

DEFENSE HEALTH AGENCY  
UNIFORM BUSINESS OFFICE  
**USER GUIDE**

## Document Change History

Document Version	Posting Date	Description of Change	Affected Sections
1.0	18 January 2008	Updated section	Cosmetic Surgery
1.1	23 March 2009	Updated sections	Overview Air Evacuation Ambulance Services Claims Form Compliance Radiology Uniformed Services Family Health Plan Glossary
		New sections	Civilian Emergency Billing Third Party Collection Program (DD Form 2570)
1.2	10 July 2009	Updated sections	Accounts Receivable Dental Services Durable Medical Equipment and Supplies Pre-Authorizations/Pre-Certifications Revenue Codes
		New section	DD7/DD7A Process
		Deleted section	Report on Program Results (DD Form 2570). This information is covered in Third Party Collection Program Report.
1.3	1 July 2011	Replaced section	Observation
1.4	13 January 2012	Changed Revision date	Appendix C1
		Replaced Instruction Manual with link to current version	Appendix C3
		Changed UB-92 to UB-04	Throughout User Guide
		Updated section title	Glossary & Definitions
1.5	25 November 2013	Added sections	Help Desk Support (formerly Appendix A – Helpdesk & Hotline Support) Billing Inpatient Services Billing Outpatient Services U.S. Coast Guard Billing VA-DoD Resource Sharing Billing

Document Version	Posting Date	Description of Change	Affected Sections
			Appendix A – Procedure to Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate Files
		Revised sections	Overview Helpful Links Ambulatory Procedure Visits DD7/DD7A Reports Process Emergency Department Services File and Table Maintenance Laboratory Services (Codes 80048-89356) Patient Categories (formerly Patient Administration) Pharmaceuticals (formerly Pharmacy Services) Pre-Authorizations/Pre-Certifications Providers Rate Tables Third Party Collection Program – Report on Program Results (DD Form 2570) and UBO Metrics Report
		Changed TMA to DHA	All sections except those that were not revised in this version
		Deleted sections	Billable Encounters replaced with Billing Inpatient Services, Billing Outpatient Services Inpatient Fiscal Year Rates Outpatient Services Not Related to Inpatient Admissions Technicians, Nurses, and “Incident To”
1.6	29 April 2014	Added section	Medicare Claims
		Revised sections	Accounts Receivable Aeromedical Evacuation Coordination of Benefits Elective Cosmetic Procedures (replaces Cosmetic Surgery) Evaluation and Management Services

Document Version	Posting Date	Description of Change	Affected Sections
			Medical Affirmative Claims (MAC) Medical Services Account (MSA) Claims (formerly Medical Services Account (MSA) Billing Forms) Manual Billing Refunds Revenue Codes Uniformed Services Family Health Plan (USFHP) Units of Service
		Deleted sections	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and DME/DMS Rate Table

Note: The date in the footer of each page reflects when any part of the guide was last reviewed or changed. The date that each individual guideline was reviewed appears below the title of that guideline. Reviewing and updating these guidelines is a continuous process. Titles of new and revised sections are highlighted in yellow.

## **TABLE OF CONTENTS**

OVERVIEW.....	- 8 -
HELPFUL LINKS.....	- 10 -
<b>ACCOUNTS RECEIVABLE</b> .....	- 12 -
<b>AEROMEDICAL EVACUATION</b> .....	- 15 -
ALLERGY TESTING/ALLERGEN IMMUNOTHERAPY .....	- 16 -
AMBULANCE SERVICES.....	- 17 -
AMBULATORY DATA MODULE (ADM).....	- 19 -
AMBULATORY PROCEDURE VISITS.....	- 20 -
ANCILLARY LINKING AND HOLD PERIODS.....	- 22 -
ANESTHESIA PROVIDER SERVICES .....	- 25 -
ANTEPARTUM/OUTPATIENT OBSTETRICAL SERVICES .....	- 26 -
BILLING COMBINED MEDICALLY NECESSARY/COSMETIC PROCEDURE WHEN A PORTION OF THE PROCEDURE IS COVERED BY INSURANCE.....	- 27 -
BILLING INPATIENT SERVICES .....	- 30 -
BILLING OUTPATIENT SERVICES .....	- 32 -
BUNDLING/UNBUNDLING SERVICES .....	- 33 -
CASE MANAGEMENT SERVICES .....	- 34 -
CHEMOTHERAPY.....	- 36 -
CIVILIAN EMERGENCY BILLING .....	- 37 -
CLAIM FORMS (Paper) .....	- 38 -
CODING COMPLIANCE EDITOR (CCE) .....	- 41 -
COMPLIANCE .....	- 43 -
<b>COORDINATION OF BENEFITS</b> .....	- 44 -
COSMETIC SURGERY .....	- 45 -
DD7/DD7A REPORTS PROCESS .....	- 46 -
DENTAL SERVICES.....	- 49 -
DIAGNOSIS POINTERS.....	- 50 -
DIALYSIS .....	- 51 -
DoD REIMBURSABLE DISASTER VICTIM .....	- 52 -
EDUCATION SERVICES.....	- 55 -
ELECTROCARDIOGRAM SERVICES .....	- 56 -
<b>ELECTIVE COSMETIC PROCEDURES</b> .....	- 57 -
EMERGENCY DEPARTMENT SERVICES.....	- 62 -
<b>EVALUATION AND MANAGEMENT SERVICES</b> .....	- 63 -
FILE AND TABLE MAINTENANCE .....	- 65 -
GRADUATE MEDICAL EDUCATION.....	- 68 -

HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) CODES.....	- 70 -
HEALTH INSURANCE.....	- 71 -
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).....	- 73 -
HELP DESK SUPPORT.....	- 81 -
IMMUNIZATION/INJECTION/INFUSION SERVICES.....	- 84 -
ITEMIZED POSTING OF RECEIPTS.....	- 85 -
LABORATORY SERVICES.....	- 87 -
<b>MEDICAL AFFIRMATIVE CLAIMS (MAC)</b> .....	- 90 -
<b>MEDICAL SERVICES ACCOUNT (MSA) CLAIMS</b> .....	- 92 -
<b>MEDICARE CLAIMS</b> .....	- 94 -
MENTAL HEALTH SERVICES.....	- 98 -
MODIFIERS.....	- 99 -
NATIONAL DISASTER MEDICAL SYSTEM (NDMS) BILLING.....	- 102 -
OBSERVATION SERVICES.....	- 106 -
OPHTHALMOLOGY, OPTOMETRY & VISION SERVICES.....	- 109 -
OTORHINOLARYNGOLOGY SERVICES.....	- 110 -
PAIN MANAGEMENT SERVICES.....	- 111 -
PATIENT CATEGORIES.....	- 112 -
PHARMACEUTICALS.....	- 113 -
PRE-AUTHORIZATIONS/PRE-CERTIFICATIONS.....	- 117 -
PROLONGED SERVICES.....	- 118 -
PROVIDERS.....	- 119 -
PULMONARY FUNCTION.....	- 121 -
RADIOLOGY.....	- 122 -
RATE TABLES.....	- 123 -
<b>REFUNDS</b> .....	- 125 -
REHABILITATION SERVICES.....	- 126 -
<b>REVENUE CODES</b> .....	- 127 -
SYSTEM CHANGE REQUESTS/SYSTEM INCIDENT REPORTS.....	- 129 -
THIRD PARTY COLLECTION PROGRAM – REPORT ON PROGRAM RESULTS (DD FORM 2570) and UBO METRICS REPORT.....	- 130 -
U.S. COAST GUARD BILLING.....	- 132 -
<b>UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)</b> .....	- 134 -
<b>UNITS OF SERVICE</b> .....	- 135 -
VA-DOD RESOURCE SHARING BILLING.....	- 136 -
APPENDIX A – Procedure to Request DHA UBO Program Office–Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate Files.-	- 139 -
APPENDIX B – UB Claim Form Instructions for Outpatient Services***.....	- 141 -

.....	- 141 -
APPENDIX B1 – UB-04 Claim Form Instructions .....	- 142 -
APPENDIX B2 – UB-04 Claim Form Quick Guide.....	- 160 -
APPENDIX C – CMS 1500 Claim Form Instructions .....	- 166 -
APPENDIX C1 – CMS 1500 (08-05) Claim Form Instructions .....	- 167 -
APPENDIX C2 – Quick Guide to Key Changes in Revised Form CMS 1500 (08-05) .....	- 172 -
APPENDIX C3 – National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version .....	- 176 -
APPENDIX D – Prescription Drug Uniform Claim Form (UCF) .....	- 177 -
APPENDIX D1 – Revised Universal Claim Form Instructions .....	- 178 -
APPENDIX D2 – Universal Claim Form Instructions .....	- 185 -
APPENDIX E – DD7A Instructions .....	- 192 -
APPENDIX F – I&R Instructions .....	- 194 -
GLOSSARY & DEFINITIONS .....	- 196 -

## OVERVIEW

Revised: November 2013

1. General. This user guide provides functional guidance on data collection and Uniform Business Office (UBO) practices and billing procedures for Military Treatment Facilities (MTFs). This is a living document that is updated by the Defense Health Agency (DHA) UBO Program Office as necessary.

2. Background. MTF UBOs recover the cost of health care provided to patients seen in MTFs, as authorized by U.S. law. The DHA UBO Program Office is responsible for developing health care reimbursement rates, setting policy, and providing program oversight for the health care cost recovery programs: Medical Services Accounts (MSA), Third Party Collection (TPC), and Medical Affirmative Claims (MAC). The Services and the National Capital Region (NCR) Medical Directorate establish and operate UBOs at Defense Health Program (DHP) fixed MTFs throughout the world and administer these programs with the overall goal of optimizing the recovery of health care costs. The UBO focus is to: identify billable services and payer information; generate accurate and complete claims; and receive appropriate collections.

2.1. Medical Services Accounts (MSA) activities involve billing and collecting funds for medical, cosmetic, and dental treatment and services from: other government agencies (e.g., Department of Veterans Affairs (VA), U.S. Coast Guard (USCG), National Oceanic and Atmospheric Administration (NOAA), and U.S. Public Health Service (USPHS)); Department of Defense (DoD) beneficiaries; DoD civilians and contractors; Nonappropriated Fund (NAF) employees; authorized foreign military; DoD Dependents School employees; Army and Air Force Exchange Service (AAFES) employees; Secretarial Designees; and civilian emergency patients.

2.2. Third Party Collection (TPC) activities involve billing third-party payers, such as commercial health insurance carriers, on behalf of eligible DoD beneficiaries, excluding Active Duty (AD) members, for their treatment and services.

2.3. Medical Affirmative Claims (MAC) activities involve recovering the cost of furnishing health care to DoD beneficiaries, including AD members, who are injured or suffer an illness caused by a third party. MAC involves billing all areas of liability insurance, such as automobile, general casualty, homeowners and renters, medical malpractice (by civilian providers), and workers compensation (for persons other than federal employees).

3. Reimbursement. Healthcare providers document medical services based on current Military Health System (MHS) guidelines; medical coders use the documentation to assign specific codes to the services and supplies provided; billing systems assign charges to the codes and generate claims; and billing personnel verify accuracy and submit claims. Billing an encounter usually requires at least one International Classification of Diseases (ICD) diagnosis code and one Current Procedural Terminology (CPT®<sup>1</sup>)/Healthcare Common Procedural Coding System (HCPCS) code.<sup>2</sup> Billable charges are recorded as line items on standard medical claim formats (e.g., Uniform Billing form (UB)-04/837I, Centers for Medicare & Medicaid Services (CMS) 1500/837P, National Council for Prescription Drug Programs (NCPDP) D.0, American Dental Association (ADA) claim forms), and MHS billing forms (e.g., Invoice and Receipt (I&R) and Department of Defense (DD) Forms 7 and 7A). Services and supplies are billed at rates according to the patient's category (PATCAT).

---

<sup>1</sup> CPT is a registered trademark of the American Hospital Association

<sup>2</sup> "Pass-through" bills, most commonly used in billing VA-DoD resource sharing encounters, may not always have a CPT/HCPCS code.

3.1. All three cost recovery programs use the same DHA UBO rates highlighted below.<sup>1</sup> The funds collected return directly to the operations and maintenance (O&M) budget of the MTF where the care was delivered and are used to improve the quality of healthcare. Often the funds allow the continuation of programs or purchasing of equipment at the facilities for which there would otherwise not be funding.

3.2. Outpatient Billing. Outpatient billable charges include the cost of clinic encounters and supplies, ambulatory procedure visits (APVs), emergency department (ED) visits, observation visits, dental services, and internally and externally ordered ancillary services (i.e., laboratory, radiology, and clinician administered pharmacy). These services and supplies: may be provided by MTF staff or purchased from outside the MHS; are coded with CPT/HCPCS codes; and are billed as line-items. DHA UBO develops Outpatient Billing rates for these services and supplies.

3.3. Inpatient Billing. Inpatient billable charges include the costs for support staff, facility costs, ancillary services, pharmacy, and supplies. For TPC, MAC, and most MSA, the charges are based on the number of relative weighted products (RWP) associated with the Medicare Severity Diagnosis Related Group (MS-DRG) assigned to the encounter multiplied by Adjusted Standardized Amounts (ASA) rates. Due to MHS data system limitations, adjustments are made for length of stay (LOS) outliers, and the institutional charge is increased to include an allowance for professional services. Under VA-DoD resource sharing agreements, however, professional fees may be billed separately unless prohibited by local sharing agreements. ASA rates are MTF-specific and developed for full /Third Party Collections, Interagency Rate (IAR), and International Medical Education and Training (IMET) billing.

4. Pharmacy Billing. Pharmacy billable charges include the costs for pharmaceuticals provided by MTF pharmacies. For TPC, MAC, and most MSA, the charges are based on the rate of the pharmaceutical's National Drug Code (NDC), the quantity dispensed, and a dispensing fee. For VA-DoD resource sharing, there are separate NDC rate tables and pharmacy dispensing fees.

---

<sup>1</sup> MAC rates must be approved by the Office of Management and Budget and published in the *Federal Register* before they can be used for MAC purposes.

## HELPFUL LINKS

Revised: November 2013

Note: These links may be accessed from this document by pressing CTRL + click (left mouse click over the link until you see the hand).

Armed Forces Health Longitudinal Technology Application (AHLTA): <http://www.ahlta.us/>

Air Force Medicine: <http://www.afms.af.mil/index.asp>

Air Force E-Publishing (includes publications and forms): <http://www.e-publishing.af.mil/>

Army Medicine: <http://www.armymedicine.army.mil/index.html>

Army Publishing Directorate (includes publications and forms): <http://www.apd.army.mil/>

Code of Federal Regulations (CFR) (includes agency regulations):  
<http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>

Defense Health Agency (DHA): <http://tricare.mil/tma/>

[DHA ICD-10 Updates and Newsflash: http://www.tricare.mil/tma/hipaa/icd-10.aspx](http://www.tricare.mil/tma/hipaa/icd-10.aspx)

[DHA Manuals \(i.e., Operations, Policy, System, and Reimbursement\): http://manuals.tricare.osd.mil/](http://manuals.tricare.osd.mil/)

DHA Rates and Reimbursement: <http://www.tricare.mil/tma/Rates.aspx>

DHA Uniform Business Office: <http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm>

[Defense Health Services Systems \(e.g., M2, MDR, CCE, TPOCS\): http://health.mil/DHSS/](http://health.mil/DHSS/)

DoD Comptroller (includes DoD reimbursable rates): <http://www.dod.mil/comptroller/>

[DoD Dictionary of Military Terms \(Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms"\): http://www.dtic.mil/doctrine/dod\\_dictionary/](http://www.dtic.mil/doctrine/dod_dictionary/)

[DoD Health Affairs Policies and Guidelines: http://www.health.mil/HAPolicies.aspx](http://www.health.mil/HAPolicies.aspx)

DoD Issuances (i.e., Directives, Instructions, Publications, and Manuals):  
<http://www.dtic.mil/whs/directives/>

DoD Financial Management Regulations (FMR) 7000.14-R: <http://www.dod.mil/comptroller/fmr/>

Defense Medical Information System [Facility] Identifier (DMIS ID) Table:  
<http://www.tricare.mil/tma/gri/dmis/downloads.aspx>

Embassy addresses and Web Sites: <http://embassy.org/embassies/>

Federal Register (includes agency rules, proposed rules and notices):  
<http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR>

Financial Management Service (FMS, U.S. Treasury) Intra-Governmental Payment and Collection System (IPAC): <http://www.fms.treas.gov/ipac/index.html>

FMS forms and applications (i.e., IPAC, FedDebt, OTCnet):  
[http://www.fms.treas.gov/index\\_systems.html](http://www.fms.treas.gov/index_systems.html)

General Services Administration (GSA) Forms Library: <http://www.gsa.gov/portal/forms/type/TOP>

Navy Medicine: <http://www.med.navy.mil/>

Navy Medicine Directives (includes directives, publications, and forms):  
<http://www.med.navy.mil/directives/>

National Capital Region (NCR) Medical Directorate: <http://www.capmed.mil/SitePages/Home.aspx>

Office of Management and Budget (OMB) (includes reports to Congress and President's budgets):  
<http://www.whitehouse.gov/omb/budget>  
[http://www.whitehouse.gov/omb/legislative\\_reports](http://www.whitehouse.gov/omb/legislative_reports)

OTC Channel Application ("OTCNet", enables federal Agencies to integrate check capture and deposit reporting activities, consolidating management of all check and cash deposits through one web-based application.): <http://www.fms.treas.gov/otcnet/index.html>

United States Code (USC) (for U.S. laws):  
<http://www.gpo.gov/fdsys/browse/collectionUSCode.action?collectionCode=USCODE>

## ACCOUNTS RECEIVABLE

Revised: 29 April 2014

1. General. Accounts Receivable (ARs) are amounts due from the public (nonfederal) or U.S. government organizations or funds (intra-governmental). They must be recognized (i.e., established) and recorded (i.e., posted) for all health care related services and goods provided if they require payment from others. This must be done at the time the right to payment is established (i.e., when the health care is provided); however, public and intra-governmental ARs are recorded separately. Also, because of Military Health System (MHS) billing system limitations and requirements, ARs are recorded (i.e., posted) when a bill is generated, which may be up to 17 days after the service was provided.

2. Authority and Guidance. The Department of Defense (DoD) Financial Management Regulation (FMR) 7000.14R directs statutory and regulatory financial management requirements, systems, and functions for all UBO activities and is available at <http://comptroller.defense.gov/fmr/index.html>. It consists of individual volumes by functional area, including:

1. GENERAL FINANCIAL MANAGEMENT INFORMATION, SYSTEMS AND REQUIREMENTS
4. ACCOUNTING POLICY AND PROCEDURES
5. DISBURSING POLICY
- 6A. REPORTING POLICY
- 6B. FORM AND CONTENT OF THE DEPARTMENT OF DEFENSE AUDITED FINANCIAL STATEMENTS
- 11A. REIMBURSABLE OPERATIONS, POLICY AND PROCEDURES
12. SPECIAL ACCOUNTS, FUNDS AND PROGRAMS
13. NONAPPROPRIATED FUNDS POLICY

*DoD Manual Number 6010.15-M, "Military Treatment Facility Uniform Business Office (UBO) Operations,"* prescribes uniform billing procedures and accounting practices for managing and following up on patient accounts, including collecting, depositing, posting, and reconciliation. It is available at [http://www.tricare.mil/ocfo/mcfs/ubo/policy\\_guidance/manuals.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/manuals.cfm).

3. Types of ARs. ARs for medical services and goods include Medical Services Accounts (MSA), Third Party Collections (TPC), and Medical Affirmative Claims (MAC).

3.1. MSA. MSA includes patient pay and interagency billing.

3.1.1. Civilian Emergencies (CEs). MTF personnel may submit claims to third party payers on behalf of CEs, however the non-beneficiary patient is responsible for the entire claim, including all remaining balances if the payer does not pay in full. Thus, AR should be posted against the non-beneficiary patient.

3.1.2. Foreign military, including Foreign Military Sales (FMS) and International Military Education and Training (IMET). Foreign military, including FMS and IMET, claims are submitted to the individual or other government agency depending on the patient category. If no payment is received, follow your Service or National Capital Region Medical Directorate (NCR MD) specific guidance on processing the bad debt.

3.1.3. Medicare. Medicare claims are submitted to the individual or the MTF's Medicare Administrative Contractor (MAC), depending on Service or NCR MD guidance. If no payment is received, follow your Service or NCR MD guidance on processing the bad debt. Unpaid balances that are neither the responsibility of Medicare nor the patient will be closed in the billing system using the transaction code and sales (source) code identified in your Service or NCR MD-specific guidance. For more information on billing procedures see the "Medicare Claims" section of this User Guide.

3.1.4. Medicaid. Medicaid claims are submitted to the individual or the Medicaid fiscal agent or intermediary, depending on Service or NCR MD guidance. If no payment is received, follow your Service or NCR MD guidance on processing the bad debt. If the MTF chooses to participate in billing Medicaid

for care provided to Medicaid patients, the MTF must have a current, signed agreement with its State Medicaid program. The agreement binds the MTF to accept the Medicaid payment as “payment in full,” with no balance billing to the patient for any amounts not covered. State Medicaid is billed at the full reimbursable rate (FRR). Unpaid balances that are neither the responsibility of the State nor the patient will be closed in the billing system using the transaction code and sales (source) code identified in your Service or NCR MD-specific guidance.

3.1.5. Elective cosmetic surgery. Elective cosmetic surgery procedures must be paid by the patient prior to scheduling the surgery (this includes active duty personnel). However, after the medical record is coded, additional procedures may be coded that were not indicated on the initial estimate provided to the patient. If this occurs, a bill is produced, generating an AR. The patient is billed on an Invoice and Receipt (I&R) statement; if this bill is not paid within 90 days, follow your Service or NCR MD-specific guidance for debt processing. For more information on billing procedures see the “Elective Cosmetic Surgery” section of this User Guide.

3.2. TPC. TPC includes billing private health care coverage payers for inpatient and outpatient care.

3.2.1. Inpatient TPC Accounts

3.2.1.1. TPC is on a “cash basis,” meaning the AR is not currently included in the Service and NCR MD accounting system and is not created until receipt and posting of the funds to the system. Future billing solutions that interface with the financial system will correct this problem.

3.2.1.2. As payments are received and posted (in the MSA module), the AR is reduced. If the claim is not paid in full but was paid correctly, the account is closed manually using the correct write-off code, which reduces the AR further. If the claim was not paid in full and was incorrectly discounted, follow Service or NCR MD guidance.

3.2.2. Outpatient TPC Accounts

3.2.2.1. Outpatient claims may contain numerous line item charges for services rendered. Posting and follow-up may require accounting for and reconciliation of multiple service line item charges.

3.2.2.2. Posting payments, adjustments, and write-offs are itemized. If the claim is not paid in full but was paid correctly, the account is closed manually using the correct write-off code, which reduces the AR further. If the claim was not paid in full and was incorrectly discounted, follow Service or NCR MD guidance.

3.3. MAC. MAC includes billing tort liability or contractually based insurance. Coordinate claims with the MTF’s Military Department–designated Recovery Judge Advocate (RJA) per *the DoD Manual Number 6010.15-M*.

4. Outstanding Accounts. Any account outstanding past 30 days must be followed up in accordance with procedures prescribed in the *DoD Manual Number 6010.15-M*.

5. Delinquent Accounts. TPC accounts outstanding beyond 180 days and MSA accounts outstanding beyond 90 days are considered delinquent. Refer to the *DoD Manual Number 6010.15-M*, and Service or NCR MD guidance for additional instructions.

6. Depositing Collections. All non-intra-governmental TPC and most MSA collections for health care services are deposited in the year of receipt. Intra-governmental MSA collections, however, are deposited in the year services are rendered whether rendered in the current year or a prior year in order to liquidate the intra-governmental receivable established when the services were rendered. Collections for all Defense Health Program (DHP)-funded activities must be in compliance with Assistant Secretary of Defense for Health Affairs (ASD-HA) Memorandum, “Defense Health Program Accounts Receivable

Policy,” dated May 2, 2008.

## AEROMEDICAL EVACUATION

Revised: March 2014; replaces Air Evacuation

General. DHA UBO rates for aeromedical evacuation services represent the cost of providing medical care during aeromedical transport. Appropriate charges are billed by the Global Patient Movement Requirements Center (GPMRC). For more information, see the DHA UBO annual rates letter at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/outpatient.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/outpatient.cfm).

## ALLERGY TESTING/ALLERGEN IMMUNOTHERAPY

Revised: 6 March 2006

1. Allergen immunotherapy is the administration of allergenic extracts at periodic intervals so individuals can be exposed to an allergen while avoiding an adverse reaction. It is a billable service when performed by a privileged provider. When the service is performed by a technician, it is not currently billable due to the issues associated with technician coding accuracy.

2. CPT codes for allergen immunotherapy include the professional services. There may be an Evaluation and Management (E/M) code for the first encounter as the allergist is obtaining the history and examination necessary to determine how to proceed. Except for the first encounter, the services are usually just the procedure and there is no separately identifiable E/M.

3. Allergy testing is not an ambulatory procedure visit. Patients should remain in the area for at least 20 minutes in case there is an allergic reaction, but this is not a “medically supervised recovery.”

4. Allergy Testing CPT codes 95004-95078. These codes are for testing and are billable.

5. Allergen Immunotherapy CPT codes 95115-95199. For billing, there are two basic types of immunotherapy codes, one that includes the provision of the substance, and one that does not include the provision of the substance.

5.1. Allergen Immunotherapy CPT codes 95115-95117. These codes are for the desensitization injection only. They do not include provision of the substance. There are rates associated with these codes and the service should be billed.

5.2. Allergen Immunotherapy with Substance Provided CPT Codes 95120-95170. In the MHS, because patients frequently relocate, Walter Reed Army Medical Center (WRAMC) produces and furnishes allergens/substances. Otherwise, due to the variability in allergens/substances, every time a patient is treated in a new location, the desensitization might have to be repeated. WRAMC furnishes the allergens/substances to the MTFs. WRAMC receives separate funding just for this service. WRAMC does not bill the patient when furnishing the allergen/substance as it is not dispensing it to the patient, but is sending the allergen/substance to the MTF. The MTF where the allergen/substance is dispensed would use the appropriate code from the 95120-95170 series. The allergen is issued to a specific patient, kept in the clinic only for that patient's use, and administered in the clinic. Then for additional injections from the same vial, the allergy clinic will use the 95115-95117 codes.

NOTE: In the civilian sector, allergens/ substances are coded and billed when dispensed.

5.2.1. Codes 95120-95134. The TMA UBO is working with Walter Reed Army Medical Center to determine the average price of an allergen/substance. Until an average price can be determined, there are no prices for the 95120-95134 codes.

5.2.2. 95144-95170. These codes represent both the substance and the injections. Currently, the price of the substance is not included, but the price of the injection(s) is included.

6. The usual revenue code is 924 for those few codes that may map to the UB-04.

7. Billing Form: The allergy testing as well as the antigen dispensing appears on the CMS 1500.

## AMBULANCE SERVICES

Revised: 16 March 2009

1. Ambulance services are not part of the patient visit and will not be captured or coded on the same encounter as the emergency department (ED) visit or office visit.

2. Ambulance services provided to a patient for transportation to another facility for a service and returned to the hospital are not billed separately. This transport is part of the inpatient institutional encounter.

3. Identifying Billable Ambulance Services. The Billing Office can either check for coded encounters in MEPRS FEA or arrange to receive photocopies of ambulance transport sheets from the emergency department.

3.1. Billing for ambulance transport is applicable to both emergency and non-emergency transports. The next step is to determine whether the ambulance service is billable under the Third Party Collections Program (TPCP), Medical Services Accounts (MSA), or Medical Affirmative Claims (MAC).

3.2. When an ambulance service is determined to be billable, request that a coder determine and document (on the run sheet) the appropriate International Classification of Diseases, Ninth Edition, Clinical Module (ICD-9-CM) diagnosis code, Current Procedural Terminology (CPT) code, and modifiers to use for billing.

4. Generating the Bill. Ambulance service bills must be created manually. In the Third Party Outpatient Collections System (TPOCS), create the bill using Bill Type 4. For MSA, create an account and enter a one-time charge of the manually calculated appropriate rate.

4.1. Only HCPCS code A0999 has a DoD Rate assigned; however, claims with A0999 may be denied. On paper claims, manually change HCPCS code A0999 to the appropriate Ambulance HCPCS code documented on the run sheet.

4.2. The biller can select the appropriate modifier to identify location of onload and offload if the coder did not document it on the run sheet. The most common combination is SH.

D	Diagnostic or therapeutic site other than 'P' or 'H' when these codes are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

4.3. MHS Ambulance Billing Units. Currently, MHS ambulance charges are based on hours of service in 15-minute increments. The hourly charge for Ambulance Services is all-inclusive. Supplies and mileage are not billed separately. Billing Offices will calculate the charges based on the number of hours, fractions of an hour, that the ambulance is logged out on a patient run. Fractions of an hour are rounded up to the next 15-minute increment (e.g., 31 minutes are charged as 45 minutes). Refer to the Medical and Dental Services Rate Package for appropriate fiscal year hourly charge. This rate package can be

found on both the TMA UBO Web site and the Comptroller Web site. TPOCS Bill Type 4 form will calculate the charges based on HCPCS Code A0999 and the minutes of service. Manually calculate the charges if creating a one-time charge account in the CHCS MSA billing module.

4.4. Revenue Code. Ambulance Services code A0999 is mapped to revenue code 540 on the revenue code mapping table.

4.5. Occurrence Code. If this transport is related to an injury/accident, use the appropriate occurrence code on the UB-04. Occurrence codes can be found in the Uniform Business Editor or in appendix B-1 of this document.

5. Purchased Services. When a facility purchases ambulance services from a non-DoD source, the cost of the purchased services can be billed instead of the DoD rate. Obtain this information from the Resource Management Division. TPOCS cannot be used to create this type of bill since TPOCS does not allow for changing/adjusting rates. Billing for the actual cost of purchased services requires either creating a "Passthrough" account in MSA or a bill created manually using a typewriter. If the services are purchased or contracted on a flat fee per month/year instead of per run, use the DoD rate.

6. Ambulance Responds but No Transport. When an ambulance is dispatched to an incident, but no patient is transported, there is no appropriate coding or billing for this service.

## AMBULATORY DATA MODULE (ADM)

Revised: 7 March 2006

1. The ADM is the data collection module in CHCS for both inpatient and outpatient professional services. Data collected in AHLTA (the CHCS electronic documentation module for some outpatient encounters) flow to ADM. Data may be entered directly in the ADM, which is frequently the case for specialties not currently in AHLTA such as obstetrics, anesthesiology, and emergency medicine.
2. Inpatient Professional Services. Upon admission, transfer to another service and the census hour (i.e., 0015 each morning), an encounter will be generated in the ADM module. These uncoded encounters are not viewable by the provider in his open/uncoded encounter list.
  - 2.1. It is intended that inpatient professional encounters will be coded by the inpatient coders at the same time the inpatient professional coding is entered in CHCS. This is because the documentation is kept in the inpatient record. All professional services where the provider's time is collected his time in the "A\*\*\*\*" MEPRS are included in the MHS inpatient composite bill. Therefore, inpatient professional services shall not be billed separately if there is an inpatient institutional bill.
3. ADM data flow to the Coding Compliance Editor (CCE). CCE data flow to TPOCS.
4. Coders may correct coding in the ADM. To correct coding in AHLTA, the provider must amend the encounter in AHLTA.

## AMBULATORY PROCEDURE VISITS

Revised: November 2013

1. General. An ambulatory procedure visit (APV) is a procedure or surgical intervention that requires pre-procedure care, an actual procedure to be performed, and immediate post-procedure care as directed by a qualified health care provider. Minor procedures that are performed in an outpatient clinic setting that do not require post-procedure care by a medical professional are not considered APVs. The nature of the procedure and the medical status of the patient combine as a short-term care requirement, but not for inpatient care. These procedures are appropriate for all types of patients (e.g., obstetrical, surgical, and non-surgical) who, by virtue of the procedure or anesthesia, require post-procedure care and/or monitoring by medical personnel. (Within this user guide, “provider” refers to a “physician or other qualified health care professional.”)

1.1. Pre- and post-operative appointments are documented in the Ambulatory Data Module (ADM) of the Composite Health Care System (CHCS) as separate encounters.

1.2. If the APV is scheduled in advance, the encounter during which the decision for the procedure is made, the pre-operative physical, and the procedure will be coded and billed as separate encounters.

1.3. If the procedure is emergent (e.g., dislocation of the shoulder), the encounter during which the decision for procedure is made may be the same day as the procedure. It is coded with a modifier -57 and also billed separately from the procedure.

1.4. Post-operative care after discharge is also coded separately as Current Procedural Terminology (CPT®<sup>1</sup>) code 99024. There is no rate for this code.

2. Components. Typically two major components of the APV are collected in the same ADM record: professional and institutional. The professional component may be submitted as a single claim or broken into separate ones on a Centers for Medicare & Medicaid Services (CMS) 1500 paper or 837P electronic claim. The institutional component is coded with CPT code 99199 and is submitted on a Uniform Bill (UB)-04 paper or 837I electronic claim. Depending on the payer, claims may be paid if submitted as they are created by the billing system. Some payers will not permit the surgical procedure and the anesthesia to be on the same claim. In that case, cancel the original CMS 1500/837P claim where they were combined and generate two separate ones.

2.1. Professional Component. The professional component of an APV includes professional charges covering the pre-operative examination of the patient, the actual procedure(s) performed, and follow-up for the procedure. Identify all providers (e.g., anesthesiologist) for each procedure.

2.2. Institutional Component. The institutional component of an APV includes charges for the use of Military Health System (MHS) facilities, supplies, nursing and ancillary services, and anesthesia pharmaceuticals until the patient is discharged. In the MHS, per DoD Health Affairs Policy, “Use of CPT® Code 99199” (dated 14 Sept 2004), the institutional component of the APV is coded with CPT code 99199; submit this on a UB-04/837I claim.

3. Admission from an Ambulatory Patient Unit (APU). If an APV encounter leads directly to an inpatient admission, do not bill APV institutional or professional charges for Third Party Collections (TPC), Medical Affirmative Claims (MAC), and most Medical Services Accounts (MSA) encounters because those charges are included in the inpatient charge.

---

<sup>1</sup> CPT is a registered trademark of the American Medical Association.

3.1 Exception: For Department of Veterans Affairs (VA)-DoD resource sharing agreement care, bill the professional charges for APVs unless prohibited by your local sharing agreement. (See the *VA-DoD Resource Sharing Billing* section of this User Guide for the menu path to identify professional charges.)

3.2 Exception: If the patient is admitted following the APV with a diagnosis unrelated to the APV pre-operative diagnosis, bill the APV and the inpatient admission separately.

4. Discontinued Procedures. Do not generate claims with modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) or modifier -74 (Discontinued Outpatient [Procedure] After Anesthesia Administration) as these are institutional modifiers, and the 99199 is a flat rate code. If there was a procedure, the entire 99199 fee will be charged.

5. Multiple Primary Providers. Modifier -62 added to a CPT code refers to two providers who worked as primary together performing distinct part(s) of a procedure. Modifier -66 refers to a surgical team of more than two providers. Billing personnel may create separate claims for each provider.

6. Assistant Providers. Modifier -80 identifies an assistant provider's services; modifier -81 identifies services of minimum assistant providers. Billing personnel may create separate claims for procedures coded with either of these modifiers.

7. Revenue Codes Applicable to APVs. Refer to the Defense Health Agency (DHA) UBO revenue mapping table available at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm) for revenue codes applicable to APVs.

## ANCILLARY LINKING AND HOLD PERIODS

Revised: 7 March 2006

1. The only time a diagnosis will automatically be linked to a laboratory, radiology or prescription, is when the laboratory test, radiology study, or prescription was ordered in CHCS in conjunction with an outpatient encounter. When the Ordering Provider selects the clinical encounter that relates to the ordered ancillary, both the clinical encounter and the ancillary service are assigned a matching Appointment Internal Entry Number (IEN). This Appointment IEN is then used to match the two encounters once transmitted to TPOCS, during which time the diagnosis code from the clinical encounter is shared with the ancillary service. Note: The LAB, RAD, and PHR sub-systems within CHCS do not have a field to capture the diagnosis code. System Change Requests (SCRs) were submitted requesting this additional field. NOTE: Linking ancillary procedures to diagnoses from the outpatient encounter only applies to TPOCS billing. The diagnosis does not appear on the Invoice and Receipt, the DD7, the DD7A, or the MSA generated UB-04 for inpatient TPC billing.

2. Ancillary services bills are associated with an ADM encounter bills in one of two ways:

2.1. Imposing mandatory Hold Periods after records are transmitted to TPOCS. All encounter and ancillary data is held in a TPOCS suspense file, during which time the system will attempt to match the ancillary to the visit based on Treating DMIS ID, Patient ID, Date of Service, Requesting Location, and Ordering Provider. If all of the criteria match, TPOCS will link the ancillary service to the ADM encounter.

2.1.1. If the ADM encounter is linked, this will result in the ICD-9-CM diagnosis code from the ADM encounter being reported properly. Note: Currently, when the ancillary service is linked with the ADM encounter, the date and provider of the outpatient encounter are reported for all procedures. This could be incorrect when billing a radiology study that was interpreted five days after the outpatient encounter by a radiologist. This could result in an invalid claim, as usually insurers do not expect family practice providers billing for interpretations of CT scans of the cardiovascular system. In addition, sometimes the first listed diagnosis is not the diagnosis which should be linked to the ancillary test/study/prescription. Attention to appropriate diagnosis code and procedure code links is required to ensure that a potentially invalid claim is corrected before submission.

2.1.2. Billing Office personnel may review the associated diagnoses and link a diagnosis to the procedure. Staff may not input a diagnosis which was not in the Ambulatory Data Module (ADM) record. Staff may "unlink" a diagnosis.

2.2. If an ancillary service cannot be linked, the data is processed as a stand-alone service. An ICD-9-CM diagnosis code will NOT be automatically included on the claim. Manual review is required for claims without an associated ICD-9-CM code.

2.2.1. Any identified LAB or RAD claim without an ICD-9 diagnosis should not be billed until the appropriate diagnosis is matched to the service. This usually involves reviewing the documentation that caused the LAB or RAD to be ordered.

2.2.2. An ICD-9 diagnosis code is required on a UB-04. It is not required on a UCF unless the medication dispensed is a controlled substance.

3. Externally Ordered Ancillary Services. Because there is no outpatient encounter at the MTF to link to externally-ordered ancillary services, an ICD-9-CM diagnosis will not automatically be associated with the ancillary service. Therefore, no ICD-9-CM diagnosis code will transmit to TPOCS. An ICD-9-CM diagnosis code must be entered manually into TPOCS in order to complete the claim. Obtaining the correct diagnosis may involve contacting the civilian provider who ordered the service.

4. ADM records are no longer rejected if a linked ancillary comes to TPOCS first. It used to be that if an ancillary service that had been linked in CHCS to an ADM encounter entered TPOCS first (ADM

encounter not completed within three days), TPOCS rejected the ADM encounter. This was because TPOCS was programmed to receive ADM encounters prior to ancillary encounters and not in the reverse manner to avoid duplicate billing.

4.1. It is still good practice to ensure that ADM encounters are coded as soon as possible. There is an MHS policy that outpatient encounters should be coded within 72 hours of the encounter. For APVs and excisions of lesions in the office, this may be slightly delayed to ensure the laboratory results are back so the excisions can be correctly coded as benign or malignant.

NOTE: This applies to both TPOCS billing (for patients with OHI) and MSA billing (for patients with PATCATs that generate MSA bills such as civilian emergency and interagency).

5. Hold Periods. Hold periods have nothing to do with diagnoses. Hold periods are the amount of days a bill will remain in “limbo” until it prints out or is sent electronically. Hold periods are in place to consolidate bills.

5.1. In CHCS, a 3-day hold period is standard for all eligible ADM, LAB, RAD, and PHR records. This 3-day hold can be very useful.

5.2. All DD Form 2569s should be collected and entered daily. Because of the 3-day hold, if OHI is identified at an encounter, it permits the MTF to verify and enter the data to have the encounter automatically flow to the billing system.

5.3. Pre-certifications/Pre-authorizations. The 3 days can also be used to obtain pre-certifications and pre-authorizations. Billing personnel should work with radiology, pharmacy, and the operating room. If billing personnel can receive a list of all patients receiving MRIs and CTs, high cost pharmaceuticals and having APVs, the lists can be checked to identify patients with OHI. Pre-certifications can then be obtained prior to the bill flowing to the billing system.

