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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 17
7950.2-M
JULY 16, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM), FEBRUARY 2008**

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

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

CONREQ: 14998

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 AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TRM, Change No. 30.



Jack Arendale
Chief, Purchased Care Systems
Integration Branch

ATTACHMENT(S): 9 PAGES
DISTRIBUTION: 7950.2-M

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

CHANGE 17
7950.2-M
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REMOVE PAGE(S)

CHAPTER 2

Section 1.1, pages 9 through 11

Section 2.5, pages 5 and 6

Section 4.1, pages 1 and 2

Section 5.3, pages 5 and 6

INSERT PAGE(S)

Section 1.1, pages 9 through 11

Section 2.5, pages 5 and 6

Section 4.1, pages 1 and 2

Section 5.3, pages 5 and 6

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

All claims submitted by the foreign contract shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Numbers with a '3', or '4', or '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 Overseas Program (TOP). 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 TOP. The BATCH/VOUCHER CLIN/ASAP Account Number with a '6' in position 8 shall be used for all Marine deployed claims covered by TOP.

6.2.2 Criteria For Selecting TMA Non-Financially Underwritten ASAP Account (excludes foreign contract and claims that meet criteria specified under paragraph 6.2.1)

All non-financially underwritten claims shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Number with a '1' in position 8.

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

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 ASAP Type (Pass Through) BATCH/VOUCHER CLIN/ASAP Account Number based on 'Active' Dates (Fiscal Year)

All ASAP Type 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 fiscal years. The BATCH/VOUCHER Date (0-030) is the field TMA shall use when editing for proper selection of ASAP Type BATCH/VOUCHER CLIN/ASAP Account Number based on date. All disbursements shall be made using a currently 'active' ASAP Type 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 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.

6.2.5 Criteria For Selecting CLIN TYPE (UNDERWRITTEN) BATCH/VOUCHER CLIN/ASAP Account Number based on 'Active' Dates (Fiscal Year and Option Period)

All CLIN Type 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 or fiscal year. The BEGIN DATE OF CARE (1-275 or 2-150) is the field TMA shall use when editing for proper selection of CLIN Type BATCH/VOUCHER

CLIN/ASAP Account Number based on date. All disbursements shall be made using the CLIN Type BATCH/VOUCHER CLIN/ASAP Account Number that was 'active' at the time care started. All credits shall cite the original CLIN Type BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement.

7.0 INTERIM INSTITUTIONAL PAYMENTS

7.1 In certain cases, providers can submit interim bills for institutional claims **as a method to facilitate cash flow**. Interim-interim **and interim-final TED records with filing dates before January 1, 2011** must be submitted as an adjustment using the same TED Record Indicator (TRI) as the initial submission.

7.2 Interim-interim and interim-final TED records (FREQUENCY CODES '3' and '4') with filing dates on or after 01/01/2011 **with the exception of interim billings reimbursed under the DRG or Home Health Agency (HHA) payment methodology** must be submitted with a unique TRI and must be submitted on batch/vouchers with HEADER TYPE INDICATOR '0' or '5'. DRG and HHA interim-interim and interim-final TED records will continue to be submitted as an adjustment using the same TRI as the initial submission.

7.3 For claims that are reimbursed under the TRICARE Diagnosis Related Group (DRG) payment methodology please see the TRICARE Reimbursement Manual (TRM), [Chapter 6, Section 3](#) for requirements on submitting DRG interim bills.

7.4 For claims that are reimbursed under the Home Health Agency Prospective Payment System (HHA PPS) methodology, please see the guidelines on submitting interim bills in the TRM, [Chapter 12, Section 6](#).

8.0 PROCESS FOR REPORTING EXTERNAL RESOURCE SHARING ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to External Resource Sharing encounters.

8.1 Special Processing Code

For External Resource Sharing encounters, submit a TED record which includes SPECIAL PROCESSING CODE of 'S' Resource Sharing - External, for each patient encounter.

8.2 "Amount" Field Reporting

The "amount" fields must contain the following:

8.2.1 Amount Billed By Procedure Code

If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated/discounted rates, report these amounts in the Amount Billed By Procedure Code field.

