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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 146
6010.55-M
MARCH 15, 2012**

**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: COMBINED CODING AND CLARIFICATION UPDATES - 2011

CONREQ: 15442

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 154.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 22 PAGE(S)
DISTRIBUTION: 6010.55-M**

CHANGE 146
6010.55-M
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REMOVE PAGE(S)

CHAPTER 1

Section 20, pages 3 - 5

CHAPTER 4

Section 3, pages 5 and 6

Section 4, pages 3 - 7

CHAPTER 12

Section 5, pages 1 - 8

CHAPTER 13

Section 2, pages 17 - 20

INSERT PAGE(S)

Section 20, pages 3 - 5

Section 3, pages 5 and 6

Section 4, pages 3 - 7

Section 5, pages 1 - 8

Section 2, pages 17 - 20

SUMMARY OF CHANGES

CHAPTER 1

1. Section 20. Clarifies the language to bring the policy into compliance with the State Agency Billing Agreement (see Chapter 1, Addendum A).

CHAPTER 4

2. Section 3. Corrected a typographical error to read \$52.00.
3. Section 4. Eliminated the requirement for TRICARE beneficiaries, who were awarded Social Security Disability Insurance (SSDI) on appeal, to enroll in Medicare Part B back to their Medicare Part A effective date. Effective as of October 28, 2009.

CHAPTER 12

4. Section 5. Providers clarification to allow referral to HHC by an attending physician rather than solely a PCM.

CHAPTER 13

5. Section 2. APCs 0172 and 0173 are updated to 0175 and 0176 to match Medicare's update as of January 1, 2011.

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CHAPTER 1, SECTION 20

STATE AGENCY BILLING

CONDITION	PROCEDURE
Lack of itemization on inpatient hospital bills; i.e., hospital detail is lacking	Beginning and ending dates of hospital stay are required. Breakdown of detailed services and supplies must be detailed enough to determine the Revenue Code major category. Contractors may assume the charges are for a semi-private room, in absence of evidence to the contrary, and report with Revenue Code "12X." In every instance, the Revenue Code in the Institutional Record must comply as required by the TRICARE Systems Manual (TSM), Chapter 2, Sections 3 through 8. Waiver of the requirement to develop for the breakdown of services does not excuse the contractor from coding the detail which is present on the claim.
No breakdown of service detail; e.g., multiple office visits or multiple lab services, etc.	Waive: For TEDs, the contractor is authorized to estimate frequency of the charge by using a reasonable approximation. For example, June 1 - 8, CPT ¹ procedure code 90050 with a \$57.00 charge. Assume two office visits @ \$28.50.
Quantity, strength, etc., missing on drug claims.	Waive: Pay as billed and assume that the state agency has a control system in place. If evidence develops to refute this assumption, contact the state agency for development of appropriate controls. Process drug claims from state agencies as if they were consolidated drug claims.
Diagnosis Missing	<u>Waive</u> on office visits (unless services appear to be for a routine physical or related to other excluded services); consultations; drugs; lab; x-ray; assistant surgeon and anesthesiology. Use ICD code 799.9 in absence of a correct code.
Diagnosis Missing	<u>Require</u> on hospital, surgery and mental health. For DME, if the record provides information other than a diagnosis which can reasonably support the payment, proceed. Return the incomplete claim, which requires a diagnosis, to the state for supporting information.
Timely filing limits.	The state shall file no later than one year following the date of service: one year after the date the prescription was filled; one year after the date of discharge if the services were rendered during an inpatient admission; or one year after the state received the results of the annual data match from the Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) Division. For waivers, see the TOM, Chapter 8, Section 3, paragraph 2.0.

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3. TRICARE Encounter Data (TED) Reporting of State Agency Claims

Claims received for state agencies will be processed with the Special Processing Code '1' on TEDs (see the TSM, [Chapter 2](#)). TED coding will follow the basic requirements for a participating claim with the state Medicaid agency designated as the payee. The amount paid by the government must be reported in the Amount Paid by Government Contractor field.

4. Development with State Agencies

States are obligated to provide the data needed to process the claims they submit, including eligibility and other beneficiary information. In some cases, the contractor will need to develop data through DEERS or other in-house information to accurately process the claim. For other required data, or in case of failure to locate essential information, the contractor **shall deny** the claim. If a state routinely fails to submit required data on its claims, the contractor shall contact the state agency and request cooperation. TRICARE Management Activity (TMA) shall be advised of any such problems and the results of any contacts.