5.4. At the end of the 3-day hold period, MSA encounters are transmitted to the MSA billing module in CHCS. TPC encounters that have been associated with other health insurance (OHI) are transmitted to TPOCS at the end of the 3-day hold period.

6. MSA hold period. An additional 14-day hold period is imposed to allow for the finalization of associated services and to allow for appending and excluding charges as necessary. All MSA services performed on the same date of service for the same patient are printed on the same I&R.

7. TPOCS hold periods.

7.1. ADM, LAB, and RAD Services – The hold period for laboratory and radiology is a site parameter from 7 to 99 days. Usually a 7-day hold (in addition to the 3 days to flow to TPOCS) period is imposed on ADM and LAB/RAD services to: 1) allow for the finalization of associated services; 2) reduce the number of claim forms produced; 3) receive automated updates from the ADM, LAB, and RAD sub-systems in CHCS; and 4) associate an ICD-9-CM diagnosis code from the corresponding ADM encounter to the ancillary service.

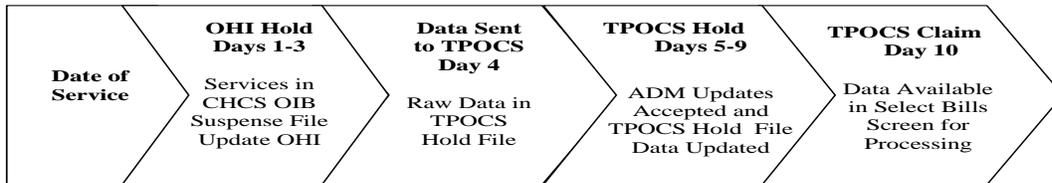
7.2. ADM and LAB/RAD bills are not usually printed on the same bill as usually ADM encounters (e.g., office visits) are printed on a CMS 1500 and the laboratory and radiology bills are on the UB-04. The laboratory and radiology bills “pull” the diagnosis from the ADM encounter.

7.2. PHR (Pharmacy) Services - An additional 14-day hold period is imposed on PHR services to allow for medications to be picked up by the patient.

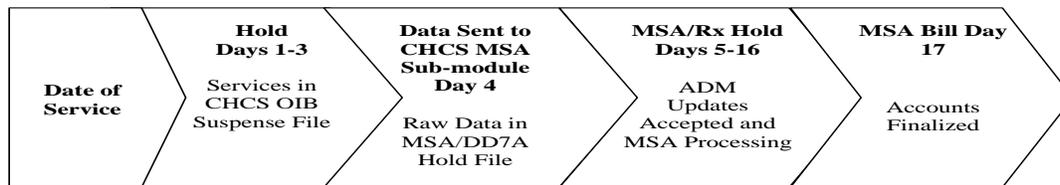
7.2.1. Note: The date of service for pharmacy services is the date the label was printed; however, the transaction cannot be closed until the medication is picked up. Even if PHR services have a corresponding ADM encounter, all services will default to a Pharmacy Bill Type, and will display the associated ICD-9-CM diagnosis code of the ADM encounter. If the medication is not picked up, it is the

responsibility of the MTF pharmacy to re-stock the supply, and clear out the claim in TPOCS prior to the 14<sup>th</sup> day when the bill will release.

### Billing Cycle Timeline for TPC



### Billing Cycle Timeline for MSA



## ANESTHESIA PROVIDER SERVICES

Revised: 6 March 2006

1. See the APV Section of this Guide for billing anesthesia services in the 0XXXX range associated with an APV. The codes in the 0XXXX range include the initial anesthesia consult prior to the surgical procedure, the anesthesia provided during the surgical procedure, and anesthesia care provided post operatively until care for the patient is transferred to the nurse in the post anesthesia care unit. Separately codable procedures not in the 0XXXX range performed during an APV will be billed on a separate CMS 1500 from the surgeon.

1.1. For outpatient anesthesia services in non-MTFs (e.g., external resource sharing), the anesthesia will be billed on a CMS 1500 at the anesthesia rate.

2. Services provided by anesthesia personnel that are not in the 0xxxx range should be billed on a separate CMS 1500. For instance, when anesthesia personnel are providing outpatient pain management services, the services would be coded in the anesthesia provider's name in the "B" MEPRS.

3. Inpatient Anesthesia Services. Inpatient anesthesia services are part of the Adjusted Standardized Amount and will not be billed separately. Inpatient post-operative pain management is part of the surgeon's responsibility and would not be furnished by anesthesia personnel unless there was a written request in the inpatient record.

3.1. For inpatient anesthesia services in non-MTFs (e.g., if the MHS furnishes anesthesia at a civilian hospital under a external resource sharing agreement), the anesthesia services are included in the professional component percentage (For FY2006, it is 7 percent). The surgeon's and anesthesia provider's services would be itemized on the CMS 1500 without itemized pricing, and a final line indicating "Inpatient Professional Services for DRG \_\_," and the professional component price.

## ANTEPARTUM/OUTPATIENT OBSTETRICAL SERVICES

Revised: 7 March 2006

1. 0500, 0501F, 0502F, and 0503F do not have rates.
2. MHS inpatient obstetrical (OB) services diagnosis related groups (DRGs) do not include antepartum or postpartum care.
3. The MHS does not bill for antepartum care until after the patient has delivered.
4. Work with your systems personnel to generate a monthly ad hoc that reports:
  - 4.1. Patient name;
  - 4.2. All encounters with 0500F – initial prenatal care visit, 0501F – prenatal flow sheet documented in the medical record by first prenatal visit, 0502F – subsequent prenatal care visit, 0503F – postpartum care visit, 59430 – postpartum care only;
  - 4.3. Date of patient's last menstrual period (LMP).
5. When you see a patient with a 0503F or 59430, there is an outcome of pregnancy.
  - 5.1. In those instances where the patient does not deliver at your facility or changes location of antepartum care, you will not see an encounter with 0503F or 59430. Coordinate with coding staff to determine when it would be appropriate to submit the antepartum bill (e.g., nine months after the 0500F or 0501F encounter).
  - 5.2. To produce a bill, identify all encounters for each patient that is coded with 0500F, 0501F, and 0502F.
6. CPT codes 59425, 59426, and 59430 are called "clump codes." The encounter coded with 59430 has a rate and will generate a billable encounter.
  - 6.1. Provide this information to coding staff, requesting that they identify which provider should appear on the bill and which clump code should be billed:
    - 6.1.1. 4-6 encounters, 59425
    - 6.1.2. 7 or more encounters, 59426
  - 6.2. Create a manual bill in either TPOCS or the MSA module of CHCS.
  - 6.3. These clump codes are mapped to the CMS 1500 in TPOCS.
  - 6.4. If the patient was seen for fewer than four encounters, ask coding staff to re-code these encounters based on documentation for regular E&M codes.
    - 6.4.1. Create manual bills in either TPOCS or the MSA module of CHCS based on these E&M codes.
    - 6.4.2. These E&M codes are mapped to the CMS 1500 in TPOCS.

## BILLING COMBINED MEDICALLY NECESSARY/COSMETIC PROCEDURE WHEN A PORTION OF THE PROCEDURE IS COVERED BY INSURANCE

Revised: 9 March 2006

1. The total procedure will be composed of:

1.1. Medically necessary professional component

1.2. Cosmetic professional component

1.3. Institutional and anesthesia (I&A) components

NOTE: The patient is totally responsible for the I&A, but the insurer may pay some of the I&A as part of the medically necessary procedure. There are two different types of funds involved, third party and MSA.

2. The MHS is moving from flat rate institutional and anesthesia (I&A) billing for ambulatory procedure visits (APVs) to fee-for-service for institutional and anesthesia for APVs. MHS current cosmetic procedure billing is similar to fee-for-service. The current Third Party Collections is a flat rate for institutional and anesthesia.

3. Professional Components. The medically necessary *professional* component will be paid by the insurance company. The cosmetic *professional* component will be paid by the patient.

4. Institutional and Anesthesia (I&A) Components. Both entities are responsible for the I&A components, but the MTF needs to recover the I&A costs just once. The patient is ultimately responsible for the entire cost of the *cosmetic* procedure (e.g., professional, institutional, anesthesia, implants).

5. Steps to Determine the Institutional and Anesthesia (I&A) Amounts Due From the Insurance Company and the Patient.

5.1. Calculate the I&A cost for both the medically necessary procedure covered by the insurance company and the cosmetic procedure.

5.1.1. Example: A patient is having a bilateral blepharoplasty, *upper* eyelid; with excessive skin (CPT code 15823), which is covered by insurance as it is medically necessary. During the same APV, the patient will also have a cosmetic bilateral blepharoplasty, *lower* eyelid, with excessive skin (CPT code 15821). It will be performed in a bedded MTF in the operating room with general anesthesia.

NOTE: Be sure to obtain a pre-authorization for the medically necessary procedure from the insurance company.

5.1.1.1. The I&A components for the medically necessary (*insurance pays*) procedure in a bedded MTF operating room will be:

Institutional (MHS CPT 99199) flat rate = \$819.18  
Anesthesia MHS flat rate = \$749.00  
**Insurance I&A Total = \$1,568.18**

5.1.1.2. The I&A components for the cosmetic (*patient pays*) procedure, in a bedded MTF operating room, will be:

CPT 15821 Institutional in bedded OR = \$875.01  
CPT 15821 Anesthesia = \$236.99  
**Patient I&A Total = \$1,112.00.**

5.2. The institutional/anesthesia “MTF I&A Amount to be Collected” will be the higher of the two amounts.

5.2.1. Example: In the above example, the medically necessary procedure has the higher I&A total cost so that will be the MTF I&A *amount to be collected*.

MTF I&A AMOUNT TO BE COLLECTED: \$1,568.18.

5.3. The patient must pay for the total cosmetic procedure in advance. Therefore, the patient will pay the professional, I&A and implant fees of the cosmetic procedure in advance.

5.3.1. Example: CPT 15821 Professional fee (first eye \$449.73 + bilateral \$224.87) = \$674.60  
CPT 15821 I&A (CPT 15821 Institutional + CPT 15821 Anesthesia) in bedded  
operating room = \$875.01+ \$236.99 = \$1,112.00  
CPT 15821 Implants = \$0  
Patient Will Pay Total In Advance: \$1,786.60

5.4. Insurance will be billed:

5.4.1. Example: CPT15823 Professional fee (first eye 529.37 + bilateral \$264.69) = \$794.06 on the CMS 1500

Institutional (MHS CPT 99199) flat rate = \$819.18 on the UB-04  
Anesthesia flat rate= \$749.00 on the CMS 1500  
Bills to insurance company will total: \$2362.24

5.5. Remittance will be received from the insurance company. The professional fee for the surgeon will be posted. The remittance from the institutional and anesthesia (I&A) portions will be added together. Subtract the institutional and anesthesia portions from the MTF I&A Amount to be Collected determined in step 5.2.1.

5.5.5. Example: Because the patient needed to satisfy the annual deductible of \$500, the insurance company remitted \$768.18 for the institutional component and \$300 for the anesthesia component, for a total of \$1,068.18. The MTF Amount to be Collected is \$1,568.18 from step 5.2.1. The insurance company reimbursement is less than the MTF I&A Amount to be Collected by \$500.

NOTE: (Insurance institutional and anesthesia remittance + patient institutional and anesthesia payment) – MTF I&A Amount to be Collected = amount due back to patient.

5.6. Determine if the I&A component paid by the patient for the cosmetic procedure is more than or less than the amount necessary to meet the MTF I&A Amount to be Collected.

5.6.1 When the total of the amounts received for I&A (from both insurance company and patient) exceed the MTF I&A Amount to be Collected, the patient will be refunded the overage.

5.6.1.1. Example: For the institutional and anesthesia, the patient had paid \$1,112.00. As the MTF only needs \$500 to meet the MTF I&A Amount to be Collected of \$1,568.18, the MTF will refund the patient \$612.00.

5.6.2. If the I&A payments combined are less than is necessary to meet the MTF I&A Amount to be Collected there will be no refund to the patient.

5.6.2.1. Example: The I&A payments exceed the MTF I&A Amount to be Collected, so this step does not apply.

6. MSA and TPOCS Instructions.

6.1. Generate the patient's bill using the amounts calculated by the Cosmetic Surgery Estimator tool.

- 6.1.1. Enter the amounts in MSA.
- 6.1.2. Collect the total amount from the patient.
- 6.2. TPOCS will generate a bill for the insurance company. Send the bill. Post the funds received.
- 6.3. If the total I&A received (from insurer and patient combined) exceeds the MTF I&A Amount to be Collected,
  - 6.3.1. Go in to the original MSA account for the surgery.
  - 6.3.2. Generate a One-Time Charge for the new institutional amount (\$263.01, see below calculations).
  - 6.3.3. Back out the original amount for the institutional (\$875.01).
  - 6.3.4. This should create a credit balance (\$612.00). When you get the credit balance you will be given a notify message that a refund is due on the account. And you can produce the SF 1049 Public Voucher for Refund.
  - 6.3.5. Refund the amount to the patient.
7. Calculations for updating the original MSA Bill.
  - 7.1. MTF I&A Amount to be Collected = \$1,568.18
  - 7.2. Insurance company I&A remitted \$1,068.18 (\$ 768.18 for the institutional and \$300 for the anesthesia)
  - 7.3. Patient originally I&A paid \$1,112.00 (\$875.01 for the institutional and \$236.99 for the anesthesia)
  - 7.4. New I&A amount owed by patient ( $\$1,568.18 - \$1,068.18$ ) = \$500.00
  - 7.5. Excess Remittance ( $\$1,068.18 + \$1,112.00$ ) - \$1,568.18 = \$612.00
  - 7.6. New I&A amount owed by patient to be entered in MSA module  $\$875.01 - \$612.00 = \$263.01$  for the institutional.
  - 7.7. Leave the anesthesia bill in MSA as it was originally (\$236.99). This is just easier than trying to adjust both the anesthesia and institutional bills.

## BILLING INPATIENT SERVICES

**Revised: November 2013**

1. General. Inpatient bills are submitted on Uniform Bill 04 (UB-04) paper or the 837I electronic claim formats based on the Medicare Severity Diagnosis Related Group (MS-DRG) assigned to the episode of care. Each MS-DRG assignment translates to a number of relative weighted products (RWPs)—a common measure of inpatient workload. The number of RWPs associated with an episode of care may be adjusted upward based on the length of stay (LOS) when the LOS exceeds the long LOS outlier criteria for the MS-DRG. MS-DRGs, associated RWPs, and LOS outlier criteria are established by TRICARE. The inpatient charge is computed by multiplying the total episode RWPs (base MS-DRG RWPs plus LOS adjustment, if any, by the appropriate Military Treatment Facility (MTF)-adjusted standardized amount (ASA)). The ASA is the MTF's approved charge per RWP.

1.1. The individual ASAs, including examples of how to calculate the reimbursement charge, are updated each fiscal year (FY) and published in the annual rates letters on the Defense Health Agency (DHA) UBO website (<http://www.tricare.mil/ocfo/mcfs/ubo>).

1.2. MS-DRG weight tables are updated in Military Health System (MHS) systems each fiscal year; hold inpatient billing beginning 1 October until the new weight tables are updated.

1.3. Do not bill an inpatient service if there is no rate.

2. Third Party Collections (TPC), Medical Affirmative Claims (MAC), and most Medical Services Accounts (MSA). Charges are computed based on MTF-specific ASAs (e.g., the MTF's cost structure, including indirect medical education (IME) costs). ASAs include the cost of both inpatient institutional (93%) and professional (7%) services and apply to reimbursement from TPC, MAC, MSA, International Military Education and Training (IMET), and Interagency Rate (IAR) payers. Since the professional services reimbursement is bundled into the MS-DRG institutional claim, do not charge separately for professional services.

2.1. MTFs without inpatient services, but whose providers deliver inpatient care in a civilian facility, bill professional charges at the approved DHA UBO Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) rates for their locality.

2.2. In the absence of an MTF-applied ASA rate for the facility, use the high, low, or overseas ASA rate based on the average for the type of core-based statistical areas (CBSA) in which the MTF is located. Contact the [UBO.Helpdesk@altarm.org](mailto:UBO.Helpdesk@altarm.org) to determine the applicable CBSA.

2.3. For inpatient services provided under Department of Veterans Affairs (VA)-DoD resource sharing agreements, the MS-DRG payment is based on the TRICARE ASA—the level of reimbursement TRICARE will allow—rather than the DHA MTF cost-based ASA. (See the VA-DoD Billing section of this User Guide for instructions on billing Resource Sharing Agreement care.)

2.4. For inpatient services provided to U.S. Coast Guard (USCG) beneficiaries at Army, Navy, and National Capital Region (NCR) Medical Directorate facilities, the USCG makes prospective payments to the DoD. Do not bill USCG for these beneficiaries. These payments do not include reimbursement for other health insurance (OHI); bill payers if beneficiaries carry OHI. (See the USCG Billing section of this User Guide for USCG billing instructions and for billing inpatient services provided at Air Force facilities).

3. Inpatient admissions from Emergency Department (ED). Do not bill the institutional charges incurred in the ED when the patient is admitted from the ED. For TPC, MAC, and most MSA patients, do not bill the professional charge because the inpatient institutional charge includes an allowance (7%) for professional services.

3.1. For services provided under VA-DoD resource sharing agreements, bill professional services separately unless otherwise agreed to in local agreements. (See the VA-DoD Billing section of this User Guide for instructions on billing Resource Sharing Agreement care.)

3.2. As with other inpatient and outpatient services, Army, Navy, and NCR Medical Directorate MTFs do not bill the USCG for ED services. (See the USCG Billing section of this User Guide for USCG billing instructions.)

4. Family Member Rate (FMR). In addition to billing inpatient charges as explained in this section, bill all DoD beneficiaries the FMR except: (a) family members of Active Duty personnel enrolled in TRICARE Prime, and (b) members whose OHI has been billed. The FMR is updated each fiscal year and is published in the ASA rates letter.

## BILLING OUTPATIENT SERVICES

Revised: November 2013

1. General. Services that are not related to a hospital admission are billed as outpatient services.
2. Outpatient Billing Rates. DHA UBO rates are developed on the calendar year 1 July to 30 June, are specific to an MTF's locality and the Provider Class, and are published in the annual rates letter on the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/outpatient.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/outpatient.cfm). (See the *Rates Table* section of this User Guide for which outpatient rates tables to use.)
3. Outpatient Charges. To compute total charges, use the outpatient rates effective on the date of service assigned to the Current Procedural Terminology (CPT®<sup>1</sup>)/Healthcare Common Procedure Coding System (HCPCS) code. If the code includes modifiers, see the *Modifiers* section of this User Guide for additional billing guidance.
4. Non-Billable Services. For Third Party Collections (TPC), Medical Affirmative Claims (MAC), and most Medical Services Account (MSA) patients, do not bill services within the emergency department (ED) prior to an admission or outpatient services within three (3) days prior to an admission if the diagnoses are the same in both cases. These services are considered "incident to" the admission, and the inpatient charge covers these services—both institutional and professional.
5. Department of Veterans Affairs (VA)-DoD Resource Sharing Agreements. Under VA-DoD Resource Sharing Agreement care, the institutional component of the ED visit is not billable if the patient is admitted. VA-DoD local resource sharing agreements may allow billing for professional charges, including those connected to an admission. (Refer to your local VA-DoD Resource Sharing Agreement(s)).
6. Billing for Services and Supplies Not in Standard Rate Files. An outpatient service cannot be billed if the Defense Health Agency (DHA) UBO has not established a rate for the item or service. However, under certain circumstances, if there is a TRICARE or Centers for Medicare & Medicaid Services (CMS) rate, the DHA UBO will review an out-of-cycle request. Follow the *Procedure To Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate* in Appendix A for submitting a request.

---

<sup>1</sup> CPT is a registered trademark of the American Medical Association.

## BUNDLING/UNBUNDLING SERVICES

Revised: 8 March 2006

1. Bundling. Inclusive grouping of codes related to a procedure when submitting a claim. These are generally considered services that are included as an integral part of the procedure or service.

1.1. Bundling is a coding concept originated to simplify billing and decrease the number of claims. For instance, the code for dialysis is for an entire month's services, not each time dialysis is performed. This is because dialysis patients tend to have long-term dialysis, frequently 10-15 times each month. Bundling the services into one bill decreases billing and payer workload.

1.2. There are issues related to bundling in the MHS because the MHS data collection system attempts to provide credit to each provider for each encounter. For instance, there is a global code for the entire professional component for obstetrical services from the time the pregnancy is diagnosed, including the delivery, to the post-partum encounter. One code, one bill. However, in the MHS, you may have different providers performing part of the care. Each provider should have a part of the workload credit. Therefore, in the MHS, coders do not use the global obstetrical code of 59400.

1.3. Bundling involves minor services that are included in a larger service.

1.3.1. Example: If a patient has an office visit and the provider draws blood to send to the lab, the drawing of blood is included in the office visit. However, if the patient reports directly to the laboratory, the laboratory has a separate code for blood drawing.

1.3.2. Example: During a surgery, any incision made must be repaired. The repair is not coded separately, but is part of the surgery. Whereas, if a patient cuts himself with a knife and the emergency room doctor puts in nine stitches, the doctor will code just for the surgical repair.

2. Unbundling. Breaking a single service into its multiple components to increase total billing charges. *Fragmentation* is the same as unbundling.

2.1. It is not unbundling to separately bill antepartum services, delivery, and post partum services in the MHS as it does not increase the total billing charges. This is because the professional component of the delivery is 4% of the institutional component, significantly less than if the delivery was billed as an independent professional component not associated with the delivery.

### Example:

Bundled code (correct):           80048 Basic metabolic panel

This is the correct code to use when coding for all of the following: Carbon dioxide (82374), creatinine (82565), chloride (82435), glucose (82947), potassium (84132), sodium (84295), urea nitrogen (BUN) (84520) and calcium (82310).

Unbundled code (incorrect):   80051 Electrolyte Panel  
  82565 Creatinine, blood  
  82947 Glucose  
  84520 Urea Nitrogen (BUN)  
  82310 Calcium

Note: All listed codes would be included in the Basic Metabolic Panel (80048) code.

## CASE MANAGEMENT SERVICES

Revised: 8 March 2006

1. Case management is an important part of comprehensive healthcare. When performed properly, it decreases costs. Case management is performed on an inpatient and outpatient basis.

1.1. Inpatient case management includes activities such as arranging for skilled nursing facility (SNF) availability so when the patient is medically able to transfer out of the hospital, there is a SNF bed available, thereby eliminating the need to stay in the more expensive hospital setting. Arranging for oxygen at a patient's home, or for follow-up home physical therapy is also an inpatient case management activity. This is considered to be part of the hospitalization since it is usually performed by a nurse and is included in the diagnosis related group (DRG).

1.2. Outpatient case management takes many forms. It is frequently performed as part of an encounter, such as the family practice doctor calling to arrange for a surgeon to see a patient later in day because of a cyst that needs immediate surgical intervention. This is coded as part of the evaluation and management (E&M) of the family practice doctor. It is not a separate code or bill from the E&M code.

2. Coordination of care can also occur outside of the E&M encounter. There are separate codes for team conferences, telephone calls, case management (T1016), targeted case management (T1017), and reviewing plans for nursing home patients. It depends upon the documentation as to which services are separately codable. It then depends on the code as to whether it is billable.

2.1. *Documented* coordination of care with a group of at least three *interdisciplinary* providers or agencies without a patient encounter on that day that takes more than 30 minutes may be coded with case management codes (99361-99362) if it meets the requirements of the code. It is *very* seldom in the MHS that this level (e.g., minimum of 30 minutes on a patient) is met and documented. Proper adherence to coding guidelines must be followed because these codes are for the provider with an interdisciplinary team of health professionals of community agencies (e.g., primary care manager/family practice, oncologist, and cardiologist meeting to coordinate the care of a referral patient to that facility).

2.2. Mental Health has "team conferences" that do not meet the requirements of the codes.

2.2.1. Frequently, the meeting is with the active duty member's commander and first sergeant. It would be the same thing as if you worked at McDonalds and you had a problem reporting to work on time, and your supervisor and the store manager had a meeting with your social worker.

NOTE: This would not happen in the civilian sector so it is not a medical issue, but a military personnel issue, which has no applicable code.

2.2.2. The other common "team conference" is when the mental health department meets weekly to spend about five minutes per patient to review goals, note progress during the past week, and determine goals for the next week. This is an *intradisciplinary* meeting and the "team conference" code does not apply.

2.3. Telephone Calls. Because MHS rates are currently related to TRICARE rates, telephone calls are not reimbursable. This does not mean they should not be coded, relative value units are associated with telephone calls at the TRICARE Management Activity level.

NOTE: In the civilian sector, telephone calls may be documented and coded by any provider who meets the requirements in that the call is to coordinate care with another provider or the call impacts medical treatment of the patient. For instance, telephone calls are not coded when they are a continuation of a prior encounter as is the case when the doctor's office calls the patient to notify the patient that the pregnancy test is positive and they set up an appointment.

2.3.1. Some Services have restrictions on coding telephone calls. For instance, one Service limits coding telephone calls to primary care providers.

2.4. T1016/T1017. These codes do not have associated rates; they do not impact billing.

2.5. The billing office is strongly encouraged to request documentation and have it re-coded by a coder to verify any 99361-99362 codes prior to submitting bills.

## CHEMOTHERAPY

Revised: 01 October 2003

1. Chemotherapy administration codes 96400 through 96549 are used when the administered drugs are antineoplastic and the diagnosis is cancer.
2. If a significant separately identifiable E/M service is performed in conjunction with the above listed chemotherapy codes, the appropriate E/M service code should be reported with modifier -25.
3. Use revenue code 636 to report HCPCS Level II J codes for drugs administered during chemotherapy for outpatient services.

## CIVILIAN EMERGENCY BILLING

Revised: 16 March 2009

1. A civilian emergency (CE) is generally defined as an individual who is not a beneficiary of the Military Healthcare System, and not otherwise entitled to care at a military treatment facility (MTF), but who presents to the MTF for emergency treatment or for acute care.
2. The CE patient is to be treated only during the period of emergency and should be transferred to a civilian facility as soon as the emergency period ends.
3. The CE patient has no entitlement to MTF care and is entirely responsible financially for the cost of any care provided. This includes ambulance run, ancillary services (radiology, pathology, pharmacy) and all medical care provided.
4. The ER or admitting personnel should ensure the CE patient completes and signs a DD Form 2569, "Third Party Collection Program/Medical Services Account/Other Health Insurance," for billing information and also as authorization to release medical records in support of reimbursement. It is highly advisable for the intake personnel to obtain copies of the patient's insurance cards, driver's license, and employment information to provide to the billing office.
5. The Medical Services Account Officer (MSAO) may elect to submit a claim to the patient's medical insurer; however, the non-beneficiary patient is responsible for following-up with their insurance company to ensure timely payment, and the patient is ultimately responsible for all charges incurred during the course of treatment at the MTF.
6. Courtesy insurance billings for the CE patient must be manually produced due to the inability of CHCS to accept other health insurance (OHI) policy information for non-beneficiaries.
7. The Emergency Medical Treatment and Active Labor Act (EMTALA) is the federal law that gives all individuals the right to be treated for an emergency medical condition regardless of their ability to pay.
  - 7.1 EMTALA does not preclude the hospital from billing.
  - 7.2 Although EMTALA requires hospitals to treat emergency cases even if the patient cannot afford to pay, hospitals are still allowed to bill patients and their insurers for care that is provided. Visit this Web site for more information: <http://www.emtala.com/>.

## CLAIM FORMS (Paper)

Revised: 16 March 2009

NOTE: This section does not include information on electronic billing, such as the 837P (professional), 837I (institutional), 837D (dental), and the NCPDP (National Council on Prescription Drug Programs) version 5.1.

1. Multiple claim forms are used in DoD billing. Paper forms used in the MHS include:

- CMS 1500, Health Insurance Claim Form
- DD Form 7, Report of Treatment Furnished Pay Patients Hospitalization Furnished
- DD Form 7A, Report of Treatment Furnished Pay Patients Outpatient Treatment Furnished -
- I&R - Invoice and Receipt
- UB-04 – Uniform Bill form
- UCF – Universal Claim Form, copyrighted by NCPDP (for pharmacy only).

1.1. TPOCS generates bills for third party collection outpatient services. TPOCS generates the UB forms, CMS 1500, and the UCF. TPOCS cannot generate an I&R.

1.2. MSA. The MSA module of CHCS cannot generate a CMS 1500 or a UCF.

1.2.1. Inpatient. MSA generates bills for inpatient third party, interagency and civilian emergencies. The MSA inpatient third party UB form is unique in the MHS as it reflects both the inpatient professional (e.g., doctor's rounds, anesthesia services) *and* the institutional component (e.g., diagnosis related group DRG). These can be on the UB form, the DD 7, and the Invoice and Receipt (I&R).

1.2.2. Outpatient. MSA generates bills for outpatient interagency and civilian emergencies. These can be automatically generated on the DD 7A and the I&R. Generating a UB form must be performed manually.

1.3. MAC. MAC does not have a system to generate claims.

1.3.1. MAC Outpatient. Many sites use the TPOCS module for non-hospitalizations. This is accomplished by using a different site/reporting code (e.g., M for MAC) from the site's actual TPOCS site/reporting code (e.g., M). The site/reporting code is MTF-specific.

1.3.1.1. The other option is to manually generate the bill in TPOCS, print it, go to "select bill" and delete it. This way the bill will not post and will not impact your accounts receivable. Instructions are in the TPOCS manual. Follow Service-specific guidelines.

1.3.2. MAC Inpatient. Since TPOCS only generates outpatient services, all MAC inpatient bills must be generated manually. Usually this involves a typewriter (so make sure you don't let Logistics take it way). Depending on the lawyer working the MAC bills, you may be asked to furnish a UB form for the inpatient bills or plain paper with the information.

1.4. Manual generation. A manual bill can be generated for inpatient professional services furnished at non-MHS MTFs. This is usually performed using a typewriter. Refer to Service-specific guidance.

2. UB Claim Form.

2.1. The UB Claim Form is used for institutional, technical, pharmacy, and ancillary (e.g., laboratory and radiology) services. UB forms for outpatient services can be generated in TPOCS or manually prepared. UB forms for inpatient services can be generated in MSA or manually.

2.2. CPT Codes on the UB form.

2.2.1. Military Health System Bills. In the MHS, there are some differences. Because of the current billing system, each code can only have one price. This is not the case in the civilian sector where if the code appears on the CMS 1500 there can be one price, and on the UB form there is a second price. For instance, in the MHS:

2.2.1.1. Ambulatory Surgery Center: For third party billing, CPT code 99199 is used on the UB form to represent the MHS institutional flat rate fee for APVs. This is because separate codes are not available to bill a separate rate for each level ambulatory surgery center as in the civilian sector.

2.2.1.2. Emergency Room. Currently the MHS cannot assign both a professional price (e.g., \$64) for an ED visit and a different institutional price (e.g., \$200) to the same CPT code (99282). Therefore, the emergency room bill will have the emergency service CPT code (99281-99285) on the UB form. It is inclusive of both the institutional and professional components of the encounter. This will change with the CY'07 rate release.

2.2.1.3. Observation. Observation also has a professional component, and an institutional component which cannot be done in the provider's office. The observation code for the first day of observation (99218-99220) will appear on the UB form. It includes both the professional component and the institutional component.

NOTE: In the civilian sector, when a CPT (both E/M and procedures) code appears on a UB claim form bill, it represents only the institutional component of the encounter. For example, when 99285 (a high intensity emergency department visit) appears on the UB form, it represents the institutional services only. When the code 11770 Excision of pilondial cyst; simple, appears on the UB form, the insurer thinks "a level 3 ambulatory surgery center bill." When the same CPT 11770 Excision of pilondial cyst, simple, appears on the CMS 1500, the insurer thinks "the doctor's bill for cutting out that slimy cyst."

Doctor's surgery charge:	Ambulatory surgery center charge:
CPT code 11770;	CPT code 99282-5
CMS1500 form: \$169	UB form: \$510

2.3. In TPOCS and MSA, outpatient hospital and ancillary services (laboratory, radiology, and pharmacy) performed in the MTF are generally billed on the UB Claim Form. When using TPOCS, at payer request, services can be submitted on the CMS 1500 by changing the claim form type in the Table Maintenance function of TPOCS. Refer to the TPOCS User's Manual for more information.

2.4. Submitting UB Claim Forms to Payers.

2.4.1. The UB Claim Form consists of Form Locators (FLs) that pertain to patient, payer, billing, and diagnosis information required when submitting claims to payer organizations.

2.4.2. Outpatient institutional and ancillary services are itemized with revenue codes with their description, CPT/HCPCS codes, and associated charges when submitting the UB Claim Form to payer organizations.

2.5. Multiple UB claim forms on one day. There may be multiple claim forms generated per encounter. For instance, if the patient is treated in the emergency department, the encounter appears on the UB claim form. A separate UB form could be generated for any laboratory tests, radiology studies, and prescriptions ordered during the ED visit, which were completed at a different date.

3. CMS 1500 Health Insurance Claim Form (Versions 12/90 and 08/05; use of the Form CMS 1500 (08-05) became effective 1 June 2007.)

3.1. The CMS 1500 Health Insurance Claim Form is used for professional services. It can only be generated in TPOCS or produced manually. At payer request, professional services can be submitted on

the UB claim form by changing the claim form type in the Table Maintenance function of TPOCS. Refer to the TPOCS User Manual for more information.

3.2. Minor changes have been made to the form to accommodate the National Provider Identifier (NPI) as well as current identifiers for a transition period until the NPI is implemented.

3.3. The CMS 1500 Claim Form consists of 33 items pertaining to patient, payer, billing, and diagnosis information that are required when submitting claims to payer organizations. The CPT/HCPCS code appears on the CMS 1500, representing the professional component of the encounter. Place of service codes are used on the CMS 1500. For MTFs, the place of service code 26 should automatically print in item 24B, except when BIA\* indicates Emergency Room and then TPOCS will populate place of service code 23. Revenue codes are not used on the CMS 1500.

3.4. E/M codes are itemized first, if applicable. All other professional services and supplies follow.

NOTE: See para 2.2.1. for those few instances when an E/M code will appear on the UB Claim Form for an encounter.

3.5. There may be both a CMS 1500 and UB Claim Form generated for one encounter.

4. Invoice and Receipt. See the Appendix in this Guide for instructions on completing the I&R. Always obliterate (e.g., blacken out) the SSAN on the I&R prior to mailing.

5. DD7/DD7A. See the Appendix E in this Guide for instructions on completing the DD7/DD7A.

6. UCF. See the Appendix D in this Guide for instructions on completing the Uniform Claim Form.

## CODING COMPLIANCE EDITOR (CCE)

Revised: 8 March 2006

1. The coding compliance editor (CCE) is a program that performs a logic check on codes assigned to an Ambulatory Data Module encounter. CCE does not edit codes collected in the radiology or laboratory module. It does not perform logic checks on radiology and laboratory codes linked to an ambulatory data module (ADM) encounter.

1.1. CCE flags coded encounters where the programmed logic indicates there may be an issue with the assigned codes. It takes a coder to review every CCE flagged encounter, review it against the documentation, and make a decision. If the coder determines the documentation reflects different codes, the coder can update the ADM record. The updated ADM record feeds back to CHCS and generates an updated Standard Ambulatory Data Record (SADR).

NOTE: Is there a problem with every flagged encounter? No. Can the CCE “fix” the identified issue? No.

1.2. The CCE is to coding as a calculator is to balancing your check book. When you receive your statement from the bank, you take your calculator and enter the balance the bank thinks you have, then you enter what you think you have, make adjustments for outstanding checks and deposits, and hope the answer is “0.” Sometimes, when you are entering an amount, the decimal point does not take, so the amount on the calculator scares you beyond belief. You know there is something wrong. This is the same with the CCE. Codes are entered and CCE alerts the coder when there appears to be something illogical occurring.

1.3. There are two ways CCE can be used. It can perform logic checks on codes that flow from the ambulatory data module, or the coder can use the documentation to enter the codes in CCE. Either way, codes that are entered, along with other data about the patient (such as age and gender), flow to CCE.

2. A number of claims that have circulated in the MHS regarding the CCE are incorrect.

2.1. CCE is a coding tool. The CCE walks coders through a series of steps to aid a coder in assigning all the applicable codes based on the documentation. Codes are collected in the ADM, which feeds to the CCE. Based on documentation, codes may be changed in CCE, which feeds back to the ADM and to a SADR, which feeds the clinical data repository (CDR). The CDR is where data are collected and feeds to the MHS Mart (M2). It is from the CDR and M2 where most MHS and Service reports are generated. The reports in the CCE at the MTF level are only MTF data.

NOTE: CCE is not “an enterprise-wide coding, compliance, data collection, and reporting solution for the MHS.”

2.2. CCE will identify to the coder where there may be a conflict between codes. It is the coder who will determine the most correct codes based on coding. There are many things that might improve third party collections, such as complete documentation, identifying patients with other health insurance and having correct provider specialty codes. CCE will assist in assuring bills reflect services documented.

NOTE: CCE will not “improve third-party collections.”

2.2.1. Some Services plan to have a coder review all documentation as part of implementing CCE. It is having a trained coder review documentation where procedures that have not been coded by the provider will be identified and coded by the coder. CCE will assist in identify incorrectly coded encounters, both those that were upcoded and those that were under-coded.

NOTE: CCE will not “improve revenue generation and collection.”

2.3. CCE is not documentation and will not change documentation. Training providers how and what to document to assign the most correct codes to reflect what was done will assist in standardizing documentation.

NOTE: CCE is not “intended to standardize the method for documenting the type and level of care provided in the inpatient and ambulatory care setting.”

2.4. CCE is a tool, needing trained coders in excess of what are currently available in the MHS. CCE does not automatically change codes.

2.5. CCE is *not* to “optimize reimbursement” but is to assist a coder in determining the most correct codes.

NOTE: CCE is not a “complete coding solutions for end-to-end processing.”

2.6. CCE is *not* a reimbursement system. Codes, after having logic checks, feed to both billing systems, TPOCS and MSA.

3. Availability. CCE is being deployed.

4. Hold Time. There is a significant problem with CCE. The individuals performing the implementation recommended a hold time of greater than three days when the CCE flags an encounter. For instance, a correctly coded encounter edits because an unspecified CPT code (e.g., 28899 unlisted procedure, foot or toes) is used. There was an associated E&M and the diagnosis is correct. An x-ray of the foot was ordered along with a laboratory test to determine if the patient has gout. Because the CCE has a 60-day hold unless an encounter is cleared by a coder, the x-ray and lab tests will flow to billing, but the encounter will not. This means there is no diagnosis associated with the tests. This causes significant billing problems. It is *very* important that any site with CCE ensures the leadership understands the importance of having the encounters for patients with OHI be coded and have the encounter flow to TPOCS within three days of the encounter.

## COMPLIANCE

Revised: 23 March 2009

1. Compliance is the strict adherence to established rules and regulations in an effort to reduce fraud, waste, abuse, and mismanagement. An effective compliance program also ensures that the billing office is operating at optimum efficiency. This in turn ensures that employees are working effectively, which increases employee morale as each employee can complete his or her tasks more quickly and more accurately.
2. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to business practices. A compliance program ensures the training is provided and guidance is available so that staff may work efficiently and at optimal levels. It is updated as needed to reflect changes in law and/or procedures. Adhering to a compliance plan will avoid many billing and clinical errors.
3. All billing offices should have a compliance program as stated in the 28 February 2002 OASD(HA) memorandum to the Surgeons General of the Army, Navy, and Air Force (<http://www.tricare.mil/ocfo/docs/Compliance%20Plan%20Implementation%20Policy.pdf>)
4. Compliance programs should be developed in accordance with Chapter 2 of DoD 6010.15-M, MTF UBO Manual ([http://www.tricare.mil/ocfo/mcfs/ubo/policy\\_guidance/manuals.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/manuals.cfm)). This chapter is based on the model compliance guidance released by the Department of Health and Human Services Office of Inspector General.
5. Refer to the TMA UBO Web site's "Policy Guidance: Letters" page for additional procedural guidance ([http://www.tricare.mil/ocfo/mcfs/ubo/policy\\_guidance/letters.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/letters.cfm)).
6. Questions concerning compliance should be directed to the MTF's Compliance Officer or other designated offices in accordance with the procedures outlined in the UBO Manual or by your Service representative.

