CHAPTER 2
SECTION 1.1

DATA REPORTING - TRICARE ENCOUNTER DATA RECORD SUBMISSION

1.0. GENERAL

1.1. TRICARE Encounter Data (TED) Records provide detailed information for each treatment encounter and are required for TMA healthcare and financial reporting. A TED Record is submitted as either an institutional or non-institutional record. Institutional TED Records usually reflect a treatment encounter created by the formal acceptance of a hospital or other authorized institutional provider of a TRICARE beneficiary for the purpose of occupying a bed with the reasonable expectation that the patient will remain on inpatient status at least 24 hours with a registration and assignment of an inpatient number or designation. Institutional TED records may also reflect outpatient care in a Hospice or Home Health Program. This outpatient care is clearly identified by the Type of Institution code. A non-institutional TED record reflects either inpatient or outpatient health care services exclusive of inpatient institutional facility services.

1.2. All elements of the TED records must be maintained in the contractor's claims history file. The claims history will reflect the data submitted to TMA on the TED Record including initial submissions, resubmissions, adjustments and cancellations to records with no provisional errors, and a2djustments and cancellations to records with provisional errors. Claims history will also contain all data necessary to reproduce a TED record as required by this manual and to reproduce an EOB, if required.

1.3. All other treatment encounter data including institutional care in connection with ambulatory surgery must be reported on a non-institutional TED Record.

1.4. There are three types of TED Records:

1.4.1. Initial Submission

1.4.2. Adjustment/Cancellation Submission

There are two types of Adjustment/Cancellation submissions; adjustments and cancellations to TED records with no provisional errors; and adjustments and cancellations to TED records with provisional errors.

1.4.3. Resubmission

1.5. These types of records are discussed in the following paragraphs. Complete record layouts, data requirements by Element Locator Number (ELN), and edit criteria are detailed in Chapter 2, Section 2.4 through 2.9.

1.6. TED Records within a day's cycle are processed by TMA first in Filing Date order, then by TYPE OF SUBMISSION (I, O, D, R first; A, B, C, E second).

2.0. INITIAL SUBMISSION OF TED RECORDS

Initial submission applies only to the **first** submission of a **new** TED Record. Initial submissions are identified by TYPE OF SUBMISSION codes 'I', 'D', and 'O' on the TED Record.

2.1. All data indicated as "required" in the data element definition must be reported. If not received in the treatment encounter data, this data must be developed.

2.2. All signed numeric data elements on the initial submission must be reported as positive values.

2.3. When institutional TED Records are reported for other than the complete inpatient hospital stay, the TED Records must be reported to TMA in the sequence that the care was provided (FREQUENCY CODES, 2-Initial, 3-Interim or 4-Final). Refer to paragraph 7.0. for requirements on submitting interim bills for institutional claims.

3.0. SUBMISSION OF ADJUSTMENT/CANCELLATION TED RECORDS

3.1. "Adjustment" and "cancellation" submissions correct two types of TED Records; records with no provisional errors (fully accepted records) and records with provisional errors. Adjustments and cancellations to TED Records with no provisional errors correct records with claims processing errors or update prior data on the record with more current/ accurate information. Adjustments and cancellations to records with provisional errors correct relational edit errors incurred upon TED record submission and may, when required, correct other claims processing errors or update prior data at the same time.

Adjustments and cancellations to complete denial or cancellation TED records with no provisional errors are not permitted. Denied or cancelled TED Records with no provisional errors that require further claims processing activity must be submitted as new, initial submissions. Adjustments and cancellations to complete denial or cancellation TED Records with provisional errors must only correct relational edit errors and must not correct other claims processing errors, update prior data or change the original submission type.

NOTE: The TED Record Correction Indicator must be coded on all adjustments and cancellations. This data element identifies whether the adjustment or cancellation is to: 1) correct provisional errors only, 2) correct claims processing errors or update prior data, or 3) correct both provisional errors and claims processing errors or update prior data.

3.2. Adjustments and cancellations to TED Records with or without provisional errors must be submitted on the same header type (batch or voucher) as the original submission.