5. Duplicate Checking

Contractors shall ensure that precautions are taken to prevent duplicate payments, as provided in the TOM, [Chapter 8, Section 9](#). In cases where the exact type of service data has not been provided, but a duplication of types of service is apparent; e.g., apparent duplication of lab and office services, the contractor shall attempt to resolve the case with the data available in-house. If the matter cannot be resolved, assume duplication and deny the claim. If the state agency has information to the contrary, it may resubmit with the necessary documentation to refute the assumption. If a beneficiary or provider has submitted claims for services directly to TRICARE and the same services have also been sent to the state for Medicaid payment, the possibility of fraud must be considered. Since the patient would have been TRICARE-eligible, any fraud would have been an offense against the state program. Return the claim to the state agency and advise them of the facts including that payment has been made by TRICARE. The contractor shall cooperate in any state investigation to the extent possible under TRICARE guidelines. In any case of doubt about what information can be released in an investigation, contact TMA for instructions.

6. Nonavailability Statement (NAS)

The state must include the address of the beneficiary on the claim and the contractor shall verify whether a Nonavailability Statement is required, using normal processing rules, including a check of the related history files to determine if an NAS is on file. If an NAS is required, and none is available, the claim will be denied and the State Medicaid Agency notified on the Explanation of Benefits (EOB). No further action is required by the contractor.

7. Providers

Providers must be TRICARE-approved or TRICARE-eligible in accordance with the TOM, [Chapter 2](#). If the provider named on the claim is not on the contractor provider files, but is in a category which is normally acceptable under TRICARE; e.g., a physician,

psychologist, hospital, etc., the contractor shall follow normal procedures to certify. If the provider is not in a certifiable category under the contract, return the claim to the state.

8. Third Party Liability (TPL)

When submitting claims to TRICARE for recovery of payments made, the state agency should attach information regarding possible "Third Party Liability" (TPL) for those claims which carry a diagnosis requiring development (see the TOM, [Chapter 11](#)). However, if the TPL data submitted is not adequate to provide all the information required, return the claim to the state agency to obtain the necessary information. **If the state agency does not provide the necessary information within 35 days, the claim shall be denied.** It is expected that the state agency will have a fully developed file to establish or to rule out possible TPL. If TPL is involved, the state should have exercised its subrogation rights and the state's beneficiary claim file should reflect complete data, including the amount paid under TPL. Where TPL does exist, the TRICARE claim liability should be minimal. The contractor should not contact the beneficiary or the provider(s).

B. Reimbursement Procedures and Requirements

The contractor shall reimburse the State Medicaid Agency directly for all claims submitted by the agency providing an EOB for each claim, unless arrangements and agreement between the contractor and the state agency provide for a summary payment voucher. No EOB or other notice will be sent to either the beneficiary or the provider. The allowance determination shall be based on the amount billed to the Medicaid Agency by the provider of care. The contractor shall calculate the net amount which would have been payable by TRICARE including, when appropriate, the COB reduction, deductible and cost-share amounts in the determination. The state shall be paid the lesser of the amount it actually paid or the amount that TRICARE would have paid. The Medicaid billing by a provider is frequently less than the provider's customary charge. These charges shall not be included in the determination of the prevailing charges for an area. If a provider of care subsequently bills, requesting payment for the difference between the Medicaid payment and the amount customarily billed, the claim shall be denied as a duplicate. No additional payment shall be made. If a service which would be allowable by TRICARE has been denied by Medicaid and is subsequently submitted by a provider of care, the charge shall be considered as any other claim.

- END -

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CHAPTER 4, SECTION 3

COORDINATION OF BENEFITS

STEP 2: \$ 60.00 - Billed charge
 - 0.00 - Paid by double coverage - total billed amount credited deductible
 \$ 60.00 - Unpaid balance

STEP 3: TRICARE pays \$8.00 on this claim since it is the lower of STEPS 1 and 2. The beneficiary is responsible for paying the \$52.00 remainder of the bill. The beneficiary's TRICARE individual deductible for the fiscal year is satisfied.

EXAMPLE 5: Above beneficiary has additional care with date of service, April 2002, and this claim is received after the claim for the July services.

STEP 1: \$ 200.00 - Allowable charge
 x 80% - TRICARE portion
 \$ 160.00 - Amount payable by TRICARE in the absence of double coverage

STEP 2: \$ 200.00 - Billed charge
 - 75.00 - Paid by OHI - \$100 was credited to the OHI's deductible and \$25 to the OHI cost-share.
 \$ 125.00 - Unpaid balance

STEP 3: TRICARE pays the \$125.00 balance, since it is not more than it could have paid in the absence of double coverage. The beneficiary's bill has been paid in full. No adjustment is made to the claim for the July services to give credit for the April double coverage plan deductible.

VI. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE

In the following examples, "allowable charges" means that all non-covered charges have been deducted.