8.2.2 Amount Allowed/Amount Allowed By Procedure Code

The Amount Allowed By Procedure Code field must contain the CHAMPUS Maximum Allowable Charge (CMAC) or negotiated/discounted rates as appropriate.

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

Blood clotting factor reimbursement will be calculated based on the reimbursement methodology described in the TRM. Blood clotting factor charges will not be submitted separately from the DRG reimbursable hospital charges but will be included on the institutional TED record.

9.1 Data Reporting

The following are data reporting requirements specific for TED records containing blood clotting factor charges.

- Revenue Code 0636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor.
- UNITS OF SERVICE will reflect the number of units billed on the claim, not the number of payment units.
- AMOUNT BILLED (TOTAL) is the sum of all billed charges on the claim including charges for the blood clotting factor.
- AMOUNT ALLOWED (TOTAL) is the sum of DRG allowed amount and the allowable reimbursement for the blood clotting factor.

- END -

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 2.5

Data Requirements - Institutional/Non-Institutional Record Data Elements (E - L)

DATA ELEMENT DEFINITION

ELEMENT NAME: FREQUENCY CODE

| RECORD NAME | RECORDS/LOCATOR NUMBERS | | REQUIRED |
|---------------|-------------------------|-------------|------------------|
| | LOCATOR# | OCCURRENCES | |
| Institutional | 1-250 | 1 | Yes ¹ |

PRIMARY PICTURE (FORMAT) One (1) alphanumeric character.

DEFINITION Code that describes the frequency of billing from the institution. **For filing dates before January 1, 2011 all TED records for interim-interim and interim-final institutional bills must be submitted as an adjustment using the same TRI as the initial submission. Effective with filing dates on or after 01/01/2011 all TED records for interim-interim and interim-final institutional bills with the exception of interim billings reimbursed under the DRG or HHA payment methodology must be submitted as a unique TRI. See Section 1.1, paragraph 7.0.**

| CODE/VALUE SPECIFICATIONS | LOCATOR# | DESCRIPTION |
|---------------------------|----------|------------------------------------|
| | 0 | Non-Payment/Zero Claim |
| | 1 | Admit through Discharge TED record |
| | 2 | Interim-Initial TED record |
| | 3 | Interim-Interim TED record |
| | 4 | Interim-Final TED record |
| | 7 | Replacement of Prior Claim |
| | 8 | Void/Cancel of Prior Claim |
| | 9 | Final claim for HHA PPS Episode |

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

| SUBORDINATE | GROUP |
|-------------|--------------|
| N/A | TYPE OF BILL |

NOTES AND SPECIAL INSTRUCTIONS:

¹ The initial, interim, and final TED records must be submitted to TMA in correct sequence. If the person is transferred and the care is processed under DRG rules, then code '1' must be used; all other Transfers must use code '1' or '4' as appropriate.

Effective with filing dates on or after January 1, 2011, interim-interim and interim-final TED records (FREQUENCY CODES '3' and '4') must be submitted on batch/vouchers with HEADER TYPE INDICATOR '0' or '5'. DRG and HHA interim billings are excluded from this requirement.

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Chapter 2, Section 2.5

Data Requirements - Institutional/Non-Institutional Record Data Elements (E - L)

DATA ELEMENT DEFINITION

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE

| RECORD NAME | RECORDS/LOCATOR NUMBERS | | REQUIRED |
|-------------------|-------------------------|-------------|----------|
| | LOCATOR# | OCCURRENCES | |
| Institutional | 1-136 | 1 | Yes |
| Non-Institutional | 2-201 | Up to 99 | Yes |

PRIMARY PICTURE (FORMAT) One (1) alphanumeric character.

DEFINITION The code used to identify for each insured in managed care the category of copayment and deductible they must pay based on external forces for a particular health care coverage period. Actual rates depend on HCDP Plan Coverage Code. Download field from DEERS.

| CODE/VALUE SPECIFICATIONS | | |
|---------------------------|---|--------------------------------|
| | A | Active duty E-4 and below rate |
| | B | Active duty E-5 and above rate |
| | C | Retiree rate |
| | W | Unknown copayment factor |
| | Z | Not applicable |

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

| SUBORDINATE | GROUP |
|-------------|-------|
| N/A | N/A |

NOTES AND SPECIAL INSTRUCTIONS:

If person not on DEERS but claim is payable (i.e., government liability), report 'Z' in this field.