## COORDINATION OF BENEFITS

Revised: 29 April 2014

1. General. Coordination of Benefits (COB) describes the steps used to determine the obligations of payers when a patient is covered under two or more separate healthcare benefit policies.
2. Verify the primary and secondary payers provided on the DD Form 2569.
3. The primary payer is billed initially, and, after payment is received, any remaining balance is forwarded to the secondary payer.
  - 3.1. If the patient is a subscriber of an employer's insurance plan, that insurance is considered primary. The coverage obtained through the health plan of a spouse's employer is secondary. For example: The spouse of a retiree received treatment at an MTF. The patient is employed and has an insurance policy with his or her employer. This insurance is considered "primary" Other Health Insurance (OHI). The retired member's policy is secondary. The MTF will submit a claim to the patient's insurance carrier for services rendered to the patient. The MTF, on receiving the remittance from the primary insurer, will bill the secondary insurer for the balance.
  - 3.2. If a patient is a dependent of two individuals with insurance through their employers, the parent with the birthday first in the calendar year will be considered the primary payer. For instance, if the mother's birthday is 2 February and the father's birthday is 3 November, the mother's insurance is primary. This is called the "birthday rule."

COSMETIC SURGERY  
[See **ELECTIVE COSMETIC PROCEDURES**]

## DD7/DD7A REPORTS PROCESS

Revised: November 2013

1. General. Department of Defense (DD) Form 7, "Report of Treatment Furnished Pay Patients – Hospitalization Furnished (Part A)" and DD Form 7A, "Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished (Part B)" when used, these reports are bills generated by the Composite Health Care System (CHCS) for inpatient and outpatient services. (See *Medical Services Account (MSA) Billing Forms* of this User Guide and Appendix E.) These reports must be generated monthly and are an aggregation of services by Patient Category (PATCAT) (e.g., all Active Duty U.S. Public Health Service (P11) visits are printed on one report and all Family Members and Retirees of U.S. Public Health Service (P41) are printed on another). Note that this is different from the Medical Services Accounts (MSA) Invoice and Receipt (I&R), which is created for individual MSA billable patients.

2. DD Form 7. This report when used identifies non-DoD beneficiaries (e.g., National Oceanic and Atmospheric Administration (NOAA) and United States Public Health Service (USPHS)) who receive inpatient care at an MTF. Once coded by the Patient Administration Division (PAD) in the Encoder Grouper (which calculates the Diagnosis Related Group (DRG)), CHCS MSA calculates the charge for the admission at the Interagency Rate (IAR). The DD7 report can be printed and submitted to the NOAA or USPHS with a Standard Form (SF) 1080 as the coversheet.

2.1. This report must be run monthly; the charges generate when the admission is coded. There is no mechanism for UBO personnel to make changes or corrections to this report. The CHCS menu path is as follows: **MSA\MRM\DD7\Print**.

2.2. The MTF Commander, or authorized representative (e.g., MSA Officer), must sign each page of the report.

2.3. The DD7 report may not reflect all the admissions for the month being billed. Other CHCS reports are available by specific dates (e.g., 01 Dec 10 – 31 Dec 10). For example:

2.3.1. Admission By Diagnosis Report. Some MTFs use this report to gather ALL inpatient admissions. It is a very large report, and it reflects ALL PATCATs. The CHCS menu path is as follows: **MOUT MEPRS Reports Menu\ADT Processing Menu Option\AOUT ADT Processing Output Menu\#3 Admission by Diagnosis Report**.

2.3.2 Ad Hoc Reports. Select DD7A Billing Menu Option: **INCP GS INPT BY DIV NOAA, CG, PHS**.

2.4. DD7 charges can be appended and excluded in the same manner as MSA accounts. Charges billed on the DD7 do not establish an accounts receivable (A/R). Accounting for these charges is performed manually.

2.5. The DD7 must be finalized and printed monthly. Services for the current month's DD7 cannot be displayed until the previous month's report has been finalized. Once the report has been finalized, no further changes can be made to that month.

2.6. DD7 reports are maintained in CHCS for the current month and the one previous. It is necessary to maintain a printed copy of the report for MSA records.

3. DD Form 7A. This report when used identifies non-DoD beneficiaries who receive outpatient care at an MTF. Once coded by the Outpatient Clinic staff in the ADM Module of CHCS and released from Coding Compliance Editor (CCE) by the Outpatient Coders, the coding information is passed to CHCS MSA, which calculates the charge for each Current Procedural Terminology (CPT®), Healthcare Common Procedural Coding System (HCPCS), or Code of Dental Terminology (CDT) code at the IAR. Ancillary services are generated when the service is performed and entered into the laboratory (LAB), radiology (RAD), or Pharmacy modules in CHCS. At the same time, the information is passed to CHCS MSA, and

charges are calculated at the IAR. A DD7A report can be printed and submitted to the U.S. Coast Guard (USCG) (if a patient is seen at an MTF that has not entered an Interagency Agreement (IAA)), NOAA, or USPHS with an SF1080 as the coversheet.

3.1. The DD7A report must be run monthly; the charges generate when the admission is coded. The CHCS menu path to print the preview listing per treating Defense Medical Information System [facility] identifier (DMIS ID), Patient, and Date of Service for review prior to finalization is: **MSA\DD7A\PRE>Select (D) Detail or (S) Summary**, based on your needs\PRINT.

3.2. Review the listing and exclude or deselect accounts with a \$0.00 or duplicate balances or invalid charges (check the Defense Eligibility Enrollment System (DEERS) and verify the PATCATs for each patient); this is normally due to a telephone consult or because the patient is Medicare eligible. Use the following menu path: **MSA\DD7A\MBP**.

3.3. All encounter procedures, ancillary support services, and issued supplies are calculated as line item charges, but they are summarized per treating DMIS ID, patient, and date of service on the monthly DD7A billing report.

3.4. DD7A charges can be appended and excluded in the same manner as MSA. Charges billed on the DD7A do not establish an A/R. Accounting for these charges is performed manually.

3.5. The DD7A must be finalized and printed monthly. Services for the current month's DD7A cannot be displayed until the previous month's report has been finalized. Once the report has been finalized, no further changes can be made to that month.

3.6. DD7A reports are maintained in CHCS for the current month and the one previous. It is necessary to maintain a hard copy of the report for MSA records.

4. Submission to Responsible Agency. Submit these reports along with the SF1080, "Voucher for Transfer between Appropriated and/or Funds" to the responsible agency<sup>††</sup> for payment.

U.S. Coast Guard  
U.S. Dept of Homeland Security – USCG (DCMS-831)  
2100 2nd St SW STOP 7902  
Washington DC 20593

(Note: Beginning in FY12, the DoD and U.S. Coast Guard implemented a prospective payment system to recover the cost of health care provided to USCG beneficiaries in Army, Navy, and National Capital Region (NCR) Medical Directorate MTFs. Thus, for those MTFs, do not send the SF1080 to the USCG; rather, follow the guidance in the *U.S. Coast Guard Billing* section of this User Guide.)

NOAA  
U.S. Dept. of Commerce – NMAO  
8403 Colesville Rd., Suite 500  
Silver Spring, MD 20910-3282

USPHS (Navy)  
U.S. Dept. of Health and Human Services – PHS  
8455 Colesville Rd., Suite 910  
Silver Spring, MD 20910

USPHS (Army)

---

<sup>††</sup> These addresses are subject to change. Verify them before submitting forms.

Medical Affairs Branch  
5600 Fisher Lane, RM 4C-04  
Rockville, MD 20857-5000

5. Further Information. Refer to the Appendix E of this User Guide for more information on the DD7 and DD7A form instructions.

## DENTAL SERVICES

Revised: 01 July 2009

1. If the Ambulatory Data Module (ADM) is used to capture dental encounters associated with the Medical Expense and Performance Reporting System (MEPRS) Code C\*\*\*, accounts are generated in Third Party Outpatient Collection system (TPOCS) and Medical Services Accounts (MSA) in the same manner as B level MEPRS codes.

1.1. If ADM is not used, entries are hand-keyed into MSA and TPOCS from the supplied dental superbill.

2. Rates for dental procedures are calculated based on the DoD Dental Rate Table that originates from the American Dental Association Code on Dental Procedures and Nomenclature (CDT) codes.

2.1. CDT codes are alpha-numeric Healthcare Common Procedural Coding System (HCPCS) Level II codes ranging from D0100 to D9999.

2.2. The dental rate table in TPOCS is maintained for three years (current year and two prior years).

2.3. The Dental Rate Table contains billing rates for Interagency rates (IAR), International Military Education and Training (IMET), and full reimbursement rate (FRR).

3. Dental Ambulatory Patient Visit (APV) Services.

3.1. All dental procedures are billable with a CDT code or a Current Procedural Terminology (CPT) code along with any ancillary service as a line-item charge representing procedures that were performed, regardless of the location where the procedure was performed.

3.2. CPT codes are used when billing for oral and maxillofacial surgery (OMS) such as surgical procedures or oral implants reconstruction.

3.3. A series of dental CDT (ADA) codes are located on the CHAMPUS Maximum Allowable Charge (CMAC) Rate Table with rates for billing dental and oral surgeries and procedures.

4. Modifier ET. This code is used only for emergency dental procedures. It is not available at this time for the D-HCPCS codes, but it will be added at the next release.

# DIAGNOSIS POINTERS

Revised: 7 March 2006

1. TPOCS Diagnosis Pointers. Only TPOCS can generate the CMS 1500. Diagnoses are collected in the Ambulatory Data Module

1.1. Diagnosis and other ICD-9-CM codes are listed in block 21 of the CMS 1500. These are fed from the Ambulatory Data Module to TPOCS.

1.2. Billing personnel must be familiar with HCPCS/CPT codes displayed on the CMS 1500 that are associated with a valid diagnosis and the Diagnosis Code (pointer) listed on the CMS 1500 Claim Form block 24E.

2. The CMS 1500 block 24E diagnosis code pointer (Diagnosis Code) must contain "1", "2", "3," and/or "4". Diagnosis pointers must also be in sequential order on the claim.

3. The diagnosis code is indicated by an ICD-9-CM code, which is displayed on a CMS 1500 Claim Form in Item 21.

4. The HCPCS/CPT codes are displayed in Item 24D on the CMS 1500 Claim Form and as line items on the MSA I&R.

5. The DD7A will provide the ability to display all line item charges for a specific patient; however, the monthly report will list only summary charges per Patient and Date of Service.

6. Refer to the CMS 1500 Claim Form Instructions in the Appendix for more information.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)													
1	388.70				3	482							
2	380.4				4	478.1							

24	A				B	C	D		E	F		G	H	I	J	K
	DATE(S) OF SERVICE						PROCEDURES, SERVICES, OR SUPPLIES			DIAGNOSIS CODE	CHARGES					
MM	DD	YYYY	MM	DD	YYYY	Service	Code									
	10	10	2001	10	10	2001	26	99212	1,2,3,4	75	00	1				
	10	10	2001	10	10	2001	26	69210	2	250	00	1				

POS 26 = Military Treatment Facility

## DIALYSIS

Revised: 8 March 2006

1. Dialysis is usually billed on a per month basis, at the beginning of the month following the services.
2. There are separate codes to be used to represent less than monthly dialysis treatments. These are used when the patient first begins dialysis treatments, when a patient is hospitalized during the month, the patient is not in the area and receives treatment elsewhere during the month (e.g., two week vacation in Florida), or the patient dies.
3. Dialysis is performed by a nurse under the written orders of a physician.
4. Dialysis is an ancillary service. The encounters are collected in the ambulatory data module (ADM) in the DGB\* or DGD\* MEPRS. As the D\*\*\* MEPRS currently do not flow automatically to TPOCS these bills will need to be generated manually.
5. To monitor the effectiveness of the dialysis services, with each monthly bill, a separate line must be added to the bill. The code will be 90999. The description will be "Unlisted dialysis procedure, inpatient or outpatient." Billing personnel will need to review the latest blood urea nitrogen (BUN) test dialysis unit documentation and determine the result. Based on the result, the appropriate modifier will be appended to 90999. The blood urea nitrogen tests are laboratory codes 84520-84525. The URR is determined using the pre- and post dialysis BUN samples.

G1 – Most recent Urea Reduction Ratio (URR) reading of less than 60

G2 – Most recent URR reading of 60-64.9

G3 – Most recent URR reading of 65-69.9

G4 – Most recent URR reading of 70-74.9

G5 – Most recent URR reading of 75 or greater

G6 – End Stage Renal Disease patient for whom fewer than 6 dialysis sessions have been provided in a month

- 5.1. The Revenue code will be 820, 821, or 829.
- 5.2. The code 90999 is a no charge code.
- 5.3. CMS will profile your MTF based on the pre- and post- dialysis blood urea nitrogen (BUN) samples.
6. Other data that may be needed will be identified on the explanation of benefits with codes such as:

211 – date(s) of dialysis training provided to patient

212 – date of last routine dialysis

213 – date of first routine dialysis.

## DoD REIMBURSABLE DISASTER VICTIM

Revised: 8 March 2006

NOTE: This section of the User Guide only applies to large disasters that are declared disasters by FEMA, and for which the MHS receives a Mission Assignment. This section does not apply to local disasters (e.g., a tornado, localized flooding) that are not declared a disaster by FEMA. See also, National Disaster Medical System (NDMS) Billing, in this Guide.

1. Under the Stafford Act (Public law 93-288, Robert T. Stafford Disaster Relief and Emergency Assistance Act), regular labor of permanent federal agency personnel and overhead costs are not eligible for reimbursement except when costs incurred would normally be paid from a trust, revolving, or other fund. This means that if an MTF hires someone specifically to provide services for the disaster, or if the MTF pays someone overtime for the services provided, and the services were provided in the MTF, the services *may* be billable. If the MTF paid travel, per diem, or transportation, those costs *may* be billable, but not through the UBO.

2. The Federal Emergency Management Agency (FEMA) is responsible for implementing the Stafford Act.

3. In general, the only money available to cover charges for non-beneficiary emergency services is the patient's insurance (or Medicare/Medicaid). Otherwise, the patient is responsible for the charges.

4. There are two special instances, both involving disasters. For emergency non-beneficiary patients regulated to an MTF by the National Disaster Medical System (NDMS), see the NDMS section. The other possible source of reimbursement is through FEMA Mission Assignment.

4.1. Actions required for FEMA reimbursement for services permissible to be reimbursed under the Stafford Act:

4.1.1. FEMA requests DoD support, using a Mission Assignment (MA) [each mission assignment has its own number]→DoD Concurs →Northern Command issues an Execution Order (EXORD) →Military Services perform tasks.

5.1. Federal agencies providing disaster assistance under their own authorities independent of the Stafford Act *are not* eligible for Federal Emergency Management Agency (FEMA) reimbursement.

5.2. FEMA will not reimburse for regular labor of permanent federal agency personnel and overhead costs unless costs would normally be paid for from a trust, revolving, or other fund. 1. In general, the only money available to cover charges for non-beneficiary emergency services is the patient's insurance (or Medicare/Medicaid). Otherwise, the patient is responsible for the charges.

6. For the UBO to bill, the patient must be treated in an MTF. If the MTF responded to a Mission Assignment by sending a bus load of staff and supplies to the disaster area, and the MTF staff worked out of a tent, the costs would be forwarded to TMA RMO through the appropriate Service channels. For UBO to bill FEMA, the following must be met/available:

6.1. The patient is not a DoD beneficiary.

6.2. The patient is not an NDMS regulated non-beneficiary inpatient. NDMS reimbursable disaster victims are non-beneficiary inpatients regulated to an MTF by the National Disaster Medical System. For NDMS regulated non-beneficiaries, see the separate NDMS section of this Guide.

6.3. The MTF must have and submit patient demographics to specifically identify the patient. Examples of demographic information the MTF must have are the patient's SSAN, full name, date of birth, address prior to disaster, temporary address, and the name and address of next of kin.

6.4. The documentation maintained at the MTF must reflect the clinical course of the services.

6.5. Cause of Injury/Illness. The patient must have been treated for injuries or illnesses (a) caused by or compounded by the disaster, (b) the evacuation due to the disaster, or (c) received due to assisting with recovery from the disaster.

6.6. The patient must have been treated for an emergency condition (i.e., threat to life, limb or sense; or permanent disfigurement) or non-deferrable care. This would not include preventive services such as vaccinations. It would also not include many emergent (i.e., arising unexpectedly) or urgent, non-emergency conditions.

6.7. The services were furnished within 30 days of the disaster.

6.8. There is administrative patient documentation reflecting:

6.8.1. The date, time, county, and state where the work was actually performed.

6.8.2. A complete, DD Form 2569, signed by the patient (or the patient's representative if the patient was unable to sign, such as the patient never regained consciousness), and

6.8.2.1. If there is insurance, that co-pays, deductibles and the insurance remittance combined do not cover billed charges; or

6.8.2.2. If the patient is covered by Medicare, that co-pays, deductibles, insurance remittance (if applicable) and the Medicare remittance combined do not cover billed charges.

6.8.3. If the patient has insurance or is covered by Medicare, the patient is responsible for paying co-pays and deductibles.

6.8.3.1. Note: Medicaid (a state program) pays after FEMA (a federal program). Example: If a patient is treated for a service which is not usually available in the area except at the MTF, such as hyperbaric medicine, even if the patient met the other conditions to be a disaster patient, the patient is not a disaster patient. In this case, the patient would probably be a civilian emergency.

6.9. Certification that emergency services were temporarily not available, at the time the MTF furnished the services, in the local area for the condition treated.

7. Business Office Actions During Emergency Situations.

7.1. Be safe. Avoid becoming another casualty.

7.2. Emergency patient care takes priority over business office activities. Example: If a patient was relocated from the disaster area to an unfamiliar area, and comes to a MTF for emergency care because he did not know where else to get care, he is not a disaster patient if care for his condition was available elsewhere in the new area.

7.3. Collect other health insurance information (OHI) on all non-active duty patients. This is the same as during non-emergency situations. Do not interfere with patient care while collecting OHI information. Remind MTF staff not to discharge/release patients until OHI information is collected. A good way to remind staff of the need to collect OHI information is to include a DD Form 2569 on the clipboard used by the patient affairs/PAD emergency reception team. If your MTF has "emergency admissions packages" the DD Form 2569 should be included in these packages.

7.4. Contact your Service UBO representative to determine if there is a FEMA Mission Assignment. The mission assignment number is on the actual mission assignment document.

## 8. Business Office Actions Post Emergency.

8.1. Keep your Service UBO representative updated as to the number of possible FEMA reimbursable patients by inpatient/outpatient category, with/without insurance, with/without Medicare, and approximate costs.

8.2. Collect necessary documentation to support FEMA billing. Since it will be very rare for the services to have been furnished by staff hired specifically for the emergency or by staff being paid overtime while furnishing the services, it will be very rare for an MTF to submit a FEMA package.

8.3. When requested, forward copies of the required documentation and bills to your Service representative. Documentation includes a copy of the signed DD Form 2569 and applicable UB- 92 and CMS 1500 for each patient. The Standard Form (SF) 1080, Voucher For Transfers Between Appropriations and /or Funds, will be used to consolidate the bills. The SF 1080 will have your MTF UBO point of contact information in the block "Department, establishment, bureau, or office receiving funds." In the "Article or Services" block will be the MA number, FEMA disaster number, the state where services were furnished, and the type of bill (e.g., UB-04 or CMS 1500). Each bill will be listed separately. Quantity will be "1" for each bill. "Unit Price" will not be used. Amount will be the amount of the bill. Total will be the total of all the bills attached. For instance, if there were two qualifying patients treated by providers being paid for overtime or who were hired just for the disaster work, and each had a CMS 1500 and UB 92, there would be four listed services.

8.4. Source documents must be kept by the MTF for 6 years and 3 months after final payment.

## EDUCATION SERVICES

Revised: 9 March 2006

1. Education can be performed one-on-one or in a group setting and is billable if it meets the requirements of an Evaluation and Management visit. Refer to the Evaluation and Management Services section of this Guide.
2. Counseling and/or risk factor reduction intervention services are provided by other appropriate sources for the purpose of promoting health and preventing illness or injury. These services include issues such as family problems, diet and exercise, or injury prevention.
3. Diabetic education is now billable in the MHS when provided by a privileged provider and properly coded.

## ELECTROCARDIOGRAM SERVICES

Revised: 01 October 2003

1. Electrocardiograms (EKGs) are only billable with a defined diagnosis supported by valid documentation.
2. If an EKG is performed as a “D” level MEPRS code, it is not billable; however, when performed in association with a clinic visit a “B” level MEPRS code it is billable. Note: Please refer to the Future Enhancements/Current Changes section for future billable services.
3. Electrocardiogram CPT codes: 93000–93278, 93799

## **ELECTIVE COSMETIC PROCEDURES**

Revised: 29 April 2014; formerly **COSMETIC SURGERY**

1. General. Elective cosmetic procedures are not a covered benefit under TRICARE. These procedures are restricted to TRICARE-eligible beneficiaries, as defined in 10 United States Code (U.S.C.) Chapter 55. Elective cosmetic procedures are permitted in support of graduate medical education, board eligibility and certification, and skill maintenance for certified specialists.

1.1. Only privileged staff and residents in the specialties of plastic surgery, otorhinolaryngology, ophthalmology, dermatology, and oral-maxillofacial surgery may perform elective cosmetic surgery procedures.

1.2. Cosmetic surgery procedures may be performed on a “space-available” basis only.

2. Patient Responsibility. Patients undergoing elective cosmetic surgery procedures accept responsibility for all procedure charges, including applicable professional, facility, and anesthesia fees plus the cost of any implants, pharmaceuticals, and other separately billable items provided by the MTF.

2.1. The Cosmetic Surgery Estimator (CSE) is used to generate elective cosmetic surgery procedure estimates. Rates for elective cosmetic procedures are updated annually by the Assistant Secretary of Defense for Health Affairs (ASD-HA).

2.2. Estimated charges are based on the Department of Defense (DoD) rates applicable at the time of payment. Rates cannot be guaranteed until estimated charges have been paid in full.

3. Reconstructive or Cosmetic Procedures. Some procedures can be considered reconstructive or cosmetic. Cosmetic surgery is “any elective plastic surgery performed to reshape normal structures of the body in order to improve the patient’s appearance or self-esteem.” Reconstructive surgery is “any plastic surgery performed on abnormal structures of the body which are caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive surgery is generally performed to improve function, but may also be done to approximate normal appearance.” The provider determines if the service is medically necessary (reconstructive) or elective cosmetic.

3.1. If the provider determines the procedure is elective cosmetic, then the first diagnosis code will be from the V50.x series.

3.2. If the provider determines the procedure to be medically necessary, then the first diagnosis code will not be from the V50.x series and the procedure will be considered a covered benefit. Medically necessary procedures may be processed under the Third Party Collection Program (TPCP) if the DoD beneficiary has valid other health insurance (OHI) and the required documentation is presented to justify medical necessity. For medically necessary procedures, obtain a pre-certification or pre-authorization number prior to treatment, when possible.

4. Included in the Cosmetic Surgery Program. Only the elective cosmetic procedures listed in the current year CSE are billable. In addition to the cost of elective cosmetic procedures, patients may be responsible for any applicable services, such as laboratory, radiology, and pharmacy.

5. Billable Elements of Elective Cosmetic Procedures. Elective cosmetic procedures are billed at the full reimbursement rate (FRR), regardless of the Patient Category (PATCAT). The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) national average (locality 300) rates are used for all procedure locations. Charges are not adjusted for the treating MTF’s geographic location.

5.1. Professional Fees. Professional fees are based on Current Procedural Terminology® (CPT)<sup>##</sup> codes, which describe the type of procedures to be performed. Procedure rates are derived from the CMAC rate table, when available. When CMAC is not available, professional fees are determined based on estimates of the medical resources required relative to similar procedures that have CMAC pricing.

5.2. Institutional Fees. The institutional charge is based where (e.g., inpatient operating room, outpatient operating room, or provider's office) the procedure is performed.

5.2.1. CMAC non-facility physician allowable rates are used for services furnished in a provider's office. Location costs are included in the CMAC non-facility physician rate; therefore, no additional facility fees will be applied.

5.2.2. CMAC facility physician allowable rates are used for services furnished in a hospital operating room whether the patient is considered an inpatient or outpatient. If the procedure is performed in an inpatient operating room, the facility fees are included in the Diagnosis Related Group (DRG) rate. If the procedure is performed in an outpatient operating room, the facility fee is based on the TRICARE Ambulatory Payment Classification (APC) rate for the CPT code indicated.

5.3. Anesthesia Fees. Anesthesia fees associated with elective cosmetic procedures include the cost of anesthesia pharmaceuticals, supplies, and the professional fees of an anesthesiologist. Anesthesia fees are only applied to procedures performed in a provider's office or in an outpatient operating room setting. Anesthesia fees for procedures performed in an inpatient operating room setting are included in the DRG rate.

5.3.1. Topical and local anesthesia fees are included in the price of the procedure selected for all locations of service. The fee for moderate sedation is a flat fee based on the CMAC rate for CPT code 99144. Fees for General/Monitored Anesthesia Care are calculated using the TRICARE national average anesthesia conversion factor, multiplied by the sum of anesthesia base units and national average time units (measured in 15 minute increments) of the primary procedure. An additional anesthesia charge, based on additional minutes of service, is added for additional procedures performed during the same surgical encounter.

5.4. Additional Procedures During the Same Session. If multiple elective cosmetic procedures are performed during the same surgical encounter, a discount is applied. Professional, facility, and anesthesia fees are reduced by 50% from the initial charge.

5.5. Multiple Quantities and Sessions. Some procedures can be performed in multiple quantities during a single surgical encounter (quantitative procedures). Multiple quantity procedures are discounted by 50%. Other procedures generally require multiple sessions (separate surgical encounters) to achieve optimal results. There is no discount applied to procedures requiring additional sessions or multiple visits. Each session is priced at 100% whether it is listed as a primary or additional procedure.

5.6. Add-on Codes. Add-on codes are used to capture additional charges for secondary procedures that can only be done in conjunction with a specific primary procedure. They are performed by the same physician during the same surgical encounter as the primary procedure and must never be billed as a stand-alone procedure. Add-on codes are NOT subject to multiple-procedure discounting as they are inherently discounted codes.

5.7. Pharmaceuticals. Pharmaceuticals may be used for subcutaneous injection of filling material procedures (11950, 11951, 11952, and 11954) and chemodenervation procedures (64612, 64616, 64642, 64643, 64644, 64645, 64646, 64647, 64650, 64653). There are no TRICARE allowable prices for the subcutaneous injection of filling material pharmaceuticals. The cost of the fillers/injectables used for the elective cosmetic procedure(s) should be obtained from the MTF pharmacy. For chemodenervation

---

<sup>##</sup> Registered trademark of the American Hospital Association

procedures, three of the potential pharmaceuticals (Botox®, Dysport®, and Xeomin®) have TRICARE allowable prices. The prices applicable for the current version of the CSE are pre-populated in the pharmaceutical cost field. However, users are able to override the price of the pharmaceutical if the MTF pharmacy provides a purchase price for the pharmaceutical.

5.8. Implants. If the MTF provides implants/supplies to the patient, the patient is responsible for reimbursing the MTF for the cost of the implants/supplies.

6. Discounts. Discounts are available when: elective cosmetic procedures are performed in conjunction with a medically necessary procedure, a dermatology resident performs the procedure, and for bilateral procedures.

6.1. Medically Necessary Discount. If an elective cosmetic procedure is combined with a medically necessary procedure during the same surgical encounter, charges for the primary elective cosmetic procedure are discounted to avoid duplicate facility and anesthesia charges. Facility and anesthesia fees for an elective cosmetic procedure, when combined with a medically necessary procedure, are reduced by 50% from the initial charge.

6.1.1. Billing Elective Cosmetic and Medically Necessary Procedures Performed During the Same Session. The components of the service include the medically necessary professional component, the cosmetic professional component, institutional fees, anesthesia charges, pharmaceuticals, and implants/supplies.

6.1.2. The patient must pay for the entire cosmetic portion of the procedure prior to scheduling.

6.1.3. The medically necessary portion of the procedure should be billed to the patient's OHI.

6.2. Dermatology Resident Discount. A reduced professional flat rate per chemodenervation procedure is charged when performed by a Dermatology resident physician. This discount is built into the CSE.

6.3. Bilateral Procedures. The bilateral discount is applied to the second half of the procedure. The first procedure is charged at 100% and the second at 50% of the initial fee. The total charge for a bilateral procedure is 150% of the initial fee.

7. Estimate Calculation. To calculate a charge, use the CSE in effect on the day the patient presents a completed Superbill to the Medical Services Account (MSA) office. To obtain the latest version of the CSE, contact your UBO Service or NCR MD Program Manager for log-in credentials. Note: The CSE is designed for MSA use only.

7.1. CSE Instructions. For step-by-step instructions on how to use the CSE, refer to the CSE User's Guide in effect on the estimate date. The CSE User's Guide provides detailed instructions on how to generate an estimate in the CSE.

7.2. CSE Website. The CSE User's Guide is posted on the ubocse.org website (password protected), the DHA UBO website under the MHS Rates-Cosmetic Surgery page. The User's Guide can also be accessed by using F1 while in the CSE database.

8. Letter of Acknowledgment. Patients must sign a letter of acknowledgment accepting financial responsibility for costs associated with the procedure(s). Patients must agree that estimated charges are not final and additional charges (e.g., radiology, anesthesia, laboratory, pharmacy) may apply. Do not provide a receipt until the letter is signed and in the patient's file. Elective cosmetic procedures are not to be scheduled until a receipt is available.

9. MSA Bill Generation. The MSA Office must collect the estimated cost of the procedure in advance of treatment.

9.1. CSE Billing Process. Billing elective cosmetic procedures in MSA is a manual process. The MSA bill must be created in the Composite Health Care System (CHCS)/MSA billing module. **The initial procedure charge is posted and paid prior to treatment with additional charges billed once all services are complete.** Payment for additional services is due within thirty (30) calendar days from the presentation of the final bill.

9.1.1. The MSA Office must also ensure that all charges associated with the cosmetic procedure are excluded from the DD7A billing menu for DD7A billable patients.

9.2. Post-Surgical Billing Adjustment. Until coding for the surgical procedure is complete, the full charges for the elective cosmetic procedure(s), including all ancillary services, will not be available. Consequently, the MSA Office may not be able to collect full payment in advance of services performed.

10. Cosmetic Surgery Documentation. At a minimum, the patient's elective cosmetic procedure file must contain the following documentation prior to closing out the case:

10.1. Cosmetic Surgery Superbill. Original completed by the provider.

10.2. CSE Cost Report. Generated from the CSE.

10.3. Letter of Acknowledgment. A letter signed by the patient acknowledging financial responsibility for costs associated with the procedure(s), which may include additional charges associated with complications. These additional charges are due no later than 30 days after the final bill is presented.

10.4. Coding from the Surgical Encounter. If different from the initial invoice, a copy of the rebilling and payment/refund.

11. Cancellation. If the procedure was prepaid, and the procedure was cancelled:

11.1. Implant Refund. If the implants have not been opened and can be returned, the cost of the implants less the restocking fee will be refunded if the MTF paid for the implants. If implants cannot be returned, the cost of the implants will not be refunded.

11.2. Payment Refund Prior to Anesthesia. If the procedure is cancelled prior to the scheduled procedure date or administration of anesthesia, patients are entitled to a refund of all monies paid for the cancelled procedure(s).

11.3. Payment Refund Prior to Incision. If anesthesia administration begins, but there is no incision, funds will be refunded minus the costs of the implants and the anesthesia costs.

11.4. Payment Refund Once Surgery Begins. If anesthesia is administered and surgery begins, funds will not be refunded.

12. Cosmetic Surgery Complications. Complications of cosmetic surgery procedures are excluded from coverage under TRICARE. See TRICARE Policy Manual (TPM) Chapter 4, Section 1.1 (current version).

12.1. Patient Responsibility for Complication Charges. The patient is responsible for all charges related to the complications.

12.2. Patient Acknowledgment of Complication Charges. The patient must acknowledge this disclosure and a copy of the signed letter of acknowledgment must be filed in the patient's medical record.

12.3. Medical Services for Complications. Medical services may be provided by the MHS for cosmetic surgery complications when the complication represents a medical condition separate from the condition that the non-covered surgery was directed towards.

12.3.1. A complication may be considered a separate medical condition when it causes a systemic effect or occurs in a different body system from the non-covered treatment or is an unexpected complication. *For example: Treatment for toxic shock syndrome (a systemic effect) following breast augmentation would be a covered benefit.*

12.4. Benefit Exclusions. The patient is responsible for all costs associated with complications that occur in the same body system or the same anatomical area of the non-covered treatment and when the complication is one that commonly occurs. *For example: In a breast augmentation procedure, a localized wound infection would be excluded and non-covered.*

## EMERGENCY DEPARTMENT SERVICES

Revised: November 2013

1. General. Emergency department (ED) visits may include a visit involving only evaluation and management (E&M) Current Procedure Terminology (CPT®<sup>§§</sup>) codes 99281 through 99285 and 99291 and 99292; or a visit involving an E&M CPT code and additionally coded services. The current Military Health System (MHS) billing systems are unable to store and use both the professional and institutional rates for the same code. Therefore, Defense Health Agency (DHA) UBO rates (TRICARE Ambulatory Payment Classification (APC) rates) for ED E&M 99281 – 99285 services are used to determine the DoD ED institutional charges; bill those E&M CPT codes on the institutional claim (Uniform Bill (UB)-04/837I). CPT codes 99291 and 99292 are currently mapped for MHS billing systems to professional claims Centers for Medicare & Medicaid Services (CMS) 1500/837P.
2. Inpatient Admission from ED. If the patient is admitted directly from the ED, either by the emergency services provider or by a referring provider, the discharge type from the ED should be “admitted.” In that case for Third Party Collection (TPC), Medical Affirmative Claims (MAC), and most Medical Services Account (MSA) patients, do not bill for institutional or professional ED services. However, in the case of Veterans Affairs (VA)-DoD Resource Sharing Agreement care, bill the professional charges, including CPT codes 99291 and 99292, unless precluded by the local sharing agreement.
3. Radiology and Laboratory with ED Admission. For TPC, MAC, and most MSA, radiology (RAD) and laboratory (LAB) services ordered during an encounter where the discharge status is “admitted” become part of the institutional component of the hospitalization. If these services generate a bill, the bill should be cancelled. Under VA-DoD Resource Sharing Agreement care, however, bill the professional components of ancillary services separately. (See *VA-DoD Billing* section of this User Guide for instructions.)
4. Billing Tips. The chief complaint (the patient’s reason for the visit) should be listed in Form Locator 70a-c on the institutional claim. The revenue code for the ED institutional claim is 450.

---

<sup>§§</sup> CPT is a registered trademark of the American Medical Association.

## EVALUATION AND MANAGEMENT SERVICES

Revised: 29 April 2014

1. General. Evaluation and Management (E&M) codes are a subset of the American Medical Association's (AMA) Current Procedural Terminology (CPT®)\*\*\* codes. The Military Health System (MHS) limits E&M to mean the CPT codes 99201 through 99499. These codes describe the non-procedural portion of services furnished during a health care encounter by a health care provider or other qualified health care professional (e.g., obtaining the patient's history, performing an exam, and making a medical decision) and indicate the level of service. There are separate specific codes for most resource-intensive procedures. (NOTE: The civilian sector also includes the mental health, physical/occupational therapy, and optometry/ophthalmology E&M codes when using the term "E&M.")
2. Billing Formats. MHS legacy billing systems are unable to store and use both the professional and institutional rates for the same code (future billing solutions including the Armed Forces Billing and Collection Utilization Solution (ABACUS) will be able to do so). Therefore, the following codes should be used.
  - 2.1. For Third Party Collections (TPC), Medical Affirmative Claims (MAC) and most Medical Services Account (MSA) patients, Defense Health Agency (DHA) UBO rates (TRICARE Ambulatory Payment Classification (APC) rates) for Emergency Department (ED) E&M 99281 – 99285 services are used to determine the Department of Defense (DoD) ED institutional charges; bill those E&M CPT codes on the institutional claim (Uniform Bill (UB)-04/837I). After transition to ABACUS, bill CPT codes 99281 – 99285 on the 1500/837P.
  - 2.2. All other E&M CPT codes are currently mapped for MHS billing systems to professional claims Centers for Medicare & Medicaid Services (CMS) 1500/837P. After transition to ABACUS, all E&M CPT codes will be mapped to 1500/837P claims.
  - 2.3. Exception: Under Department of Veterans Affairs–Department of Defense (VA-DoD) Resource Sharing Agreement care, charges for E&M CPT Codes 99281 – 99285 are based on TRICARE Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) rates. Thus, in those cases, submit these codes on the CMS 1500/837P.
3. Consultation Codes. The MHS does not recognize outpatient consultation codes CPT 99241 through 99245 or inpatient consultation codes CPT 99251 through 99255, thus: they should not be coded, and the DHA UBO rates for these codes are set to zero (\$0.00). Do not bill these outpatient and inpatient consultation codes if they flow through on an encounter record; send them back to the coding department for review and correction.
4. Privileged Providers. Privileged providers may use the full range of E&M codes except inpatient and outpatient consultation codes. At least one, and up to three E&Ms, can be associated with an encounter.
5. Non-privileged Providers. Non-privileged providers may use the E&M CPT code 99211, which may be billable, depending on the provider specialty. Billing systems are designed to filter billable and non-billable encounters.
6. Placeholder E&M. Code 99499 is used in the MHS as a placeholder for administrative telephone calls or encounters or episodes of care that would have not previously been captured or coded with the appropriate administrative V Code as a diagnosis. There is no charge associated with 99499.
7. Diagnosis Code. Each E&M code associated with an encounter must be linked to a Diagnosis Code.

---

\*\*\* CPT® is a registered trademark of the American Medical Association

8. In the MHS, as in the civilian sector, E&M codes appear in the same field as all other CPT/HCPCS (Healthcare Common Procedural Coding System) codes.

9. E&M codes have a specific subset of modifiers. At this time, the MHS only applies the E&M to the professional component, except for the emergency and observation E&M. Because the institutional component is not considered, the modifier -27 (an institutional modifier) would be inappropriate to use in the MHS. Common MHS E&M modifiers are:

<u>Modifier</u>	<u>Descriptor</u>
-24	Unrelated evaluation and management service by the same physician during a post-operative period
-25	Significant, separately identifiable evaluation and management services by the same physician on the same day of procedure or other service
-32	Mandated services
-52	Reduced services
-57	Decision for surgery
-GC	Service by resident under direction of a teaching physician
-SM	2 <sup>nd</sup> surgical opinion
-SN	3 <sup>rd</sup> surgical opinion

## FILE AND TABLE MAINTENANCE

Revised: November 2013

1. General. Files and tables are system components that are essential for accurate, up-to-date billing.
2. Purpose. Many files and tables must be correctly entered in Military Health System (MHS) applications so the correct data can be collected and flow to the billing systems (e.g., Third Party Outpatient Collection System (TPOCS), Medical Services Accounts (MSA), or other billing solutions). Incorrect or obsolete patient, provider, procedure, diagnosis, billing rate, health insurance payer, or other reference files can cause: billable encounters not to flow to the billing system; non-billable encounters to flow to the billing system; and billable encounters to flow but generate claims with incorrect or incomplete data.
3. Non-UBO Tables. While many reference tables (e.g., billing rate tables) are considered UBO tables, others that impact billing do not belong to the UBO. The Patient Category (PATCAT), Provider Specialty Code (PSC), International Classification of Diseases (ICD), and Current Procedural Terminology (CPT®<sup>+++</sup>)/Healthcare Common Procedural Coding System (HCPCS) tables belong to the Unified Biostatistical Utility (UBU), but the UBO provides input to these tables. The Medical Expense and Reporting System (MEPRS) tables belong to the MEPRS Management Improvement Group (MMIG). The other health insurance (OHI) and the standard insurance table (SIT) are shared with purchased care (PC) and pharmacy benefit managers (PBMs).
  - 3.1 The SIT is updated centrally in the Defense Enrollment Eligibility Reporting System (DEERS), with copies being downloaded to the Composite Health Care System (CHCS) through a subscription process, and the UBO Verification Point of Contact (VPOC) verifies the SIT. The UBO, PC, and PBMs update the OHI as new or updated OHI is gathered. Changes flow to DEERS. The SIT is also updated from DEERS when patient OHI is queried. DEERS feeds the most current OHI information down to CHCS. As OHI is updated on the SIT, it is updated in CHCS, and changes flow from CHCS to billing systems.
  - 3.2. Coding Compliance Editor (CCE). At the beginning of every fiscal year, the CCE is updated with current diagnosis code tables, Medicare Severity Diagnosis Related Group (MS-DRG) grouping logic, and Relative Weighted Product (RWP) values assigned to each MS-DRG. To ensure the most current MS-DRG/RWP-assignment codes are available for that fiscal year, inpatient facilities should hold coding completion and billing discharges after 1 October of that year until the updates are made.
4. Tables Used for UBO Operations. The following files and tables contain the rates, costs, business rules, and mapping tables associated with procedures performed and supplies used.