3.3. Adjustments and cancellations to TED Records with or without provisional errors are identified by TYPE OF SUBMISSION codes 'A', 'B', 'C', and 'E' on the TED Record. Adjustments and cancellations to non-TED records (TYPE OF SUBMISSION codes 'B' or 'E') with or without provisional errors must be reported using TYPE OF SUBMISSION codes 'B'

or 'E'. The use of the proper TYPE OF SUBMISSION code is essential for accurate processing of adjustments.

3.4. Adjustment and cancellation conditions include, but are not limited to, the following:

3.4.1. Error in information received from the provider or beneficiary

3.4.2. Late submission of data from providers

3.4.3. Error in processing by current or prior contractor (if applicable)

3.4.4. Deductible corrections

3.4.5. Successful recoupment of monies, or receipt of a refund from the provider, beneficiary, or third party

3.4.6. Stale dated payment checks

3.5. When health care is charged to the wrong risk category (i.e., financially underwritten vs. non-financially underwritten) the original record must be cancelled and a new, initial TED Record submitted under the correct risk category.

3.6. Adjustment submissions are **positive** (where additional monies are being paid by the contractor), **negative** (where monies are being credited back to the contractor), or **statistical** (serve to correct prior information but have no impact on payment amount).

NOTE: If an adjustment to a record with or without provisional errors, results in the net effect of a complete cancellation (i.e., where the AMOUNT ALLOWED, AMOUNT GOVERNMENT PAY, and AMOUNT PATIENT COST SHARE = zero, and all line items are denied) of the TED Record, the adjustment must be reported with TYPE OF SUBMISSION codes 'C' or 'E'. Refer to the examples later in this Section, for an example of a complete cancellation TED Record. An adjustment to a TED Record which would change the Type of Submission from 'I', 'R', or 'A' to 'O' is not allowed. The original TED record must be cancelled and a new, initial record submitted with the correct TYPE OF SUBMISSION 'O'.

3.6.1. Adjustment and cancellation submissions to TED Records with or without provisional errors must be reported using the TED RECORD INDICATOR reported on the initial submission TED Record, regardless of the number of adjustments to the initial TED Record. However, an adjustment that would result in submission of a different RECORD TYPE INDICATOR (e.g., change an institutional record, type 1, to a non-institutional record, type 2) is not permitted. In this instance, the initial TED Record must be completely cancelled (TYPE OF SUBMISSION code 'C' or 'E'), and a new initial TED Record submitted with the correct record type.

3.6.2. All data as reported on the initial TED Record for adjustments and cancellations with or without provisional errors must be resubmitted except for signed numeric fields, and those numeric fields requiring correction. Data contained within each line item in the variable portion of the adjustment TED Record must be reported in the same sequence, with

the same LINE ITEM NUMBER as on the initial TED Record. An adjustment TED Record with or without provisional errors can add additional detail line items, but cannot remove previously reported line items. All signed numeric fields and those non-signed numeric fields requiring correction must be reported according to the following:

3.6.2.1. All signed numeric data elements affected by the adjustment must reflect the **net_difference** between what was **initially** reported and the **correct** amount. If adjustments were made in signed numeric fields prior to the current adjustment, these data elements must reflect the difference amounts after combining the amounts in the initial and all prior adjustment submissions with this submission. Those signed numeric data elements that are unaffected by the adjustment netting process must be set to zero.

3.6.2.2. Alphanumeric data elements requiring correction or update must reflect the most current information applicable to the service(s) being reported. All other alphanumeric data elements must be reported as on the initial submission, or if prior adjustments corrected/updated the initial data, the data from the most recent submission must be reported.

3.6.2.3. Adjustment and complete cancellation TED Records with or without provisional errors are matched and applied to their corresponding initial submission TED Record and any other adjustment TED Records at TMA using the TMA database which consists of all TED Records and HEALTH CARE SERVICE RECORD INDICATOR table. The resulting "net" TED Record is completely edited through the TMA edit system as if it were an initial submission TED Record. Thus, the original and any prior adjustments must have passed TMA validity edits before a new adjustment is reported.

3.6.3. Examples

Examples of adjustment submissions are located following. Example paragraph 3.6.3.1. portrays a positive adjustment, example paragraph 3.6.3.2. portrays a negative adjustment, and example paragraph 3.6.3.3. portrays an adjustment correcting information without impact on payment amount.

