



DEFENSE
HEALTH AGENCY

HPOB

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**CHANGE 193
6010.56-M
SEPTEMBER 6, 2016**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: GENDER DYSPHORIA

CONREQ: 18119

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides an administrative correction.

EFFECTIVE DATE: October 3, 2016.

IMPLEMENTATION DATE: October 1, 2016.

This change is made in conjunction with Feb 2008 TPM, Change No. 169.

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REMOVE PAGE(S)

CHAPTER 8

Section 6, pages 5 and 6

INSERT PAGE(S)

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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.

9.3 A claim that contains services, supplies or equipment covering more than one contractor's jurisdiction shall be split. See [Section 2](#), for information on transferring partially out-of-jurisdiction claims.

9.4 An inpatient maternity claim which is subject to the TRICARE Diagnosis Related Group (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 TRM, [Chapter 1, Section 31](#).

9.5 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 Current Procedural Terminology (CPT) codes) shall be reported on a non-institutional format. See the TRM, [Chapter 11, Section 4](#).

9.6 A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for:

9.6.1 Charges for services which are included in the prospective group payment rate;

9.6.2 Charges for services which are not included in the prospective group payment rate and are separately allowable; and

9.6.3 Physician's fees which are allowable in addition to the facility charges. See the TRM, [Chapter 9, Section 1](#).

9.7 A claim submitted with both non-financially underwritten and financially underwritten charges shall be split.

9.8 A non-institutional financially underwritten claim where Begin Date of Care (TRICARE Systems Manual (TSM) Data Element 2-150) crosses contract option periods shall be split. See the TSM, [Chapter 2, Section 1.1, paragraph 6.0](#).

9.9 A claim that contains both institutional and professional services may be split into separate claims for:

9.9.1 Charges for services included in the Outpatient Prospective Payment System (OPPS); and

9.9.2 Charges for professional services which are not included in the OPPS and are separately allowable.

9.10 Claims which include services covered by NDAA for FY 2008, Section 1637, Transitional Care for Service-Related Conditions (TCSRC) shall be processed in accordance with [Chapter 17, Section 3, paragraph 2.5.5](#).

9.11 Outpatient claims with dates of service that cross the mandated date, as directed by HHS, for ICD-10 implementation, the date for ICD-10-CM coding implementation, must be split to accommodate the new coding regulations. A separate claim shall be submitted for services provided before the mandated date, as directed by HHS, for ICD-10 implementation, and be coded in accordance with the ICD-9-CM, as appropriate. Claims for services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, shall be submitted and coded with the ICD-10-CM as appropriate.

10.0 PROVIDER NUMBERS

10.1 Claims received from covered entities with the provider's National Provider Identifier (NPI) (individual and organizational) shall be processed using the NPI. Electronic claim transactions received from covered entities without the requisite NPIs in accordance with Implementation Guide for the ASC X12N 837 transaction shall be denied. See [Chapter 20](#) for further information.

10.2 Claims received (electronic, paper, or other acceptable medium) with 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 TSM, [Chapter 2](#), on the TED records.

11.0 TRANSGENDER BENEFICIARIES

If a beneficiary or provider notifies the contractor of the beneficiary's status as **transgender individual** (either prospectively or through an appeal), the contractor shall flag that patient's file and defer claims for medical review when there is a discrepancy between the patient's gender and the procedure, diagnosis*, ICD-9-CM surgical procedure code (for procedures before the mandated date, as directed by HHS, for ICD-10 implementation), or ICD-10-PCS surgical procedure code (for procedures on or after the mandated date, as directed by HHS, for ICD-10 implementation). For care that the review determines to be medically necessary and appropriate, the contractor shall override any edit identifying a discrepancy between the procedure and the patient's gender. TED record data for claims **made by a transgender individual** must reflect the Person Sex as downloaded from DEERS (TSM, [Chapter 2, Section 2.7](#)) and the appropriate override code.

Note: *The edition of the International Classification of Diseases, Clinical Modification reference to be used is determined by the date of service for outpatient services or date of discharge for inpatient services. Diagnoses coding for dates of service or dates of discharge prior to ICD-10 implementation should be consistent with the ICD-9-CM. Diagnoses coding for dates of service or dates of discharge on or after the mandated date, as directed by HHS, for ICD-10 implementation, should be consistent with ICD-10-CM.

12.0 DRUG SEEKING BENEFICIARIES

12.1 The contractor shall screen drug claims and/or medical claims and/or dental claims for potential overutilization and substance abuse. If a potential drug abuse situation is identified by a private physician, a physician reviewer in the course of business for the contractor, a dentist, pharmacist, or a physician in a hospital setting, as representing an addictive state in the beneficiary, the beneficiary shall be placed on 100% prepayment review. The [32 CFR 199.4](#) precludes government cost-sharing of benefits to support or maintain potential drug abuse situations. This is