EXAMPLE 1: The total bill for outpatient care for a retiree is \$1,000.00, of which \$800.00 is considered allowable by TRICARE. The double coverage plan paid \$600.00 of the bill. The provider who is a participating, non-network provider submits a claim for \$1,000.00 to the contractor along with an EOB from the double coverage plan. The beneficiary's deductible has been met.

STEP 1: \$ 800.00 - Allowable charges
 x 75% - TRICARE portion for retirees
 \$600.00 - Amount payable by TRICARE in the absence of other coverage

STEP 2: \$ 1,000.00 - Billed charges
 - 600.00 - Paid by OHI
 \$ 400.00 - Unpaid balance

STEP 3: TRICARE pays the \$400.00 balance, since it is less than the \$600.00 which TRICARE would have paid in the absence of double coverage. No deduction is made for the patient's cost-sharing portion of 25% since the \$600 paid by the double coverage plan satisfies this.

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COORDINATION OF BENEFITS

EXAMPLE 2: The total bill for outpatient services provided by a participating, non-network provider to a retiree is \$400.00. This includes four separate services, each of which has a billed charge of \$100.00. The TRICARE allowable amount for these services is \$300.00 (\$100.00 for each of three services. The claim did not contain sufficient information to process the fourth service; and the information was not received upon development). The double coverage plan paid \$200.00 (\$50.00 for each service). The TRICARE deductible had been met. The beneficiary submits the claim to TRICARE along with the OHI EOB which clearly indicates that it paid \$50.00 for each service.

STEP 1: \$ 300.00 - Allowable charge
 x 75% - TRICARE portion for retirees
 \$ 225.00 - Amount payable by TRICARE in the absence of other coverage

STEP 2: \$ 400.00 - Billed charge
 -100.00 - Charge for service not allowed
 \$ 300.00 - Net billed charge
 -150.00 - OHI payment applicable to allowed services
 \$ 150.00 - Unpaid balance

STEP 3: TRICARE pays \$150.00, since it is the lower of the two computations.

If the claim is subsequently submitted with the information necessary to process the fourth service, it would be processed as follows:

STEP 1: \$ 100.00 - Allowable charge (the first three services would be deleted since they duplicate previously processed services)
 x 75% - TRICARE portion for retirees
 \$ 75.00 - Amount payable by TRICARE in the absence of other coverage

STEP 2: \$ 400.00 - Billed charge
 -300.00 - Duplicate charge
 \$ 100.00 - Net billed charge
 - 50.00 - OHI payment applicable to allowed service
 \$ 50.00 - Unpaid balance

STEP 3: TRICARE pays \$50.00, since it is the lower of the two computations.

EXAMPLE 3: The total bill for outpatient care for a retiree from a network provider is \$1,000.00, of which \$800.00 is considered allowable by TRICARE based on the provider's network agreement. The double coverage plan paid \$600.00 of the bill. The provider submits a claim for \$1,000.00 to the contractor along with an EOB from the double coverage plan. The beneficiary's deductible has been met.

STEP 1: \$ 800.00 - Allowable charges
 x 75% - TRICARE portion for retirees
 \$ 600.00 - Amount payable by TRICARE in the absence of other coverage

and pay the claim as the primary payer. In most cases, under served areas will be identified by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the Centers for Medicare and Medicaid Services (CMS) web site at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

NOTE: Under the TRICARE Provider Reimbursement Demonstration Project for the State of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

f. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare denies payment based on their Competitive Bidding Program (CBP) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), the TRICARE contractor shall process the claim as second payer for otherwise covered items of DMEPOS. In such cases, the TRICARE payment shall be the amount TRICARE would have paid had Medicare processed and paid the claim. Public use files containing the competitive bid single payment amounts per Healthcare Common Procedure Coding System (HCPCS) code are posted on the CMS' competitive bidding contractor's web site: <http://www.dme.competitivebid.com/palmetto/cbic.nsf/DocsCat/Home>. TRICARE contractors shall identify the competitive bid single payment amount using the above CMS web site to identify what Medicare would have allowed had the beneficiary followed Medicare's rules. Implementation of Medicare's DMEPOS CBP pricing is effective January 1, 2011.

g. Effective October 28, 2009, TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination awarded upon appeal remain eligible and are considered to have coverage under the TRICARE program (see the TRICARE Operations Manual (TOM), Chapter 22, Section 1, paragraph 2.6.) for the retroactive months of their entitlement to Medicare Part A, notwithstanding the gap in coverage between Medicare Part A and Part B effective dates. For previously processed claims and claims for dates of service before the beneficiary's original Medicare Part B effective date (which corresponds with the date of issuance of the retroactive determination by the Social Security Administration), jurisdiction remains with the contractor that processed the claim. Recoupment actions shall not be initiated and existing actions should be terminated. Out-of-jurisdiction rules apply to claims for dates of service on or after the original Medicare Part B effective date. These claims should be forwarded to the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor for action. Medicare becomes primary payer effective as of the original Medicare Part B effective date. Eligible beneficiaries are required to keep Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A.