- CPT®-to-Modifier Mapping (three tables for CHCS also referred to as the “main driver”)
- CPT®-TPOCS Mapping
- CPT®-to-Revenue Code Mapping
- CMAC Professional Services (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge)
- CMAC Component (procedures with separate technical and professional components)
- Defense Medical Information System [facility] identifier (DMIS ID)/CMAC–Locality Mapping (to match each MTF to the correct geographic location)
- Pharmacy National Drug Code (NDC) Rate (pharmacy ingredient unit measure charges)
- Pharmacy Dispensing Fee
- Immunization Rates
- Anesthesia Rates
- Dental Rates

---

<sup>+++</sup> CPT® is a registered trademark of the American Medical Association.

Ambulance Rates  
Durable Medical Equipment (DME)/Durable Medical Supplies (DMS) Rates  
International Medical Education and Training (IMET)/Interagency Rates (IAR) Rates  
Inpatient Adjusted Standardized Amount (ASA) Inpatient Rates  
CHCS Provider Specialty, CHCS Provider Class, and Health Insurance Portability and  
Accountability Act (HIPAA) Provider Taxonomy  
PATCAT Assignment to Rate Structure

4.1. The MTF UBO staff should ensure that their system administrator has received and downloaded the most current and updated version of the file and tables for appropriate billing.

4.2. Pharmacy Tables. Appropriate billing for pharmaceuticals depends on maintaining pharmacy files and tables.

4.2.1. Managed Care Pricing File (MCPF). This file lists over 100,000 NDCs with a number of important data elements, including NDC description, package size, unit of measure, dosage form, generic drug class, active ingredient(s), and pricing information. The NDCs that have unit measure prices listed in the UBO pharmacy rate files come from the MCPF. The CHCS Pharmacy module transmits the NDC and quantity dispensed to the billing system. Refer to the "DHA UBO Formulary and OTC Unit Rate–Billers' Edition" file posted on the DHA UBO website to translate dosage and unit measures for pricing.

4.2.2. New Pharmaceutical Items. Newly created NDCs may not be in the UBO rate file. An item or service cannot be billed if the UBO has not established a rate for the item or service. However, in the case of NDC-priced pharmaceuticals, if the MTF pharmacy has a cost, follow the *Procedure To Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate* in Appendix A for submitting a request.

4.2.3. Obsolete NDCs. NDCs tend to stay on the NDC rate table for some time after the manufacturer has stopped marketing the NDC because it can take time for the entire product supply to be dispensed. Eventually, the NDC will be dropped from the MCPF and hence the UBO NDC rate table. In most cases, when an MTF has an issue with this, it is because the pharmacy at the MTF is not updating its tables to reflect the new and obsolete NDCs being marketed. MTFs need to work with their pharmacies when obsolete NDCs are passed to the billing systems.

4.3. TPOCS files. The following files are used to transmit patient data through the CHCS/TPOCS interface:

CHCS Daily SIT  
CHCS Daily Provider File  
CHCS Daily OHI  
ADM (Ambulatory Data Module (of CHCS) Encounter Data  
CHCS LAB/RAD (Laboratory and Radiation) Extract  
CHCS Pharmacy Extract

4.3.1. The systems administrator must verify that the files have been sent to TPOCS and that proper synchronization has taken place.

4.3.2. Designated MTF personnel must process these files regularly to ensure that updates have been incorporated into TPOCS tables. Files and tables that are not maintained regularly can affect reimbursement and possibly result in a non-compliant bill or claim.

4.3.3. Safeguards must be in place to prevent unauthorized creation, disclosure, modification, or destruction of these files.

4.3.4. The interface must be safeguarded to ensure that the data is accurate, complete, and readily available. Back-up files should be inspected periodically to ensure they are correct.

4.3.5. Data files transmitted across the interface fall under the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act, and the DoD Privacy Program.

## GRADUATE MEDICAL EDUCATION

Revised: 8 March 2006

1. Residents are individuals who have completed medical school, but are in an additional training program. Residents have provider specialty codes that are different than those physicians who have successfully completed the residency.

NOTE: The correct CHCS Provider Specialty Code assignment and the correct HIPAA Health Care Provider Taxonomy for each encounter are essential to correct billing.

1.2. The term “intern” is sometimes used for residents in their first year of residency. In this section, interns are included in the term resident.

NOTE: “Internist” is an internal medicine physician. An “internist” is NOT the same thing as an “intern.”

1.3. A “fellow” is used in this section for physicians who have successfully completed a residency and have stayed to continue specialized training. Sometimes you will hear fellows referred to as residents.

1.3. Medical Students are individuals participating in, but not yet graduated from, a medical school.

2. Provider Specialty Code (PSC). PSCs are entered in the provider’s profile, usually created in the Credentials Section at the MTF. A provider usually has one PSC, but if the provider has multiple specialties, the provider may have multiple provider specialty codes. For example, an OB/GYN physician who enters a Flight Medicine Residency would have a provider specialty codes of 150 (OB/GYN physician) *and* 301 (Aerospace Medicine Resident).

2.1. Adding a Provider to a CHCS “Clinic.” The data in the CHCS provider profile are used when a provider is added to a “Clinic.” A “Clinic” in CHCS is how the computer system knows the appointment availability of providers in the physical walls of the clinic. For example, there may be five aerospace medicine physicians, one medical student and two residents working in an Aerospace Medicine Clinic. To be able to make appointments for these individuals in CHCS, a “Clinic” is established in the CHCS, indicating the available hours, if the encounters will all be non-count or if there will be count encounters, etc. Then, when a new aerospace medicine resident arrives at the MTF, the CHCS systems people add the provider’s name, PSC, etc., to the CHCS “Clinic.”

2.1.1. In the example above describing an OB/GYN becoming an Aerospace Medicine resident, if the OB/GYN physician still pulled call and delivered babies, the OB/GYN physician would be entered in the OB Clinic using the 150 PSC and would be added to the Aerospace Medicine Clinic using the 301 PSC for Aerospace Medicine resident.

2.2. Medical Students. Medical students are entered as generic technicians using the 900 PSC.

2.3. Residents With or Without Licenses. When performing duties associated with their residency, residents will use the resident provider specialty codes.

2.4. Fellows have successfully completed the residency. Fellows use the specialist PSCs.

3. HIPAA Health Care Provider Taxonomy.

3.1. Medical students will be assigned a HIPAA Health Care Provider Taxonomy of: Student, Health Care 390200000x.

NOTE: 390200000x was new as of 1 January 2005. It was not yet in the CHCS HIPAA table. The HIPAA table was released in November 2005. A message was sent to the Services when the new HIPAA table is loaded.

3.2. Residency does not confer a HIPAA Health Care Provider Taxonomy. Each resident must be assessed to determine if the resident has a license to practice medicine.

3.2.1. Resident With or Without License. If the resident has, or does not have a license, and is performing duties associated with the residency, the resident will be assigned the HIPAA Health Care Provider Taxonomy: Student, Health Care 390200000x.

3.2.2. Residents performing services outside of the residency program, qualifying for another HIPAA taxonomy and performing services associated with the other HIPAA taxonomy, will be assigned the other HIPAA taxonomy. For instance, if a resident also happens to be a physician assistant and is seeing patients in the Emergency Room without supervision of the supervising provider of the residency program, will have that workload associated with the HIPAA taxonomy for a physician assistant which is:

Physician Assistant, Medical: 363AM0700X

Physician Assistant, Surgical: 363AS0400X

3.3. Fellows have medical licenses and have successfully completed a residency. When performing duties in that specialty, the fellow will use the appropriate specialty HIPAA Health Care Provider Taxonomy.

## HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) CODES

Revised: 8 March 2006

1. HCPCS codes are grouped into three levels.

1.1. Level I: Current Procedural Terminology (CPT). The CPT codes are primarily services by privileged providers, commonly called professional services. The codes matched to the nomenclature are copyrighted by the American Medical Association. TMA buys a site license for each MTF annually.

1.2. Level II: HCPCS. These codes are listed in a book of the same name, HCPCS. They are not copyrighted. The list is maintained by the Centers for Medicaid and Medicare Services (CMS). National codes primarily cover services by individuals other than physicians (e.g., dentists, mental health/substance abuse services) and supplies. It also includes provider services, such as screenings, that will be reimbursed by CMS. For instance, if a physician performs an annual woman's exam, the CPT code 99395 would be coded. However, because CMS only pays for the screening and not the entire physical, there is a code just for the screening.

1.2.1. When both CPT and HCPCS Level II codes have virtually identical narratives for a procedure or service, the CPT code is used. If, however, the narratives are not identical (e.g., the CPT code narrative is generic, whereas the HCPCS Level II code is specific) the Level II code is used.

1.2.2. HCPCS Level II codes begin with a single letter (A through V) followed by four numeric digits. They are grouped by the type of service or supply they represent. HCPCS Level II codes listed on the CMAC Rate Table (J, G, P and Q) and are billable.

1.2.3. Durable Medical Equipment and Durable Medical Supplies (DME/DMS) are billed based on the DME/DMS Rate Table. This is automated by systems to apply the correct rate.

## HEALTH INSURANCE

Revised: 8 March 2006

1. Standard Insurance Table (SIT). The SIT serves to centralize claim address information across the MHS resulting in use of up-to-date and accurate payer information.

1.1. Users assigned the SIT Security Key in CHCS may add Temporary (Temp) entries to their local SIT.

1.2. Users should avoid adding a duplicate entry to the SIT by “looking up” insurance companies by their street address (instead of the Insurance Company Name or Short Name fields) before adding a Temp entry.

1.3. Prior to adding a Temp entry to the SIT, the insurance company’s claims address and contact information should be verified by calling the insurance company before being entered.

1.4. Data for the Temp entries should be entered as accurately and completely as possible.

1.5. “Local Comment” Fields may be used as a free text field, allowing users to include important, site specific notes on each SIT entry. Example: “Ask for Tammy in Medical Claims Department.”

1.6. The “Standard Comment” field is used to share information that may be useful to all sites in submitting claims to a certain payer. This field is only populated by the DoD Verification Point of Contact (VPOC).

2. Adding Temp Entries. All temp entries added to the local CHCS SIT, should also be submitted to the VPOC so that the centrally managed SIT database can be updated.

2.1. Use the SIT Request spreadsheet posted on the TMA UBO website to submit the new entry to the VPOC.

2.2. Make sure you complete the MTF name, your name, and contact number at the top of the form. All requests must be verified.

2.3. Required data elements include the following:

- Insurance Company Name
- Street Address
- City, State, Zip Code
- At least one valid telephone number

2.4. E-mail SIT requests to ubo@tma.osd.mil and include in the subject line: SIT ADD REQUEST

2.4. Refer to the Future Enhancements/Current Changes section of this Guide for additional information on adding new Temp entries with the CHCS/New DEERS Interface.

3. Other Health Insurance (OHI). Section 1095 of USC Title 10 established the right of the United States to bill and collect reasonable charges from third party payers for healthcare services provided by facilities of the Uniformed Services to covered beneficiaries who are also covered by the third party payer’s insurance. This includes workers’ compensation and Medical Affirmative Claims (MAC).

3.1. The law mandates that the operation of the Third Party Collection Program is not dependent upon a participation agreement, or any similar contractual relationship, between MTFs and third party payers. This includes PPOs and any third party liability insurances.

3.2. The Code of Federal Regulations implements the law. Title 32, Section 220.2(d) of the code states that an assignment of benefits or other submission by the beneficiary is not necessary for MTFs to bill third party payers.

3.3. Admissions personnel must collect information pertaining to other health insurance (OHI) for all DoD beneficiaries, except active duty members. OHI is defined as the existence of insurance coverage, excluding TRICARE and Medicare.

3.3.1. Ideally, this information should be collected at the time of registration, appointment, and/or check-in.

3.4. OHI information will be reviewed annually and verified with the beneficiary at every visit. Additionally, insurance information should be verified with the insurance carrier before entering in CHCS.

3.5. OHI will be collected on Third Party Collection Program - Record of Other Health Insurance, DD Form 2569.

3.6. The original (complete, signed, and dated) DD Form 2569 will be placed in the patient's medical record. Another form may be used to collect the data, as long as the form is attached to the DD Form 2569 (on which is written "See attached"). A copy of the documentation (DD 2569 and/or the other form) is forwarded to Billing. Billing personnel will verify the documentation, and then enter it in CHCS. A completed, original, current DD Form 2569 must be in the inpatient record, the outpatient record and all ambulatory procedure visit records.

3.7. MTF-specific OHI collection forms may not be maintained in the medical record.

3.7.1. Ancillary OHI Form, Negative Response. A common practice for the ancillary "no, I don't have any other insurance" forms is to keep them in a file in Billing by month. At the end of 12 months, the documents are shredded and the new month's forms are placed in the file. Another practice is to file the "ancillary OHI no" forms alphabetically by patient's last name.

3.7.2. Ancillary OHI Form, Affirmative Response. For OHI collected by ancillary departments, the ancillary OHI forms are kept in Billing, filed by patient name.

3.8. CHCS is the repository for all OHI data and transmitted to TPOCS. Modifications to OHI must be made in CHCS.

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Revised: 9 March 2006

1. Background. The 1996 Health Insurance Portability and Accountability Act (HIPAA), established new standards and requirements for health plans, clearinghouses, and healthcare providers that transmit health information electronically. Implementing regulations issued by the Department of Health and Human Services established requirements for standard code sets to be used when transmitting HIPAA compliant transactions, information security guidance, as well as rules to protect patient confidentiality.

2. HIPAA Provider Taxonomy – Military Unique Codes. These codes are used only by the Military Health System (MHS) and the US Coast Guard. Except for the IDCs and IDMTs, the appropriate individual taxonomies, such as radiologist, psychologist, certified registered nurse anesthetist, and optometrist are listed in the Health Care Provider Taxonomy list available on the UBO website. The non-individual (organizational) HIPAA codes listed in paragraph 2.2., below, will probably be the only HIPAA organizational codes used by a military treatment facility (MTF).

## 2.1. Individuals

1710I1002X Independent Duty Corpsman – A Navy Independent Duty Corpsman (IDC) is an active duty Sailor who has successfully completed one of the Navy's specific IDC training programs. IDCs are formally trained and educated to perform primary medical care and minor surgical services in a variety of health care and non-health care settings worldwide under indirect physician supervision. IDCs provide care to Department of Defense operational forces and other supporting forces, such as contractors and foreign nations.

1710I1003X Independent Duty Medical Technicians – an Independent Duty Medical Technician (IDMT) is specially trained and educated to perform primary medical care, minor surgical services, and treatment of dental disorders for active duty military members in a variety of health care and non-health care settings worldwide under direct and indirect physician supervision. An IDMT may take medical histories, perform physical exams, order lab tests and x-rays, prescribe medications, and give immunizations. IDMTs work under the direct supervision of a physician preceptor when at home station and indirectly when assigned to a Mobile Aid Station, Mobile Medical Unit, remote site, or otherwise deployed specifically as an IDMT.

An IDMT may be an experienced Aerospace Medical Service Technician who meets special qualifications and is recommended for training by the Aerospace Medical Service Functional Manager at their Medical Treatment Facility.

IDMTs maintain certification as Nationally Registered Emergency Medical Technicians and as Immunization Back-up Technicians.

## 2.2. Agency

261QM1101X – Military and U.S. Coast Guard Ambulatory Procedure – That part of a “fixed” (non-temporary, non-deployed) DoD or Coast Guard entity furnishing surgical procedures requiring medically supervised recovery. This is similar to a civilian ambulatory surgical center. It may be in shared resources with a DoD or Coast Guard Clinic or a DoD Hospital. It does not include items issued directly to a patient from an outpatient pharmacy or patient transport. It includes initial “take home” pharmaceuticals.

261QM1103X – Military Ambulatory Procedure Visits Operational (Transportable) – “Non-fixed” facilities or distinct parts of a “non-fixed” facility, providing outpatient surgical procedures requiring medically supervised recovery. It does not include items issued directly to a patient from an outpatient pharmacy or patient transport. It includes initial “take home” pharmaceuticals.

261QM1100X – Military/U.S. Coast Guard Outpatient – The Defense Health Program or U.S. Coast Guard funded “fixed” facilities or distinct parts of a facility, providing outpatient medical and dental services, primarily for Uniformed Services beneficiaries. A “fixed” facility is a non-temporary, non-deployed facility. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the “fixed” facility. It includes, as examples, the institutional portion of outpatient encounters (except Ambulatory Procedure Visits), supplies issued (e.g., glasses, ostomy supplies, crutches), and radiology and laboratory studies. It does not include items issued directly to a patient from an outpatient pharmacy or patient transport.

#### 286500000X – Military Hospital

2865M2000X – Military General Acute Care Hospital – A Department of Defense (DoD) healthcare organization furnishing inpatient care 24 hours per day in “fixed” facilities, primarily for DoD beneficiaries. The entity is Defense Health Program (DHP) funded. A “fixed” facility is a non-temporary, non-deployed facility usually used for healthcare services. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the “fixed” facility. It includes those services and institutional costs usually included in a Diagnosis Related Group as well as “pass-through” items.

2865X1600X – Military General Acute Care Hospital; Operational (Transportable) – A DoD healthcare organization furnishing inpatient care 24 hours per day in “non-fixed” or deployed facilities. The entity is not DHP funded. Services are primarily intended for DoD active duty although some services may be furnished for non-DoD active duty. “Non-fixed” facilities are generally deployed DoD healthcare activities that do not provide services on or in association with a DoD fort or base. “Non-fixed” facilities include hospital ships.

291900000X – Military Clinical Medical Laboratory – A DoD medical clinical reference laboratory not associated with a DoD Hospital or DoD Clinic. An example is the Armed Forces Institute of Pathology.

332000000X – Military/U.S. Coast Guard Pharmacy – A DoD or U.S. Coast Guard entity whose primary function is to store, prepare, and dispense pharmaceuticals and other associated items to Uniformed Services beneficiaries. These pharmacies may be associated with a DoD or U.S. Coast Guard clinic, DoD Hospital or may be freestanding. This is usually associated with outpatient services.

### 2.3. Transportation

341800000X – Military/U.S. Coast Guard Transportation – Definitions to come .... (1/1/2005: new)

3418M1120X – Military or U.S. Coast Guard Ambulance, Air Transport – Vehicle and staff for patient emergency or non-emergency air transport. (1/1/2005: new)

3418M1110X – Military or U.S. Coast Guard Ambulance, Ground Transport – Vehicle and staff for patient emergency or non-emergency ground transport. This includes traditional ambulances as well as ambulance buses. (1/1/2005: new)

3418M1130X – Military or U.S. Coast Guard Ambulance, Water Transport  
Vehicle and staff for patient emergency or non-emergency sea/water transport. (1/1/2005: new)

### 3. HIPAA Electronic Billing Function Business Rules Overview

3.1. The HIPAA “837” refers to the electronic health care claim transaction. It refers to both professional (837p) and institutional (837i) transactions. Within the scope of the Military Treatment Facilities (MTF) business office operations, the electronic 837 transaction currently applies only to the Third Party

Collections Program (TPCP) Outpatient Itemized Billing (OIB) program. It is not anticipated that the MSA module in CHCS will ever generate electronic bills. The Charge Master Based Billing (CMBB) software billing system will generate electronic bills.

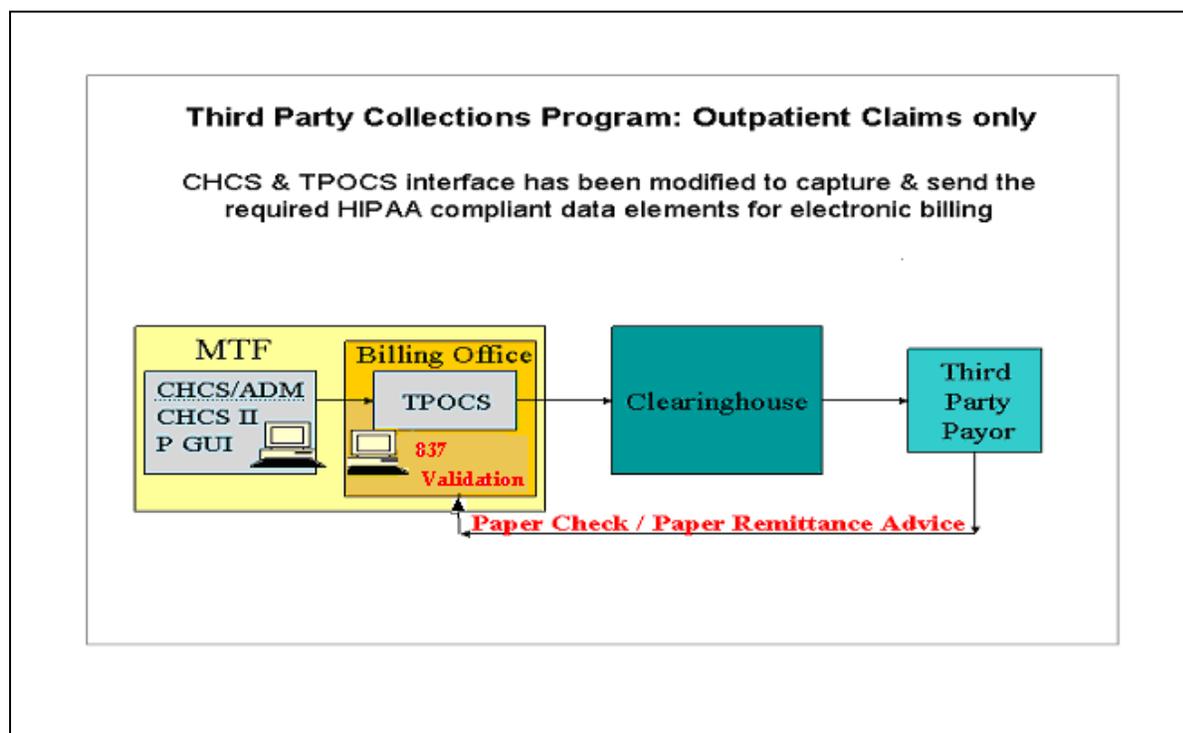
3.2. The HIPAA compliant format mandates specific data elements. The interface between CHCS and TPOCS captures and sends the required HIPAA compliant data elements for electronic billing. Data required for electronic billing cannot be entered in TPOCS. TPOCS performs a HIPAA edit check prior to the transmission of all electronic claims. If the claim does not meet the HIPAA electronic transmission requirements, it will result in a paper claim. Outpatient visits and pharmacy claims are the primary types of services currently being electronically billed.

3.3. Only bills flowing to TPOCS are currently able to generate an electronic bill. Bills that are manually entered in TPOCS cannot be electronically billed.

3.3.1. The following claims submissions will require paper format: ambulance, dental, inpatient TPC, MSA, MAC, and ancillary services, to include laboratory and radiology.

3.4. Currently, remittances sent to the MTF by the Third Party Payer (e.g., Explanation of Benefits [EOBs] and payments), continue to be in the paper format.

#### 4. Process Flow Diagram of the MTF HIPAA 837 Electronic Billing Process



#### 5. MTF Revenue Cycle Front

##### 5.1. CHCS/ADM: Data Element Collection Requirements

##### 5.1.1. Capture of Other Health Insurance (OHI)

Subscriber's gender and date of birth (DOB): HIPAA required fields.

Data Source: CHCS.

5.2. The patient is NOT always the OHI policy holder/subscriber: Patient is defined as the beneficiary covered by the subscriber's insurance policy; Subscriber is defined as the name listed in the health insurance policy.

5.3. The HIPAA software conversion will automatically populate these fields *if* the subscriber has been previously entered into CHCS. If the subscriber information is not contained in CHCS and/or is not authorized to receive care in an MTF, the MTF will need to establish procedures to obtain this information (subscriber's gender and date of birth) and input the data into CHCS (Other Health Insurance – Enter/Edit Continuation Screen).

5.3.1. Additional insurances have been added. Legacy insurance selections in CHCS have been mapped to the new HIPAA Insurance Type Table. Below is a list of additional HIPAA insurance types that have been added to the CHCS table for HIPAA compliance.

#### Insurance Type Code

AP	Auto Insurance Policy, e.g. GEICO policy
C1	Commercial, e.g. BC/BS fee for service or 80/20 policy
CP	Medicare Conditionally Primary – primary for a particular condition, e.g. conditionally, Medicare benefits may be paid while a workers compensation claim is pending payment
GP	Group Policy – risk sharing, group policy through place of employment
HM	Health Maintenance Organization, network of providers, need referrals, e.g. CIGNA Healthcare
IP	Individual Policy – no risk sharing, e.g. individual that is self-employed and owns policy
LD	Long Term Policy – policy for long term care, e.g. assisted living/nursing home
LT	Litigation – MAC or tort claim, liability may lie elsewhere rather than healthcare coverage
MB	Medicare Part B
MI	Medigap Part B – supplement to Medicare Part B
MP	Medicare Primary – Medicare Part A, Medicare is patient's primary insurance
OT	Other
PP	Personal Payment – self-pay, no insurance
SP	Supplemental Policy – any policy that is not patient's primary insurance

#### 5.4. Pregnancy Related Claims

NOTES: (1) HIPAA alpha test site recommended MTF business practice: Include the patient's LMP and estimated date of birth data field in the new OB orientation paperwork. If data are entered into an OB clinic database, provide access to other MTF clinics, to include outpatient coding staff. (2) HIPAA alpha test site recommended MTF business practice: Include the patient's LMP and estimated date of birth on all OB consults/ referrals to other MTF clinics/specialty providers. If this information is not available, the dates are estimates based on information provided by the patient.

5.4.1. Pregnancy Related Indicator: new data field;  
Situational HIPAA requirement for clinical encounters that are pregnancy related.  
Data source: ADM (P-GUI & CHCS II fields will be available by May 2004).

5.4.2. If the Health Care Provider (HCP) enters "Yes" in the Pregnancy Related Field, the last menstrual period (LMP) and estimated date of birth required fields are triggered for data entry. Data entry will require the MM/DD/Year format.

5.4.3. Specialty care: when a pregnant patient receives treatment in a specialty clinic the following guidance is provided:

5.4.3.1. Pregnancy related conditions: HCP should enter "Yes" in the Pregnancy Related Field. This will trigger the LMP and estimated date of birth fields, which will require data entry to complete the ADM encounter.

5.4.3.2. NOTE: pregnancy related conditions pertain to treatment received during the prenatal timeframe and not during the post-partum period.

Non-pregnancy related conditions: HCP enters “No” in the Pregnancy Related Field. MTF staff responsible for coding the encounter should use ICD-9-CM V22 (V22.0, V22.1, V22.2) diagnosis codes.

## 5.5. Injury Related Claims

NOTE: This HIPAA requirement pertains to the initial treatment of an injury, not the subsequent after-care. Pursuant to national and MHS ADM Coding Guidelines, E-Codes are used to code the treatment for an initial injury. The ADM record will require an E-Code in order to complete the record.

5.5.1. Injury Related Field: new data field;  
Situational HIPAA requirement based on the reason for the encounter and the Common Procedural Treatment (CPT) codes used.  
Data source: ADM/PGUI/AHLTA.

5.5.2. If the HCP/MTF staff enters “Yes” in the Injury Related Field, the date and cause code (reason for injury) fields are triggered. The Injury Related Field will automatically trigger to “Yes” with the use of an E-code by the HCP/MTF coding staff.

5.5.3. Cause Codes: (Note: User can select up to 3 Cause Codes)

AA- Automobile- the injury involved an automobile  
AP- Another Party Responsible- liability lies with another individual or entity  
EM- Employment- Occurred while on the job  
OA- Other Accident- All other injuries

5.5.3.1. The AA cause code will trigger an additional field, geographical location, which requires data input. HIPAA mandates the use of [ISO] standard state/country codes to identify the place where the injury occurred.

5.5.3.2. CONUS: Pick-list available from FIPS state codes (TPOCS will convert to ISO standard)

5.5.3.3. OCONUS: Pick-list available for OCONUS sites and ship locations

5.5.4. Previous Record Entry/Current Functionality in ADM – This is an existing ADM functionality that may impact new HIPAA-related data. It pulls over ICD-9-CM codes from the patient’s last encounter. It is clinic specific.

5.5.4.1. Implication of this functionality is the possibility of auto populating an E-code from the prior initial injury related encounter. Injury related information is collected for initial injury only. In this instance, user must switch “Yes” to “No” for “Injury Related” and edit the E-code. The MTF CHCS administrator has the capability to turn this function “on or off,” as directed by the clinic manager/supervisor.”

## 5.6. Ancillary Services

5.6.1. Laboratory: MTFs will be required to use the paper format to submit all laboratory claims.

5.6.1.1. Future functionality – if an MTF has the CHCS lab interoperability in use, a new data field is required: the Clinical Laboratory Improvement Amendment (CLIA) number. The CLIA will be required for all external labs. The CLIA number will require a one-time entry into the MTF’s laboratory file and table fields.

5.6.2. Radiology: MTFs will be required to use the paper format to submit all radiology claims.

5.6.3. Pharmacy: Pharmacy can be billed electronically or using paper forms.

5.6.4. Ambulatory Procedure Visits (APV) – Database administrators should ensure that the MTF location file is set up appropriately to identify APV appointments.

5.6.4.1. User adds prior authorization number to an APV, as required. It is recommended that current business process of acquiring prior authorization numbers be evaluated. An APV prior authorization number MUST be entered in CHCS to be pushed to TPOCS to result in a HIPAA compliant electronic bill.

5.6.4.2. During an APV, the user is prompted to identify additional providers associated with the encounter. Name, order and role of providers are entered. The provider in the first position is always the Appointment Provider.

5.6.4.3. “Operating Provider” has been added to the drop down list available for Appointment Provider for an APV. Operating Provider is the default role for APVs.

## 6. Provider Taxonomy

6.1. Provider taxonomy is a required HIPAA electronic billing field. Providers are mapped to a CMAC provider class and a HIPAA provider taxonomy code based on their medical specialty in CHCS. This occurs when a provider profile is created for the provider in CHCS. This table is maintained in CHCS and the appropriate provider taxonomy code is automatically pushed to TPOCS for billing purposes.

6.2. Provider specialties/taxonomy for outside providers: at least one provider specialty is required for all new outside providers if they meet the following criteria:

Provider flag is “PROVIDER”  
Provider has a DEA#  
Provider class is “OUTSIDE PROVIDER”

6.2.1. If a user attempts to enter a new outside provider without a provider specialty, the following message is generated:

“At least one provider specialty is required for external providers. If you do not know which specialty to enter, enter 000 for GENERAL MEDICAL OFFICER if the external provider is a physician. (CMAC Provider Class = 01)”

## 7. Claims in Paper Form

7.1. Currently, ambulance, dental, inpatient TPC, MSA, MAC, laboratory, radiology, and manual bills will print on a paper claim.

## 8. MTF Revenue Cycle Third Party Collections Office (in TPOCS, not in CHCS)

8.1. Condition Codes (to be entered by billing personnel with drop down menu availability) – These are two-digit number codes entered on the UB-04 to indicate that a condition applies to a claim, coverage exists under another insurance, whether the injury or illness is related to employment, or identifies conditions that may affect payment processing

8.2. Payer specific – Billing personnel should contact payers and determine what condition codes payers require. Up to four codes may be listed. Below is a list of condition codes used in the outpatient setting. Please refer to this list when talking with payers.

<u>Code #</u>	<u>Condition Code</u>	<u>Applicability</u>
03	Patient Covered by Insurance Not Reflected Here	Applicable for outpatient services (commercial billing)

<u>Code #</u>	<u>Condition Code</u>	<u>Applicability</u>
04	Patient is HMO Enrollee	Applicable for outpatient services (commercial billing)
06	ESRD Patient in First 18 Months of Entitlement covered by Employer Group Health Insurance	Applicable for outpatient services (commercial billing)
18	Maiden Name Retained	Applicable for outpatient services (commercial billing)
19	Child Retains Mother's Name	Applicable for outpatient services (commercial billing)
28	Patient and/or Spouse's Employer Group Health Plan is Secondary to Medicare	May be applicable to Medicare electronic billing
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	May be applicable to Medicare electronic billing
30	Non-Research Services Provided to Patients Enrolled in a Qualified Clinical Trial	Applicable for outpatient services (commercial billing)
31	Patient is Student (Full-Time Day)	Applicable for commercial billing
32	Patient is Student (Cooperative/Work Study Program)	Applicable for commercial billing
33	Patient is a Student (Full-Time Night)	Applicable for commercial billing
34	Patient is Student (Part-Time)	Applicable for commercial billing
78	New Coverage Not Implemented by HMO	For Medicare billing (when HMO does not cover)
<b>B3</b>	<b>Pregnancy Indicator</b>	<b>Required by HIPAA</b>
G0	Distinct Medical Visit	Applicable for Medicare electronic billing when multiple medical visits occurred on the same day in the same revenue center with different chief complaints

### 8.3. New Tables, Reports, and Data Capture in TPOCS

8.3.1. Provider Taxonomy Descriptions and Codes Table – non-editable by billing personnel. HIPAA requires Provider Taxonomy to be sent on an electronic claim.

8.3.2. Person Relationship Description and Code Table – non-editable by billing personnel. Relationship table has been remapped from CHCS to HIPAA relationship codes and sent to TPOCS.

8.3.3. Insurance Type Description and Code Table – non-editable by billing personnel. Additional insurances are added and remapped to HIPAA insurance table.

8.3.4. HIPAA Validation Error Report – Report to show claims that were tagged for electronic billing, but did not meet new HIPAA requirements and defaulted to a paper bill (Refer to Table A below). New message to show why a claim was tagged for electronic billing but did not meet the new HIPAA requirements and defaulted to a paper bill (Refer to Table B below).



## HELP DESK SUPPORT

Revised: November 2013

1. General. MTF personnel should first contact their MTF, Region, or Service/Defense Health Agency (DHA) Program Manager for assistance and guidance. Additional assistance is available from several resources regarding UBO functions and Military Health System (MHS) systems. **Do NOT send patient protected health information (PHI) or personally identifiable information (PII), see Security Precaution in the box on this page.**

2. DHA UBO Help Desk. Submit questions about UBO rates, processes, and policies to [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) or call (571) 733-5935. Replies are provided, in general, within one business day. Inquiries are routed to the appropriate DHA UBO Contract Support Subject Matter Expert for research and response. If resolved, the ticket is “closed.” If necessary and as appropriate, the issue may be elevated to the Service UBO Program Manager or the DHA UBO Program Office for review and response.

3. DHA UBO Verification Point of Contact (VPOC) Helpdesk. Address questions about the Standard Insurance Table (SIT) and Other Health Insurance (OHI) to the VPOC at [VPOC.Helpdesk@altarum.org](mailto:VPOC.Helpdesk@altarum.org). Use this email as well to enter and update OHI and SIT information and to keep a subscription current in the master SIT, in addition to updating your local SIT.

4. DHA UBO Website. View UBO information and resources at <http://tricare.osd.mil/ocfo/mcfs/ubo/index.cfm>

5. DHA UBO Learning Center. View free, on demand, online, and archived DHA UBO webinars at [http://tricare.mil/ocfo/mcfs/ubo/learning\\_center.cfm](http://tricare.mil/ocfo/mcfs/ubo/learning_center.cfm). They provide current and topical DoD and industry medical billing and coding training to support the MHS's revenue cycle management and patient accounting activities. Submit recommendations for speakers and topics to [UBO.LearningCenter@altarum.org](mailto:UBO.LearningCenter@altarum.org).

6. MHS Help. For assistance with MHS systems and applications, contact the following sources.

6.1. Website (Common Access Card (CAC) required):  
[https://www.mcis.osd.mil/cm/user\\_support.cfm](https://www.mcis.osd.mil/cm/user_support.cfm)

Tier 1 application support analysts answer, document, and triage all inbound calls and email Incidents. Tier 2 application support analysts provide advanced software/systems support and assist Tier 1 analysts on supported MHS applications and escalated Incidents.

- AHLTA (military electronic health record; Armed Forces Longitudinal Technology Application)
- TOL (TRICARE Online)
- DMHRSi (Defense Medical Human Resources System – Internet)
- MHS Learn
- DMLSS (Defense Medical Logistics Support System)
- CHCS (Composite Health Care System)

**SECURITY PRECAUTION:**  
*Review all e-mails prior to sending them to the Help Desks to ensure they do not contain PHI or PII. Remove and de-identify all unique person identifiers in your data before sending. Blocking or covering PHI or PII in a screen shot of encounter data is not sufficient.*

### Sample UBO Help Topics

1. Content of code and rate tables
2. Mapping of codes to the rate tables
3. Billing policy
4. SIT/OHI reporting issues

### Sample CHCS Help Topics

1. Database (DB) warning/error messages displayed to the user
2. Nightly data feeds from CHCS/Ambulatory Data Module (ADM) not being received and/or loaded into the system
3. Hardware warning messages/failure
4. Security/Information Assurance Vulnerability Alert (IAVA) issues
5. Server not loaded with the current code and/or rate table release
6. Server not loaded with the current release of the client application
7. Server not loaded with the current database upgrades

## 6.2. Telephone Numbers

CONUS (Continental U.S.) Toll Free: **1-800-600-9332**

OCONUS (outside CONUS) Toll Free:

Belgium: 0800-72115

Germany: 0800-1011129

Greece: 00800-12-5629

Guam: 1-866-637-8725

Italy: 800-782407

Japan: 00531-1-20743

Korea: 00798-14-800-5242

Netherlands: 0800-0228847

Panama: 001-800-151-1005

Portugal: 800-8-12305

Turkey: 0-800-151-1005

United Kingdom: 08-005871786

Spain: 900-951895

DSN (Defense Switched Network): **312-838-3000**

### 6.3. Email

For email incidents: [mhssc@tma.osd.mil](mailto:mhssc@tma.osd.mil)

For comments, questions, or concerns: [mhssd tm@tma.osd.mil](mailto:mhssd_tm@tma.osd.mil)

6.4. Administrative Support –The MHS Excellence Dashboard. The MHS Excellence Dashboard is a web-based portal that allows access to MHS Service Desk (MHSSD) performance metrics and the status of incidents submitted by MTFs. The Dashboard is available to Program Management Offices (PMOs) and MTFs and provides a real-time view into current Incidents, as well as the ability to generate standard reports and customize charts by location. Access requires valid CAC. Go to <https://timpodash.timpo.osd.mil>, complete the registration form, and submit your request. Requests are generally processed within 24 hours.

6.5. Online Training. View various MHS training courses, including mandatory Privacy Act and Health Insurance Portability and Accountability Act (HIPAA) training, at <http://www.tricare.mil/tma/privacy/MilitaryHealthSystemLearningPortal.aspx> (CAC required).

## IMMUNIZATION/INJECTION/INFUSION SERVICES

Revised: 8 March 2006

1. When an immunization or injection is the only service provided, the appropriate immunization/injection code is used to bill for this service. There will be a code for the actual injection and a separate code to reflect the vaccine product. There is no applicable Evaluation & Management Code (E&M), but to have data flow to TPOCS, the E&M code 99499 needs to be entered in the E&M field.

2. For data collection purposes, when a patient is seen in a clinic setting and then referred to an immunization clinic for injections, two encounters are generated. One encounter relates to the clinic visit, and the other relates to the immunization visit. This will generate two claim forms, one for the injection (UB-04) and one for E&M (CMS 1500).

3. If the injection is given during the initial clinic visit, the visit will have a minimum of three codes, one E&M code, one injection code (e.g., 90471), and the vaccine code. It will also have multiple diagnosis codes, one for the reason for the visit, and a V-code to explain the need for the vaccination, such as V04.81 Need for prophylactic vaccination for influenza.

### 4. Vaccines/Toxoids

4.1. Immunization administration CPT codes 90471-90472 and 90473-90474 must be billed in addition to one of the appropriate vaccine/toxoid CPT codes 90476-90749.