3.6.3.1. Positive Adjustment

A TED Record was submitted by the contractor and processed by TMA with an amount billed of $200.00, amount allowed of $100.00, and $50.00 applied to the deductible. The amount allowed should have been $180.00 and no monies should have been applied to the deductible. The amount billed, however, was unchanged.

INITIAL TED RECORD POSITIVE ADJUSTMENT AMOUNTS

INITIAL TED RECORD	
Amount Billed	$200.00
Amount Allowed	100.00
Amount to Deductible	50.00
Amount Paid (75%)	37.50

INITIAL TED RECORD POSITIVE ADJUSTMENT AMOUNTS (CONTINUED)

ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	80.00
Amount to Deductible	-50.00
Amount Paid (75%)	97.50
EFFECT AT TMA	
Amount Billed	200.00
Amount Allowed	180.00
Amount to Deductible	0
Amount Paid	135.00

3.6.3.2. Negative Adjustment

A TED Record was submitted by the contractor and processed by TMA with an amount billed of $500.00, an amount allowed of $500.00, and amount paid by the contractor of $500.00. However, other health insurance (OHI) was involved and their payment of $400.00 was recouped. The amounts billed and allowed were correct but the amount paid should have been $100.00.

TED RECORD NEGATIVE ADJUSTMENT AMOUNTS

INITIAL TED RECORD	
Amount Billed	$500.00
Amount Allowed	500.00
Amount to OHI	0
Amount Paid	500.00
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	0
Amount to OHI	400.00
Amount Paid	- 400.00
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Amount to OHI	400.00
Amount Paid	100.00

3.6.3.3. Statistical Adjustment

A TED Record was submitted by the contractor and processed by TMA for a hospitalization spanning 20 bed days and $2,000.00 in billed charges. Fifteen (15) of the days were considered authorized. Subsequently, the total number of bed days was found to be 30

and billed charges were actually $3,000.00. However, the allowable days and amount paid by the contractor remained unchanged.

TED RECORD STATISTICAL ADJUSTMENT

INITIAL TED RECORD	
Amount Billed	$2,000.00
Amount Allowed	1,500.00
Covered Days	15
Amount Paid (75%)	1,125.00
ADJUSTMENT TED RECORD	
Amount Billed	1,000.00
Amount Allowed	0
Covered Days	0
Amount Paid	0
EFFECT AT TMA	
Amount Billed	3,000.00
Amount Allowed	1,500.00
Covered Days	15
Amount Paid	1,125.00

3.6.3.4. Negative Adjustment (Complete Cancellation)

A TED Record was submitted by the contractor and processed by TMA with an amount billed of $500.00, allowed of $500.00, and amount paid by government contractor of $375.00. Subsequently, the contractor processed an adjustment to pay in full, reporting an increase of $125.00 in the amount paid by government contractor. The contractor then determined the care was processed in error and recouped the entire $500.00 payment.

TED RECORD NEGATIVE ADJUSTMENT

INITIAL TED RECORD	
Amount Billed	$500.00
Amount Allowed	500.00
Patient Cost-Share	125.00
Amount Paid	375.00
Covered Days	5
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	0
Patient Cost-Share	-125.00
Amount Paid	125.00
Covered Days	0

TED RECORD NEGATIVE ADJUSTMENT (CONTINUED)

EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Patient Cost-Share	0
Amount Paid	500.00
Covered Days	5
CANCELLATION TED RECORD	
Amount Billed	0
Amount Allowed	-500.00
Patient Cost-Share	0
Amount Paid	-500.00
Covered Days	-5
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	0
Patient Cost-Share	0
Amount Paid	0
Covered Days	0

4.0. RESUBMISSION OF TED BATCH/VOUCHERS AND TED RECORDS

4.1. Batches/vouchers that fail any edits at the header record level will be rejected and returned to the contractor for correction. Header level rejections require the resubmission of the entire batch/voucher with the appropriate data corrections. The RESUBMISSION NUMBER must not be incremented from what was reported on the prior submission.

4.2. Institutional and Non-Institutional Records which fail only relational edits will be "provisionally" accepted on the TMA TED database, and returned to the contractor for correction. Provisionally accepted records must be corrected and resubmitted as an adjustment, in a new voucher/batch. Refer to paragraph 3.0. for requirements on correction of TED Records with provisional errors.