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CHAPTER 4, SECTION 4

SPECIFIC DOUBLE COVERAGE ACTIONS

2. Services that are a benefit under Medicare but not under TRICARE. TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

3. Services that are a benefit under TRICARE but not under Medicare. If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor knows that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply.

4. Services that are provided in a non-Department of Defense (DoD) government facility. If services or supplies are provided in a TRICARE authorized non-DoD government facility, such as a Veterans Administration (VA) hospital pursuant to the TRICARE Policy Manual (TPM), [Chapter 11, Section 2.1](#), Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

NOTE: In order to achieve status as a TRICARE authorized provider, VA facilities must comply with the provisions of the TPM, [Chapter 11, Section 2.1](#).

5. Services provided by a Medicare at-risk plan. If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries co-pay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

6. Beneficiary Cost-Shares. Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost shares for services received from network providers shall be TRICARE Extra cost shares. Services received from non-network providers shall be TRICARE Standard cost shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TRICARE for Life (TFL) population.

7. Application of Catastrophic Cap. Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

D. End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age - Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

II. TRICARE AND MEDICAID

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid,

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TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See [Chapter 1, Section 20](#).

III. MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see [Chapter 4, Section 1](#)).

IV. TRICARE AND VA

Eligibility for health care through the VA for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the VA and is also eligible for TRICARE, he/she may use either TRICARE or Veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same episode of care through the VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

V. TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or injury might be work related, the contractor will process the claim following the provisions as provided in TOM, Chapter 11, Section 5, [paragraphs 5.0](#) and [6.0](#) and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

VI. TRICARE AND SUPPLEMENTAL INSURANCE PLANS

A. Not Considered Double Coverage. Supplemental or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service Health Maintenance Organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

B. Income Maintenance Plans. Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, length of stay, or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

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C. Other Secondary Coverage. Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation and policy and are subject to the usual double coverage requirements.

VII. SCHOOL COVERAGE - SCHOOL INFIRMARY

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

VIII. TRICARE AND PREFERRED PROVIDER ORGANIZATIONS

See [Chapter 1, Section 26](#).

IX. DOUBLE COVERAGE AND EXTENDED CARE HEALTH OPTION (ECHO)

All double coverage rules and procedures which apply to claims under the basic program are also to be applied to ECHO claims. All local resources must be considered and utilized before TRICARE benefits under the ECHO may be extended. If an ECHO beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximums established in TPM, [Chapter 9](#). The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

NOTE: The requirements of [paragraph IX](#), notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act (IDEA) in accordance with the Individualized Family Service Plan (IFSP) and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

X. PRIVATELY-PURCHASED, NON-GROUP COVERAGE

Privately-purchased, non-group health insurance coverage is considered double coverage.

XI. LIABILITY INSURANCE

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential Third Party Liability (TPL) (see the TOM, [Chapter 11, Section 5](#)). The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act (FMCRA), if the Other Health Insurance (OHI) does not cover all expenses.

XII. TRICARE AND PRE-PAID PRESCRIPTION PLANS

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee

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and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

XIII. TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

XIV. SURROGATE ARRANGEMENTS

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy may be cost-shared only as a secondary payer, and only after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother's medical care. If brought to the contractor's attention, the requirements of TOM, [Chapter 11, Section 5, paragraph 2.10](#), would apply.

- END -

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - PRIMARY PROVIDER STATUS AND EPISODES OF CARE

ISSUE DATE:

AUTHORITY: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)

I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

This policy describes the methods used in designating the primary provider of home health services and for tracking the episodes of care for payment under the HHA PPS.

III. POLICY

A. Background.

1. With the advent of the home health agency prospective payment system (HHA PPS) and home health consolidated billing, Medicare had to establish a means of identifying a "primary" home health agency for payment purposes (i.e., a HHA that would receive payment for all services during a designated episode of care). Medicare addressed this problem through the establishment of an administratively complex on-line inquiry transaction system [i.e., a Health Insurance Query for Health Agencies (HIQH)] whereby other home health providers could determine whether or not the beneficiary was currently in a home health episode of care. This on-line query system required the establishment of a HHA PPS episode auxiliary file which is continually updated as requests for anticipated payments (RAPs) and claims are processed through the Regional Home Health Intermediary's (RHHI) claims processing systems. The HIQH system must be able to immediately return the following information to providers querying the system: 1) contractor and provider numbers; 2) episode start and end dates; 3) period status indicator; 4) HHA benefit periods; 5) secondary payer information; 6) hospice periods; and 7) HIQH header information. The HIQH transaction system must also be able to access 36 episode iterations displayed two at a time.

