



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

PRD

CHANGE 43  
6010.51-M  
JANUARY 16, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: JANUARY 2007 CHANGES TO HOSPITAL OUTPATIENT  
PROSPECTIVE PAYMENT SYSTEM (OPPS)

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Ongoing changes/clarifications to OPPS  
implementing instructions, revision to the TSM Chapter 2, Addendum O (Default  
HCPCS Codes), application of OPPS Bilateral Discounting, and including End Stage  
Renal Disease (ESRD) services under OPPS.

EFFECTIVE AND IMPLEMENTATION DATE: June 1, 2007.

This change is made in conjunction with Aug 2002 TRM, Change No. 57 and Aug  
2002 TSM, Change No. 40.

Evie Lammle  
Director, Program Requirements Division

ATTACHMENT(S): 6 PAGES  
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

**CHANGE 43**  
**6010.51-M**  
**JANUARY 16, 2007**

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 8**

Section 6, pages 3 and 4

Section 6, pages 3 through 5

**CHAPTER 10**

Section 3, pages 5 through 7

Section 3, pages 5 through 7

## **5.0. INDIVIDUAL PROVIDER SERVICES**

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

- Identification of the provider of care;
- Dates of services;
- Place of service, if not evident from the service description or code, e.g., office, home, hospital, skilled nursing facility, etc.;
- Charge for each service;
- Description of each service and/or a clearly identifiable/acceptable procedure code; and
- The number/frequency of each service.

## **6.0. UNDELIVERABLE/RETURNED MAIL**

When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

## **7.0. TRICARE ENCOUNTER DATA DETAIL LINE ITEM - COMBINED CHARGES**

Combining charges for the same procedures having the same billed charges under the contractor's "financially underwritten" operation, for TRICARE Encounter Data records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from 03/25/2004 to 04/15/2004 and surgery was performed on 04/08/2004, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between 03/25 and 03/31, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month.

## **8.0. CLAIMS SPLITTING**

Under TEDs, a claim shall be split under the following conditions:

**8.1.** A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under TEDs for different beneficiaries.

**8.2.** A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under TEDs.

**8.3.** A claim that contains services, supplies or equipment covering more than one contractor's jurisdiction shall be split. The claim and attached documentation shall be

duplicated in full, and identification shall be provided on each document as “processed” by the contractor and then mailed to the other appropriate contractor having jurisdiction. The contractor splitting the claim, counts the remaining material as a single claim, and the contractor receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.

**8.4.** An inpatient maternity claim which is subject to the TRICARE/CHAMPUS DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the TRICARE Reimbursement Manual, Chapter 1, Section 32.

**8.5.** Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a non-institutional format. See the TRICARE Reimbursement Manual, Chapter 11, Section 4.

**8.6.** A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician’s fees which are allowable in addition to the facility charges. See the TRICARE Reimbursement Manual, Chapter 9, Section 1.

**8.7.** A claim submitted with both non-financially underwritten and financially underwritten charges shall be split. Non-financially underwritten charges shall be submitted as a voucher and financially underwritten charges shall be submitted as a batch.

**8.8.** *A claim that contains both institutional and professional services may be split into separate claims for: (1) charges for services included in the Outpatient Prospective Payment System (OPPS), and (2) charges for professional services which are not included in the OPPS and are separately allowable.*

## **9.0. PROVIDER NUMBERS**

Claims received (electronic, paper, or other acceptable medium) with the provider’s Medicare Provider Number (institutional and non-institutional) shall not be returned to the provider to obtain the TRICARE Provider Number. The contractor shall accept the claim for processing, develop the provider number internally, and report the TRICARE Provider Number as required by the TRICARE Systems Manual, Chapter 2, on the TED records.

## **10.0. TRANSGENDERED BENEFICIARIES**

If a beneficiary or provider notifies the contractor of the beneficiary’s transgendered status (either prospectively or through an appeal), the contractor shall flag that patient’s file and defer claims for medical review only when there is a discrepancy between the patient’s gender and the procedure, diagnosis or ICD-9 surgical procedure code. For care that the review determines to be medically necessary and appropriate, the contractor shall override

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 8, SECTION 6

CLAIM DEVELOPMENT

---

any edit identifying a discrepancy between the procedure and the patient's gender. TED record data for transgendered claims must reflect the Person Sex as downloaded from DEERS (TRICARE Systems Manual, Chapter 2, Section 2.7) and the appropriate override code.