4.2. Payers now require specific prophylactic diagnosis codes (ICD-9-CM V-codes) for immunization(s). They generally no longer accept V07.8 (other specified prophylactic measure) when billed with an immunization.

### 5. Therapeutic/Prophylactic/Diagnostic Injections

5.1. CPT codes 90782-90799 are used for the *administration* of therapeutic, prophylactic, or diagnostic injections. These administration codes do not include the substance(s) injected.

5.2. The appropriate HCPCS Level II J-code *must* be used in addition to the administration codes(s) to bill for the substance(s) *injected if it was specially ordered by the clinic for the patient*. If the substrate is from clinic stock, or issued to the patient by the pharmacy, the J-code should not be used. If it is from routine clinic stock, the cost is included in the institutional component of the clinic visit. If it is issued to the patient by the pharmacy, the pharmacy will show the substance was dispensed.

### 6. Therapeutic or Diagnostic Infusion (Excluding Chemotherapy)

6.1. Time-based codes 90780-90781 are used to bill infusion *administration*. A physician's presence is required for these infusion services. Ringers or other solutions that are transfused are part of the institutional component of the administration code when the solution was clinic stock or issued to the patient by the pharmacy.

6.2. The appropriate HCPCS Level II J-code *must* be used in addition to the administration codes(s) to bill for the substance(s) infused if the infused diagnostic or therapeutic substance was ordered for the patient and paid for with clinic funds.

### 7. Billing Vaccinations.

## ITEMIZED POSTING OF RECEIPTS

Revised: 8 March 2006

1. As Explanations of Benefits (EOB) are remitted reflecting a full or partial payment to the MTF, the user must post payments to the General Ledger on a line-item basis.
2. Because many payers submit payments for multiple claims and multiple beneficiaries, all line-items on the EOB should be reconciled with Accounts Receivable (A/R) prior to posting payments and depositing funds.
3. Prior to posting payments, the A/R clerk should at a minimum:
  - 3.1. Obtain the Control Number for each payment.
  - 3.2. Verify the amount paid against the amount billed.
  - 3.3. Determine amounts to be written off by applying DoD approved closure reasons.
4. Upon entering the control number in TPOCS, the General Ledger screen populates with each line item billed for that claim. Each line item must be processed separately.
5. For each line item displayed in the Detail Posting Tab, the following will not be editable:
  - 5.1. Procedure Code (CPT, HCPCS, NDC) and associated modifier(s),
  - 5.2. Original Amount (this amount changes as payments, write-offs or adjustments are made and saved),
  - 5.3. Either the Credit or Debit field; depending upon the transaction code selected,
  - 5.4. Current Balance,
  - 5.5. Percent Paid.
6. If payment is received in full, a "Pay in Full" button is available for instant posting to all line items.
7. If appropriate, the user must write off the balance of the line item with the "Write Off" button.
8. Any adjustments to be made to the account can be accomplished at the "Adjustment" tab or by choosing Adjustment from the General Ledger drop down menu.
9. *Any patient having a secondary OHI policy is identified in the Itemized posting screen by an alert prompting the user to indicate whether or not secondary billing is desired.*

*Reviewers: Which one is it?*

*Option A. After you have input and save with a write-off transaction code, you will be permitted to bill secondary insurance.*

*Option B. If secondary insurance exists and the user proceeds with secondary billing, the account for the primary payer is automatically closed and the remaining balance is billed to the secondary insurer.*

The secondary claim is reported with the same control number followed by an "a" (e.g., A12345a).

10. The UBO will migrate to HIPAA denial/adjustment reason codes in the future when the DD Form 2570 is revised to accommodate itemized posting.

11. Please refer to the TPOCS Users' Guide for instructions on posting payments and other General Ledger transactions.

12. A manual process must be put into place by the MTF for the acceptance of *payments* that do not belong to the MTF. It is recommended that MTFs create a log to track manual deposits and refunds and a separate customer number to deposit these collections into.

12.1. Payments received in error by TPP. There will be time that you receive a payment on a patient that does not belong to you. Since you do not have a bill in either TPOCS or CHCS recommended action would be:

12.1.1. If the check only includes this payment error, return check and make a note on your check log that the check was returned.

12.1.2. If the check includes payments that belong to you, post those payments where they belong.

12.1.3. Create a separate DD1131 to deposit into a separate customer number for that portion of the check that could not be posted.

12.1.3.1. Note on the DD1131 the patient, payer, check number, date of check, reason for manual deposit, etc.

12.1.4. Log in manual deposit information on a manual deposit tracking log.

12.4.1.1. Forward manual deposit information to the person responsible for approving refund actions.

13. TPOCS is not programmed to accept posting of payments or adjustments larger than the amount of the original bill for that line item. Most common reasons are TPP keyed in the wrong amount billed causing an overpayment, interest payment, TPP allowed more than the amount billed. You could either deposit the payment in to the appropriate TPCP customer number or you could establish a separate customer to deposit overpayments into.

14. It is imperative that the user reconciles all payments prior to posting and before depositing funds.

15. The Itemized posting process involves a significant number of steps to process payments and close claims. The A/R clerk should allow adequate time for the posting process.

Examples:

Line item overpaid due to processing error by TPP.

You billed BCBS \$50.00 for an office visit. BCBS incorrectly keyed in amount billed as \$500.00 and paid \$480.00 (office visit copay of \$20.00)

You would post \$30.00 to the line item.

Manually deposit \$450.00.

Refund \$450.00 due to TPP processing error.

Line item overpaid due to TPP allowed more than billed.

You billed AARP \$113.57 for CPT 90371, AARP allowed \$571.40 and paid 20% - \$116.28.

You would post \$113.57 to the line item.

Manually deposit \$2.71.

Refund \$2.71 due to overpayment.

## LABORATORY SERVICES

Revised: November 2013

1. General. Laboratory Services are billed based on the Current Procedural Terminology (CPT®<sup>11</sup>) code assigned. The Defense Health Agency (DHA) UBO assigns rates to the CPT codes. Only DHA UBO–assigned rates can be used unless the tests were performed under supplemental care MTF paid another entity, and the fee is a “pass-through.”
2. Billing for Tests Performed External to the MTF and Billed to the MTF by the External Laboratory. MTFs bill payers for laboratory services performed by external laboratories using the modifier -90, Reference (Outside) Laboratory. The charge will be the price paid by the MTF to the external laboratory. Billing personnel will need obtain this price from Resource Management.
3. Billing for Tests Performed External to the MTF and NOT Billed to the MTF. The Military Health System (MHS) has reference laboratories, such as Armed Forces Institute of Pathology (AFIP) and the Wright-Patterson Medical Center Laboratory. There are also instances where a small MTF collects specimens that are tested at a larger MTF, and the results returned to the MTF so that the patient can receive the results from his or her provider. Use the DHA UBO rates when samples are collected at the MTF and sent to an external laboratory but the external laboratory does not bill the MTF. These tests should have the modifier -90, Reference (Outside) Laboratory, to indicate they were not done by the MTF.
4. Billing. DHA UBO rates provide separate professional and technical component rates for procedures where applicable and a single global rate when separate charging is not applicable for the procedure. When separate technical and professional rates are available, the global rate is the sum of the technical and professional component rates.
  - 4.1. A service that has a professional component in which the provider reads and interprets the results of a test performed by a technician is designated by a CPT/Healthcare Common Procedure Coding System (HCPCS) code and modifier -26 on the professional claim.
  - 4.2. The technical component is reported on the institutional claim with the modifier -TC. In the Composite Health Care System (CHCS) Laboratory module, modifier -32 is used to indicate the technical component. When this modifier flows to the billing application, it is changed to -TC, which will appear on the bill.
  - 4.3. Procedures that have separate professional and technical component rates but no -26 or -TC modifier indicate that the entire procedure was performed, and the global (combined) rate is applied.
5. Claim Forms. In general, laboratory services without modifiers and those with the modifier -TC will be reported on the institutional Uniform Bill 04 (UB-04) paper or 837I electronic claim. When only a professional component of a laboratory service is performed, the CPT with the professional claim with modifier -26 should be reported on the professional Centers for Medicare & Medicaid Services (CMS) form 1500 paper or 837P electronic claim. Verify the assigned revenue code for each CPT/HCPCS code submitted. (See *Revenue Code* section in this User Guide for further guidance.) The number of outpatient laboratory tests for each CPT code is entered in Form Locator (FL) 46 “Service Units” on the institutional claim and Item Number (IN) 24.G “Days or Units” on the professional claim.
6. Pre-Admission Services. Diagnostic services performed for pre-admission are itemized and billed separately from the inpatient bill. Pre-admission services are normally not included in the inpatient Medicare Severity Diagnosis Related Group (MS-DRG) inpatient charge. However, if the patient is admitted from the emergency department, charges are bundled into the MS-DRG charge. For Third Party Collection (TPC), Medical Affirmative Claims (MAC), and most Medical Services Accounts (MSA) payers,

---

<sup>11</sup> CPT is a registered trademark of the American Medical Association

there is no separate charging for emergency department services leading directly to an admission. Under Department of Veterans Affairs (VA)-DoD Resource Sharing Agreements, unless modified by a local agreement, professional services, including the professional components of procedures with separate rates, are billable in addition to the MS-DRG charge.

## **MANUAL BILLING**

Revised: April 2014

1. General. MHS billing systems generate required claim formats in almost all cases. However, there may be instances where a manual claim must be created. Refer to the DHA UBO online training modules Data and Billing in Sync: UB-04/837I and [Centers for Medicare and Medicaid Services (CMS) form] 1500/837P available at [http://www.tricare.mil/ocfo/mcfs/ubo/learning\\_center.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/learning_center.cfm).

## **MEDICAL AFFIRMATIVE CLAIMS (MAC)**

Revised: April 2014

1. General. The Federal Medical Care Recovery Act (FMCRA) authorizes MTFs to recover the cost of furnishing health care to DoD beneficiaries, including active duty beneficiaries, who are injured or suffer an illness caused by a third party. Medical Affirmative Claims (MAC) is the military program established to accomplish this activity. MAC activities involve billing all areas of liability insurance, such as automobile, homeowner and renter, general casualty, medical malpractice (by civilian providers), and workers compensation (for persons other than Federal employees).
2. Identifying MAC Cases. It is the billing personnel's responsibility, working with patient administration personnel, provider(s), coder(s), and the MTF's Recovery Judge Advocate (RJA) to identify MAC cases. For these cases, identify those services, items, and pharmaceuticals related to the accident or injury. Detailed encounter information for a potential MAC claim is retrieved from the inpatient, ambulatory, laboratory, radiology, and pharmacy modules within Military Health System (MHS) clinical systems. Follow the MAC Enhancement Report menu path below or the Service or National Capital Region (NCR) Medical Directorate (MD)–specific guidelines to identify MAC claims.

### **MAC Enhancement Report**

**1. CHCS Menu path: ADM Ambulatory Data Module ->2 Ambulatory Data Reports ->MAC Medical Affirmative Claims Services Report**

**2. Security Key: KG ADS MAC**

**If a user does not currently have access to the ADM menu, they can gain access through assignment of the new secondary menu option:**

**Secondary menu: KG ADS RPT INJURY REPORT**

*Medical Affirmative Claims Ser KG ADS RPT INJURY REPORT*

*Medical Affirmative Claims Services Report*

You may need to obtain the security key from your System Administrator. Follow Service or NCR MD–specific guidance to generate the actual form.

3. Claims. MAC claims are created similar to commercial claims and as requested by the MTF's RJA. Follow Service or NCR MD–specific guidance to provide your RJA with MAC information and claims. Additional MTF responsibilities and procedures are available in *DoD Manual Number 6016.5, "Military Treatment Facility (MTF) Uniform Business Office (UBO) Operations,"* at [http://www.tricare.mil/octo/mcfs/ubo/policy\\_guidance/manuals.cfm](http://www.tricare.mil/octo/mcfs/ubo/policy_guidance/manuals.cfm).

4. Rates. The rates used for MAC billing are the same as those included in the DHA UBO inpatient, outpatient, and pharmacy rate packages. However, inpatient and outpatient rates must be approved by the Office of Management and Budget (OMB) and published in the *Federal Register* before they can be used for MAC. Refer to the date of service to determine which inpatient or outpatient rate file applies.

OMB-approved rates are published on the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/mac.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/mac.cfm).

Prescription drugs rates do not require OMB approval and thus are not affected by OMB publishing delays; use rates applicable on date of service  
[http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/pharmacy.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/pharmacy.cfm).

## **MEDICAL SERVICES ACCOUNT (MSA) CLAIMS**

Revised: April 2014

1. General. MSA activities involve billing and collecting funds for medical and dental services provided in MTFs, including cosmetic procedures, from:

- a. Department of Defense (DoD) beneficiaries,
- b. Other government agencies,
- c. DoD civilians and contractors,
- d. Non-Appropriated Fund (NAF) employees,
- e. Authorized foreign military members,
- f. DoD Dependent School employees,
- g. Army and Air Force Exchange Services (AAFES) employees,
- h. Secretarial Designees,
- i. Civilian emergency patients, and
- j. Other non-DoD beneficiary patients authorized to receive treatment in MTFs.

2. Claims. MSA claim formats are used depending on the type of patient (i.e., Invoice and Receipt, DD7/7A, SF1080). See the *Claims Formats* section of this User Guide for more information.

3. Billing and Accounting Procedures. Follow DOD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual (available at [http://www.tricare.mil/ocfo/mcfs/ubo/policy\\_guidance/manuals.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/manuals.cfm)) and Service or National Capital Region (NCR) Medical Directorate specific guidelines for billing and accounting procedures.

### 3. SF 1080

3.1. The Voucher for Transfers between Appropriations and/or Funds (SF1080) is used to bill inpatient and outpatient medical charges for patients with a Pay Mode of SF 1080 on the PATCAT Billing Table.

3.2. Currently, CHCS does not itemize outpatient charges on the SF 1080. A work-around process must be developed to ensure that all patients are appropriately charged for services rendered (e.g., choosing an alternate PATCAT that will produce charges). See the Future Enhancements/Current Changes section of this Guide for further information on SF 1080 billed patients.

## MEDICARE CLAIMS

Added: April 2014

1. General. MTFs may bill non–Uniformed Services (“civilian”) Medicare enrollees directly for emergency treatment at the appropriate full outpatient reimbursement rate (FOR) or full (inpatient) reimbursement rate (FRR), based on Military Department or National Capital Region (NCR) Medical Directorate–specific guidance.

1.1. Options. MTFs may either participate in Medicare or elect to enroll as a nonparticipating provider for certain emergency care and submit claims to Medicare for care provided to civilian Medicare enrollees within the continental United States (CONUS), again based on Military Department or NCR Medical Directorate–specific guidance. In either case, whether participating or electing to submit claims to Medicare, the following guidelines apply.

1.1.1. The MTF must follow Medicare rules.

1.1.2. The MTF must bill Medicare at the interagency inpatient or outpatient rate (IAR or IOR).

1.1.3. The MTF may only submit Parts A (inpatient) and B (professional services and outpatient) claims<sup>12</sup> for emergency department (ED) care provided to these civilian Medicare enrollees within the continental United States (CONUS)<sup>13</sup>.

1.1.4. The MTF must submit all claims for Medicare patients to Medicare for the calendar year.

1.1.5. The MTF must agree to accept Medicare reimbursement as payment in full.

1.1.6. The MTF should bill the patient for any Medicare-authorized deductibles and co-payments.

1.2. Direct Billing. If the MTF bills a civilian patient directly, the patient should be registered under Patient Category (PATCAT) K92 (Civilian Emergency) and must be charged the DHA UBO FOR or FRR. If the MTF bills Medicare on behalf of the civilian patient, whether the MTF is participating or nonparticipating, the patient should be registered under PATCAT K93 (Medicare Civilian Emergency), and Medicare is charged the DHA UBO interagency rates (IAR/IOR).

2. Billable Services/Items. Medicare covers different levels of ED care depending on whether the claim is submitted by a participating or nonparticipating provider.

2.1. Participating Providers. Medicare will reimburse participating hospitals for ED and critical care visit codes if the services provided were medically necessary and match the code description. For further information see *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 12, Sections 30.6.11, “Emergency Department Visits (Codes 99281 – 99288),” and 30.6.12, “Critical Care Visits and Neonatal Intensive Care (Codes 99291 – 99292),” available at [CMS Internet-Only-Manuals](#).

2.2. Nonparticipating Providers. In the case of nonparticipating MTFs, covered emergency services are limited to “inpatient or outpatient hospital services that are necessary to prevent death or serious

---

<sup>12</sup> Pharmaceutical scripts are not dispensed to these civilian ED patients, therefore Medicare Part D (drug coverage) claims are not generated.

<sup>13</sup> In general, Medicare does not cover health care provided to enrollees while they are traveling outside the continental U.S. (OCONUS). For more information, see *Medicare Claims Processing Manual*, CMS Pub. 100-04, Chapter 3, Sections 110.1B, “Beneficiary Services Outside United States,” and 110.5, “Coverage Requirements for Emergency Hospital Services in Canada or Mexico,” available at [CMS Internet-Only-Manuals](#).

impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.”<sup>14</sup> Also,

2.2.1. Medicare will not pay federal hospitals for emergency items or services furnished to Veterans, retired military personnel, or eligible dependents.

2.2.2. Provider documentation describing the emergency services and MTF location as most accessible and information indicating when the emergency ended<sup>15</sup> must be submitted with the claim.

2.2.3. MTFs may submit a copy of the patient’s chart or use CMS form 1771 (Attending Physicians Statement and Documentation for Medicare Emergency CMS) described in paragraph 6.

2.2.4. If Medicare determines provider documentation does not support this level of ED care and the claim is denied, the nonparticipating MTFs should re-register the civilian patient under PATCAT K92 (Civilian Emergency Care) and must charge the full reimbursement rate (FRR/FOR).

3. Assignment of Claims. For both participating and nonparticipating MTFs, collect and maintain on file the civilian patient’s Department of Defense (DD) Form 2569 (Third Party Collection Program/Medical Services Account/Other Health Insurance). This contains his or her assignment of benefits required to receive Medicare reimbursement.

4. Medicare Enrollment or Election. To submit claims as a participating provider, MTFs must enroll and update/revalidate enrollment in Medicare as explained in subparagraph 4.2. To submit claims as a nonparticipating provider, MTFs must file an election annually with Medicare also as explained in subparagraph 4.2. In either case, CMS requires that providers and suppliers obtain their National Provider Identifier (NPI) prior to enrolling or updating their enrollment record with Medicare, and, once enrolled, MTFs will receive a Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN)—a Medicare provider number used in survey and certification, assessment-related activities, and communications.

4.1. Participating MTFs. Complete, submit, and periodically update (revalidate) an enrollment application to the CMS to submit claims to Medicare.

4.1.1. An enrollment/revalidation fee is required.<sup>16</sup>

4.1.2. Online enrollment and revalidation applications and additional guidance are available at the [CMS Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\)](#) webpage.

4.1.3. A paper enrollment application process (i.e., CMS Form 855A) is available at the [CMS Enrollment Applications](#) webpage.

4.1.4. MTFs choosing to participate in Medicare must also submit CMS Form 588, “Electronic Funds Transfer Authorization Agreement” (CMS-588) with their enrollment application. The form is available at the [CMS Forms](#) webpage. CMS requires that providers and suppliers who are enrolling in the Medicare

---

<sup>14</sup> 42 CFR §424.101. For more information on how to determine whether a nonparticipating hospital meets CMS’s accessibility requirements see Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 3, Section 110.12.1, “Accessibility Criteria” available at available at [CMS Internet-Only-Manuals](#).

<sup>15</sup> For inpatient hospital services, this is the earliest date on which the beneficiary could be safely discharged or transferred to a participating hospital or other institution.

<sup>16</sup> A “hardship” exemption request may be submitted with the enrollment application and is considered case by case. For more information, see the CMS MLN publication MM7350 Revised available at [CMS LearningNetwork MM7350](#). More information on the application fee and a matrix outlining who is required to pay is available at [Medicare Provider Application Fee](#).

program or making a change in their enrollment data receive payments via electronic funds transfer. Each section of the form must be completed, and the form must be signed by the authorized official who signed the Medicare enrollment application. Signatures must be original and in ink (blue preferable). Copied or stamped signatures will not be accepted.

4.2. Nonparticipating MTFs. To submit claims to Medicare for ED care provided to Medicare-eligible civilians, nonparticipating MTFs must file an election with Medicare.

4.2.1. To file an election, the MTF must use CMS Form 2628, "Foreign HI Claim or Emergency Services Accessibility Documentation and Determination," available at [CMS Forms 2628](#) webpage.

4.2.2. Alternatively, an authorized MTF official may sign a statement stating the MTF elects to receive reimbursement as a nonparticipating provider for all emergency services provided to Medicare beneficiaries during a calendar year.

4.2.3. Election to bill is on a calendar year basis and expires each December 31st.

4.2.4. An MTF may not file an election for the calendar year if it has already charged any Medicare beneficiary for covered services furnished in that year.

4.2.5. An election to bill cannot be withdrawn during the year; however, MTFs retain the right to elect to bill Medicare at any time during the coming year if, when the MTF makes its election, it has not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to them.

4.2.6. Once an MTF has filed an election to bill Medicare, it must submit claims for emergency services furnished to Medicare beneficiaries throughout the year and may not submit claims to Medicare beneficiaries beyond deductibles, coinsurance, and non-covered services in the calendar year it has elected to bill Medicare.

4.2.7. For more information see *Medicare Claims Processing Manual*, CMS Pub. 100-04, Chapter 3, Section 110.11, "Elections to Bill for Services Rendered Nonparticipating Hospitals," available at [CMS Internet-Only-Manuals](#) webpage.

5. Medicare Administrative Contractors (MACs). Medicare operations are managed by designated MACs and fiscal intermediaries (FIs). They serve specific States or jurisdictions and can answer MTF questions about enrollment and claims processing. Contact and other information is available [CMS Contractor Directory-Interactive Map](#).

6. Claims. For both participating and nonparticipating MTFs, submit Medicare claims at the Interagency Rate (IAR) using the appropriate format (UB-04/837I or CMS 1500/837P) and to the appropriate MAC based on the MTF's geographical location.<sup>17</sup>

6.1. Electronic Claims. Electronic claim submissions are required if an MTF submits more than 10 per month. Review the patient's Medicare card for MAC information.

6.2. Institutional Claims. On the institutional claim, enter "hospital filed emergency admission" in Form Locator 80, "Remarks".

6.3. Nonparticipating Providers. Claims submitted by nonparticipating providers must be supported with documentation that shows the services were "necessary to prevent the death or serious impairment of the health of the individual."

---

<sup>17</sup> For example, if a beneficiary lives in one state but receives emergency services from DOD provider in another state, the claims should be processed in the state where the emergency services were rendered.

6.4. CMS 1771. Use CMS form 1771 “Attending Physicians Statement and Documentation for Medicare Emergency” available at [CMS Forms 1771.html](#). For more information, see *Medicare Claims Processing Manual*, CMS Pub. 100-04, Chapter 3, Section 110.2, “Establishing an Emergency”, available at [CMS Internet-Only-Manuals](#). Review the Medicare Remittance Advice (MRA) for patient deductible and co-payment amounts and submit claims to the patient for those amounts; do not balance bill him or her.

6.5. Time Limitations. In general, claims by both participating and nonparticipating providers must be filed to the appropriate Medicare claims processing contractor no later than 12 months, or one calendar year, after the date the services were furnished.

6.5.1. For claims that include span dates of service, claims filing timeliness is determined as follows: The “Through” date is used to determine the date of service for institutional claims; the “From” date is used to determine the date of service for professional claims.

6.5.2. Claims filed after the specified time will be denied with no appeal rights. Exceptions are provided in the Centers for Medicare and Medicaid Services (CMS) Manual below. For more information, see *Medicare Claims Processing Manual*, CMS Pub #100-04, Chapter 1, Section 70 - Time Limitations for Filing Part A and Part B Claims available at [CMS Internet-Only-Manuals](#).

6.6. CMS Instructions. Follow claim instructions for required and conditional information in Chapters 25 (Completing and Processing the Form CMS-1450 Data Set (includes information related to ASC X12 837 institutional claims)) and 26 (Completing and Processing the Form CMS-1500 Data Set (related to ASC X12 837 professional claims)) of the Medicare Claims Processing Manual available at [CMS Internet-Only-Manuals](#).

6.7. Incomplete or Invalid Claims Returned. Services not submitted in accordance with CMS instructions will be returned to the MTF billing provider.

6.7.1. The status of these data elements will affect whether or not an incomplete or invalid submission (hardcopy or electronic) will be returned to the MTF billing provider.

6.7.2. FIs should not deny claims and afford appeal rights for incomplete or invalid information as specified in the CMS Instructions.

6.7.3. Denials are subject to appeal, since a denial is a payment determination.

6.7.4. Rejections may be corrected and re-submitted.

7. Other Health Insurance (OHI). Generally, if the patient is insured by a third party payer in addition to Medicare (e.g., employer plans), that payer is primary and should be billed at the appropriate FOR or FRR before billing Medicare at the IAR.

7.1. Medigap. If the patient is also insured with a Medicare supplemental insurance (Medigap) plan, bill Medigap third.

7.2. Secondary Plans. If the patient has a plan that specifically applies as secondary after Medicare, bill Medicare first.

## MENTAL HEALTH SERVICES

Revised: 9 March 2006

1. Mental health services have many components. In some places, they are called "Life Skills." Some services that may appear to be mental health are not funded by the Defense Health Program (DHP) and should not be coded; therefore there should be no billing. Common examples are many Family Advocacy and Substance Abuse activities in the Air Force. For instance, a family advocacy officer, who happens to be a clinical social worker, is seeing a parent who has a child in the exceptional family member program prior to the active duty member being transferred to an overseas appointment. This is not a codable encounter and there should be no bill.
2. Psychotherapy CPT codes are based on the place of service (office/outpatient or inpatient); the type of therapy (interactive or insight-oriented); time spent in the encounter (minutes of service); and whether an Evaluation and Management (E&M) service is performed.
3. E&M services should not be billed separately when using billing codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829.
  - 3.1. Use codes 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, or 90828 when medical E&M services are provided in addition to mental health services.
    - 3.1.1. However, since there is a CHCS systems requirement for an E&M code, use 99499 as the place holder.
4. Psychotherapy services are based on rates from the CMAC rate table for provider classes 02 and 03. Refer to Provider section of this Guide.
5. Psychotherapy CPT codes are mapped to the UB-04 in TPOCS.
6. The usual revenue codes are 91X, 90X and 94X.

## MODIFIERS

Revised: 8 March 2006

1. Modifiers are important as many of them impact billing. Modifiers are used with CPT and HCPCS codes. There are no ICD-9-CM modifiers (there are DoD extenders, unique to the DoD, but they do not impact billing and do not flow to any of the billing systems). As with any code, modifiers must be supported by medical documentation.

2. Modifiers are two-character descriptors. Modifiers are added after the CPT/HCPCS code, such as 27780-RT for treatment of a closed fracture of the right proximal fibula, without manipulation. Modifiers impact billing by indicating that a service was altered from the stated CPT/HCPCS description. Common examples directly impacting billing are:

2.1. -24. Modifier -24 is used when a provider sees a patient for an unrelated issue during a postoperative period. For instance, if a family practice provider performed a vasectomy on Monday (vasectomies have a 10-day postoperative period), then treated the patient as a walk-in for a sore throat on Friday, the provider would need to append modifier -24 to the office visit code. Without the modifier, the insurance company may not pay as the insurance company would think the office visit was part of the global follow-up for the procedure. Yes, you would think that the diagnosis would make it obvious, but many insurance edit systems do not take the diagnosis into account as the edits would be very difficult to keep updated. It is easier to send the incorrectly coded encounter back to be fixed.

2.2. -25. Separate E&M on the same day as another E&M or procedure. For instance, a pediatrician performs a well-baby exam and also treats the child's conjunctivitis (pink eye) at the same visit. The pediatrician would code the physical (e.g., 99392) without a modifier and would code the office visit for the conjunctivitis with a modifier (e.g., 99212 -25). When the insurance company pays, it may slightly decrement the payment for the code with the modifier (in this example, the 99212).

2.3. -26. Professional Component. This is usually used with modifier -tc for the technical component. Other than urology, pathology and laboratory, the most common time this would be seen would be fetal stress tests. If a nurse on the OB unit did the technical component of the fetal contraction stress test (59020) or the fetal non-stress test (59025), and the OB/GYN provider only interpreted the results, the provider would code the procedure as 59020-26, or 59025-26. This will cause the rate from the "Cmp" (component) CMAC rate table to appear on the CMS 1500.

2.4. -50. Bilateral. For instance, a patient has cataracts removed from both eyes during the same surgical session. The rate will be multiplied by 2. Insurance companies may decrement payment for the second procedure, sometimes up to 50%.

2.5. -51. Multiple Procedures. The procedures on the bill will all be listed at the standard rate. Many insurers pay only 50% of the professional fee for multiple procedures. For instance, a patient has a colonoscopy with biopsies and stopping bleeding. The insurer will pay 100% for stopping the bleeding, but only 50% of the fee for the biopsy.

2.6. -52. Reduced Services. The bill will generate at 100% of the rate. Typically insurers will request documentation of how the procedure was reduced and may reimburse less than 100% of the bill.

2.7. -54. Surgical Care Only. For instance, a fracture is set in the Emergency Department, but after care will be done in Orthopedics. The bill will generate at 100% of the rate, but many insurers will discount the procedure 20-40 % depending on the amount of the total global procedure which is the actual surgery.

2.8. -55. Postoperative Management Only. For instance, the orthopedic clinic does only the after care for a fracture treated in the Emergency Room at the downtown hospital. The bill will generate at 100% of the rate, but many insurers will discount the procedure 60-80% depending on the amount of the total global procedure is for the postoperative follow-up.

2.9. -56. Preoperative Management Only. For instance, an emergency room may do the preoperative component of the care for an open fracture reduction, with the orthopedic surgeon coming in to actually perform the procedure. The bill will generate at 100% of the rate, but many insurers will discount the procedure up to 90% depending on the amount of the total global procedure is for the intraoperative and the postoperative follow-up.

2.10. Modifiers -62, -80, -81 and -82. In ADM, the same code cannot be entered multiple times on the same encounter. This is an issue when using modifiers -62, -80, -81 and -82 (indicating multiple surgeons and assistants at surgery). In ADM, when there are two surgeons or a surgeon and an assistant surgeon, each surgeon/assistant surgeon will need to generate a separate ADM. This is because the principle surgeon will code the procedure code without a modifier, e.g., 58660, laparoscopy, surgical; with lysis of adhesions. The assistant surgeon would code the procedure as 58660-80. Because ADM will only allow the code to be entered once, there is no way to show both surgeons doing the work. Remember, only the principle surgeon will have the 99199 code for the institutional component and the anesthesia services. The second surgeon (modifier -62) and the assistant surgeons (modifier -80, -81, -82) will not have the 99199 and will not have the anesthesia services. One CMS 1500 will be generated for the principle surgeon. One CMS 1500 will be generated for the assistant surgeon or the second surgeon.

2.10.1. For assistant surgeons, remember to use the modifier “- AS” if the assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist. Technicians and operating room nurses will not be coded as assistant surgeons.

3. Modifiers Which Don't Directly Impact Billing. There are many codes which need a location modifier. For instance, a modifier is needed for a fracture of an arm to tell if it is the right (-RT) or left (-LT) arm. Some bills will be returned if the location modifier is not on the bill. Look out for eyelids, fingers, toes, arms, and legs which all need modifiers.

3.1. Specialty Modifiers. Modifiers can indicate the provider's specialty, such as an anesthesiologist, certified registered nurse anesthetist (CRNA), psychologist, clinical social worker or nurse midwife. Some insurers will pay 100% for physicians, psychologists and dentists and pay a reduced rate for physician extenders. These modifiers will become less important when the HIPAA taxonomies become mandatory.

4. The ADM currently accepts up to three modifiers of a CPT/HCPCS code.

5. Some modifiers affect the amount of reimbursement for a particular procedure while others provide additional information only. The following logic works for both TPOCS and MSA/DD7A:

5.1. When the first listed modifier is informational, the rate is multiplied by 1.

5.2. When the first listed modifier is calculable, the rate is multiplied by the number listed in the Baseline Modifier Mapping Table.

5.3. If the modifier is in the 2<sup>nd</sup> or 3<sup>rd</sup> position, a rate is applied if the modifier is calculable.

6. In the MHS, because most of the coding is professional, and outpatient institutional coding is limited to the code 99199 (representing the institutional flat rate of an ambulatory procedure visit), modifiers which are only for institutional use are not used. Specifically, modifier -27 is not appropriate for MHS use at this time.

NOTE: In the civilian sector, not all payers accept modifiers.

7. When coding professional services, there are three different computer systems. These computer systems may have less than complete sets of modifiers available. For instance, the preoperative, intraoperative, and postoperative modifiers are not currently available for the S-HCPCS codes when coding in the ambulatory data module (ADM). The Coding Compliance Editor (CCE) may have a new

modifier (such as the out-of-cycle CMS disaster patient modifier) which is not yet available in ADM or AHLTA.

7.1. TPOCS and MSA have the same modifiers that are available in the ADM. AHLTA is very responsive and should have all the appropriate modifiers. If a modifier is not appropriate for the code, the modifier may not appear. Even if the modifier is not in AHLTA, but when reviewed by the CCE, a modifier is appropriate, the modifier can be added in CCE, which flows to ADM, which flows to TPOCS, MSA and the SADR. Modifiers do not currently flow in the SADR to the Clinical Data Repository (which feeds the M2).

## NATIONAL DISASTER MEDICAL SYSTEM (NDMS) BILLING

Revised: 7 March 2006

National Disaster Medical System (NDMS) billing was discussed at the 6 January 2006 NDMS Executive Secretariat Meeting. This meeting, held at the Department of Health and Human Services (HHS), included representatives from the Department of Veterans Affairs, Military Health System, Federal Emergency Management Agency (FEMA), HHS, including the Centers for Medicare and Medicaid Services (CMS).

NOTE: See also DoD Reimbursable Disaster Victim, in this Guide.

1. Reimbursable FEMA Costs. During the meeting, it was verified that it is not legal to include billing medical fee-for-service charges in a Mission Assignment. The Mission Assignment is only for reimbursement of costs incurred above and beyond normal healthcare operations. Mission assignment does not include funds for salaried individuals, or those hourly individuals who would normally be working the hours worked. Reimbursable costs in a Mission Assignment would include items such as per diem (e.g., TDY/TAD expenses), overtime, and medical supplies.

1.1. The Services were asked to identify the cost of health care provided to non-beneficiaries as the result of Hurricanes Katrina and Rita. Total costs identified by the Services were \$78,101 in outpatient fee-for-services and \$142,786 for inpatient billable services. For the MHS, using MEPRS data, the average cost of medical supplies for outpatient services is 5.81 percent of the total cost. The Services identified \$78,101 as the cost of outpatient services provided. The MEPRS inpatient factor for medical supplies is 9.75 percent with the Services identifying \$142,786 as the cost of inpatient services provided.

Outpatient: Total \$78,101 x .0581 = \$4,537.67

Inpatient (\$230,761-\$87,975 NDMS): Total non-NDMS \$142,786 x .0975 = \$14,064.42

NOTE: The total inpatient amount reported was \$230,761. Of that total, \$87,975 was for NDMS inpatient billable services, which is separate from FEMA billing.

1.2. TMA UBO reported the \$18,602 (\$4,537.67+\$14,064.42) for medical supply costs to Lt Col Julian, TMA Resource Management, for inclusion in the Mission Assignment bill sent to FEMA.

2. Reimbursable NDMS Costs. NDMS may only be billed for definitive care which is interpreted to mean "inpatient hospitalizations." NDMS may only be billed for patients regulated by FEMA through a Federal Coordination Center (FCC) to the inpatient facility. NDMS may only be billed after other payers (except TRICARE and Medicaid) have paid their obligations. NDMS may not be billed for patient deductibles or co-pays; the patient will always be responsible for these obligations.

2.1. The Services reported seven NDMS patients as having been regulated by an FCC to an MHS facility (two at Brooks Army Medical Center for Katrina and five at William Beaumont Medical Center for Rita).

2.2. NDMS may only be billed for up to 110 percent of the CMS rate for charges for which others do not have an obligation to pay. For instance, if there is a third party payer (insurance), be it medical insurance or some other kind of insurance (e.g., homeowners if a ceiling fell on a patient, or automobile if a person lost control of his car in rapidly flowing flood water), the third party's obligation may not be included in the amount billed to NDMS. Additionally, any co-pays or deductibles owed by the patient should be excluded from the amount billed to NDMS.

2.3. Generating Bills for NDMS Reimbursable Services. TMA provided guidance to the Services a number of times prior to and after the disasters directing that third party payers must be identified and billed first before any claims were submitted to NDMS for reimbursement.

2.3.1. When There Are No Third Party Payers. NDMS is part of FEMA which is part of the Department of Homeland Security. As such, the bills will be generated using the Intra Agency rate.

2.4. Usually, the total MHS inpatient bill is submitted on a single UB-04. This UB-04 is a consolidated bill that contains both inpatient professional and institutional charges.

2.4.1. For NDMS, the bill must be split so that the inpatient institutional component is on the UB-04, and the professional component is on the CMS 1500. This is because unless each of the professional services is listed, the claims processor will have no way of determining what professional services were furnished. NDMS will reimburse up to 110 percent of the CMS rates. CMS has separate rates for professional bills and institutional bills.

3. Institutional Component. The UB-04 must be adjusted to reflect the removal of the professional component. For discharges after 1 October 2005, 7 percent of the Adjusted Standardized Amount is the professional component, and 93 percent is the institutional component. One UB-04 will be submitted indicating the Diagnosis Related Group (DRG) and the NDMS claims processor will reimburse up to 110 percent of what CMS would have paid for the inpatient institutional component for that DRG.

4. Professional Services. CMS 1500s will be submitted for the professional services, and the NDMS claims processor will reimburse up to 110 percent of what CMS would have paid for the inpatient professional services.

4.1. Example: A patient was discharged with a DRG with a relative weighted product (RWP) of 1. The Adjusted Standardized Amount (ASA) for the MTF was \$10,712.34, with 7 percent of that being professional services. The MTF will generate a UB-04 for  $\$10,712.34 \times .93 = \$9,962.48$  for the institutional component (this includes radiology, laboratory, and inpatient pharmacy). The MTF will also generate applicable CMS 1500 for the professional services, such a CMS 1500 for E&M 99222 for \$120.96, one for four subsequent hospital days using 99231 for \$36.48 per day, and one for 99238 hospital discharge day for \$76.15. NDMS will pay up to 110 percent of the CMS allowable rate for that service for that location.

NOTE: This example is only applicable if there is a signed DD Form 2569 in the medical record indicating that the patient has no insurance and is not Medicare beneficiary.

4.2. When reimbursement payments received from a payer(s) and the patient (for deductibles or co-pays) equal or exceed the MTF's inpatient bills, no bill will be submitted to NDMS.

4.2.1. A patient was discharged with a DRG with a relative weighted product (RWP) of 1. The ASA for the MTF was \$10,712.34. The insurer was billed, at the Full Reimbursement Rate (FRR), \$10,712.34. The patient had a deductible of \$500 and a co-pay amount of \$212.34. The insurance company paid \$10,000. Total amount paid, plus deductible and co-pays covered the amount due to the MHS, so there is no need to separate professional encounters from the total inpatient bill as there will be no bill submitted to NDMS.

4.3. When a bill is not totally satisfied by the payer's reimbursement, and patient deductible and co-pay costs, the MTF will submit a bill to NDMS for the remaining balance using the appropriate forms (CMS 1500 and UB-04).

4.3.1. The MTF will calculate the interagency bill. The MTF will subtract the applicable percentage (for discharges after 1 October 2006, 7 percent) from the interagency rate to determine the amount of the inpatient institutional bill. The MTF will code the applicable professional services and determine the prices using the interagency rate. This includes separate CMS 1500 for anesthesia services, if applicable.

4.3.2. When a third party payer pays a portion of the bill, and/or the patient pays a deductible/co-pay, these payments will be made against the professional component of the bill.

4.3.3. A patient was discharged with a DRG with a relative weighted product (RWP) of 1. The ASA for the MTF was \$10,712.34 (FRR), with 7 percent of that being professional services. So the MTF will generate a UB-04 for  $\$10,712.34 \times .93 = \$9,962.48$  for the institutional component (this includes radiology, laboratory, and inpatient pharmacy). The MTF will also generate an applicable CMS 1500 for the professional services, such as E&M 99222 for \$120.96, one for four subsequent hospital days using 99231 for \$36.48 per day, and one for 99238 hospital discharge day for \$76.15.