2. The implementation and maintenance of such an on-line transactional query system would be administratively burdensome and costly for the program. It would have to

be maintained by one of the claims processing subcontractors since it is a national system requiring continual on-line updating. Determining “primary” provider status from the query system (i.e., the first RAP or, under special circumstances, the first claim submitted and processed by the RHHI) would circumvent the contractors’ utilization management responsibilities/requirements under their existing managed care support contracts. In other words, the contractors would no longer be able to assess and direct home health care within their region(s). Designation of primary HHA status (i.e., the only HHA allowed to receive payment for services rendered during an episode of care) would be dependent on the first RAP or claim submitted and processed for a particular episode of care. The determination of where and by whom the services are provided would be dependent on the provider instead of the **Managed Care Support Contractor (MCSC)**.

3. An alternative approach is being adopted that will meet the primary goals of ensuring Medicare PPS payment rates and benefit coverage while retaining utilization management. Under this alternative approach, the preauthorization process will determine “primary status” of the HHA. Authorization screens (part of the automated authorization file) will be used to house pertinent episode data. This alternative will necessitate contractor preauthorization for all home health care (i.e., home health care delivered under both Prime and Standard). Expansion of the existing authorization requirements is a viable option given the fact that one of the MCSCs is already authorizing home health care for standard beneficiaries under its contract. The alternative authorization process is preferable to the development and maintenance of a national on-line transactional query system, given its enormous implementing and maintenance costs. Adoption of the above alternative will preclude implementation of Medicare’s on-line transactional system and maintenance of complex auxiliary episode files. However, adoption of this alternative process does not preclude the prescribed conventions currently in place for establishing episodes of care; e.g., transfers, discharges and readmissions to the same facility within 60-day episodes, significant changes in condition (SCICs), LUPAs, and continuous episodes of care will all be monitored and authorized as part of the authorization process. Contractors will maintain and update episode data on expanded authorization screens.

B. Designation of Primary Provider.

1. Preauthorization Process. The preauthorization process is critical to establishment of primary provider status under the HHA PPS; i.e., designating that HHA which may receive payment under the consolidated billing provisions for home health services provided under a plan of care.

a. The contractor is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries (both Prime and Standard) seeking home health care. In other words, home health care can only be accessed by TRICARE beneficiaries upon referral by the PCM **or attending physician**, and with preauthorization by the contractor. The contractor shall establish and maintain these functions to facilitate referrals of beneficiaries to home health agencies. For example, a beneficiary in need of home health services will request preauthorization and placement by the **MCSC** or other contractor designee. The MCSC will search its network for a HHA which will meet the needs of the requesting beneficiary. The beneficiary will be granted preauthorization approval for home health services provided by

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the selected HHA. The selected HHA will in turn be notified of its primary provider status under TRICARE (i.e., the selected HHA will be notified that it will be the only HHA authorized for payment for services provided to the referred TRICARE beneficiary) and must submit a request for anticipated payment after the first service has been rendered. The RAP will initiate the episode of care under the preauthorization process.

b. The preauthorization process will extend to all intervening events occurring during the episode period (e.g., preauthorization will be required for transfers to another HHA and readmission to the same HHA within 60 days of previous discharge). In each case, the MCSC will maintain responsibility for designating primary provider status under the HHA PPS.

2. Data Requirement/Maintenance. The tax identification number (9-18 positions) of the designated primary provider (HHA) will be maintained and updated on the automated authorization file (i.e., the authorization screen).

C. Opening and Length of HHA PPS Episode. While the authorization process will take the place of the HIQH in designation of primary provider status and maintenance and updating of pertinent episode data, it will not preclude the following conventions for reporting and payment of HHA episodes of care:

1. In most cases, an HHA PPS episode will be opened by the receipt of a RAP, even if the RAP or claim has zero reimbursement. The MCSC will have already notified the selected HHA of its primary status for billing under the consolidated standards prior to submission of the RAP. The preauthorization requirement will negate the need for a query system (i.e., the need for keeping other home health providers informed of whether a beneficiary is already under the care of another HHA), since providers will be keenly aware of this requirement for primary status under TRICARE. In other words, if an HHA has not received prior notification from the MCSC of its selection for treatment of a TRICARE beneficiary, it does not have primary provider status under the Program.

2. Claims, as opposed to RAPs, will only open episodes in one special circumstance: when a provider knows from the outset that four or fewer visits will be provided for the entire episode, which always results in a low utilization payment adjustment (LUPA), and therefore decides to forego the RAP so as to avoid recoupment of the difference of the large initial percentage episode payment and the visit-based payment. This particular billing situation exception is referred to as a No-RAP LUPA.