4.3. Institutional and Non-Institutional Records which fail validity edits will be rejected and returned to the contractor for correction and resubmission. All returned records which fail the validity edits within a **voucher** must be returned by the contractor at the same time and balance to the outstanding TOTAL AMOUNT PAID and number of outstanding records at TMA. All returned records which fail the validity edits within a **batch** must be returned by the contractor at the same time and balance to the outstanding number of records. Upon resubmission, the records will again be processed through the TMA editing system. Resubmission batch/vouchers are identified by the BATCH/VOUCHER RESUBMISSION NUMBER in the Header Record. Resubmission applies to all Institutional and Non-Institutional TED Records which have failed to pass the TMA validity edits, whether or not the TED Records incur relational edits as well.

4.4. TED Record resubmissions must be reported using the TED RECORD INDICATOR reported on the initial or adjustment TED Record, regardless of the number of times the TED Record is resubmitted.

4.5. All data as reported on the initial or adjustment TED Record must be resubmitted except for that data changed in order to correct the error(s).

4.6. If a TED Record with TYPE OF SUBMISSION = 'I' (initial) is rejected for validity errors, report the correction TED Record with TYPE OF SUBMISSION = 'R' (resubmission).

All other TED Records rejected for validity errors must retain their original TYPE OF SUBMISSION code throughout the validity error resubmission process.

4.7. To liquidate or "clear" a voucher, both TOTAL AMOUNT PAID and the number of outstanding TED Records must zero out. When a TED Record passes editing (including provisionally accepted records), the TOTAL NUMBER OF RECORDS and the TOTAL AMOUNT PAID submitted on the original voucher are decremented on the TMA database by the corresponding amount. A voucher "clears" when both totals reach zero and the TMA database reflects no outstanding record or paid amounts.

4.8. To liquidate or "clear" a batch, the number of outstanding records must zeroed out.

4.9. If TMA edits identify that the dollar amounts on the voucher are incorrect, the contractor must correct the related monetary data to balance to the AMOUNT PAID BY GOVERNMENT CONTRACTOR reported on the TED Record. **Do not change the AMOUNT PAID BY THE GOVERNMENT CONTRACTOR on the TED record**. Correction of the payment error will be reflected through the contractor's processing and subsequent submission of the adjustment/cancellation TED Record.

5.0. ASSIGNMENT OF TED RECORDS TO THE ACCRUAL FUND

5.1. All contractors that are required to separate costs between Automated Standard Application for Payment (ASAP) accounts (appropriated funds and accrual funds) shall use the algorithm below to determine the appropriate ASAP account to use when paying a claim.

5.2. When ASAP accounts are assigned to a contractor, the government will specify the appropriate fund that the ASAP account shall be linked to. All claims grouped to the Accrual Fund shall use the algorithm specified below. All claims that do not group with the Accrual Fund shall be grouped with the Appropriated Fund ASAP account.

ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS		
IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A **OR**
	C	MEDICARE PART A & B **OR**
	H	MEDICARE HMO
AND HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE =	005	TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**

ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS (CONTINUED)	
010	TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
015	TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
017	TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
020	TFL FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
022	TFL FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
023	TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
110	TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
131	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
132	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
134	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
135	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS **OR**
136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
141	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
142	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**

ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS (CONTINUED)		
	143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
	144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
	147	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS **OR**
	148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
	149	TRICARE PLUS COVERAGE WITH CHC FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
	151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
THEN TED RECORD IS TO BE GROUPED ON THE ACCRUAL VOUCHER		

ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS		
IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A **OR**
	C	MEDICARE PART A & B
AND HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE =	F	FORMER MEMBER **OR**
	H	MEDAL OF HONOR RECIPIENT **OR**
	R	RETIRED MILITARY MEMBER ELIGIBLE FOR RETIRED PAY **OR**
	W	FORMER SPOUSE
THEN TED RECORD IS TO BE GROUPED ON THE ACCRUAL VOUCHER		
NOTE: THIS ALGORITHM IS BASED ON THE SUPPOSITION THAT CHILDREN OF RETIRED DECEASED SPONSORS ARE INCLUDED IN ONE OF THE LISTED VALUES UNDER HEALTH CARE COVERAGE MEMBER RELATIONSHIP CODE. VERIFICATION IS PENDING FROM DEERS.		