Header Edit Requirements (ELN 000 - 099)

| ELEMENT NAME: HEADER TYPE INDICATOR (0-001) | | | |
|---|---|---|---|
| VALIDITY EDITS | | | |
| 0-001-01V | HEADER TYPE INDICATOR MUST = | 0 | BATCH HEADER (USED ON ALL PROVIDER BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR |
| | | 5 | VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR |
| | | 6 | VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE OR |
| | | 9 | BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) |
| RELATIONAL EDITS | | | |
| 0-001-01R | IF HEADER TYPE INDICATOR = | 5 | VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR |
| | | 6 | VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE OR |
| | | 9 | BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) |
| | THEN BATCH/VOUCHER IDENTIFIER MUST = | 5 | INSTITUTIONAL/NON-INSTITUTIONAL (BATCH/VOUCHER) |
| 0-001-02R | IF CONTRACT NUMBER = (NEW FOREIGN CONTRACT) | | |
| | THEN BYPASS THIS EDIT | | |
| | ELSE IF HEADER TYPE INDICATOR = | 5 | VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR |
| | | 6 | VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE |
| | AND TYPE OF SUBMISSION ≠ | B | ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR |
| | | E | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| | THEN ADJUSTMENT KEY MUST = | 5 | VOUCHER |
| 0-001-03R | IF HEADER TYPE INDICATOR = | 0 | BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR |
| | | 9 | BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK ADMIN CLAIM RATE ELIGIBLE RED RECORDS) |
| IF THE FIRST POSITION OF EACH BATCH/VOUCHER HEADER RECORD IS NOT A '0', '5', '6', OR '9' THEN THE ENTIRE BATCH/VOUCHER WILL BE REJECTED. | | | |

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Chapter 2, Section 4.1

Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: HEADER TYPE INDICATOR (0-001) (Continued)

| | | | |
|------------------|--|----|---|
| | AND TYPE OF SUBMISSION ≠ | B | ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR |
| | | E | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| | AND BATCH/VOUCHER IDENTIFIER = | 5 | INSTITUTIONAL/NON-INSTITUTIONAL |
| | THEN ADJUSTMENT KEY MUST = | 0 | BATCH |
| 0-001-04R | IF HEADER TYPE INDICATOR = | 5 | VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR |
| | | 6 | VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE |
| | AND TYPE OF SUBMISSION = | D | COMPLETE DENIAL OR |
| | | O | ZERO PAYMENT TED RECORD DUE TO 100% OHI |
| | THEN AMOUNT INTEREST PAYMENT MUST = ZERO | | |
| | AND FOR INSTITUTIONAL RECORDS AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO | | |
| | FOR NON-INSTITUTIONAL RECORDS THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO | | |
| 0-001-05R | IF DRG NUMBER IS NOT BLANK OR | | |
| | TYPE OF INSTITUTION = | 70 | HHA |
| | THEN BYPASS THIS EDIT | | |
| | ELSE IF FILING DATE IS ≥ 01/01/2011 | | |
| | AND FREQUENCY CODE ON ANY INSTITUTIONAL RECORD = | 3 | INTERIM-INTERIM OR |
| | | 4 | INTERIM-FINAL |
| | THEN HEADER TYPE INDICATOR MUST = | 0 | BATCH HEADER (USED ON ALL PROVIDER BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR |
| | | 5 | VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE |

IF THE FIRST POSITION OF EACH BATCH/VOUCHER HEADER RECORD IS NOT A '0', '5', '6', **OR** '9' THEN THE ENTIRE BATCH/VOUCHER WILL BE REJECTED.

ELEMENT NAME: CONTRACT NUMBER (0-010)

VALIDITY EDITS

0-010-01V MUST BE A VALID VALUE FOUND ON THE TMA DATABASE.