- A third party payer paid \$500, the deductible was \$500, and the co-pay was \$500.
- The MTF would determine the interagency rate for the original services, in this case, \$10,150.54.
- The MTF would subtract 7 percent from the interagency bill to determine the UB-04 bill to be \$9,440.01.
- The MTF would determine all the CMS 1500 services at the interagency rate.
- This would be approximately  $\$343.03 \times .9475$  (interagency multiplier) or \$325.00.
- \$1,500 in payments - \$325 (the professional fees) = \$1,175.
- \$9440.01 (UB-04 Interagency bill) - \$1,175 (amount already paid not posted against the professional fees) = \$8,265.01
- The MTF would not send to NDMS the CMS 1500s. It would send the UB-04 with a charge of \$8,265.01.
- NDMS will pay up to 110 percent of the CMS allowable rate for that service for that location.

4.4. Submitting NDMS Bills. Prior to submitting claims, the MTF must determine the amount of any deductibles, co-pays, and obligations by third party payers, to include Medicare obligations. In the most recent cases, since most patients were discharged prior to 1 November 2005, this coordination with third party payers and Medicare should be complete. As discussed on a 19 January 2006 teleconference, claims may be submitted beginning 24 January 2006 to TrailBlazer, the NDMS claims processor. All NDMS claims must be submitted to TrailBlazer by 31 March 2006. See attached files for more instructions regarding billing NDMS.



**acrobat Documentacrobat Documentacrobat Document**

## 5. Usual Billing Steps for NDMS.

5.1. Physician determines a patient, regulated to the MTF by an FCC, needs to be admitted.

5.2. Billing office personnel collects Other Health Insurance (OHI) information on the DD Form 2569. This includes information on Medicare and Medicaid coverage. Patient signs the DD Form 2569.

5.3. Billing office personnel assigns the appropriate patient category (PATCAT). As eligible beneficiaries would not be NDMS patients, the PATCATs in A, B, C, F, M, N, P, and R would not be applicable. The most likely PATCATs would be K92A Civilian Emergency Care and K92C Civilian Emergency - Social Security Beneficiary.

5.4. If there was OHI or the patient was a Social Security beneficiary, the applicable organization(s) would be contacted to obtain a pre-certification.

5.5. The patient hospitalization would occur. The patient would be discharged. The record would be coded. A diagnosis related group (DRG) would be assigned.

5.6. The MTF would generate a bill and provide it to the patient. If the patient had OHI or Medicare, and the patient assigned his benefits to the MTF, the MTF could bill the OHI. Upon receipt of the OHI payment, or if there was no OHI, the appropriate bill would be submitted to Medicare.

5.7. The patient would pay any applicable patient deductibles/co-pays.

5.8. Upon resolution of payments from OHI, Medicare, patient's deductible/co-pay, the appropriate bill will be generated for NDMS claims processor.

# OBSERVATION SERVICES

Revised: 01 July 2011

## 1. General Background.

1.1. Observation (OBS) is an outpatient billable service. The Assistant Secretary of Defense for Health Affairs issued a memorandum titled "Policy for Billing for Observation Services in Fixed Military Treatment Facilities." This memorandum cancels policy titled "Policy for the Reporting and Billing of Observation Services," dated August 11, 2010, and implements new policy for billing for observation services in fixed MTFs. This section of the User Guide has been prepared to ensure correct billing for both TPC and MSA functions. prepared to ensure correct billing for both TPC and MSA functions.

1.1. Under the policy referenced above, the use of functional cost code B\*\*0 is no longer authorized.

1.2. Observation services shall only be provided in two locations: the hospital's Emergency Department (ED) or in a nursing unit/ward of the hospital.

1.2.1. Current MTF information systems can only support outpatient observation services for patients in the ED. Current systems allow capture the required billing data including ED MEPRS code and procedure codes for services rendered in the ED, including OBS.

1.2.1.1 Observation services (professional and facility) that are initiated in the ED following an ED evaluation, and result in the patient being discharged home (or to an external location outside the MTF) are captured in the Ambulatory Data Module (ADM) on the "B\*\*\*" ED SADR.

1.2.2. For continuity of care reasons, patients placed on a nursing unit/ward that require observation care will be "admitted" to the hospital via the CHCS.

## 2. Coding and Documentation Background to Billing.

2.1. There must be a separate medical observation record with proper documentation of the admitting orders, nursing notes and progress notes while in observation status. This record will be referenced by coders and billers as source validation of documentation to ensure correct coding and subsequent billing.

2.2. Coding and documentation guidance specific to observation services was updated and published with an effective date of 1 January 2011. Appendix H - Observation Services, of the MHS Coding Guidelines can be found at: [http://www.tricare.mil/ocfo/bea/ubu/coding\\_guidelines.cfm](http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm)

2.3. Clinical "pathways" are outlined in the coding guidance define the typical scenarios for episodes of observation care that originate on the nursing unit/ward, in the ED, or when a patient is subsequently converted to inpatient status (from ward or ED).

2.4. MTFs have the ability to code facility HCPCS codes (G0378 and if applicable, G0379) for each hour in observation status. This is in addition to the provider's professional E/M services and any other appropriate services reflecting all care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) during observation care, provided the patient is not subsequently converted to an inpatient.

2.5. A coding methodology was developed to identify or flag patients on the nursing unit/ward in OBS status who were discharged home (or to an external location outside the MTF) rather than converted to an inpatient status. These episodes of care are identified based on diagnosis code V71.9 will be the first-listed code on the SIDR and an MS-DRG assignment of 951.

2.6. For patients originally placed in observation status in the nursing unit/ward and subsequently converted to inpatient status, coding of the inpatient SIDR will be accomplished by sequencing V71.9 in the last-listed code on the SIDR. This allows for tracking of episodes of care where OBS status originated in the nursing unit/ward and converted to an acute care hospital admission.

2.7. All observation services rendered on the nursing unit/ward, both facility and professional, will be captured on the associated "A" SADR/CAPER in the Rounds module in the CHCS.

### 3. Billing when the Patient is Not Converted to Inpatient Status

3.1. MTFs have the ability to bill facility, provider professional services, and other services reflecting all care provided during observation care, provided the patient is not subsequently converted to an inpatient.

3.2. Billing staff will review all inpatient claims/invoices to identify patients on the nursing unit/ward in OBS status, and who were discharged home (or to an external location outside the MTF) based on diagnosis code V71.9 will be the first-listed code on the SIDR and an MS-DRG assignment of 951 to identify incorrect inpatient claims/invoices.

3.2.1. For TCP/IP inpatient claim: The insurance claim appears in print queue in CHCS; claim is printed and reviewed by the biller.

3.2.2. For inpatient MSA: Invoicing for inpatient admissions appears on the DD7 report in CHCS.

3.2.3. Does V71.9 and DRG 951 appear on the CHCS-generated insurance claim form? If yes, flag claim/invoice as Observation.

3.3. For those incorrect inpatient claims/invoices, billing staff will cancel the incorrect claim/invoice and manually generate appropriate outpatient claims/invoices for all services rendered during the OBS episode of care.

Cancel the claim or write off charges in CHCS to the appropriate closure code (as determined by each Service)

Write off I&R charges generated in CHCS(as determined by each Service)

Pass information to outpatient or other designated billing staff

3.4. Facility HCPCS codes (G0378 and if applicable, G0379), provider professional services and any other services reflecting care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) during observation care should be billed based on the patient category and outpatient itemized billing rates.

3.5. Refer to the Patient Summary Report in CHCS. Do admission and discharge date, or start and end times, etc., indicate less than a 24 hr. stay? If yes, flag claim/invoice as a possible Observation or other non-inpatient episode of care (e.g., post APV overnight stay).

Confer with HIM staff/Coding Guidelines for assistance in admission status determination

Proceed with claim cancelation/invoice write-off followed by outpatient billing or inpatient billing as appropriate

### 4. Billing when the Patient is Converted to Inpatient Status.

4.1. Facility HCPCS codes (G0378 and if applicable, G0379), provider professional services and any other services reflecting care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) are not billable when a subsequent "true" admission occurs.

4.2. Likewise, the attending provider's professional services on the A\*\*\* Rounds SADR are not billable when a subsequent "true" admission occurs.

4.3. When a “true” admission occurs, MTFs will bill based on normal inpatient billing procedures computing charges based on the patient category and approved adjusted standardized amount (ASA) rates, MS-DRG assignment, and MS-DRG relative weighed products and length of stay outlier criteria.

## OPHTHALMOLOGY, OPTOMETRY & VISION SERVICES

Revised: 9 March 2006

1. Medical issues such as conjunctivitis (pink eye), detached retinas, scratched corneas, removal of foreign bodies and glaucoma are usually covered services in insurance policies.

1.1. Medical issues are usually coded using the office visit codes in the CPT 99201-99215 and 99241-99245.

2. Frequently, vision services are not covered. Vision services would include screening eye exams and glasses/contacts.

2.1. Vision services are usually coded with codes in the CPT 92002- 92396 and the V2020-V2799. Therefore, frequently vision service bills are denied as an uncovered/excluded service.

3. With few exceptions, CPT codes 92002-92004, 92012-92014, and 92015-99195 are mapped to print on the CMS 1500.

## OTORHINOLARYNGOLOGY SERVICES

Revised: 01 October 2003

1. Special otorhinolaryngologic services are diagnostic and treatment services that are not included in a comprehensive otorhinolaryngologic evaluation or office visit and are reported separately.
2. Speech therapy is included as part of the special otorhinolaryngologic services.
3. Hearing tests such as whisper voice or tuning fork are considered part of the general otorhinolaryngologic service and are not reported separately.
4. Hearing test codes are inherently bilateral. If testing is applied to just one ear, use modifier -52.
5. Otorhinolaryngology CPT codes: 92502-92526, 92531-92534, 92541-92548, 92551-92597, and 92601-92617.

## PAIN MANAGEMENT SERVICES

Revised: 01 October 2003

1. Pain management services are evaluated using the 8 to 10-point McGill pain pattern scale. If the patient's level of pain is below the 8 to 10 point scale, then the services will fall below the stipulated guidelines for billing. Pain management reimbursement policies are carrier-specific.

### 2. Pain Management Consultations

2.1 Pain management consultations are carefully watched for abuse. Medicare has targeted office codes 99241–99245 and hospital codes 99251–99255 for careful scrutiny.

2.2 When a surgeon requests a post-operative pain consultation for a patient immediately following surgery (24 hours), documentation is required in the surgical medical record.

### 3. Epidural Catheter Placement

3.1 Physicians place epidural catheters for post-operative pain management at any of four sites along the spine.

3.2 Placement of a cervical or thoracic catheter should be coded using CPT code 62318.

3.3 Placement of a lumbar or sacral catheter should be coded using CPT code 62319.

3.4 Post-operative pain management with epidural or subarachnoid drug administration is coded with CPT code 01996. Presently, this is a flat rate.

### 4. Trigger Point Injections

4.1 Trigger Point Injections should be coded according to the muscle groups targeted, not according to the number of injections administered.

4.2 When multiple injections are administered at the same site, only a single injection should be coded.

4.3 Complete documentation is critical in establishing medical necessity for a trigger point injection. An injection (CPT code 20550) is covered when the following criteria are met: the patient's clinical condition is marked by substantial pain and/or significant functional disability; appropriate conservative treatment has not provided acceptable relief; and there is a reasonable likelihood that the injection will significantly improve the patient's pain and/or functional disability.

4.4 For subsequent trigger point injections received in a series, the patient's medical record must state the degree of relief the patient experienced from the previous injection.

PATIENT CATEGORIES  
Revised: November 2013

1. General. Patient categories (PATCATs) are codes used to identify a patient's level of eligibility for care in an MTF. PATCATs classify patients by:

- Sponsor Service
- Beneficiary Category
- Special Patient Groups

PATCATs are directly linked to UBO billing and tell what reimbursable rate (if any) is applicable for health care services provided, what billing forms are used, and which cost recovery program is responsible for billing the encounter.

2. Assignment. Patient administration personnel assign PATCATs to patients during registration. Billing personnel are encouraged to work closely with patient administration personnel to ensure correct PATCAT assignment. A patient's PATCAT is dynamic; he/she may have dual PATCAT assignment (e.g., retiree for one encounter and an occupational health patient for the next encounter). Patients should be registered according to their highest level of eligibility. For example, a patient should be registered as a dependent if he/she is both a military retiree and a family-member dependent (i.e., married to an active duty personnel). For questions contact your patient administration personnel.

3. Reference Materials. The PATCAT table, a Finder Guide, and a training module are available online at <http://www.tricare.mil/ocfo/mcfs/ubo/patcat.cfm>. The table lists the PATCAT codes, definitions, and billing structure for patients. The Finder Guide provides decision tree logic to classify the patient into the correct PATCAT. The training module provides an overview of what PATCATs are, how the table is structured, and how PATCATs should be assigned.

## PHARMACEUTICALS

Revised: November 2013

1. General. Pharmaceuticals are a significant opportunity for UBO revenue. To maximize reimbursement, MTF personnel need to understand the processes, concepts, and definitions that affect whether pharmacy claims will be paid. These include: internal and external prescriptions; initial fills and refills; the number of units that will be reimbursed; types of coverage; and claim forms.

2. Internal Prescriptions. An “internal prescription” is one prescribed by an MTF provider who saw the patient at the MTF. Internally ordered prescriptions are linked to an encounter feed to the billing applications via the pharmacy feed. If the prescription is filled and dispensed within the MTF and a holding-time is applied before the claim is created, the claim will pull in data from the encounter. This simplifies MTF personnel’s task of obtaining all required data for the pharmaceutical claim including: the provider’s National Provider Identifier (NPI), the name of the pharmaceutical, the National Drug Code (NDC) number, the quantity dispensed, and the diagnosis code.

3. External Prescriptions. An “external prescription” is one prescribed by a civilian or MTF provider external to an MTF. External prescriptions are not tied to an MTF encounter and often do not include all required data for the pharmaceutical claim (required data listed above in paragraph 2). MTF personnel must follow up with the external provider to obtain this information.

4. Provider Information. Providers have a number of associated data elements including: name, Drug Enforcement Agency (DEA) Number, license number, Composite Health Care System (CHCS) Provider Specialty Code, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Provider Class, Health Insurance Portability and Accountability Act (HIPAA) Taxonomy, and National Provider Identifier (NPI) Type 1 that are needed for various claims and/or situational conditions. Military Health System (MHS) direct care billing systems build provider files that allow the look-up of provider data as required. These applications will, in most cases, automatically provide the information for providers working within the MTF. However, for an external provider, MTF personnel must contact the provider or search an external provider database, such as the National Plan and Provider Enumeration System (NPPES) and build a provider “profile” in the clinical or billing system. Billing applications can then pull in provider data as needed.

5. Diagnosis. The requirement to provide the diagnosis on a pharmacy claim is situational. A payer may require it if this field could result in: different coverage, pricing, patient financial responsibility, or drug utilization review outcome. When the diagnosis does not automatically flow to the billing system—this occurs frequently with external prescriptions—contact the prescribing provider to obtain the applicable diagnosis.

6. Quantity Limits. Many payers may limit initial fills, refills, and quantities of pharmaceuticals. Certain pharmaceuticals, such as narcotics, may have additional Food and Drug Administration (FDA) limits on the quantities that a pharmacy may dispense. Regardless of payer limits on payment, billing personnel must submit claims stating the correct quantity actually dispensed.

7. Refills. Normally, there are no visits associated with refills. There will be no associated diagnosis when the pharmacy refill claim feeds to the Third Party Outpatient Collection System (TPOCS) or CHCS (for Medical Services Account (MSA) claims). Obtain the diagnosis by researching it on the original prescription fill in the billing system or CHCS or contact the provider who prescribed the pharmaceutical to obtain it. The fill number is reported on the standard National Council for Prescription Drug Programs (NCPDP) electronic pharmacy claim. The Uniform Billing form (UB)-04 claim form does not have a form locator field in which to enter the refill information. Thus, MTF personnel must enter the term “refill” next to the NDC number in form locator 43 of the UB-04.

8. Pre-authorization/Pre-certification of Prescription Drugs. Many payers require pre-authorization of certain pharmaceuticals. Defense Health Agency (DHA) UBO publishes a reference list of those for which

payers commonly require pre-authorization on its website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/pharmacy.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/pharmacy.cfm). MTF personnel should review this list before submitting a claim and obtain pre-authorization, if necessary. If a pharmacy claim is denied due to lack of pre-authorization, MTF personnel must submit an authorization request as follows.

8.1. Create and maintain tracking lists of payer requirements.

8.2. Obtain a blank pharmacy authorization request from the payer or its website.

8.3. Submit completed authorization request to the payer.

8.4. Some payers may have step-therapy guidelines; refer to the payer for requirements.

9. Coverage Types. There are three principal types of insurance that may pay for prescriptions: medical, pharmacy, and comprehensive. If a pharmaceutical claim is denied based on invalid coverage type, MTF UBO personnel should follow up with the payer and then the patient to determine if he or she carries pharmaceutical coverage.

10. Claim Forms. Payers expect pharmacy claims from commercial pharmacies (e.g., Rite-Aid) or mail-order pharmacies in the UB-04/NCPDP format and may not recognize and thus reject other claim formats. In DoD MTFs, TPOCS records pharmacy claims on the UB-04 and the NCPDP. For some MSA payers, pharmacy claims record on the DD Form 7/7A or invoice and receipt (I&R), depending on the patient's category (PATCAT). For other MSA claims submitted to payers (e.g., Medicare, Medicaid), MTF personnel must use the billing system to manually generate the UB-04/NCPDP claim.

11. Over-the-Counter (OTC) Medications. Most MTF pharmacies dispense OTC medications; however they are normally not a covered benefit provided by payers. Some OTCs (e.g., diabetic supplies) are frequently covered. The DHA UBO Program Office (PO) provides a table to identify OTCs at this link [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/pharmacy.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/pharmacy.cfm).

12. Documentation Requirements. For some prescriptions, there are payer-specific requirements and supportive medical record documentation that must be submitted with the claim (e.g., medical necessity form, pre-authorization form). Obtain and provide this documentation if a payer requests it or a claim is denied.

13. Rates and Charges. Rates and charges are made up of a pharmaceutical ingredient charge and a dispensing fee.

13.1. Pharmaceutical Ingredient Charge. MTF billing systems automatically calculate the pharmaceutical ingredient charge by multiplying the number of units by the DHA UBO unit cost (rate) and adding a pharmacy dispensing fee for all prescriptions, both new and refills. DHA UBO rates are developed using the Managed Care Pricing File from Defense Supply Center Philadelphia (DSCP). For some medications, this rate is lower than what the MTF may be paying to obtain the medication. MTF personnel must use and may not change the DHA UBO pharmaceutical rate.

13.2. Dispensing Fee. A dispensing fee representing the charge per prescription is updated and loaded into MTF billing systems along with the pharmacy ingredient rate updates. Add the dispensing fee to the ingredient charge to determine the total pharmaceutical charge. If there is no ingredient charge, submit the dispensing fee on the claim to the payer.

14. Medicare Supplemental Plans. MTFs can bill Medicare supplemental plans for prescription drugs in the same manner they bill other health insurance.

15. Revenue Codes. Revenue code 250 must be reported on UB-04 pharmacy claims. NCPDP claims do not require a revenue code.

16. Non-Issued Prescriptions. A claim is created and flows to the billing application when a prescription label is printed, not when the prescription is actually issued to the patient. If a patient does not pick up the prescription within 14 days, the pharmacy should update the Pharmacy module in CHCS so the cancellation flows to the billing application before the claim is created. If a claim has already been submitted for a prescription that is subsequently canceled, the biller should cancel the claim to the payer. In the event that a payer pays for a subsequently canceled transaction, the payment must be refunded.

## PRE-AUTHORIZATIONS/PRE-CERTIFICATIONS

Revised: November 2013

1. General. Some payers require approval of an admission, a procedure, a drug, or supply before furnishing it or at the time of service before they will reimburse an MTF. (Note: For this section, the terms pre-authorization and pre-certification are used interchangeably.)

2. Admissions. A process must be in place for Admissions staff members to notify the UBO staff when a patient with other health insurance (OHI) is admitted (e.g., via email group, by providing Department of Defense (DD) Form 2569, or by phone call). A UBO staff member or a Utilization Review (UR) nurse should call the payer's pre-authorization phone number or use a secure online process to certify the admission. Verify pre-authorization prior to each patient admission, if possible.

2.1. The payer provides an authorization number if the reason for admission is approved. Enter the authorization number in the patient insurance information (PII) module of Composite Health Care System (CHCS); it will be reported on form locator 63 of the Uniform Billing form (UB)-04. Keep documentation of authorization for each admission or ambulatory procedure visit (APV) in the billing file. Failing to obtain pre-authorization may require additional "clinical review" and be subject to a reduction in reimbursement. In some cases, no authorization is needed for a diagnosis or where Medicare is considered the primary payer.

2.2. Payers may require a "clinical review," which may be facilitated by UBO staff or a UR nurse may verbally provide the medical documentation supporting the request. The payer may require follow-up documentation (e.g., a copy of the medical record).

3. Outpatient Surgery (i.e., APVs) and Diagnostic Imaging/Radiology Therapy. A process must be in place to obtain a copy of future appointments. Look for patients with insurance to see if there are any schedules, procedures, or visits that require pre-authorization.

3.1. Call for pre-authorization. Authorization may be given by telephone after providing a reason for procedure; however, additional information may be required from the medical record, and a clinical review may be necessary.

3.2. Enter the authorization number in the PII module of CHCS; it will be reported on the UB-04 form locator 63 or on the Centers for Medicare & Medicaid Services form (CMS) 1500 in item number 23.

4. Pharmacy Scripts. A process must be in place for UBO personnel to identify scripts that require pre-authorization; payer requirements may vary and may not be known until a denial is received. Prior to submitting the claim, check the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/pharmacy.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/pharmacy.cfm) for a reference list of payers that commonly require pre-authorization. An MTF staff member should review this list before submitting a claim and obtain pre-authorization, if necessary. If a pharmacy claim is denied due to lack of pre-authorization, an MTF staff member must submit an authorization request as follows.

4.1. Create and maintain tracking lists of payer requirements.

4.2. Obtain a blank authorization request from the payer or its website.

4.3. Submit completed authorization request to the payer.

4.4. Some payers may have step-therapy guidelines; refer to payer for requirements.

## PRE-AUTHORIZATIONS/PRE-CERTIFICATIONS

Revised: November 2013

1. General. Some payers require approval of an admission, a procedure, a drug, or supply before furnishing it or at the time of service before they will reimburse an MTF. (Note: For this section, the terms pre-authorization and pre-certification are used interchangeably.)

2. Admissions. A process must be in place for Admissions staff members to notify the UBO staff when a patient with other health insurance (OHI) is admitted (e.g., via email group, by providing Department of Defense (DD) Form 2569, or by phone call). A UBO staff member or a Utilization Review (UR) nurse should call the payer's pre-authorization phone number or use a secure online process to certify the admission. Verify pre-authorization prior to each patient admission, if possible.

2.1. The payer provides an authorization number if the reason for admission is approved. Enter the authorization number in the patient insurance information (PII) module of Composite Health Care System (CHCS); it will be reported on form locator 63 of the Uniform Billing form (UB)-04. Keep documentation of authorization for each admission or ambulatory procedure visit (APV) in the billing file. Failing to obtain pre-authorization may require additional "clinical review" and be subject to a reduction in reimbursement. In some cases, no authorization is needed for a diagnosis or where Medicare is considered the primary payer.

2.2. Payers may require a "clinical review," which may be facilitated by UBO staff or a UR nurse may verbally provide the medical documentation supporting the request. The payer may require follow-up documentation (e.g., a copy of the medical record).

3. Outpatient Surgery (i.e., APVs) and Diagnostic Imaging/Radiology Therapy. A process must be in place to obtain a copy of future appointments. Look for patients with insurance to see if there are any schedules, procedures, or visits that require pre-authorization.

3.1. Call for pre-authorization. Authorization may be given by telephone after providing a reason for procedure; however, additional information may be required from the medical record, and a clinical review may be necessary.

3.2. Enter the authorization number in the PII module of CHCS. It will be reported on the UB-04 form locator 63 or on the Centers for Medicare & Medicaid Services form (CMS) 1500 in item number 23.

4. Pharmacy Scripts. A process must be in place for UBO personnel to identify scripts that require pre-authorization; payer requirements may vary and may not be known until a denial is received. Prior to submitting the claim, check the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates/pharmacy.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/pharmacy.cfm) for a reference list of payers that commonly require pre-authorization. An MTF staff member should review this list before submitting a claim and obtain pre-authorization, if necessary. If a pharmacy claim is denied due to lack of pre-authorization, an MTF staff member must submit an authorization request as follows.

4.1. Create and maintain tracking lists of payer requirements.

4.2. Obtain a blank authorization request from the payer or its website.

4.3. Submit completed authorization request to the payer.

4.4. Some payers may have step-therapy guidelines; refer to payer for requirements.

## PROLONGED SERVICES

Revised: 01 October 2003

### 1. Direct (Face-to-Face) Patient Contact

1.1 Codes +99354 and +99355 are add-on codes and are used to report the total duration of face-to-face time spent by the physician involved in direct patient contact beyond the usual service. These codes should be listed separately in addition to the E/M service.

1.2 Time does not have to be continuous but must be documented.

#### Example:

A patient is seen in the Urgent Care Clinic as a result of a fall down the escalator. The patient had multiple trauma and was examined by an Orthopedic physician for a suspected hip fracture. The physician communicated to the patient the extent of the injuries and the treatment plan. The history and examination were detailed with moderate complexity decision making. The examination time was 55 minutes. The threshold was met and the visit is coded with 99214 E/M (25 minutes) and 99354 (30 minutes) for the extra time.

### 2. Without Direct (Face-to-Face) Patient Contact

2.1 Codes +99358 and +99359 are used to report the total duration of non-face-to-face time spent by the physician.

2.2 Time does not have to be continuous but must be documented.

2.3 These codes may include review of extensive records and tests, communication with other professionals (excludes telephone calls) and/or communication with the patient or family.

#### Example:

Given the above scenario, if the physician communicated with other professionals concerning the proposed treatment plan and conducted review of extensive records and tests, then the applicable prolonged services without direct face-to-face contact can be coded. Note: In order to use codes 99358 and 99359 the physician would have seen the patient prior (direct face-to-face).

## PROVIDERS

Revised: November 2013

1. General. Providers (e.g., physicians, nurse practitioners, nurses, medical technicians) in the Military Health System (MHS) are classified in several ways including Composite Health Care System (CHCS) Provider Class and Specialty Code, TRICARE Provider Category, and Health Insurance Portability and Accountability Act (HIPAA) Provider Taxonomy Code. The type of provider as well as the role of the provider for a given service affects the amount billed and may even determine if the services are billable.

2. CHCS Provider Classes. CHCS classifies providers into four Provider Classes based on the CHCS Provider Specialty Code(s), a schema for describing the provider's medical specialty, assigned to the provider by the MTF. TMA UBO rates for most professional services provided to Third Party Collection Program (TPCP), Medical Affirmative Claims (MAC) and most Medical Services Accounts (MSA) patients differ depending on the CHCS Provider Class.

Class 1 is the physician provider class (medical doctor (MD) and doctor of osteopathic medicine (DO))

Class 2 is the psychologist class (doctor of philosophy (PhD) and psychologist)

Class 3 is other mental health provider class (Certified Social Worker)

Class 4 is the extra medical provider (non-mental health only)

Rates are typically higher for Classes 1 and 2 than they are for Classes 3 and 4. The MHS maintains a table that maps each CHCS Provider Specialty Code to CHCS Provider Class as well as to the corresponding HIPAA Taxonomy. The HIPAA Taxonomy is the national standard schema for provider specialties. TPC, MAC, and billing applications maintain reference tables that tie the CHCS Provider Specialty to Provider Class and thereby calculate the correct charges for TPC, MAC and most MSA billing.

3. TRICARE Provider Categories. TRICARE Provider Categories are used to calculate charges for care provided to patients at MTFs operating under Department of Veterans Affairs (VA)-DoD resource sharing agreements. They classify providers into four categories that differ from CHCS Provider Classes. Whereas CHCS Provider Classes are determined solely by the CHCS Provider Specialty, TRICARE Provider Categories relate to a combination of the provider's HIPAA Taxonomy and the setting where the service was rendered (i.e., institutional setting versus provider's office). Correct VA-DoD resource sharing agreement billing is dependent on mapping the provider described in the encounter documentation to the correct TRICARE Provider Category shown below.

Category 1 (Facility Physician): Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) provided in a facility setting.

Category 2 (Non-Facility Physician): Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and CNMs provided in a non-facility setting.

Category 3 (Facility Non-Physician): Services, of all other providers not found in Category 1, provided in a facility setting.

Category 4 (Non-Facility, Non-Physician): Services, of all other providers not found in Category 2, provided in a non-facility setting.

4. Provider Roles. HIPAA-claim filing standards require that provider roles are described relative to care provided. These roles include: referring, ordering, supervising, rendering, attending, operating, other operating and prescribing, depending on services provided and claim format. Provider roles within CHCS do not fully align with the HIPAA required claim roles. Therefore, billing applications map the CHCS

provider roles to the HIPAA-required claim roles.

5. "Incident To" Billing. "Incident to" billing refers to the billing of services and supplies that are performed by auxiliary personnel (e.g., physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, clinical psychologists, clinical social workers and physical and occupational therapists).

5.1. Supervision of Auxiliary Personnel. Auxiliary personnel act under the supervision of the provider after the provider has seen the patient, developed a plan of care, and initiated the course of treatment. The "incident to" service provided by the auxiliary personnel is then an incidental part of the patient's treatment. The services provided must be delivered under the provider's direct supervision; the provider must be in the area where care is delivered and be immediately available to provide assistance and supervision. The patient can see the auxiliary personnel for continued treatment of the initial problem that was presented to the provider. If a new problem is identified at a visit by the auxiliary personnel, the patient must be referred back to the provider for evaluation and development of a new plan of care.

5.2. Billing process. Submit claims based on the encounter information provided by the billing system. UBO personnel may bill "incident to" care under the supervising provider's identity if the conditions in 5.1 were met. In that case, review the encounter documentation and consult with the coding staff for verification.

## PULMONARY FUNCTION

Revised: 8 March 2006

1. Pulmonary function testing is a determination of the effectiveness of the pulmonary system (e.g., the lungs). These tests usually require special equipment, but some tests will be coded with the office visit such as pulse oximetry for patients with possible oxygenation problems such as asthma or chronic obstructive pulmonary disease (COPD).

### 2. Outpatient Clinic Services.

2.1. Pulse Oximetry. When a test, such as 94760 pulse oximetry, is performed in the outpatient clinic, it needs to be linked to a diagnosis reflecting the possible oxygenation problem. If the procedure is done as a vital sign, with no symptoms to indicate a problem, and it is coded as a separate procedure, do not expect insurance companies to pay.

2.2. Spirometry. During some physicals, particularly for pilots, total lung capacity is measured. In some cases it meets the requirements for 94010, spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation. It is not usually performed for other physicals. Since active duty care is not billable, spirometry would not appear frequently on bills for physicals.

3. Pulmonary Function Clinic. These services are usually furnished in the DD\*\* MEPRS Functional Cost Code (FCC). Because they are performed and coded in the DD\*\* MEPRS, they would have to be identified and billed manually.

3.1. Many of these codes have both a technical component (the technician performs the hook up and records the test) and a professional component (the doctor reviews the tracing, does an interpretation, and writes a report). With the 17 day hold, both the technical and professional components *should* be available to bill at one time. In that case, they would be manually billed on the CMS 1500, using the code for the total procedure (tracing and interpretation) in the privileged provider's name, on the day the interpretation and report was performed.

## RADIOLOGY

Revised: 14 January 2009

1. Radiology CPT codes are in the 70010-79999 range. Radiology services coded with no modifier or appropriate modifiers except for -26 should be billed on the UB-04. Radiology services coded with modifier -26 reflects only professional services and should be billed on the CMS 1500.

2. Most radiology work is collected in the radiology module of CHCS and feeds directly to TPOCS or MSA. The Correct Coding Editor (CCE) does not review coding from the Radiology module.

2.1. Billing personnel should be aware that some of the modifiers used in the radiology module are inconsistent with general coding principles.

These modifiers are being used to calculate radiology workload values. If you have any questions about whether or not you should use the modifier on a bill, please contact a member of your facilities' coding staff. The modifier meanings within the radiology module are as follows.

- 32 modifier (Exam weight for procedure)
- 26 modifier (Reporting weight of the procedure)
- 00 modifier (Total weight value for the procedure)
- 50 modifier (Bilateral / weight is doubled)
- 51 modifier (Exam only - bilateral)
- 22 modifier (Portable/ weight is doubled)
- 99 modifier (Bilateral and portable)

3. Revenue Codes. There are several different categories of revenue codes that can be used, based on the procedure code. The general categories are: 032X-Radiology; 035X-CT Scan; 040X-Other Imaging Services; 0483-Cardiology; 061X-Magnetic Resonance Technology (MRT); and 0750-Gastrointestinal Services.

4. TPOCS Bill Type 3.

## RATE TABLES

Revised: November 2013

1. General. DoD rates tables tell what rate to apply for each coded service, procedure, supply, and pharmaceutical provided to a patient. Each outpatient service and supply is identified with a Current Procedural Terminology (CPT<sup>®18</sup>)/Healthcare Common Procedural Coding system (HCPCS) code; each inpatient medical facility has adjusted standardized amounts (ASA); and pharmaceuticals are identified based on National Drug Code (NDC). Defense Health Agency (DHA) UBO rates are available on the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm). If there is no rate available, follow *Procedure To Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate* in Appendix A.

2. Outpatient Billing Rates. The majority of rates are based on the TRICARE CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) Maximum Allowable Charge (CMAC) fee schedule, adjusted for MHS billing systems, and they include charges for additional services not reimbursed by TRICARE. If no TRICARE CMAC is available, rates are developed based on Centers for Medicare & Medicaid Services (CMS) reimbursement rates, Purchased Care data, and Medical Expense and Performance Reporting System (MEPRS), and other government rate tables. The annual Outpatient Itemized Billing (OIB) rates package includes MHS-adjusted Full Outpatient Reimbursable rates (FOR) CMAC rates and MHS standard rate tables for Dental, Immunizations/Injectibles, Anesthesia, Durable Medical Equipment/Durable Medical Supplies (DME/DMS), and Ambulance. The package also includes Interagency Outpatient Rates (IOR) and International Military Education and Training (IMET) discounts. For Department of Veterans Affairs (VA)-DoD Resource Sharing Agreement care, however, use TRICARE CMAC rates, and discounts apply.

### 2.1. UBO CMAC-based Rate Tables.

2.1.1. CHCS Provider Classes. UBO CMAC-based tables contain rates for each CMAC Provider Class applicable for each CPT/HCPCS code. Each billable provider is mapped to a CMAC Provider Class of 1 through 4. The four provider classes are: (1) Physicians, (2) Psychologists, (3) Other Mental Health Providers, and (4) Extra Medical Providers. (See the *Provider* section of this User Guide for more information on CMAC Provider Class and mapping information.)

2.1.2. Localities. UBO CMAC rates are calculated for 91 distinct “localities.” These localities recognize differences in local costs to provide health care services in the different geographic regions in which MTFs are located. Each MTF Defense Military Information System Identifier (DMIS ID) is mapped to its corresponding CMAC locality code to obtain the correct rates. For all MTFs located outside the continental United States and Hawaii, CMAC locality 391 is used. The complete DMIS ID-to-CMAC Locality table is available on the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/mhs\\_rates.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm)

2.1.3. CMAC and CMAC Component Tables. For each CMAC locality, the DHA UBO creates two sub-tables of rates: CMAC and Component. The CMAC rate table specifies the rates to use as payment for professional services and procedures identified by CPT and HCPCS codes, which cannot be separately provided as professional and technical component services. The Component rate table specifies which rates to use for CPT codes, which can be provided as distinct professional and technical components, or which are a combined professional and technical service. A separate rate is provided for each component. The professional component rates (for codes with modifier -26) are for services that are normally performed by a physician to interpret a diagnostic test. The technical component rates (for codes with modifier -TC) are institutional charges that are not normally billed separately (e.g., charges for equipment, technician services, supplies and materials used during test). The global rate is equal to the

---

<sup>18</sup> CPT is a registered trademark of the American Medical Association

sum of professional and technical charges.

2.2. Dental Rate Table. The Dental rate table provides full Third Party Collection (TPC) rate, IOR, and IMET rates for dental services based on American Dental Association (ADA) Current Dental Terminology (CDT) codes (HCPCS Level II codes).

2.3. Immunizations/Injectibles Rate Table. The Immunization/Injectibles rate table provides the full/TPC rates for vaccines and therapeutic medications (injections) administered other than by mouth as part of a clinic encounter, as identified by HCPCS Level II codes.

2.4. Anesthesia Rate Table. The Anesthesia rate table provides the Full/TPC rates for the professional portion of anesthesia services, based on the flat rate assigned to each anesthesia CPT code.

2.5. DME/DMS Rate Table. The DME/DMS rate table provides the full/TPC rate for DME/DMS based on HCPCS Level II codes and modifiers.

2.6. Ambulance Rate Table. The Ambulance rate table provides full/TPC, IOR, and IMET rates for ambulance services, based on an all-inclusive hourly rate.

2.7. IOR/IMET Rate Table. The IOR/IMET rate table provides the government discount or billing calculation factor (percentage discount) applied to the full/TPC rate when billing for IMET and IOR services.

3. Inpatient ASA Rates. ASA rates are MTF-specific-based charges per relative weighted product (RWP) applied to inpatient encounters. They are adjusted for area wage differences and indirect medical education (IME) costs, if any, for the discharging hospital. The tables provide the full/TPC, IOR, and IMET rates.

4. Pharmaceuticals. Pharmacy rate tables provide full ingredient unit measure charges for pharmaceuticals based on their NDCs. For each rate table there is a corresponding dispensing fee table.

5. Updating Rate Tables.

5.1. Outpatient. Billing system administrators must update outpatient rate tables as they are published (generally annually on a calendar year basis).

5.2. Inpatient. Designated MTF personnel must update inpatient rate tables as they are published (generally annually on a fiscal year basis). Use the following procedures to update ASA rates in CHCS.

- Log into CHCS
- Select the MSA module
- Select Office Function Menu
- Select Edit Rate Table
- Update the rates according to the published ASA rates for the MTF
- Ensure the effective date is the date of loading plus one day (not prior to the approved effective date)

5.3. Pharmacy. Billing system administrators must update Pharmacy rate tables as they are published (generally biannually).

## REFUNDS

Revised: March 2014

1. General. This section is applicable to TPOCS. Once the future billing solution ABACUS is implemented it will be revised for those procedures. Automated and manual procedures are used to correct accounting records. Manual procedures are provided when automated systems are not available. This does not pertain to Air Force billing operations; Air Force MTFs should follow Service guidance.
2. Third Party Collection Refunds. When an overpayment is received for claims billed out of Third Party Outpatient Collection System (TPOCS), the following actions must be taken.
  - 2.1. Post all monies received to the applicable TPOCS accounts and to Composite Health Care System (CHCS) Account "Outpatient Insurance."
  - 2.2. After determining the amount to be refunded, Standard Forms (SF) 1034 and 1080 must be completed and mailed to the applicable Defense Finance and Accounting Service (DFAS) address. Separate SF1034s and SF1080s must be completed for each insurance company to be refunded.
  - 2.3. After completing the above actions, there must be a refund out of CHCS. This is accomplished by going to the last outpatient CHCS business posted and backing out the amount(s) to be refunded.
  - 2.4. After backing out the amount(s) from CHCS, go to each corresponding account in TPOCS and refund the amount(s) accordingly. Note: In the itemized side of TPOCS, only the full amount posted can be refunded; the system will not allow partial refunds.
  - 2.5. If additional monies are received that are not due the MTF and the check cannot be returned, post the additional money in CHCS, then go back to steps 2 and 3.
3. Medical Services Account (MSA) Refunds. When overpayment is received for MSA claims, follow the procedures in *DoD 6010.15-M "Military Treatment Facility Uniform Business Office (UBO) Manual,"* available at [http://www.tricare.mil/ocfo/mcfs/ubo/policy\\_guidance/manuals.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/manuals.cfm).