3. Multiple episodes can be opened for the same beneficiary at the same time. The same HHA may require multiple episodes to be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes may also occur between different providers if a transfer situation exists. Again, however, the MCSCs will always be aware of the intervening events (e.g., transfers to another HHAs or discharge and readmission to the same facility during the same 60-day episode of care) due to ongoing utilization review and preauthorization requirements under contractors' managed care systems. The MCSC will be responsible for designating primary provider status whether it be

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for a new provider, in the case of transfer, or readmission to the same provider during a 60-day episode of care. The contractors' system will post RAPs received with appropriate transfer and re-admit indicators to facilitate the creation of multiple episodes. Same-day transfers are permitted, such that an episode for one agency, based on the claim submitted by the agency, can end the same date as an episode was opened by another agency for the same beneficiary, assuming preauthorization has been initiated and granted by the MCSC.

4. When episodes are created from RAPs, the system calculates a period end date that does not exceed the start plus 59 days. The system will assure no episode exceeds this length under any circumstance, and will auto-adjust the period end date to shorten the episode if needed based on activity at the end of the episode (i.e., shortened by transfer).

5. The system will reject RAPs and claims with statement dates overlapping existing episodes, including No-RAP LUPA claims, unless a transfer or discharge and re-admit situation is indicated. The system will also reject claims in which the dates of the visits reported for the episode do not fall within the episode period established by the same agency. Sixty-day episodes, starting on the original period start date, will remain on record in these cases.

6. The system will auto-cancel claims, and adjust episode lengths, when episodes are shortened due to receipt of other RAPs or claims indicating transfer or readmission. The auto-adjusted episode will default to end the day before the first date of service of the new RAP or claim causing the adjustment, even though the episode length may change once claims finalizing episodes are received. Payment for the episode is automatically adjusted (a partial episode payment or PEP adjustment) without necessitating re-billing by the HHA. If, when performing such adjustments, there is no claim in paid status for the previous episode that will receive the PEP adjustment, the system will adjust the period end date; however, if the previous claim is in paid status, both the claim and the episode will be adjusted.

7. In a PEP situation, if the first episode claim contains visits with dates in the subsequent episode period, the claim of the first episode will be rejected by the system with a reject code that indicates the date of the first overlapping visit. The claim rejected by the system will then be returned to the HHA by the contractor for correction. If the situation is also a transfer, when the first HHA with the adjusted episode subsequently receives a rejected claim, the agency can either re-bill by correcting the dates, or seek payment under arrangement from the subsequent HHA. For readmission and discharge, the agency may correct the erroneously billed dates for its own previously-submitted episode, but corrections and adjustments in payment will be made automatically as appropriate whether the HHA submits corrections or not.

8. If the from dates on two simultaneously received RAPs, or No-RAP LUPA claims, overlap, the system will reject the one for which there is no prior authorization (i.e., the RAP from the HHA for which there was no designated primary provider status by the MCSC). In such cases, contractors will return the claims rejected by the system to providers.

9. If a claim is canceled by an HHA, the system will cancel the episode. If an HHA cancels a RAP, the system will also cancel the episode. When RAPs or claims are auto-

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canceled or canceled by the system, the system will not cancel the episode. A contractor may also take an action that results in cancellation of an episode, usually in cases of fraudulent billing. Other than cancellation, episodes are closed by final processing of the claim for that episode.

D. Other Editing and Changes for HHA PPS Episodes.

1. The system will assure that the final from date on the episode claim equals the calculated period end date for the episode if the patient status code for the claim indicates the beneficiary will remain in the care of the same HHA (patient status code 30).

2. If the patient dies, represented by a patient status code of 20, the episode will not receive a PEP adjustment (i.e., the full payment episode amount will be allotted), but the through date on the claim will indicate the date of death instead of the episode end date.

3. When the patient status of a claim is 06, indicating transfer, the episode period end date will be adjusted to reflect the through date of that claim, and payment is also adjusted.

4. The system will permit a "transfer from" and a "transfer to" agency to bill for the same day when it is the date of transfer and a separate RAP/claim is received overlapping that 60-day period containing either a transfer or a discharge-readmit indicator.

5. When the status of the claim is 01, no change is made in the episode length or claim payment unless a separate RAP/Claim is received overlapping that 60-day period and containing either a transfer or a discharge-readmit indicator.

6. The system will also act on source of admission codes on RAPs; for example, "B" (indicating transfer) and "C" (indicating readmission after discharge by the same agency in the same 60-day period) will open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone will not trigger creation of a new episode.