6.0. BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER SELECTION CRITERIA FOR REGIONAL CONTRACTORS[1]

The following process is only to be used by contractors submitting both financially underwritten & non-financially underwritten claims to TMA.

6.1. Batches

For all data submissions sent to TMA using the Batch process, the contractor shall zero fill the BATCH/VOUCHER ASAP Account Number.

[1] These guidelines apply only to the benefit CLINS, they DO NOT apply to the Administrative CLINS.

6.2. Vouchers

For all data submissions sent to TMA using the Voucher process, the contractor must use one of the BATCH/VOUCHER CLIN/ASAP Numbers assigned to them by TMA, CRM in accordance with the TRICARE Operations Manual (TOM), Chapter 3, Section 2. TMA, CRM shall assign two types of BATCH/VOUCHER CLIN/ASAP Account Numbers to the contractor's non-financially underwritten ASAP Accounts (formerly known as not-at-risk bank accounts) and financially underwritten CLIN Accounts. Financially underwritten CLIN Account Numbers are comprised of the contract CLIN plus the fiscal year (position 7) plus the Region (position 8). CLINs that are only four digits long will have 00 to fill positions 5 and 6 in this field. Non-financially underwritten ASAP Accounts are usually issued on a federal fiscal year basis by TMA, CRM. Financially underwritten CLIN ASAP Accounts are usually issued twice a year, at the change of each federal fiscal year and when an Option Period is exercised. The contractor should use the procedures outlined below in order to properly group claims under the correct BATCH/VOUCHER CLIN/ASAP Account Number.

6.2.1. Criteria For Selecting TMA Foreign Non-Financially Underwritten ASAP Accounts (South Contract Only)

All claims submitted using the foreign vouchering process (South Contract only) shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Numbers with a '3', '4', '5', or '6' in position 8. The BATCH/VOUCHER CLIN/ASAP Account Number with a '3' in position 8 shall be used for all appropriated fund foreign benefit payments - excluding Navy/Marine deployed claims covered by TRICARE Global Remote Overseas. The BATCH/VOUCHER CLIN/ASAP Account Number with a '4' in position 8 shall be used for all Accrual/Trust fund foreign benefit payments. The BATCH/VOUCHER CLIN/ASAP Account Number with a '5' in position 8 shall be used for all Navy deployed claims covered by TRICARE Global Remote Overseas. The BATCH/VOUCHER CLIN/ASAP Account Number with a '6' in position 8 shall be used for all Marine deployed claims covered by TRICARE Global Remote Overseas.

6.2.2. Criteria For Selecting The TMA Domestic Non-Financially Underwritten ASAP Account (excludes claims that meet criteria specified under 6.2.1. above)

All domestic non-financially underwritten claims shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Number with a '1' in position 8. Exception: All Resource Sharing claims must follow the procedures as indicated in paragraph 6.2.3.

6.2.3. Criteria For Selecting Financially Underwritten CLINs (excludes claims that meet criteria specified under 6.2.1. and 6.2.2. above)

All financially underwritten benefit payments and all Resource Sharing claims must use the BATCH/VOUCHER CLIN/ASAP Account Number containing the TMA Benefit CLIN (positions 1 through 6 of ASAP).

6.2.4. Criteria For Selecting BATCH/VOUCHER CLIN/ASAP Account Number based on 'Active' Dates (Fiscal Year & Option Period)

All BATCH/VOUCHER CLIN/ASAP Account Numbers assigned by TMA, CRM shall have an 'active' date range assigned. The BATCH/VOUCHER CLIN/ASAP Account Number's 'active' dates shall not overlap across Option Periods (CLIN type account numbers only) or Fiscal Year (ASAP & CLIN type account numbers). The BATCH/VOUCHER Date (0-030) is the field TMA shall use when editing for proper selection of BATCH/VOUCHER CLIN/ASAP Account Number based on date. All disbursements shall be made using a currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number. All credits where reported disbursements did not occur (stale dated checks, voids, etc.) shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement. All collections (credits) of funds where the disbursement was originally reported using a CLIN Type BATCH/VOUCHER CLIN/ASAP Account Numbers shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement All collections (credits) of funds where the disbursement was originally reported to TMA using a ASAP Type BATCH/VOUCHER CLIN/ASAP Account Numbers (BATCH/VOUCHER CLIN/ASAP Account Number with a '1' or '3' or '4' or '5' or '6' in position 8) shall be credited to TMA using currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number.