**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 10, SECTION 3

DUPLICATE CLAIMS DATA

**FIGURE 10-3-2 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS**

FIELD NAME	OTHER	CPT-4 CODE	NEAR MATCH	EXACT MATCH
<b>CLAIM LEVEL</b>				
SPONSOR SSAN	✓	✓	✓	✓
PATIENT ID	✓	✓	✓	✓
PATIENT DOB				✓
PROVIDER TAX ID	✓	✓	✓	✓
PROVIDER SUB ID	✓	✓	✓	✓
PRIN DIAGNOSIS				✓
<b>LINE ITEM LEVEL</b>				
PLACE OF SERVICE				✓
TYPE OF SERVICE				✓
CARE BEGIN DATE	✓	✓	✓	✓
CARE END DATE			✓	✓
BILLED AMOUNT		✓	± 10% **	✓
ALLOWED AMOUNT				✓
PROCED CODE	✓	posn 1-3 *	✓	✓

\* The procedure code of one line item is not equal to the procedure code of the other line item but the first three characters of the procedure codes are equal.

\*\* The system calculates ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 90%; (b) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (c) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

**2.3. Exclusions**

**2.3.1. Exclusion Of Certain Claims**

The Duplicate Claims System excludes claims from the extract if they do not meet specific minimum dollar thresholds and other criteria. An individual claim is excluded if:

**2.3.1.1.** The Government paid amount at the claim level is \$0.00.

**2.3.1.2.** The total allowed amount is less than \$30.00.

**2.3.1.3.** The second byte of the claim's type of service code is 'B' (Retail Drugs & Supplies) or 'M' (Mail Order Pharmacy Drugs & Supplies).

**2.3.1.4.** The claim's type of submission code is 'B', 'D', 'E', or 'O' (adjustment or cancellation to a prior non-TED claim or 100% paid by other health insurance).

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 10, SECTION 3

DUPLICATE CLAIMS DATA

**2.3.1.5.** The claim level allowed amount on a non-financially underwritten institutional potential duplicate is less than \$30.00.

**2.3.1.6.** The claim level allowed amount on an financially underwritten institutional potential duplicate is less than \$50.00.

**2.3.1.7.** The sum of the line item level allowed amounts on a non-financially underwritten non-institutional potential duplicate is less than \$30.00.

**2.3.1.8.** The sum of the line item level allowed amounts on an financially underwritten non-institutional potential duplicate is less than \$50.00.

**2.3.2. Exclusion Of Certain Line Items**

**2.3.2.1.** *Prior to June 1, 2007, the Duplicate Claims System (DCS) excludes line items from the extract if the line item procedure code (HCPCS or CPT-4) is one of the following:*

HCPCS	CPT-4 <sup>1</sup>	DESCRIPTION
A4000 - A4999	06888	Nutrition Equipment/Supplies - Purchase
A5000 - A6500	06942	Other Equipment/Supplies - Purchase
R _ _ _ _	76499	Radiographic Procedure
P _ _ _ _	84999	Clinical Chemistry Test
P _ _ _ _	88305	Tissue Exam By Pathologist
	90593	Whole Blood Charges
	90594	Professional Components Charge
	90595	Outpatient Hospital - Physician's Charge
	90596	Outpatient Hospital - Recovery Room Charge
	90597	Outpatient Hospital - Operating Room Charge
	90599	Outpatient Hospital - Emergency Room Charge
J _ _ _ _	90782	Injection (SC)/(IM)
J _ _ _ _	90784	Injection (IV)
	94799	Unlisted Pulmonary Service Or Procedures
	99070	Special Supplies
	99088	Other Room, Ancillary and Drug Charges
	99592	Hospital Outpatient Birthing Room Charges

<sup>1</sup> CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

**2.3.2.2.** *Beginning June 1, 2007, the DCS excludes line items from the extract if the line item procedure code (HCPCS or CPT-4) is listed in paragraph 2.3.2.1. or in the TRICARE Systems Manual, Chapter 2, Addendum O.*

**2.3.3. Other Exclusions**

After potential duplicate claims have been identified and grouped into claim sets, a final test is applied to exclude certain types of claim sets least likely to contain actual duplicate claims. Claim sets are excluded if they meet any of the following conditions:

**2.3.3.1.** The claim set contains less than two claims after the elimination of claims in the set due to any of the previously listed exclusion criteria.

**2.3.3.2.** The set is a "Mother-Baby" claim set and contains no more than two claims, where one claim has a "6..." series principal diagnosis code (mother) and the other claim has a "V..." series principal diagnosis code (baby). (Applies only to institutional claims.)

**2.3.3.3.** The set is a "Multiple Birth" claim set and contains no more than two claims, where both claims have "V31..." through "V39..." series principal diagnosis codes. (Applies only to institutional claims.)