7. Claims for institutional inpatient services (i.e., inpatient hospital and skilled nursing facility services) will continue to have priority over claims for home health services under HHA PPS. Beneficiaries cannot be institutionalized and receive homebound care simultaneously. Therefore, if an HHA PPS claim is received, and the system finds dates of service on the HH claims that fall within the dates of an inpatient or skilled nursing facility (SNF) claim (not including the dates of admission and discharge), the system will reject the HH claim.

8. A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment is likely to apply. Occurrence span code 74, previously used in such situations, should not be employed on HHA PPS claims.

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9. If an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, there would be one shortened HHA PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall. The agency should cancel the PEP claim and the readmission RAP in these cases and re-bill a continuous episode of care.

10. The system will edit to prevent duplicate billing of DME. Consequently, the system must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS coding, though home health consolidated billing does not apply to DME by law.

E. Chart Summarizing the Effects of RAP/Claim Actions on the HHA PPS Episode.

TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
Initial RAP (Percentage Payments 0-60)	Open an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60 th day.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next episode.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Initial RAP with Transfer Source Code of B	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60 th day.	<ul style="list-style-type: none"> • The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of the transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs.
RAP Cancellation by Provider or Contractor	The episode record is deleted from system.	<ul style="list-style-type: none"> • No episode exists to prevent RAP submission or No-RAP LUPA claim submission.

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TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
RAP Cancellation by System	The episode record remains open on system	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present. • To correct information on this RAP, the original RAP must be replaced, canceled by the HHA and then re-submitted once more with the correct information.
Claim (full)	60-day episode record completed; episode "through" date remains at the 60 th day; Date of Latest Billing Action (DOLBA) updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Claim (discharge with goals met prior to Day 60)	Episode record complete; episode "through" date remains at the 60 th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	<ul style="list-style-type: none"> • A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date.
No-RAP LUPA Claim	Opens an episode record using claim's "from" date; the "through" date automatically calculated to extend through 60 th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • Other No-RAP LUPA claims will be rejected unless a transfer source is present. • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim.
Claim (adjustment)	No impact on the episode unless adjustment changes patient status to transfer.	<ul style="list-style-type: none"> • No impact
Claim Cancellation by Provider or Contractor	The episode is deleted from system.	<ul style="list-style-type: none"> • No episode exists to prevent RAP submission or No-RAP LUPA claim submission.

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TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
Claim Cancellation by System	The episode record remains open on system.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.

F. Episode Data Requirement. The contractor's authorization screen (part of its automated authorization file) will show whether or not the beneficiary is currently in a home health episode of care (being served by a primary HHA), along with the following information:

1. The beneficiary's name and sex;
2. Pertinent contractor and provider number;
3. Period Start and End Dates - the start date is received on a RAP or claim, and the end date is initially calculated to be the 60th day after the start date, changed as necessary when the claim for the episode is finalized;
4. DOEBA and DOBLA, dates of earliest and latest billing activity.
5. Period Status Indicator - the patient status code on HHA PPS claim, indicating the status of the HH patient at the end of the period;
6. Transfer/Readmit Indicator - Source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge);
7. The HIPPs Code(s)- up to six for any episode, representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
8. Principle Diagnosis Code and First Other Diagnosis Code - from the RAP or overlaying claim;
9. A LUPA Indicator - received from the system indicating whether or not there was a LUPA episode; and
10. At least 6 of the most recent episodes for any beneficiary.

- END -

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1. The National Quality Monitoring Contractor (NQMC) shall include in their authorized provider reports to the contractors additional data elements indicating whether the facility is a freestanding PHP (psych or SUDRF) or a hospital-based PHP (psych). The contractors shall identify hospital-based PHPs (SUDRFs) that are subject to the per diem payment under the OPPTS.

2. Services of physicians, clinical psychologists, Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), and Physician Assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services.

3. Payment for PHP (psych) services represents the provider's overhead costs, support staff, and the services of Clinical Social Workers (CSWs) and Occupational Therapists (OTs), whose professional services are considered to be included in the PHP per diem rate. For SUDRFs, the costs of alcohol and addiction counselor services would also be included in the per diem.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs, OTs, and alcohol and addiction counselors.

b. Rather, the hospital's costs associated with the services of CSWs, OTs, and alcohol and addiction counselors will continue to be billed to the contractor and paid through the PHP per diem rate.