Note: These guidelines apply only to benefit CLINs. They DO NOT apply to administrative CLINs.

7.0. INTERIM INSTITUTIONAL PAYMENTS

In certain cases, providers can submit interim bills for institutional claims. All TED Records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission.

8.0. PROCESS FOR REPORTING RESOURCE SHARING AND CAPITATED TREATMENT ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to Resource Sharing or Capitated Treatment Encounters.

8.1. Special Processing Code

For Resource Sharing and/or Capitated claims/encounters, submit a TED Record which includes the appropriate SPECIAL PROCESSING CODE, as defined in Chapter 2, Section 2.8, for each patient encounter.

8.2. "Amount" Field Reporting

The "amount" fields must contain the following:

8.2.1. Amount Billed/Amount Billed By Procedure Code

The AMOUNT BILLED/AMOUNT BILLED BY PROCEDURE CODE fields shall be the amount (institutional or noninstitutional charges) that the capitated provider would charge a patient on a capitated basis. If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated/discounted rates, report these amounts.

8.2.2. Amount Allowed/Amount Allowed By Procedure Code

The AMOUNT ALLOWED/AMOUNT ALLOWED BY PROCEDURE CODE fields must contain the appropriate DRG or per diem for institutional services, the CHAMPUS Maximum Allowable Charge (CMAC) for noninstitutional services, or negotiated/discounted rates for both institutional and noninstitutional services.

8.2.3. Amount Paid By Government Contractor

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the "lesser" of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the "Lesser" computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = $0.00.

9.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA

The following process is to be used by claims processors to report claim-related data to TMA which contain charges for blood clotting factor.

9.1. Blood Clotting Factor

Data is to be reported on the Institutional TED Record, even though they are to be reimbursed separately from the DRG methodology.

9.2. Calculation of Charge

Charges will be calculated in a two-step process, as described below.

9.2.1. First Step

The DRG-reimbursable hospital charges will be calculated in the normal way. All related financial data will be stored for later use (see below).

9.2.2. Second Step

The blood clotting factor financial data will be calculated based on the reimbursement methodology described in the TRICARE Policy Manual. All related financial data will be stored for later use. Revenue Code 0636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor only. All other drugs are to be reported using the appropriate Revenue Codes in the 025X series.

9.2.2.1. The number to be coded in the UNITS OF SERVICE field is the number of units billed on the claim, not the number of payment units (which is 100 times the number of units billed).

9.2.2.2. The billed charges for blood clotting factor are to be reported in the TOTAL CHARGE BY REVENUE CODE field of the payment record.

NOTE: While blood clotting factor charges will be priced separately, the ADJUSTMENT DENIAL REASON CODE cannot indicate DRG non-reimbursables.

9.2.3. Data Reporting

From the two steps above, merge the financial data as follows, and enter them into the appropriate cost fields:

9.2.3.1. Amount Billed

This is the sum of all billed charges **including** those for blood clotting factor.

9.2.3.2. Amount Allowed

This is the sum of the two separate amounts allowed resulting from the calculations in step 2 above.

9.2.3.3. Amount of Other Health Insurance

This is the amount paid by other primary sources of reimbursement, if applicable.

9.2.3.4. Patient Cost-Share

Enter in the appropriate field based on the Category of Beneficiary:

9.2.3.4.1. Patient Cost-Share (For Other Than Family Members of Active Duty)

This is the amount based on either 25% of the billed charges (including those for blood clotting factor) or the per diem amount times the number of days in the hospital stay.

9.2.3.4.2. Patient Cost-Share (For Family Members of Active Duty)

This is the amount based on the inpatient hospital daily rate times the number of days in the hospital stay.

9.2.3.4.3. Amount Paid By Government Contractor

This is the sum of the two separate amounts resulting from the calculations in step 2 above.