RELATIONAL EDITS

| | | | |
|------------------|---|-----|---------------------------------|
| 0-010-01R | IF CONTRACT NUMBER = | TBD | TPHARM |
| | AND BATCH/VOUCHER INDICATOR = | 5 | INSTITUTIONAL/NON-INSTITUTIONAL |
| | THEN ALL OCCURRENCES OF RECORD TYPE INDICATOR MUST = | 2 | NON-INSTITUTIONAL |
| | AND ALL OCCURRENCES OF TYPE OF SERVICE (POSITION 2) MUST = | M | MOP |
| | OR ALL OCCURRENCES OF TYPE OF SERVICE (POSITION 2) MUST = | B | RETAIL PHARMACY |

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Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: FREQUENCY CODE (1-250)

VALIDITY EDITS

1-250-01V MUST BE A VALID FREQUENCY CODE

1-250-02V IF DRG NUMBER IS NOT BLANK

| | | |
|---------------------------------|---|--|
| AND TYPE OF SUBMISSION = | A | ADJUSTMENT TO TED RECORD DATA OR |
| | C | COMPLETE CANCELLATION TO TED RECORD DATA OR |
| | I | INITIAL TED RECORD SUBMISSION OR |
| | O | ZERO PAYMENT TED RECORD DUE TO 100% OHI OR |
| | R | RESUBMISSION OF AN INITIAL TED RECORD |
| AND FREQUENCY CODE = | 2 | INTERIM-INITIAL OR |
| | 3 | INTERIM-INTERIM OR |
| | 4 | INTERIM-FINAL |

THEN THE FREQUENCY CODE SUBMISSION MUST FOLLOW THE DIRECTIONS IN THE TABLE BELOW

| FREQUENCY CODE | PREVIOUS TED RECORD FREQUENCY CODE |
|----------------|--|
| 2 | = 2 OR NO PREVIOUS TED RECORD |
| 3 | = 2 OR 3 (PREVIOUS TED RECORD MUST EXIST) |
| 4 | = 2, 3, OR 4 (PREVIOUS TED RECORD MUST EXIST) |

RELATIONAL EDITS

1-250-01R IF PATIENT STATUS = 30 STILL A PATIENT

AND AMOUNT ALLOWED (TOTAL) ≠ ZERO

OR OCCURRENCE OF SPECIAL PROCESSING CODE = T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYER) **OR**

FS TFL (SECOND PAYER)

THEN FREQUENCY CODE MUST = 2 INTERIM-INITIAL **OR**

3 INTERIM-INTERIM

UNLESS TYPE OF INSTITUTION = 70 HHA

THEN FREQUENCY CODE MUST = 2 INTERIM-INITIAL **OR**

3 INTERIM-INTERIM **OR**

7 REPLACEMENT OF PRIOR CLAIM **OR**

8 VOID/CANCEL OF PRIOR CLAIM **OR**

9 FINAL CLAIM FOR HHA EPISODE

1-250-02R IF PATIENT STATUS = 01 DISCHARGED **OR**

02 TRANSFERRED **OR**

20 EXPIRED

THEN FREQUENCY CODE MUST = 0 NON-PAYMENT/ZERO CLAIM **OR**

1 ADMIT THROUGH DISCHARGE **OR**

4 INTERIM-FINAL **OR**

7 REPLACEMENT OF PRIOR CLAIM **OR**

8 VOID/CANCELLATION OF PRIOR CLAIM **OR**

9 FINAL CLAIM FOR HHA PPS EPISODE

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Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: FREQUENCY CODE (1-250) (Continued)

| | | | |
|------------------|-----------------------------------|---|---|
| 1-250-03R | IF PRICING RATE CODE = | H | TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER |
| | THEN FREQUENCY CODE MUST = | 1 | ADMIT THROUGH DISCHARGE |

ELEMENT NAME: TYPE OF ADMISSION (1-255)

VALIDITY EDITS

| | | | |
|------------------|--|------|---------|
| 1-255-01V | VALUE MUST BE A VALID TYPE OF ADMISSION CODE. | | |
| | UNLESS REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS = | 0023 | HHA |
| | OR TYPE OF INSTITUTION = | 70 | HHA |
| | OR AMOUNT ALLOWED (TOTAL) = ZERO | | |
| | OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | 11 | HOSPICE |
| | THEN VALUE MUST BE BLANK OR A VALID TYPE OF ADMISSIONS CODE | | |

RELATIONAL EDITS

| | | | |
|------------------|---|---|---------|
| 1-255-03R | IF TYPE OF ADMISSION = | 4 | NEWBORN |
| | THEN PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO ADDENDUM E, FIGURE 2.E-1). | | |