4. PHP should be a highly structured and clinically-intensive program, usually lasting most of the day. Since a day of care is the unit that defines the structure and scheduling of partial hospitalization services, a two-tiered payment approach has been retained, one for days with three services (APC 0175) and one for days with four or more services (APC 0176) to provide PHPs scheduling flexibility and to reflect the lower costs of a less intensive day.

a. However, it was never the intention of this two-tiered per diem system that only three units of service should represent the number of services provided in a typical day. The intention of the two-tiered system was to cover days that consisted of three units of service only in certain limited circumstances; e.g., three-service days may be appropriated when a patient is transitioning towards discharge or days when a patient who is transitioning at the beginning of his or her PHP stay.

b. Programs that provide four or more units of service should be paid an amount that recognizes that they have provided a more intensive day of care. A higher rate for more intensive days is consistent with the goal that hospitals provide a highly structured and clinically-intensive program.

c. The OCE logic will require that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment. For CY 2009, payment will be denied for days when fewer than three units of therapeutic services are provided. The three units of service are a minimum threshold that permits unforeseen circumstances, such as medical appointments, while allowing payment, but still maintains the integrity of a comprehensive program.

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d. The following are billing instructions for submission of partial hospitalization claims/services:

(1) Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services. This means that each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of services are reported in Form Locator (FL) 45 "Services Date" (MMDDYY) of the CMS 1450 UB-04.

(2) The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization:

FIGURE 13-2-5 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES AND OTHER MENTAL HEALTH SERVICES OUTSIDE PARTIAL HOSPITALIZATION FOR CY 2009¹

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I ⁵ AND II CODES
0250	Pharmacy	HCPCS code not required.
043X	Occupational Therapy	G0129 ²
0900	Behavioral Health Treatment/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	G0176 ³
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90874, 90877 - 90879, and 90899
0914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829, 90845, or 90865
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	G0177 ⁴

¹ The contractor will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The contractor will not edit for matching the revenue code to HCPCS.

² The definition of code G0129 is as follows:
Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

³ The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

⁴ The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).

⁵ HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

NOTE: Codes G0129 and G0176, are used only for PHPs. Code G0177 may be used in both PHPs and outpatient mental health setting. Revenue code 250 does not require HCPCS.

(3) To bill for partial hospitalization services under the hospital OPSS, hospitals are to use the above HCPCS and revenue codes and are to report partial

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hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

(4) The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X TOB with Condition Code 41) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Level II Partial Hospitalization Payment APC (0176) there must be four or more codes from PHP List B of which at least one code must come from PHP List A. In order to be assigned payment under Level I Partial Hospitalization Payment APC (0175) there must be at least three codes from PHP List B of which at least one code must come from PHP List A. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. (Refer to PHP Lists A and B in [Figure 13-2-6](#)). All other PHP services rendered on the same day will be packaged into the PHP APCs (0175 and 0176). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

FIGURE 13-2-6 PHP FOR CY 2008

PHP LIST A	PHP LIST B	
90818	90801	90846
90819	90802	90847
90821	90816	90865
90822	90817	96101
90826	90818	96102
90827	90819	96103
90828	90821	96116
90829	90822	96118
90845	90823	96119
90846	90824	96120
90847	90826	G0129
90865	90827	G0176
G0410	90828	G0177
G0411	90829	G0410
	90845	G0411

(5) In order to assign the partial hospitalization APC to one of the line items (i.e., one of listed services/codes in [Figure 13-2-5](#)) the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from Q to N.) Partial hospitalization services with SI E (items or services that are not covered by TRICARE) or B (more appropriate code required for TRICARE OPPTS) are not packaged and are ignored in the PHP processing.

(6) Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem will be paid. Only one PHP APC will be paid per day.

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(7) Non-mental health services submitted on the same day will be processed and paid separately.

(8) Hospitals must report the number of times the service or procedure was rendered, as defined by the HCPCS code.

(9) Dates of service per revenue code line for partial hospitalization claims that span two or more dates. Each service (revenue code) provided must be repeated as a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date." Following are examples of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

FIGURE 13-2-7 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - HIPAA 837 FORMAT

RECORD TYPE	REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGE
61	0915	90849	19980505	1	\$80
61	0915	90849	19980529	2	\$160

FIGURE 13-2-8 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - CMS 1450 FORMAT

REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGES
0915	90849	050598	1	\$80
0915	90849	052998	2	\$160

NOTE: Each line item on the CMS 1450 UB-04 claim form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

5. Reimbursement for a day of outpatient mental health services in a non-PHP program (i.e., those mental health services that are not accompanied with a condition code 41) will be capped at the partial hospital per diem rate. The payments for all of the designated Mental Health (MH) services will be totaled with the same date of service. If the sum of the payments for the individual MH services standard APC rules, for which there is an authorization on file, exceeds the Level II Partial Hospitalization APC (0176), a special MH services composite payment APC (APC 0034) will be assigned to one of the line items that represent MH services. All other MH services will be packaged. The MH services composite payment APC amount is the same as the Level II Partial Hospitalization APC per diem rate. MH services with SI E or B are not included in payments that are totaled and are not assigned the daily mental health composited APC amount.

6. Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under [Chapter 7, Section 2](#).