OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 117
6010.55-M
JULY 9, 2010

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002

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

CHANGE TITLE: **TRICARE ENCOUNTER DATA (TED) INTERIM HOSPITAL BILLING**

CONREQ: 14999

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This draft change will allow the processing of inpatient facility interim-interim and interim-final billings, with the exception of interim billings reimbursed under Diagnosis Related Group (DRG) or Home Health Agency (HHA) payment methodology, as unique TED records rather than as adjustments to the TED record for the initial billing.

EFFECTIVE DATE: November 1, 2010.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 82.

John A. D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): **2 PAGE(S)**
DISTRIBUTION: **6010.55-M**

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

REMOVE PAGE(S)	**INSERT PAGE(S)**
CHAPTER 6	
Section 3, pages 3 and 4	Section 3, pages 3 and 4

a. Criteria for qualifying for interim payments. In order to qualify for interim payments the following conditions must be met. If a condition is not met, e.g., the claim is received out of chronological order, the claim is to be denied.

(1) It must be for a claim received on or after October 1, 1988.

(2) The patient has been in the hospital at least 60 days.

(3) Multiple claims for single individuals must be submitted in chronological order.

b. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill.

c. Contractor actions on interim claims. Contractors will process the initial claim as a complete claim and each subsequent claim as an adjustment. However, the interim claims are only a method of facilitating cash flow to providers, and the final bill is still the final accounting on the hospital stay. Therefore, upon receipt of the final bill, the contractor is required to review the entire claim to ensure that it has been correctly paid and to ensure that the cost-share has been correctly determined. See the TRICARE Systems Manual (TSM), Chapter 2, Section 1.1, paragraph 7.0. for TRICARE Encounter Data (TED) record submission requirements for interim hospital billings.

E. Inpatient operating costs. The TRICARE/CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1. Operating costs for routine services, such as the costs of room, board, therapy services (physical, speech, etc.), and routine nursing services as well as supplies (e.g., pacemakers) necessary for the treatment of the patient;

2. Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients (the professional component of these services is not included and can be billed separately);

3. Take-home drugs for less than $40;

4. Special care unit operating costs (intensive care type unit services); and

5. Malpractice insurance costs related to services furnished to inpatients.

F. Discharges and transfers.

1. Discharges. Subject to the provisions of paragraph III.F.2. and 3., a hospital inpatient is considered discharged from a hospital paid under the TRICARE/CHAMPUS DRG-based payment system when:

a. The patient is formally released from the hospital; or

b. The patient dies in the hospital.

c. The patient is transferred to a hospital or unit that is excluded from the TRICARE/CHAMPUS DRG-based payment system under the provisions of Chapter 6, Section 4. Such cases can be identified by Form Locator (FL) 17 on the CMS 1450 UB-04 claim form. For discharges with an admission date prior to October 1, 1998, if anything other than "02" is entered, the contractor is to process the claim as a discharge. All claims coded "02" are to be processed as transfers unless there is specific reason for not doing so (e.g., the case is classified into DRG No. 601). For discharges with an admission date on or after October 1, 1998, such cases shall no longer be processed as a discharge, but as a transfer, if the claim contains one of the qualifying DRGs listed in paragraph III.F.4., and the patient is transferred to one of the settings outlined in paragraph III.F.3.

2. Acute care transfers. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital is:

a. Paid under the TRICARE/CHAMPUS DRG-based payment system (such instances will result in two or more claims); or

b. Excluded from being paid under the TRICARE/CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the TRICARE/CHAMPUS DRG-based payment system under Chapter 6, Section 4 (such instances will result in two or more claims); or

c. Authorized as a Designated Provider (DP) [formerly Uniformed Services Treatment Facilities (USTFs)] or a Department of Veterans Affairs (DVA) hospital.

3. Postacute care transfers. A discharge of a hospital inpatient is considered to be a transfer for purposes of this subsection when the patient's discharge is assigned to one of the qualifying DRGs listed in paragraph III.F.4., and the discharge is made under any of the following circumstances:

a. To a hospital or distinct part hospital unit excluded from the TRICARE/CHAMPUS DRG-based payment system as described in Chapter 6, Section 4. Claims shall be coded 05, 62, or 63 in FL 17 on the CMS 1450 UB-04 claim form. Effective April 1, 2004, claims shall be coded 65 in FL 17 for psychiatric hospitals and units.

b. To a Skilled Nursing Facility (SNF). Claims shall be coded 03 in FL 17 on the CMS 1450 UB-04 claim form.

c. To home under a written plan of care for the provision of home health services from a home health agency and those services begin within three days after the date of discharge. Claims shall be coded 06 in FL 17 on the CMS 1450 UB-04 claim form. Claims coded 06 with a condition code of 42 or 43 in FL 18 shall be processed as a discharge instead of a transfer.