## REHABILITATION SERVICES

Revised: 01 October 2003

1. For all encounters, the ADM Record should be coded listing the appropriate V-code first (V57.1 for PT, V57.21 for OT), followed by the diagnosis code (frequently a symptom) if available.
2. For Rehabilitation Technicians rendering treatment ordered by a privileged provider (P.T., O.T., SLT), the privileged provider supervising the procedures should have the first provider position in ADM, and the technician the second provider position.
3. Rehabilitation technician services are coded using a 99499, along with appropriate modalities and therapeutic procedures.
4. Physical Therapy CPT codes: 97001 for evaluations and 97002 for re-evaluations
5. Occupational Therapy CPT codes: 97003 for evaluations and 97004 for re-evaluations
6. Athletic Training Evaluation CPT codes: 97005 for evaluations and 97006 for re-evaluations

## REVENUE CODES

Revised: April 2014

1. General. Revenue codes (RCs) are used on the institutional claim (paper Uniform Bill (UB)-04 or the electronic 837I) to identify specific accommodations (inpatient) and ancillary services (outpatient). For additional information on institutional claims, view the DHA UBO online training module Data and Billing in Sync: UB-04/837I, available at [http://www.tricare.mil/ocfo/mcfs/ubo/learning\\_center/Teleconferences.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/learning_center/Teleconferences.cfm).

1.1. A revenue code corresponds to each narrative description or standard abbreviation that identifies a specific ancillary service.

1.2. A revenue code must be assigned for each line item charge billed.

1.3. A revenue code must be valid for the type of claim being billed. For example, Days Room & Board (e.g., 011X) is valid for inpatient claims only; it is not valid for outpatient claims.

2. Reference Materials. Reference materials, including use of revenue codes, are available from a number of sources. They provide information about the correlation between Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®<sup>19</sup>) codes, revenue codes, type of bill, etc. For more information, ask your Service or National Capital Region Medical Directorate (NCR MD) UBO Program Manager.

3. Revenue Code Mapping Table. The Revenue Code to CPT Code Mapping Table is loaded annually each calendar year into the Composite Health Care System (CHCS) and billing and collections systems. For future billing solutions, this information may be distributed in a different manner.

3.1. The mapping table lists most commonly used RCs per CPT/HCPCS codes. Changes to RCs listed in the mapping table will be considered by the Defense Health Agency (DHA) UBO Program Office on request. Send requests to your Service or NCR MD UBO Program Manager.

3.2. The CHCS Inpatient Claims Module will only accept one RC for the all-inclusive hospital charges and one RC for the professional fees. Payer-specific requirements must be addressed by manually changing the RC. Future billing systems will allow more than one RC, and billers should include all appropriate RCs.

4. Commonly Used Revenue Codes. Following is a list of the most common RCs for institutional claims:

Revenue Code	Description
0001	Total charge (paper only)
010X	All-Inclusive Rate
024X	All-Inclusive Ancillary
025X	Pharmacy
026X	IV Therapy
027X	Medical/Surgical Supplies and Devices
028X	Oncology
029X	Durable Medical Equipment (other than Renal)
030X	Laboratory
031X	Laboratory Pathology
032X	Radiology – Diagnostic
033X	Radiology – Therapeutic and/or Chemotherapy Administration
034X	Nuclear Medicine
035X	CT Scan

<sup>19</sup> CPT® is a registered trademark of the American Medical Association

<b>Revenue Code</b>	<b>Description</b>
036X	Operating Room Services
037X	Anesthesia
038X	Blood and Blood Products
040X	Other Imaging Services
041X	Respiratory Services
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech Therapy – Language Pathology
045X	Emergency Room
046X	Pulmonary Function
047X	Audiology
048X	Cardiology
049X	Ambulatory Surgical Care
051X	Clinic
053X	Osteopathic Services
054X	Ambulance
061X	Magnetic Resonance Imaging (MRI)
062X	Medical/Surgical Supplies
063X	Pharmacy
073X	EKG/ECG (Electrocardiogram)
074X	EEG (Electroencephalogram)
075X	Gastrointestinal Services
076X	Treatment or Observation Room
077X	Preventive Care Services
081X	Acquisition of Body Components
082X	Hemodialysis – Outpatient or Home
090X	Behavioral Health Treatments/Services
091X	Behavioral Health Treatments/Services
092X	Other Diagnostic Services
093X	Medical Rehabilitation Day Program
094X	Other Therapeutic Services
095X	Other Therapeutic Services
096X	Professional Fees
097X	Professional Fees
098X	Professional Fees

## SYSTEM CHANGE REQUESTS/SYSTEM INCIDENT REPORTS

Revised: 01 October 2003

### 1. TMA UBO Developed Functional Change Requirements

1.1. Functional requirements are gathered from various sources, such as meetings. These requirements often need to be translated into system change requests and system incident reports (SCRs/SIRs).

1.2. The SCR/SIR form is completed.

1.3. The SCR/SIR is entered into a matrix (Word format) for the TMA UBO Program and UBO Service Managers.

1.4. Once approved, the SCR/SIR is sent either directly by the TMA UBO Program Manager or by the SCR/SIR support person on behalf of the TMA UBO Program Manager to Information Management (IM).

1.5. IM will put the SCR/SIR into Dynamic Object Oriented Reporting System (DOORS) and then add it to the UBO SCR Tracking Matrix (Excel format). Updated matrices will be sent to the SCR support person periodically for review and concurrence. The matrix will be sent to the TMA UBO Program Manager for his/her information.

1.6. Once in DOORS, the SCR will go through the budgeting process by IM.

1.7. Monthly meetings will be held to go over the status of SCRs/SIRs.

### 2. Service-Level Developed Functional Change Requirements

2.1 The Services and MTFs are allowed to directly submit SCRs/SIRs to report system issues or errors.

2.2 An SCR/SIR template can be obtained from the UBO website.

2.3 The requesting individual should submit the SCR/SIR to their UBO Service Manager and refer to the SCR/SIR process stated above in paragraph 3.

# THIRD PARTY COLLECTION PROGRAM – REPORT ON PROGRAM RESULTS (DD FORM 2570) and UBO METRICS REPORT

Revised: November 2013

1. General. The Department of Defense (DD) Form 2570, “Third Party Collection Program – Report on Program Results,” is used by UBO to report claims and collections data for their Third Party Collection Program (TPCP) to the Defense Health Agency (DHA) UBO. It is available online at <http://www.dtic.mil/whs/directives/infomgt/forms/dd/ddforms2500-2999.htm>. MTF billing staff members enter Third Party Collection data, including the inpatient disposition and outpatient visit data collected, on this report into the DHA UBO Metrics Report (MR), an automated, Web-based, data collection application that facilitates capturing, consolidating, validating, and reporting DD Form 2570 TPCP results. Results are consolidated by MTF, Region, and Service in order to benchmark and trend claims and collection results.

1.1. Each UBO office must complete a DD 2570 on the first working day after the end of each quarter. The reporting quarters are: 1st = October – December; 2nd = January – March; 3rd = April – June; 4th = July – September.

1.2. In the Third Party Outpatient Collection System (TPOCS), the default beginning date of the report is 10/01/1991. Do not change this date or the data will be incorrect.

1.3. Report data is cumulative. Prior Year (PY) 1 and PY2 will always be full cumulative fiscal year data. Cumulative Fiscal Year (CFY) will be cumulative through the quarter that is being reported.

1.4. The DD 2570 report claims and summarizes adjustment transactions based on the date-of-service fiscal year (FY). Amounts collected are reported both based on the FY date-of-service and the year of collection. Follow Service-specific guidelines for validating report data.

2. Menu Paths for DD 2570 Data Fields. As explained below, obtain Outpatient DD 2570 data from the TPOCS, Inpatient DD 2570 data from the Composite Health Care System (CHCS), and the number of non-Active Duty visits (NAD) from the CHCS Workload Assignment Module (WAM) or the Military Health System (MHS) Management Analysis and Reporting Tool (M2).

2.1. For Outpatient billing and collection data, use the following TPOCS menu path:

- Select Reports Tab
- DoD Reports
- DD Form 2570 (TPCP Program Results)
- Select the appropriate year and quarter for the data being requested
- Print Report

2.1.1. For NAD visits data.

2.1.1.1. Use the following WAM menu path to obtain the number of NAD outpatient appointments per month. The MEPRS Manager runs this report monthly.

- Select 2 – Division
- Select 1 – SAS #
- Enter the month
- Look for outpatient visit data by MEPRS (Medical Expense and Performance Reporting System) code

2.1.1.2. Use the following M2 menu path for a NAD report. Note the number of NAD visits displayed is cumulative throughout the FY (e.g., 1st Qtr + 2nd Qtr):

- Choose DMIS ID (Defense Medical Information System [facility] identifier)
- Identify Fiscal Year and Fiscal Month

- Select Beneficiary Category not equal to “4” (AD, Active Duty)
- Set Compliance Status to “R”
- Select clinic by 3- or 4-digit MEPRS code
- Exclude telephone consultations (TCONs) (Appointment Status Code = 7)
- Select Encounters
- Run the Report

2.2. For NAD Inpatient billing and collection data, use the following MSA menu path in CHCS:  
**IFM\QRP\PRR\current quarter.**

2.3. Follow Service-specific guidelines to validate all TPCP data.

3. Training Module for Metrics Reports (Archived Webinars). View the MR training modules, “How to Pull DD 2570 Data and Combine for Accuracy and What It Means” and “Metrics Report” available on the DHA UBO website at [http://www.tricare.mil/ocfo/mcfs/ubo/performance\\_measure/metrics.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/performance_measure/metrics.cfm).

3.1. User accounts are required to access the MR website. Only Service Program Managers may request new user accounts via email to [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org). Account access requests must include: User’s First/Last Name, email address, commercial phone number, DMIS ID, and type/level of access (i.e., User, Region POC (Point of Contact), Service POC, Read-Only). For Region POC access, requests must include the above information and specified Region (in lieu of DMIS ID).

3.2. Service Program Managers and Region Managers are responsible for informing the UBO MR Administrator at [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) of any account changes, including deactivation.

3.3. Enter DD 2570 data into the secure MR website at <https://www.ubometrics.org> as follows:

- Log into the UBO MR website
- Select “Add Report” tab at top of page
- Go to facility block and select your facility
- Choose Inpatient or Outpatient report
- Select Fiscal Year
- Select Quarter reporting
- Click the “Add” button

3.3.1. Each section of the DD 2570 TPOCS or CHCS report correlates with a UBO metrics data requirement field.

3.3.2. The MR checks for accuracy of data input and displays system error prompts. Correct all errors and then select “save” report.

3.3.3. For assistance, contact your Service Program Manager or Region Manager. For additional assistance, submit a trouble ticket to the UBO Help Desk using the Help feature on the MR website or by calling **571-733-5935**.

3.3.4. Each report must be validated by the Service Program Manager or Region Manager. Each Service establishes its own internal due dates and validation requirements.

3.3.5. The DHA UBO MR Administrator will roll up all reports four weeks after the end of each reporting quarter. This deadline may be extended by the DHA UBO Program Office.

3.3.6. Only Service Program Managers may submit requests for corrections or additions after the roll-up by contacting the [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) for DHA UBO Program Office review and approval.

3.4. The DHA UBO MR Administrator locks the validated reports until the final collections report is approved by the DHA UBO Program Office. Once approved, the reports (read-only format) are sent to the Service Program Managers and posted to the DHA UBO website.

## U.S. COAST GUARD BILLING

Added: November 2013

1. General. Per Interagency Agreement (IAA)<sup>20</sup>, the U.S. Coast Guard (USCG) reimburses the Army, Navy and National Capital Region (NCR) Medical Directorate (formerly Joint Task Force National Capital Region Medical, JTF CapMed) for inpatient and outpatient care provided to USCG eligible beneficiaries at their MTFs annually on a prospective basis. Payments are calculated based on actual prior fiscal year encounter data and Defense Health Agency (DHA) UBO rates. They are normalized using the appropriate medical inflation factors, force structure adjustments, and other health insurance (OHI) adjustment (a discount). The Coast Guard directly distributes prospective payment amounts (PPAs) to Army, Navy, and NCR Medical Directorate MTFs based on individual treatment Defense Medical Information System [facility] identifier (DMIS ID) PPA calculations; thus MTFs do not submit claims for these beneficiaries except as noted below in paragraphs 2 and 4. The Air Force does not participate in the IAA, thus continues to submit claims for USCG beneficiaries seen at Air Force MTFs as noted in paragraph 3.

2. IAA claims. For Army, Navy, and NCR Medical Directorate MTFs, cancel USCG DD7/DD7As and do not submit interagency claims to the USCG for inpatient or outpatient care provided to USCG beneficiaries (including dental and ancillary services, pharmaceuticals, and supplies). However, submit claims to USCG beneficiaries for patient pay services and other third party payers as follows.

2.1. The annual IAA PPA includes an adjustment for OHI. Thus, collect or update OHI information on a DD Form 2569 annually from each USCG beneficiary who receives care, and submit Third Party Collection (TPC) claims to the OHI payer if the USCG beneficiary carries OHI. If the patient has OHI, there is no Family Medical Rate (FMR) or subsistence charge to the patient. Also, if the patient is enrolled in TRICARE Prime, do not bill FMR or subsistence charges to the patient. If the patient does not have OHI and is not enrolled in TRICARE Prime, bill subsistence and FMR charges to the patient using an invoice and receipt (I&R).

2.2. The annual IAA PPA does not include reimbursement for elective cosmetic surgery (ECS). Submit a claim to and collect the full cost of ECS (including supplies and pharmaceuticals) from all eligible USCG beneficiaries in advance of the ECS service or procedure. (See the *Cosmetic Surgery* section of this User Guide.)

2.3. The annual IAA PPA does not include reimbursement for individual billable care provided to USCG newborns of former service members (Patient Category (PATCAT) 28) or USCG newborns of sponsor's daughters (PATCAT 29). Bill both of these USCG beneficiaries the full reimbursement rate.

2.4. The IAA PPA includes the cost of care for injuries or diseases provided to USCG beneficiaries for which third party payers may be responsible due to tort liability (i.e., for Medical Affirmative Claims (MAC) billing). Forward any MAC claim information to the USCG for review and collections by the USCG. Request USCG MAC contact information from your Service Program Manager.

3. Non-IAA claims. For any MTF whose Service has not signed the IAA (i.e., Air Force), submit claims to: the USCG, third-party payers, or USCG beneficiaries.

3.1. Follow Service specific guidance for forwarding information on services provided to Coast Guard patients for injuries or diseases for which third party payers may be responsible due to tort liability.

---

<sup>20</sup> Current effective IAA dated 1 October 2011 is between the USCG and Army, Navy, and NCR Medical Directorate.

3.2. Submit claims for full reimbursement to USCG former Service members and newborns of sponsor's daughters for individual billable care provided (i.e., PATCATs 28 or 29).

4. Other Health Insurance (OHI). Follow procedure described in section 2.1.

5. Exclusions from USCG Billing. Do not submit claims for USCG PATCAT C44 (USCG FAM MBR TRANSITIONAL COMP) or Medicare-eligible beneficiaries.

## **UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)**

Revised: April 2014

1. General. The Uniformed Services Family Health Plan (USFHP) is a TRICARE Prime option available to family members of active duty military, retirees, and retiree family members through not-for-profit health care systems in designated areas of the country. USFHP is not Other Health Insurance (OHI) under the Third Party Collections Program (TPCP), and any Health Insurance Carrier (HIC) identifier (ID) requests will be rejected.

2. Current USFHP Facilities. The current six facilities are listed below. For up-to-date information on authorized sponsoring organizations and covered regions, including contact information, visit the USFHP website at <http://www.usfhp.com/contact-us/>.

- a. Martin's Point Health Care, Portland, Maine
- b. Johns Hopkins Medicine, Baltimore, Maryland
- c. Brighton Marine Health Center, Boston, Massachusetts
- d. Saint Vincent Catholic Medical Centers, New York City, New York
- e. CHRISTUS Health, Galveston, Texas
- f. Pacific Medical Center (PacMed Clinics), Seattle, Washington

3. USFHP Enrollee Care at MTFs. USFHP enrollees are not eligible for care at MTFs. There are two exceptions to this limitation: (1) If there is an acute medical emergency, and the MTF is closest; or, (2) if care is not available through USFHP specialists, and the care is properly referred to an MTF pursuant to a Memorandum of Understanding (MOU) with the USFHP.

3.1. If an exception applies, the USFHP member should notify the USFHP of medical emergency care within 24 hours. The MTF should do so as well as soon as it learns about the encounter. The USFHP enrollee should be registered under Patient Category (PATCAT) K92B (USFHP Enrollee Authorized), and the MTF should manually bill the USFHP provider where the patient is enrolled. The appropriate USFHP billing address can be found on the back of the USFHP membership ID card or on the USFHP website noted above in paragraph 1.1.

3.2. If an exception does not apply, the USFHP enrollee should be registered as PATCAT K92A (Civilian Emergency Care) and, the MTF must bill the patient manually.

## **UNITS OF SERVICE**

Revised: April 2014

1. General. A unit of service is the number of times a procedure is performed (e.g., multiple biopsies), amount of time (e.g., 15 minute intervals for most physical therapy procedures), supplies (e.g., number of shoe inserts), or days that a particular Current Procedural Terminology (CPT®<sup>21</sup>)/Healthcare Common Procedural Coding System (HCPCS) code is performed or supplied.
2. Source of Information. Units of service are captured by clinical systems and feed to the billing systems, along with information on the procedures and other data required for billing.
3. Location of Field. The Units of Service field is required on both the institutional UB-04/837I and professional 1500/837P claim formats. (See appendixes B and C.)
4. Quantity. The quantity entered in the Unit of Service field is multiplied by the rate (Units x Rate) to calculate the total charges for the line item.
  - 4.1. For anesthesia services (CPT Codes 00100–01999), minutes is the Unit of Service. For billing, “minutes of service” is converted to the number of units based on 15-minute intervals.
  - 4.2. For modifier -50, bilateral procedures, the charge is adjusted.
  - 4.3. Some CPT/HCPCS codes are time-based; bill according to the range of time noted in the CPT/HCPCS description.

---

<sup>21</sup> CPT® is a registered trademark of the American Medical Association

## VA-DoD RESOURCE SHARING BILLING

Revised: November 2013

1. General. The Department of Veterans Affairs (VA) and DoD have entered into national resource sharing agreements that provide standardized reimbursement rates and policies for care provided in VA Medical Centers (VAMCs) and MTFs to the other's beneficiaries. These are available on the Defense Health Agency (DHA) UBO website at <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm>. MTFs may have specific local resource sharing agreements as well. A list of MTFs with local resource sharing agreements is available at <http://www.tricare.mil/DVPCO/va-direct.cfm>. Consult with your Service Program Manager for additional information. Care provided under VA-DoD resource sharing agreements is subject to specific business rules and rates that make submitting claims different from other interagency billing.

1.1 For patients assigned to patient category (PATCAT) K61-2 (DOD/VA SHARING AGREEMENT), follow the guidance in the national agreements as described in paragraphs 2 (Inpatient Services) and 3 (Outpatient Services) unless the terms of the local agreement differ.

1.2. MTFs that provide care to patients assigned PATCAT K61-1 (VETERANS ADMIN BENEFICIARY) are not covered under VA-DoD Resource Sharing Agreements. For billing guidance see *Inpatient* and *Outpatient Billing* sections of this User Guide.

2. Inpatient Services. To calculate inpatient institutional charges see section 2.2. For charges for professional, ambulance, and anesthesia professional services and supplies, use the TRICARE Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (TRICARE CMAC) rates, less 10%. Calculate charges for durable medical equipment (DME), pharmaceuticals, services purchased from an outside facility, and pass-through items at cost. TRICARE CMAC rates are located at <http://www.tricare.mil/cmac/>. Use the "Facility Physician" rates (Category 1) and the "Facility Non-Physician" rate (Category 3) by mapping the provider described in the encounter documentation to the correct TRICARE Provider Category shown below.

- Category 1 (Facility Physician): Services of medical doctors (MDs), doctors of osteopathic medicine (DOs), optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) provided in a facility setting.
- Category 3 (Facility Non-Physician): Services, of all other providers not found in Category 1, provided in a facility setting.

For additional guidance, view the Inpatient Billing Guidance for VA-DoD Resource Sharing Agreements at <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm#Inpatient>.

2.1. Use the following menu path in the Composite Health Care System (CHCS) to identify inpatient professional services: **FMIFE\KG ADC DATA\PATIENT NAME\SELECT APPOINTMENT\STANDARD OUTPAT? FMIFEYES//CR.**

2.2. To calculate inpatient charges to submit to VA, use the DHA UBO Inpatient Institutional Calculator package effective on the patient's date of service. There are two versions available for download on the DHA UBO website at <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm#Inpatient>.

2.2.1. MTFs with standard VA-DoD direct care resource sharing agreements (i.e., charge TRICARE CMAC rates, less 10% discount) must use the "Standard\_Modified\_VA-DoD\_Inp Inst Calculator\_FYXX" version. The 10% discount percentages are pre-populated and cannot be altered in this version.

2.2.2. MTFs that have negotiated discounts other than the standard 10% discount or that have specific negotiated reimbursement amounts must use the "Variable\_Rate\_Modified\_VA-DoD\_Inp Inst Calculator\_FYXX" version. The discount percentages are pre-populated at zero and can be changed to

reflect the negotiated discount.

2.3. Both versions include a Microsoft® Excel workbook with two worksheets (the Inpatient Institutional Calculator and Inpatient Billing Guide) and the portable document format (PDF) document, "FYXX VA-DoD Resource Sharing Inpatient Institutional Billing Modified TRICARE DRG Payment Calculator and Inpatient Billing Guide USER GUIDE." The USER GUIDE is a supplemental reference document available for download on the [DHA UBO website](#) with step-by-step instructions on how to use the Inpatient Institutional Calculator and Inpatient Billing Guide worksheets.

3. Outpatient Services. To calculate outpatient charges, use the TRICARE CMAC rate less 10% for the appropriate Current Procedural Terminology<sup>22</sup> (CPT)/Healthcare Common Procedural Coding System (HCPCS) code. If there is no TRICARE CMAC rate for a particular CPT/HCPCS code, the facility may substitute an agreed-on rate. TRICARE CMAC rates are located at <http://www.tricare.mil/cmac/>. Use the "Non-Facility Physician" rates (Category 2) and the "Non-Facility Non-Physician" rate (Category 4) by mapping the provider described in the encounter documentation to the correct TRICARE Provider Category shown below.

- Category 2 (Non-Facility Physician): Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and CNMs provided in a non-facility setting.
- Category 4 (Non-Facility, Non-Physician): Services, of all other providers not found in Category 2, provided in a non-facility setting.

For additional guidance, view the Outpatient Billing Guidance for VA-DoD Resource Sharing Agreements at <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm#Outpatient>.

3.1. To calculate outpatient charges to submit to VA, use the DHA UBO Outpatient Billing Guide. There are two versions available for download on the DHA UBO website at <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm#Outpatient>.

3.1.1. MTFs with standard VA-DoD direct care resource sharing agreements (i.e., charge TRICARE CMAC rates less 10% discount) must use the "Standard\_VA-DoD\_Outpatient\_Billing\_Guide\_FYXX" version. The 10% discount percentages are pre-populated and cannot be altered in this version.

3.1.2. MTFs that have negotiated discounts other than the standard 10% discount or that have specific negotiated reimbursement amounts must use the "Variable\_Rate\_VA-DoD\_Outpatient\_Billing\_Guide\_FYXX" version. The discount percentages are pre-populated at zero and can be changed to reflect the negotiated discount.

3.2. Both versions include a Microsoft® Excel workbook with one outpatient billing worksheet and the PDF document, "FYXX VA-DoD Outpatient Billing Guide USER GUIDE." The USER GUIDE is a supplemental reference document available for download on the [DHA UBO website](#) with step-by-step instructions on how to use the Outpatient Billing Guide.

3.3. Institutional costs for ambulatory procedure visits, emergency room visits, and observation beds must be negotiated locally.

3.4. There is no TRICARE CMAC rate table for pharmaceuticals. For resource sharing agreement care, pharmaceuticals are charged at the average wholesale price (AWP) less 60% plus a \$9.00 dispensing fee. To calculate this charge, use the VA-DoD Sharing Pharmacy Price Estimator (PPE) effective on the pharmaceutical fill date. Current and archived VA-DoD PPEs are at <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm#VAPharmacy>.

---

<sup>22</sup> CPT is a registered trademark of the American Medical Association.

3.5. For outpatient durable medical equipment (DME), charge cost. If not available, MTFs can use the Centers for Medicare & Medicaid Services (CMS) DME fee schedule available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html> to obtain a DME charge or locally negotiate the DME charge.

## APPENDIX A – Procedure to Request DHA UBO Program Office–Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate Files

**BACKGROUND.** Title 32 of the Code of Federal Regulations (CFR) Part 220.8 requires that charges for outpatient services, pharmaceuticals, and durable medical equipment and supplies (DME/DMS) are based on TRICARE prevailing rates in cases where they are available. When they are not available, Centers for Medicare and Medicaid Services (CMS) reimbursement rates or actual military expense and workload data are used to determine Defense Health Agency (DHA) UBO outpatient itemized billing (OIB) rates. If none of these rates or data is available for a service, no rate is assigned. However, in the cases of pharmaceuticals and DME/DMS, if TRICARE rates are not available, the CFR allows charges based on the average full cost of these items.

TRICARE allowable rates and CMS reimbursement rates are updated and published quarterly; available pharmaceuticals may be updated at any time. DHA UBO OIB rates files are constructed annually on a calendar year basis to reflect TRICARE or CMS allowable rates for items listed at the time the DHA UBO rates files are created. DHA UBO pharmacy rate files are updated semiannually. In either case there may be a period during which a new code for a service or DME/DMS or a new National Drug Code (NDC) does not have a DHA UBO rate. If there is no current rate, individual UBOs in general cannot charge for a service/NDC/DME/DMS. However, the DHA UBO Program Office (PO) will review a rate request if the billing office can provide sufficient justification and documentation for pricing the new service during an out-of-cycle update or documentation as to the actual cost of the pharmaceutical or DME/DMS. In those cases, the billing office may submit a rate request as follows.

### Rate Request Procedure

1. The billing office will identify the service's Current Procedural Terminology (CPT®<sup>23</sup>) procedure code, the pharmaceutical NDC, or the DME/DMS Healthcare Common Procedural Coding System (HCPCS) code that is not in the DHA UBO rates file.
  - a. In the case of a CPT procedure code that does not have a rate, the billing office will draft a written explanation telling the date(s) of service and the number of times and specific details of when or how the code is being used, including what documentation supports its use.
  - b. In the cases of a NDC or DME/DMS HCPCS code that does not have a rate, the billing office will contact its local procurement or supplies management activity to determine the actual price paid for the NDC or DME/DMS and obtain documentation or proof of purchase on the actual price paid ("the local proof of purchase"). The price paid is the government cost regardless of whether it is purchased from the MTF or central activity budget. If there is no local price, the billing office will draft a written explanation telling the dispense date and the number of times and specific details of when or how the NDC is being dispensed, including what documentation supports its use.
2. The billing office will forward the written explanation and supporting documentation or the local proof of purchase and quantity dispensed or number units and the service, dispense, or issue date to the DHA UBO Helpdesk at [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) with a request for pricing. Use the Subject line: "DHA UBO Special Price Request."
3. The DHA UBO Help Desk will forward the request and documentation to the pharmacy pricing subject matter expert (SME) or the Outpatient Itemized Billing (OIB) Services/DME/DMS pricing SME.

---

<sup>23</sup> CPT is a registered trademark of the American Medical Association

4. The pricing SME will verify that the service, NDC, or DME/DMS is not in the current rate file.
  - a. If the pricing SME confirms there is no DHA UBO current rate for a CPT code, but there is a current TRICARE or CMS rate, he or she will review the written explanation and documentation to determine whether to recommend an out-of-cycle rates update. Factors considered include whether there is a TRICARE or CMS rate for the date of service, the number of times the new code is being used, and whether similar requests have been received from other billing offices. With PO approval, the SME may send a data call to the Services.
  - b. If the pricing SME confirms there is no DHA UBO current rate for an NDC or DME/DMS HCPCS code but there is a local proof of purchase, then he or she will verify the local proof of purchase. If verified, he or she will convert the actual price submitted into the unit measure price (rate). If there is no local proof of purchase, he or she will review the written explanation and documentation to determine whether to recommend an out-of-cycle rates update. Factors considered include the whether there is a TRICARE or CMS rate for the date of service, the number of times the NDC or DME/DMS HCPCS code is being used, and whether similar requests have been received from other billing offices. The SME may send a data call to the Services. (The SME will determine the recommended charge by multiplying the quantity or number of units by the unit measure price and, in the case of pharmacy NDCs, adding the applicable dispensing fee.)
5. The pricing SME will submit the recommended charge and supporting justification and documentation (including no charge if insufficient justification and documentation) to the PO for review and approval.
6. The pricing SME will send the PO approved charge information (including if no charge) to the billing office that requested the pricing and copy the PO, the DHA UBO Help Desk, and the applicable Service Program Manager(s). Approval of a rate for services, NDCs, DME/DMS is MTF- or Activity-specific and cannot be used by other MTFs or Activities unless the PO states otherwise.

## APPENDIX B – UB Claim Form Instructions for Outpatient Services\*\*\*

**Note:** The Uniform Billing Claim Form has been updated. The boxes explain the transition schedule. Instructions for the UB-04 are found in Appendix B1; a quick guide to the UB-04 is found in Appendix B2.

<b>1 March 2007 – 22 May 2007</b>	<i>Providers can use either the current UB-04 or the revised UB-04 version.</i>
<b>23 May 2007</b>	<i>The UB-04 claim form is discontinued; only the revised UB-04 is to be used.</i> <b>Note:</b> <i>All rebilling of claims should use the revised UB-04, even though earlier submissions may have been on UB-04.</i>

### **Uniform Billing Form Transition Schedule**

<b>Dates</b>	<b>UB Form to Use</b>
<i>Prior to 1 Mar 2007</i>	<i>UB-04 only</i>
<i>1 Mar 2007 – 22 May 2007</i>	<i>UB-04 or UB-04</i>
<i>23 May 2007</i>	<i>UB-04 only</i>

**Note:** These dates are in accordance with the Centers for Medicare and Medicaid Services (CMS). Consult your Service UBO Manager for specific implementation guidance for your Service.

## APPENDIX B1 – UB-04 Claim Form Instructions

Revised: 22 May 2007

Form Locators (FL) are automatically populated by TPOCS.

### **FL 1: Provider Name, Address and Telephone Number**

**Required – Inpatient**

**Required – Outpatient**

This information is used in connection with the Medicare provider number (FL 51) to verify provider identity.

### **FL 2: Pay-to Name, address, and Secondary Identification Fields**

**Situational – For MHS, FL 2 will mirror FL 1.**

**Required** when the pay-to name and address information is different than the Billing Provider information in FL1.

### **FL 3a: Patient Control Number**

**Required – Inpatient**

**Required – Outpatient**

The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.

### **FL 3b: Medical/Health Record Number**

**Situational – Inpatient**

**Situational – Outpatient**

**Required when the provider needs to identify for future inquiries, the actual medical record of the patient**

The number assigned to the patient's medical/health record by the provider -

### **FL 4: Type of Bill**

**Required – Inpatient**

**Required – Outpatient**

This four-digit alphanumeric code gives three specific pieces of information after a leading zero.

Digit 1: Leading Zero

Digit 2: Type of Facility

- 1 = Hospital
- 2 = Skilled Nursing Facility
- 3 = Home Health
- 7 = Clinic
- 8 = Special Facility

Digit 3: Bill Classification

- 1 = Inpatient
- 3 = Outpatient
- 4 = Other

Digit 4: Frequency

- 1 = Admit through Discharge claim
- 2 = Interim-First Claim
- 3 = Interim-Continuing Claim
- 4 = Interim-Last Claim
- 5 = Late Charge

\*\*For further explanation on Type of Bill, please refer to the NUBC UB04 Official Data Specifications Manual

**FL 5: Federal Tax ID Number**

**Required – Inpatient**

**Required – Outpatient**

The format is NN-NNNNNNN. The hospital/MTF's Federal Tax number is assigned by the federal government for tax reporting purposes.

**FL 6: Statement Covers Period (From-Through)**

**Required – Inpatient**

**Required – Outpatient**

The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY).

**FL 7: Not Used**

**FL 8: Patient's Name**

**Required – Inpatient**

**Required – Outpatient**

The provider enters the patient's last name, first name, and if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).

**FL 9: Patient's Address**

**Required**

The provider enters the patient's full mailing address, including street number and name, post office box number or Rural Free Delivery, City, State, and Zip code.

**FL 10: Patient's Birth Date**

**Required**

The provider enters the month, day and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.

**FL 11: Patient's Sex**

**Required**

The provider enters an "M" (male) or an "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.

**FL 12: The Admission or Start of Care Date**

**Situational – Outpatient**

**Required – Inpatient**

This field contains the date the patient was admitted to the provider for inpatient care, outpatient services or other start of care.

The hospital enters the date the patient was admitted for inpatient care (MMDDYY).

**FL 13: Admission Hour**

**Situational – Outpatient**

**Required – Inpatient**

This FL contains the hour during which the patient was admitted for inpatient or outpatient care.

00	12:00 (midnight) – 12:59 a.m.
01	01:00 – 01:59
02	02:00 – 02:59
03	03:00 – 03:59

04	04:00 – 04:59
05	05:00 – 05:59
06	06:00 – 06:59
07	07:00 – 07:59

08	08:00 - 08:59
09	09:00 – 09:59
10	10:00 – 10:59
11	11:00 – 11:59
12	12:00 (noon) – 12:59 p.m.
13	01:00 – 01:59
14	02:00 – 02:59
15	03:00 – 03:59

16	04:00 – 04:59
17	05:00 – 05:59
18	06:00 – 06:59
19	07:00 – 07:59
20	08:00 – 08:59
21	09:00 – 09:59
22	10:00 – 10:59
23	11:00 – 11:59

**FL 14: Type of Admission/Visit**

**Required – Inpatient bills only**

This is the code indicating priority of this admission.

Code Structure	
1	<b>Emergency</b> – The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	<b>Urgent</b> – The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	<b>Elective</b> – The patient’s condition permitted adequate time to schedule the availability of a suitable accommodation.
4	<b>Newborn</b> – Use of this code necessitates the use of a Special Source of Admission codes.
5	<b>Trauma Center</b> – This code is for a visit to a trauma center/hospital as licensed or designated with authority and authorized.

**FL 15: Source of Admission**

**Required – Inpatient**

**Situational – Outpatient**

The provider enters the code indicating the source of the referral for this admission or visit.

Code Structure	
1	Physician Referral
2	Clinic Referral
3	Managed Care Plan Referral
4	Transfer from a Hospital (Different Facility)
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
Note – If type of admission code is 4, then this additional FL coding structure is used for newborn:	
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

**FL 16: Discharge Hour**

**Required – Inpatient**  
**Situational – Outpatient**

Required only for inpatient commercial claims. Hours are indicated in military time using two-character numbers.

**FL 17: Patient Status**  
**Required for Inpatient Claims**

This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to SNF with Medicare Certification in Anticipation of Covered Skilled Care
04	Discharged/Transferred to an Intermediate Care Facility
05	Discharged/Transferred to Another Type of Institution Not Defined Elsewhere in this Code List
06	Discharged/Transferred to Home Under Care of Organized Home Health Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advise or Discontinued Care
08	Reserved for National Assignment
09	Admitted As an Inpatient to This Hospital
10-19	Reserved for National Assignment
20	Expired
21-29	Reserved for National Assignment
30	Still a Patient
31-39	Reserved for National Assignment
40	Expired at Home
41	Expired in a Medical Facility Such as a Hospital, SNF, ICF or Freestanding Hospice
42	Expired, Place Unknown
43	Discharged/Transferred to a Federal Health Care Facility
44-49	Reserved for National Assignment
50	Discharged to Hospice – Home
51	Discharged to Hospice – Medical Facility
52-60	Reserved for National Assignment
61	Discharged/Transferred Within This Institution to a Hospital-Based Medicare Approved Swing Bed
62	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharges/Transfers to a Critical Access Hospital
67-70	Reserved for National Assignment
71-99	Reserved for National Assignment

**FLs 18-28: Condition Codes**  
**Situational – Inpatient**

**Situational – Outpatient****Required when there is a Condition Code that applies to this claim.**

The provider enters the corresponding code to describe any of the following conditions or events that apply to this billing period.

<b>Code Structure</b>	
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered by Insurance Not Reflected Here
04	Information Only Bill
05	Lien Has Been Filed
06	ESRD Patient in First 18 Months of Entitlement Covered by Employer Group Health Insurance
07	Treatment of Non-terminal Condition for Hospice Patient
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage
09	Neither Patient Nor Spouse is Employed
10	Patient and/or Spouse is Employed by No EGHP Coverage Exists
11	Disabled Beneficiary, but No Large Group Health Plan Coverage
12	Coders are for Payer Use Only
<b>Special Conditions</b>	
17	Patient is Homeless
18	Maiden Name Retained
19	Child Retains Mother's Name
20	Beneficiary Requested Billing
21	Billing for Denial Notice
22	Patient on Multiple Drug Regimen
23	Home Care Giver Available
24	Home IV Patient Also Receiving HHA Services
25	Patient is a Non-U.S. Resident
26	VA-Eligible Patient Chooses to Receive Services in Medicare-Certified Facility
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test
28	Patient and/or Spouse's EGHP is Secondary to Medicare
29	Disabled Beneficiary and/or Family Member's LGHP Is Secondary to Medicare
30	Non-Research Services Provided to Patients Enrolled in a Qualified Clinical Trial
<b>Student Status</b>	
31	Patient is Student (Full-Time Day)
32	Patient is Student (Cooperative/Work Study Program)
33	Patient is a Student (Full-time Night)
34	Patient is Student (Part-Time)
35	Reserved for National Assignment
<b>Accommodations</b>	
36	General Care Patient in a Special Unit
37	Ward Accommodation at Patient's Request
38	Semiprivate Room Not Available
39	Private Room Medically Necessary
40	Same-Day Transfer
41	Partial Hospitalization

42	Continuing Care Not Related to Inpatient Admission
43	Continuing Care Not Provided Within Prescribed Post-discharge Window
44	Inpatient Admission Changed to Outpatient
45	Reserved for National Assignment
<b>CHAMPUS/TRICARE Information</b>	
46	Non-availability Statement on File
47	Reserved for CHAMPUS/TRICARE
48	Psychiatric Residential Treatment Centers (RTCs) for Children and Adolescents
49	Product Replacement Within Product Lifecycle
50	Product Replacement for Known Recall of a Product
51-54	Reserved for National Assignment
55-59	Skilled Nursing Facility Related
<b>Prospective Payment</b>	
60	Day Outlier
61	Cost Outlier
62	Payer Code
63	Incarcerated Beneficiaries
64-65	Payer Only Codes
66	Provider Does Not Wish Cost Outlier Payment
67	Beneficiary Elects Not to Use Lifetime Reserve Days (LTR)
68	Patient Elects to Use LTR Days
69	IME/DGME/N&AH Payment Only
<b>Renal Dialysis Setting</b>	
70-76	
<b>Other Codes</b>	
77	Provider Accepts or Is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full
78	New Coverage Not Implemented by HMO
79	CORF Services Provided Off-Site
80	Home Dialysis – Nursing Facility
81-99	Reserved for National Assignment
<b>Special Program Indicator Codes</b>	
A0	CHAMPUS/TRICARE External Partnership Program
A1	EPSDT/CHAP
A2	Physically Handicapped Children's Program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A6	Vaccines/Medicare 100% Payment
A7	Reserved for National Assignment
A8	Reserved for National Assignment
A9	Second Opinion Surgery
AA	Abortion Performed Due to Rape
AB	Abortion Performed Due to Incest
AC	Abortion Performed Due to Serious Fetal Genetic Defect, Deformity, or Abnormality
AD	Abortion Performed Due to a Life Endangering Physical Condition Caused by, Arising

	From, or Exacerbated by the Pregnancy Itself
AE	Abortion Performed Due to Physical Health of Mother That is Not Life Endangering
AF	Abortion Performed Due to Emotional/Psychological Health of the Mother
AG	Abortion Performed Due to Social or Economic Reasons
AH	Elective Abortion
AI	Sterilization
AJ	Payer Responsible for Co-payment
AK	Air Ambulance Required
AL	Specialized Treatment/Bed Unavailable
AM	Non-Emergency Medically Necessary Stretcher Transport Required
AN	Preadmission Screening Not Required
AO-AZ	Reserved for National Assignment
BO	Medicare Coordinated Care Demonstration Claim
B1	Beneficiary Ineligible for Demonstration Program
B2	Critical Access Hospital Ambulance Attestation
B3	Pregnancy Indicator
B4	Admission Unrelated to Discharge on Same Day
B5-BZ	Reserved for National Assignment
C0-CZ	PRO Related Codes
<b>Claim Change Reasons</b>	
D0	Changes to Services Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS/Rate Codes
D3	Second or Subsequent Interim PPS Bill
D4	Changes in ICD-9-CM Diagnosis and/or Procedure Codes
D5	Cancel to Correct HICN or Provider Identification Number
D6	Cancel Only to Repay a Duplicate or OIG Payment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
DR	Disaster Related
E0	Change in Patient Status
E1-FZ	Reserved for National Assignment
G0	Distinct Medical Visit
G1-GZ	Reserved for National Assignment
H0	Delayed Filing, Statement of Intent Submitted
H1-LZ	Reserved for National Assignment
M0-MZ	Reserved for Payer Assignment
N-OZ	Reserved for National Assignment
P0	Reserved for National Assignment for Public Health Reporting Only
P1	Do Not Resuscitate Order (DNR) for Public Health Reporting Only
P2-PZ	Reserved for National Assignment for Public Health Reporting Only
Q0-VZ	Reserved for National Assignment
W0	United Mine Workers of America (UMWA) Demonstration Indicator
W1-ZZ	Reserved for National Assignment

**FL 29: Accident State****Situational**

Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code.

