1.1.2. The Functional Behavioral Assessment and Analysis and initial BP will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

9.1.1.3. Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial BP.

9.1.1.4. Reassessment of established Demonstration participants will be conducted as part of the ACSP's routine supervision services and is not separately reimbursable.

9.1.2. EIA Services rendered jointly by an EIA Supervisor and an EIA Tutor, in-person, during directly supervised fieldwork of the Tutor by the Supervisor, will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

9.1.3. EIA services provided directly by an EIA Tutor will be invoiced using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

9.1.4. Development of the required EPR and updated BP will be invoiced using CPT¹ code 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

9.1.5. Conducting the required quarterly progress meetings with the TRICARE beneficiary's caregivers will be invoiced using CPT¹ code 90887, "Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient."

9.2. Reimbursement of claims in accordance with [paragraphs 9.1.1.](#) through [9.1.5.](#) will be the lesser of:

- The CHAMPUS Maximum Allowable Charge (CMAC); or
- \$125 per hour for services provided by the EIA Supervisor and \$50 per hour for services provided by the EIA Tutor; or
- The negotiated rate; or
- The billed charge.

10.0. REQUIRED REPORTS

10.1. MCSCs shall submit the following aggregated reports:

10.1.1. Monthly

10.1.1.1. The number and percent of total participating beneficiaries by sex, age group (18 months-3 years, 4-6 years, 7-10 years, over 10 years), and sponsor's branch of Service.

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

10.1.1.2. The number of beneficiaries qualifying for the demonstration, by State, who were not receiving EIA services as of the end of that month due to lack of EIA Supervisors or EIA Tutors.

10.1.1.3. The “rolling-total” number of hours paid through the demonstration for EIA services provided in accordance with [paragraphs 9.1.2.](#) and [9.1.3.](#) per beneficiary.

10.1.2. Quarterly

10.1.2.1. The number of EIA Supervisors and EIA Tutors, by State.

10.1.2.2. The number of EIA Supervisors with 0-4, 5-9, 10-14, 15-19, and 20 or more EIA Tutors, by State.

10.1.2.3. The number of, and the reasons why beneficiaries seeking participation in the Demonstration do not meet eligibility criteria, by State.

10.1.3. Semi-Annual

10.1.3.1. The name and SSN of the sponsor of each beneficiary who received services under the Demonstration; including the total number of the sponsor’s dependents who received or are receiving EIA Services under the Demonstration.

10.1.3.2. Number and percentage of compliance audits, as specified in [paragraph 11.5.](#), that resulted in an outcome of “Fail”.

10.2. Report Requirements

10.2.1. Reports of EIA services provided per beneficiary are based on the Date of Service (DOS) regardless of the date claims for such services are processed.

10.2.2. Monthly reporting periods cover the first day of the month through the end of the month.

- The first monthly report covers the period August 1 through August 31, 2008.

10.2.3. Quarterly and semi-annual reporting periods are based on the fiscal year.

- The first quarterly report covers the period July 1 through September 30, 2008.
- The first semi-annual report covers the period March 1 through September 30, 2008.

10.2.4. Reports shall be submitted in Microsoft Excel format by the 15th calendar day of the month following the end of the reporting period via the government’s Performance Assessment Tracking (PAT) system.