A two-digit code to identify the state where the accident occurred.

**FL 30: Not Used****FLs 31-34: Occurrence Codes and Dates****Situational**

Required when there is a Condition Code that applies to this claim.

Codes and associated dates defining a significant event relating to this bill that may affect payer processing.

<b>Accident Related Codes</b>	
01	Auto Accident
02	No-Fault Insurance Involved—including Auto Accident/Other
03	Accident—Tort Liability
04	Accident—Employment Related
05	Other Accident
06	Crime Victim
07-08	Reserved for National Assignment
<b>Medical Condition Codes</b>	
09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset for a Chronically Dependent Individual (CDI)
13-16	Reserved for National Assignment
<b>Insurance Related Codes</b>	
17	Date Outpatient Occupational Therapy Plan Established or Last Reviewed
18	Date of Retirement of Patient/Beneficiary
19	Date of Retirement of Spouse
20	Guarantee of Payment Began
21	UR Notice Received
22	Date Active Care Ended
23	Reserved for National Assignment
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
26	Date SNF Bed Became Available
27	Date of Hospice Certification or Recertification
28	Date CORF Plan Established or Last Reviewed
29	Date Outpatient Physical Therapy Plan Established or Last Reviewed
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed
31	Date Beneficiary Notified of Intent to Bill (Accommodations)
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP
34	Therapy Date of Election of Extended Care Services

35	Date Treatment Started for Physical
36	Date of Inpatient Hospital Discharge for Covered Transplant Patient
37	Date of Inpatient Hospital Discharge for Non-covered Transplant Patient
38	Date Treatment Started for Home IV Therapy
39	Date Discharged on a Continuous Course of IV Therapy
<b>Service Related Codes</b>	
40	Scheduled Date of Admission
41	Date of First Test for Pre-admission Testing
42	Date of Discharge (Hospice Only)
43	Scheduled Date of Cancelled Surgery
44	Date Treatment Started for Occupational Therapy
45	Date Treatment Started for Speech Therapy
46	Date Treatment Started for Cardiac Rehabilitation
47-49	Payer Codes
50-69	Reserved for State Assignment
70-99	Reserved for Occurrence Span Codes
A0	Reserved for National Assignment
A1	Birth Date—Insured A
A2	Effective Date—Insured A Policy
A3	Benefits Exhausted
A4-A9	Reserved for National Assignment
B0	Reserved for National Assignment
B1	Birth Date—Insured B
B2	Effective Date—Insured B Policy
B3	Benefits Exhausted
B4-B9	Reserved for National Assignment
C0	Reserved for National Assignment
C1	Birth Date—Insured C
C2	Effective Date—Insured C Policy
C3	Benefits Exhausted
C4-C9	Reserved for National Assignment
D0-D9	Reserved for National Assignment
E0	Reserved for National Assignment
E1	Birth Date—Insured D
E2	Effective Date—Insured D Policy
E3	Benefits Exhausted
E4-E9	Reserved for National Assignment
F0	Reserved for National Assignment
F1	Birth Date—Insured E
F2	Effective Date—Insured E Policy
F3	Benefits Exhausted
F4-F9	Reserved for National Assignment
G0	Reserved for National Assignment
G1	Birth Date—Insured F
G2	Effective Date—Insured F Policy
G3	Benefits Exhausted

G4-G9	Reserved for National Assignment
H0-I9	Reserved for National Assignment
J0-L9	Reserved for State Assignment
M0-Z9	See Definitions Under Occurrence Span Codes (FL 36)

**FLs 35-36: Occurrence Span Code and Dates**

**Situational – Inpatient and Outpatient**

**Required when there is an Occurrence Span Code that applies to the claim.**

The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.Code and the related date that identify an event that relates to the payment of the claim.

70	Qualifying Stay Dates (For SNF Use Only) or Non-utilization Dates (For Payer Use Only on Hospital Bills)
71	Prior Stay Dates
72	First/Last Visit
73	Benefit Eligibility Period
74	Non-covered Level of Care/LOA
75	SNF Level of Care
76	Patient Liability
77	Provider Liability Period
78	SNF Prior Stay Dates
79	Payer Code
80-99	Reserved for State Assignment
M0	PRO/UR Approved Stay Dates
M1	Provider Liability—No Utilization
M2-W9	Reserved for National Assignment
X0-Z9	Reserved for State Assignment

**FL 37: Untitled**

**Currently Not Used**

**FL 38: Responsible Party Name and Address**

**Situational – Inpatient and Outpatient**

Use to print the name and mailing address of the party responsible for the bill if a window envelope is utilized.

**FLs 39-41: Value Codes and Amounts**

**Situational – Inpatient and Outpatient**

**Required when there is a Value Code that applies to this claim.**

Codes and related dollar or unit amount(s) identify data of a monetary nature that is necessary for the processing of this claim.

01	Most Common Semiprivate Room Rate
02	Hospital Has No Semiprivate Rooms
03	Reserved for National Assignment
04	Inpatient Professional Component Charges that Are Combined Billed
05	Professional Component Included in Charges and Also Billed Separately to Carrier
06	Medicare Blood Deductible
07	Reserved for National Assignment

08	Medicare Lifetime Reserve Amount in the First Calendar Year
09	Medicare Coinsurance Amount in the First Calendar Year
10	Medicare Lifetime Reserve Amount in the Second Calendar Year
11	Medicare Coinsurance Amount for Second Calendar Year
12	Working Aged Beneficiary/Spouse with EGHP
13	ESRD Beneficiary in a Medicare Coordination Period with an EGHP
14	No-Fault, Including Auto/Other
15	Workers Compensation
16	Public Health Service (PHS) or Other Federal Agency
17	Outlier Amount
18	Disproportionate Share Amount
19	Indirect Medical Education Amount
20	Total PPS Capital Payment Amount
21	Catastrophic
22	Surplus
23	Recurring Monthly Income
24	Medicaid Rate Code
25-29	Reserved for National Assignment—Medicaid
30	Preadmission Testing
31	Patient Liability Amount
32-36	Reserved for National Assignment
37	Pints of Blood Furnished
38	Blood Deductible Pints
39	Pints of Blood Replaced
40	New Coverage Not Implemented by HMO (for Inpatient Claims Only)
41	Black Lung
42	Veterans Affairs
43	Disabled Beneficiary Under Age 65 with LGHP
44	Amount Provider Agreed to Accept from the Primary Insurer When this Amount Is Less than Total Charges, but Greater than the Primary Insurer's Payment
45	Accident Hour
46	Number of Grace Days
47	Any Liability Insurance
48	Hemoglobin Reading
49	Hematocrit Reading
50	Physical Therapy Visits
51	Occupational Therapy Visits
52	Speech Therapy Visits
53	Cardiac Rehabilitation Visits
54-55	Reserved for National Assignment
<b>Home-Health-Specific</b>	
56	Skilled Nurse—Home Visit Hours (HHA Only)
57	Home Health Aide—Home Visit Hours (HHA Only)
58	Arterial Blood Gas (PO2/PA2)
59	Oxygen Saturation (O2 Sat/Oximetry)
60	HHA Branch MSA

61	Location Where Service Is Furnished (HHA and Hospice)
62-66	Reserved for National Assignment
67	Peritoneal Dialysis
68	EPO—Drug
70	Interest Amount
71	Funding of ESRD Networks
72	Flat Rate Surgery Charge
73	Drug Deductible
74	Drug Coinsurance
75	Gramm—Rudman—Hollings
76	Providers Interim Rate
77-79	Payer Codes
80-99	Reserved for State Assignment
A0	Reserved for National Assignment
A1	Deductible Payer A
A2	Coinsurance Payer A
A3	Estimated Responsibility Payer A
A4	Covered Self-Administrable Drugs—Emergency
A5	Covered Self-Administrable Drugs—Not Self-Administrable in Form and Situation Furnished to Patient
A6	Covered Self-Administrable Drugs—Diagnostic Study and Other
A7-AZ	Reserved for National Assignment
B0	Reserved for National Assignment
B1	Deductible Payer B
B2	Coinsurance Payer B
B3	Estimated Responsibility Payer B
B4-BZ	Reserved for National Assignment
C0	Reserved for National Assignment
C1	Deductible Payer C
C2	Coinsurance Payer C
C3	Estimated Responsibility Payer C
C4-CZ	Reserved for National Assignment
D0-D2	Reserved for National Assignment
D3	Estimated Responsibility Patient
D4-DZ	Reserved for National Assignment
E0	Reserved for National Assignment
E1	Deductible Payer D
E2	Coinsurance Payer D
E3	Estimated Responsibility Payer D
E4-EZ	Reserved for National Assignment
F0	Reserved for National Assignment
F1	Deductible Payer E
F2	Coinsurance Payer E
F3	Estimated Responsibility Payer E
F4-FZ	Reserved for National Assignment
G0	Reserved for National Assignment

G1	Deductible Payer F
G2	Coinsurance Payer F
G3	Estimated Responsibility Payer F
G4-GZ	Reserved for National Assignment
H0-YZ	Reserved for National Assignment
X0-ZZ	Reserved for National Assignment

**FL 42: Revenue Code**

**Required – Inpatient**

**Required – Outpatient**

Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.

**FL 43: Revenue Description**

**Not Required for electronic billing**

**Required for Inpatient Paper Claim**

**Required for Outpatient Paper Claim**

The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43... Descriptions or abbreviations correspond to the revenue codes This description must be shown in HCPCS coding.

**FL 44: HCPCS/Rates/HIPPS Rate Codes**

**Situational except when required for outpatient claims when an appropriate HCPCS code exists for this service line item.** The provider enters the HCPCS code describing the procedure here.

**Required – Inpatient**

**Not required – Outpatient**

Used when room and board revenue code is reported

**HCPCS Modifiers**

Situational except when required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. (See: Appendix A – HCPCS Modifiers Section)

**FL 45: Service Date**

**Required – Outpatient**

**Not Required – Inpatient**

The date (MMDDYY) the outpatient service was provided.

**FL 46: Units of Service**

**Required – Inpatient**

**Required – Outpatient**

A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.

**FL 47: Total Charges**

**Required – Inpatient**

**Required – Outpatient**

The total charges reflected on this claim for the statement covers period (FL 6). This field is automatically calculated and populated.

**FL 48: Non-Covered Charges**

**Situational except required if needed to report line specific non-covered charge.**

The total non-covered charges pertaining to the related revenue code in FL42.

**FL 49: Untitled**

**Not Used**

**FL 50A, B, and C: Payer Identification**

**Required – Line A (Primary Payer) – Inpatient & Outpatient**

**Situational – Lines B and C**

Enter the name of the primary payer on line A.

Secondary Payer is listed on line B.

Tertiary Payer is listed on line C.

**FL 51A: Health Plan ID**

**Required – Line A (Primary Payer) – Inpatient & Outpatient**

**FL 51B (Situational), and C (Situational)**

The number used by the health plan to identify itself.

Report the national health plan identifier when one is established.

**FLs 52A, B, and C: Release of Information Certification Indicator**

**Required – Inpatient**

**Required – Outpatient**

A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim.

I is used when the provider has not collected a signature.

**FL 53A, B, and C: Assignment of Benefits Certification Indicator**

**Required – Inpatient**

**Required – Outpatient**

Code indicates provider has a signed form authorizing the third-party payer to remit payment directly to the provider

**FLs 54A, B, and C: Prior Payments**

**Situational except required when the indicated payer has paid an amount to the provider towards this bill.**

The amount the provider has received (to date) by the health plan toward payment of this bill.

**FL 55A, B, and C: Estimated Amount Due From Patient**

**Not Required**

**FL 56: National Provider Identifier (NPI) Type 2 (Facility)**

**Required, effective May 23, 2007**

For Pharmacy billing, TPOCS will insert the NPI Type 2 of the Dispensing Pharmacy.

The unique identification number assigned to the provider submitting the bill.

**FL 57: Other Provider ID (primary, secondary, and/or tertiary)**

**Situational**

Use this field to report other provider identifiers as assigned by a health plan (as indicated in FL 50 lines 1-3) **prior** to May 23, 2007.

For Pharmacy Billing, upon request, TPOCS will allow the user to select the appropriate provider identifier; DEA# or NCPDP# or UPIN# to populate in this form locator.

**FLs 58A, B, and C: Insured's Name**

**Required for both inpatient and outpatient**

That corresponds to lettered lines (A – primary B – secondary C – tertiary) payer shown in FLs 50-54. The provider must enter the name of the individual in whose name the insurance is carried.

**FL 59A, B, and C: Patient's Relationship to Insured**

**Required – line A for inpatient and outpatient**

**Situational – line B and C**

If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured:

01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

**FLs 60A, B, and C: Insured’s Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN))**  
**Required**

**FL 61A, B, and C: Insurance Group Name**  
**Situational (required if known)**

Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the name of the group or plan through which that insurance is provided.

**FL 62A, B, and C: Insurance Group Number**  
**Situational (required if known)**

**FL 63: Treatment Authorization Code**  
**Situational unless required by payer**

Required when an authorization or referral number is assigned by the payer.

**FL 64: Document Control Number (DCN)**  
**Situational**

The control number assigned to the original bill by the health plan or the health plan’s fiscal agent as part of their internal control.

**FL 65: Employer Name**  
**Situational unless required**

The name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

**FL 66: Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**  
**Required**

Qualifier Code “9” required.

**FL 67: Principal Diagnosis Code**  
**Required – Inpatient Claims**  
**Required – Outpatient Claims**

The hospital enters the ICD-9 code for the principal diagnosis. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

**FLs 67A-67Q: Other Diagnosis Codes and POA (Present on Admission Indicator\*)**  
**Inpatient Required**  
**Outpatient - Required**

The hospital enters the full ICD-9 codes for up to eight additional conditions if they co-existed at the time

of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

\*(Note: MHS does not require Present on Admission (POA) Indicator at this time)

**FL 68:**  
**Not Used**

**FL 69: Admitting Diagnosis**  
**Required for inpatient claims**  
**Not required for outpatient claims**

Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

**FL70A – 70C: Patient's Reason for Visit**

**Situational except required for unscheduled outpatient visits or upon the patient's admission to the hospital. This information may be any documented reason for the service provided, including patients stated reason for seeking care or the reason provided by the physician as part of the order for the service. This information is not required for all scheduled outpatient encounters.**  
Patient's Reason for Visit is required for all unscheduled outpatient visits for outpatient bills.

**FL71: Prospective Payment System (PPS) Code**  
**Not Used**

**FL72: External Cause of Injury Codes**

**Situational unless required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment.**

**FL 73:**  
**Not Used**

**FL 74: Principal Procedure Code and Date**  
**Situational except when required for inpatient claims**  
Used when a procedure was performed.  
Note: Not used on outpatient claims.

**FL 74A – 74E: Other Procedure Codes and Dates**  
**Situational except when required for inpatient claims**  
Used when additional procedures were performed.  
Note: Not used on outpatient claims.

**FL 75:**  
**Not Used**

**FL 76: Attending Provider Name and Identifiers (including NPI Type 1)**

**Situational** except when required after the HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider OR required on/after the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.

For pharmacy billing, NPI type 1 of the Dispensing provider will be reported if available or NPI type 2 of the Dispensing Facility.

<b>Secondary Identifier Qualifiers</b>	
0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number

**FL 77: Operating Provider Name and Identifiers (including NPI)**

**Situational except** required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

<b>Secondary Identifier Qualifiers</b>	
0B	State License Number
1G	Provider UPIN Number
EI	Employer's Identification Number
SY	Social Security Number

**FLs 78 and 79: Other Provider Name and Identifiers (including NPI)**

**Situational except** required when the claim involves another provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.

The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim; i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Provider Type Qualifier Codes	Definition	Situational Usage Notes
<b>DN</b>	<b>Referring Provider</b>	The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.
<b>ZZ</b>	<b>Other Operating Physician</b>	An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send the name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.
<b>82</b>	<b>Rendering Provider</b>	The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim; i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

<b>Secondary Identifier Qualifiers:</b>	
0B	State License Number
1G	Provider UPIN Number
EI	Employer's Identification Number
SY	Social Security Number

**FL 80: Remarks**

**Situational**

**FL 81: Code-Code Field**

**Situational**

To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

<b>Code List Qualifiers</b>	
01-A0	Reserved for National Assignment
A1	National Uniform Billing Committee Condition Codes
A2	National Uniform Billing Committee Occurrence Codes
A3	National Uniform Billing Committee Occurrence Span Codes
A4	National Uniform Billing Committee Value Codes – not used for Medicare
A5-B0	Reserved for National Assignment
B3	Health Care Provider Taxonomy Code
Code Source: ASC X12 External Code Source 682 (National Uniform Claim Committee)	
B4-ZZ	Reserved National Assignment

## APPENDIX B2 – UB-04 Claim Form Quick Guide

### KEY CHANGES TO THE FORM

#### FL1: Required

Billing Provider Name, Address and Telephone Number and Country Code – (Required when the address is out of the United States of America)

<b>1 Provider Name</b>											
<b>Provider Address</b>											
<b>Provider City</b>			<b>State</b>			<b>Zip</b>					
<b>Provider Telephone</b>			<b>Fax</b>			<b>CC</b>					
8 PATIENT NAME					a					9 PATIENT	
b										b	
10 BIRTHDATE		11 SEX	12 DATE		ADMISSION		13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE					
a											
b											

#### FL 2: Situational

Pay-to Name, address, and Secondary Identification Fields

Note: For MHS will contain same information as in FL 1

<b>2</b>										f. #	
										g. #	
										. TAX NO.	
8 PATIENT ADDRESS										a	
b											
14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES			
								22	23	24	25









DATE		77 OPERATING	NPI	QUAL	
RE DATE		LAST	FIRST		
DATE		77 OPERATING	NPI	QUAL	
		LAST	FIRST		
		78 OTHER	NPI	QUAL	
		LAST	FIRST		
		79 OTHER	NPI	QUAL	
		LAST	FIRST		

**FL 81: Situational**

**Code-Code Field**

To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

**Code List Qualifiers:**

- 01-A0 Reserved for National Assignment
- A1 National Uniform Billing Committee Condition Codes
- A National Uniform Billing Committee Occurrence Codes
- A3 National Uniform Billing Committee Occurrence Span Codes
- A4 National Uniform Billing Committee Value Codes – not used for Medicare
- A5-B0 Reserved for National Assignment
- B3 Health Care Provider Taxonomy Code
- B4-ZZ Reserved for National A

OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	LAST	FIRST	QUAL
81CC						
a						
b						
c						
d						

**82 - Rendering Provider:** The health care professional who delivers or completes a particular medical service or non-surgical procedure.

**Secondary Identifier Qualifiers:**

- 0B - State License Number
- 1G - Provider UPIN Number
- EI - Employer’s Identification Number
- SY - Social Security Number

## APPENDIX C – CMS 1500 Claim Form Instructions

Revised: 7 May 2007

**Note:** The CMS 1500 form has been updated. The boxes below provide the transition schedule. Instructions for the CMS 1500 (08-05) are found in Appendix C1; a quick guide to key changes in the form are found in Appendix C2; and a link to the National Uniform Claim Committee's 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version appears in Appendix C3 (the manual appears elsewhere on the UBO Web site).

**2 January 2007 –  
31 May 2007**      *Providers can use either the current Form CMS 1500 (12-90) version or the revised Form CMS 1500 (08-05) version. Note: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS 1500 (08-05) by January 2, 2007.*

**1 June 2007**      *The current Form CMS 1500 (12-90) version of the claim form is discontinued; only the revised Form CMS 1500 (08-05) is to be used.*

**Note:** *All rebilling of claims should use the revised Form CMS 1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS 1500 (12-90).*

**Note: These dates are in accordance with the Centers for Medicare and Medicaid Services (CMS). Consult your Service UBO Manager for specific implementation guidance for your Service.**

## APPENDIX C1 – CMS 1500 (08-05) Claim Form Instructions

Revised: 1 July 2011

Detailed information regarding each Item Number can be found in the "National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for (08/05) Version, version 1.3 7/06". Please note that the 1500 Reference Instruction Manual is intended to provide general instructions on how to complete the claim form and not definitive billing instructions for the Department of Defense, Military Health System (DoD, MHS) purposes.

<b>CMS 1500 Transition Schedule<sup>24</sup></b>	
<b>Dates</b>	<b>CMS 1500 Form to Use</b>
<i>Prior to 2 Jan 2007</i>	<i>12/90 only</i>
<i>2 Jan 2007 – 31 May 2007</i>	<i>12/90 or 08/05</i>
<i>1 June 2007</i>	<i>08/05 only</i>

**Items are automatically populated by TPOCS.**

▶ **Item 1: Type of Health Insurance Coverage – Required**

Insurance coverage. System defaults to "Other".

**Item 1a: Insured's ID Number – Required**

Insured's social security number.

**Item 2: Patient's Name (Last Name, First Name, Middle Initial) – Required**

Insured's last name, first name, and middle initial.

**Item 3: Patient's Birth Date and Sex – Required**

Eight-digit birth date (MM|DD|CCYY) of the patient; patient's sex.

**Item 4: Insured's Name (Last Name, First Name, Middle Initial) – Required**

Insured's last name, first name, and middle initial.

**Item 5: Patient's Address – Required**

Mailing address and telephone number of the patient in the corresponding boxes.

**Item 6: Patient's Relationship to Insured – Required**

Relationship of the patient listed in Item 2 to insured listed in Item 4.

**Item 7: Insured's Address – Required, if applicable**

Mailing address and telephone number of the insured in the corresponding box. If item number 4 is completed then this field should be completed.

**Item 8: Patient Status – Required**

Marital status and full- or part-time student. NOTE: Patient Status does not exist in the electronic 837 Professional 41010A1.

**Item 9: Other Insured's Name – Required, if applicable**

If the yes box is checked in Item 11D, then this section (Items 9–9D) must be filled out. Name of the insured person (last, first, middle initial).

**Item 9a: Other Insured's Policy or Group Number – Required, if applicable**

---

<sup>24</sup> Note: These dates are in accordance with the Centers for Medicare and Medicaid Services (CMS). Consult your Service UBO Manager for specific implementation guidance for your Service.

Other insured's insurance policy or group number.

**Item 9b: Other Insured's Date of Birth/Sex – Required, if applicable**

Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box indicating the sex of this person.

**Item 9c: Employer's Name or School Name – Required, if applicable**

Employer's name or school name of the other insured person. NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1.

**Item 9d: Insurance Plan Name or Program Name – Required, if applicable**

Name of the insurance plan or program related to the other insured person.

**Item 10a-10c: Is Patient's Condition Related To: (Auto Accident/Other Accident) – Required, if applicable**

Check the appropriate box if the patient's condition is related to any of the following: employment (MAC), auto accident, or other accident.

**Item 10d: Reserved For Local Use-Blank – Not Required**

**Item 11: Insured's Policy Group or FECA Number- Conditional**

Insured's Policy Group or FECA Number Insured's policy group or FECA number.

**Item 11a: Required Insured's Date of Birth/Sex – Required**

Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box indicating the sex of the insured.

**Item 11b: Employer's Name or School Name – Conditional**

Employer's name or school name of the insured. NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1.

**Item 11c: Insurance Plan Name or Program Name – Required**

Name of the insurance plan or program of the insured.

**Item 11d: Is There Another Health Plan Benefit? – Required, if applicable**

If "Y" is checked, Items 9–9d must be completed. Check the appropriate box to indicate whether or not there is another health insurance benefit. System defaults to "No."

**Item 12: Patient's or Authorized Person's Signature – Required with a default ("Signature on file" is acceptable) AOB statement**

This item is automatically populated with the following statement, "Assignment Authorization of Benefits is assumed under 10 U.S.C. 1095."

**Item 13: Insured's or Authorized Person's Signature – Required with a default ("Signature on file" is acceptable)**

The MTF has the option of selecting one of the following statements: "Assignment of Benefits is assumed under Title 10 U.S.C. 1095" or "Signature on file."

**Item 14: Date of Current Illness, Injury, or Pregnancy – Required, if applicable**

Current date of illness, injury or pregnancy (MM|DD|CCYY).

**Item 15: If Patient Has Had Same or Similar Illness – Required, if applicable**

Past occurrence date (MM|DD|CCYY) of illness or injury if it is the same or similar illness or injury.

**Item 16: Dates Patient Unable to Work in Current Occupation – Not Required**

Blank

**▶Item 17: Referring Provider – Conditional**

**(Revised – Title was changed from Referring Physician to Referring Provider)**

Name of the Provider who referred or ordered the service.

**▶Item 17a: Other ID Number of Referring or Ordering Provider, Qualifier – Conditional (Revised – This area was shaded and a new field was added to hold the two-digit qualifier for other ID Number)**

The Provider Taxonomy code of the referring provider or ordering provider should be reported in the shaded area. The qualifier (ZZ – Provider Taxonomy) identifies the type of Other ID being reported in the shaded area.

**●Item 17b: Provider NPI # – Required, if applicable**

NPI Type 1 of the referring or ordering provider will appear in this field, if available. If there isn't a referring or ordering provider, leave blank.

**Item 18: Hospitalization Dates Related to Current Services – Required, if applicable**

Eight-digit date (MM|DD|CCYY) if the services were provided subsequent to a related hospitalization.

**Item 19: Reserved for Local Use – Not Required**

Blank

**Item 20: Outside Lab – Not Required**

Blank

**Item 21: Diagnosis or nature of illness or injury – Required**

ICD-9-CM diagnosis code for the patient's diagnosis/condition. The ICD-9-CM diagnosis code must be coded to the highest specificity and sequenced in order of priority (e.g., primary or secondary condition).

**Item 22: Medicaid Resubmission – Not Required**

Blank

**Item 23: Prior Authorization Number – Required, if applicable**

Prior authorization number for those procedures requiring prior authorization.

**▶Section 24 (Revised – To accommodate submission of both the NPI and other Provider Identifier during the NPI transition)**

**Item 24a: Dates of Service – Required**

Eight-digit date (MM|DD|CCYY) of the time period in which the services were performed.

**Item 24b: Place of Service – Required**

Code "26" represents an MTF. This code should automatically print on all CMS 1500s. However for an emergency room visit, the place of service will be coded as "23" Emergency Room. TPOCS will provide the biller the option to determine if the encounter is related to ER services. When saving the bill TPOCS will assign the place of service based on MEPRS code BIA\* and default to "Y" (yes) for Item 24c – EMG.

**▶Item 24c: EMG – Required, if applicable**

**(Revised – This was originally titled "Type of Service". This field is now titled "EMG".**

EMG represents Emergency Indicator. The indicator states whether or not a service(s) is related to an emergency. If MEPRS code is BIA\* and services are emergency related, then Y for "Yes" will appear in the box or if "No" the field will be left blank.

**Item 24d: Procedures, Services, or Supplies – Required**

HCPCS/CPT code, including modifiers when applicable, for the procedures, services, or supplies furnished to the patient.

▶ **Item 24e: Diagnosis Pointer – Required**

**(Revised – Title changed from Diagnosis Code to Diagnosis Pointer)**

Pointer number (1– 4) from Item 21 that is applicable to that specific procedure, service or supply furnished.

**Item 24f: Charges – Required**

Charge for each listed service.

**Item 24g: Days or Units – Required**

Number of days or units that were supplied for that particular HCPCS/CPT code listed in that line. If only one service was provided, the numeral 1 must be entered. This field will default to 1.

**Item 24h: EPSDT Family Plan – Not Required**

**EPSDT Family Plan**

Blank

▶ **Item 24i: ID Qualifier – Required**

**(Revised – This field was originally titled "EMG", which is now in Item 24c. This field is now titled "ID Qualifier")**

The ID qualifier will default to **(ZZ – Provider Taxonomy)** and will be used to report the type of non-NPI number of the rendering provider. The Provider Taxonomy code of the rendering provider will be reported in the shaded area of Item 24j.

▶ **Item 24J: Rendering Provider ID# – Required**

**(Revised - This field was originally title "COB". The original fields 24j and 24k were combined and renumbered and now titled "Rendering Provider ID#".)**

The Provider Taxonomy code of the rendering provider will be reported in the shaded area. NPI Type 1 of the rendering provider will be reported in the unshaded area.

▶ **Item 24k: This field was deleted and combined with 24j.**

Deleted

**Item 25: Federal Tax ID Number – Required**

Federal Tax ID number for the facility.

**Item 26: Patient's Account Number – Required**

Patient's account number that is assigned by the MTF's accounting system to identify that particular patient.

**Item 27: Accept Assignment – Required**

TPOCS defaults to "X" in the Yes box indicating assignment of benefits is accepted pursuant to Title 10 U.S.C. 1095.

**Item 28: Total Charge – Required**

**Total Charge**

Total charges for the services provided (e.g., sum of charges in Item 24F).

**Item 29: Amount Paid – Conditional**

Amount Paid

\$0.00 indicates no up-front monies were paid. DoD does not collect co-payments for services rendered.

**Item 30: Balance Due – Conditional**

Total amount of the charges. This should match Item 28.

**Item 31: Signature of Physician or Supplier – Required**

Signature of the provider of service or supplier, or his representative, and the date the form was signed. A signature or stamp is required here. Some MTFs use this area to indicate who, the biller was and that the bill has been reviewed.

**Item 32: Name and Address of Treating Service Facility – Required**

Name, address, and telephone number of the MTF.

● **Item 32a: NPI # – Required (New field)**

NPI type 2 of the treating MTF will be reported in this field.

● **Item 32b: Other ID qualifier and Other ID# – Required (New field)**

The qualifier will be reported followed by the HIPAA Taxonomy code or Treating Facility Tax ID.

**Item 33: Billing Provider Information – Required**

Physician, Supplier Billing Name, Address, Zip Code, Phone, PIN#, and Group#

Name of the physician who rendered the services. It is now required that the provider be identified with their credentials (e.g., MD, NP, PA, RN, LPN). The system should include the provider's credentials following the name.

● **Item 33a: NPI # – Required (New field)**

NPI type 2 of the billing facility will be reported.

● **Item 33b: Other ID# – Required (New field)**

The qualifier followed by the HIPAA Taxonomy code.

## APPENDIX C2 – Quick Guide to Key Changes in Revised Form CMS 1500 (08-05)

### Claim Form Version

When submitting a paper claim, use the form that has the following: carrier block located in the upper right margin, the 1500 symbol and the approval date located in the upper left margin. The version with the four black alignment bars forms in the upper left corner has been eliminated.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

### Items 17, 17a and 17b (split field)

#### Item 17: Name of Referring Provider or Other Service

TPOCS will populate the referring provider information in Items 17, 17a and/or 17b.

#### Item 17a: Other ID#

Current Provider ID and/or Tax ID will be used until the NPI # is used. Once NPI is implemented, the primary HIPAA taxonomy code associated with the provider specialty table will be reported for the referring provider, ordering or other source and will populate from TPOCS.

#### Item 17b: NPI

The NPI number of the referring provider will populate from TPOCS.

17a.		
17b.	NPI	

## Section 24

The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI, and another provider identifier and the submission of supplemental information. An example of supplemental information would be a narrative description of an unlisted code. Note: See Instructions and Examples of Supplemental Information in 1500 Reference Instruction Manual.

24. A.	DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPF Family Plan	I. NPI QUAL.	J. RENDERING PROVIDER ID. #
	From	To	MM	DD	YY									
1						23	Y						PX NPI	1123568999
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

### Items 24B and 24C

#### Item 24B – Place of Service

The place of service code identifies the location of where the service occurred. For DoD, the place of service code 26-Military Treatment Facility is hard coded in TPOCS for all 1500 claims with the exception of emergency room services.

If the MEPRS code is BIA\*, then place of service code will be **Item 23 – Emergency Room**.

**Note:** TPOCS will provide the user the option to determine if the encounter is related to ER services. When saving the bill TPOCS will assign the place of service code based on MEPRS code BIA\*.

#### Item 24C – EMG

This item was originally labeled "Type of Service" and is now the Emergency indicator "EMG". The indicator states whether the services rendered due to an emergency. For DoD, If the MEPRS code is BIA\*, the indicator will default to "Y", if not, then the field will be blank.

If MEPRS code BIA\*, then place of service code will default to 23 – Emergency room and default to "Y" for item 24c EMG

B. PLACE OF SERVICE	C. EMG
23	Y



**Items 32, 32a, and 32b**

32. SERVICE FACILITY LOCATION INFORMATION	
USAFA 10Th Medical Group/SGSBR 4102 PINION DR STE 100 USAF ACADEMY, CO 80840	
a.	b.

**Item 32- Service Facility Location**

Address for the Treating/Service Facility will appear in this block. Block 32 will be limited to 78 characters with a three-line template, 26 characters each for address. NOTE: On the print forms, there will now be a limitation of how small you can print on the forms. Therefore, item 32 and 33 will be restricted to three lines for the facility and provider address.

**Item 32a - NPI number**

The NPI number of the Treating facility - NPI Type 2 will populate from TPOCS. This field allows for 10 characters.

**Item 32b - Other ID#**

The non-NPI number will be either the Treating Facility Tax ID or HIPAA Taxonomy code preceded by the two-digit qualifier identifying the type of non-NPI number.

APPENDIX C3 – National Uniform Claim Committee 1500 Health Insurance Claim Form  
Reference Instruction Manual for 08/05 Version  
Revised: 13 January 2012

**Follow this link to the latest version of the NUCC manual.**

[www.nucc.org/content/view/33/42/](http://www.nucc.org/content/view/33/42/)

## APPENDIX D – Prescription Drug Uniform Claim Form (UCF)

**Note:** The Uniform Claim Form has been updated. The changes are described and illustrated below. Instructions for the revised form are found in Appendix D1; the instructions for the current, expiring form are found in Appendix D2.

The Prescription Drug Universal Claim Form (UCF) is used for the paper submission of third party pharmacy claims. However, at the payer's request, pharmacy services can be submitted on a UB claim form by changing the claim form type in the Table Maintenance function of TPOCS. Refer to the TPOCS User's Manual for more information.

The UCF captures up to two prescriptions per form, unless a controlled substance is prescribed (one prescription per form). The diagnosis code is not a required field on the UCF when billing for a prescription, except for controlled substances.

### Revisions – Universal Claim Form

Although the Universal Claim Form was revised, provider data elements were changed to accommodate HIPAA and the National Provider Identifier (NPI) requirements (e.g., Data for the Service Provider ID will change from reporting the NCPDP# to using NPI Type 2 for the dispensing pharmacy).

### Key Changes to the Universal Claim Form

#### Service Provider ID

[Example needed]

#### Prescriber ID

PREScriBER I.D.	QUAL (12)

#### Provider ID

PROVIDER I.D.	QUAL (16)

## APPENDIX D1 – Revised Universal Claim Form Instructions

Revised: 23 February 2007

Changes to the provider data elements were made to the Universal Claim Form (UCF) to accommodate the reporting of the National Provider Identifier (NPI). The revisions to the data elements in the Service Provider, Prescriber and Provider ID sections will be noted within this document.

**NOTE:** All Pharmacy/Bill Type-2's generated in TPOCS should include; NPI Type 2 for the facility and NPI Type 1 for the Dispensing provider (data elements for the Prescriber ID will be based on payer requirements).

For your convenience, symbols will be used to denote (●) New Item or (▶) Revision of an existing Item.

**Fields will be automatically populated by TPOCS.**

**Patient Information** – This section of the Universal Claim Form provides patient and cardholder information.

**Cardholder I.D., Required**

Cardholder's I.D.

**Group I.D., Conditional**

Group I.D.

**Cardholder Name, Required**

Cardholder's name (last, first, middle initial)

**Plan Name, Required**

Plan name

**Patient Name, Required**

Patient's name (last, first, middle initial)

**(1) - Qualifier Code, Other Coverage Code, Required**

Other coverage codes, as applicable

0 - Not Specified (Default)

1 - No other coverage identified

2 - Other coverage exists-payment collected

3 - Other coverage exists-this claim not covered

4 - Other coverage exists-payment not collected

5 - Managed care plan-denial

6 - Other coverage denied-not a participating provider

7 - Other coverage exists-not in effect at this time

8 - Claim is billing for co-pay

**(2) - Qualifier Code, Person Code, Required**

Code assigned to specific person in the family

**Patient Date of Birth, Required**

Patient's DOB three spaces MMDDCCYY

**(3) - Qualifier Code, Patient Gender Code, Required**

- 0 - Not Specified
- 1 - Male
- 2 - Female

**(4) - Qualifier Code, Patient Relationship Code, Required**

Relationship code of patient to cardholder. (Drop down box)

- 0 - Not specified
- 1 - Cardholder
- 2 - Spouse
- 3 - Child
- 4 - Other

► **Pharmacy Information** - This section of the UCF provides pharmacy information required for processing the claim. Note: NPI Type 2 of the treatment/dispensing MTF will be used for all pharmacy claims generated in TPOCS.

**Pharmacy Name, Required**

Name of Pharmacy

For DoD, the name of the MTF that filled the prescription.

► **(5) – Qualifier Code, Service Provider I.D., Required**

ID of the service provider/ followed by the following qualifier code

TPOCS will now assign qualifier **01-NPI Type 2** based on the **Dispensing DMIS ID**.

Blank - Not Specified

**01 - National Provider Identifier (NPI)**

- 02 - Blue Cross
- 03 - Blue Shield
- 04 - Medicare
- 05 - Medicaid
- 06 - UPIN
- 07 - NCPDP Provider ID
- 08 - State License
- 09 - CHAMPUS
- 10 - Health Industry Number
- 11 - Federal Tax ID
- 12 - DEA

**Address, Required**

Pharmacy street address

For DoD, the address of the MTF that filled the prescription.

**Phone Number, Required**

Pharmacy phone number

For DoD, enter the phone number of the MTF that filled the prescription.

**City, Required**

City for pharmacy address

For DoD, the city of the MTF that filled the prescription.

**Fax No., Required**

Fax # for the pharmacy.

For DoD, the fax number of the MTF that filled the prescription.

**State and Zip Code, Required**

State and Zip code for pharmacy

For DoD, the state and zip code of the MTF that filled the prescription.

**Workers Compensation Information** – This section provides information related to Worker Compensation claims.

**Employer Name, Conditional**

Employer's name for the patient

**Address, Conditional**

Employer's street address

**City, Conditional**

Employer's city

**State, Conditional**

Employer's state

**Zip Code, Required**

Employer's zip code

**Authorized Signature, Required**

Authorized signature of patient or legal guardian (handwritten)

**(6) – Qualifier Code, Carrier I.D., Required**

ID of the carrier

Code assigned to Worker's Compensation Program

Worker's Comp information is conditional and should be reported only for Workers Comp claims.

**Employer Phone Number, Required**

Employer's phone number

**Date of Injury, Required**

Date of injury

**(7) – Qualifier Code, Claim Reference I.D., Required**

Reference ID for the claim

Claim number assigned by Workers Compensation Program

**Prescription/Service Information** – Sections 1 and 2 of the Universal Claim Form require the same data. The form allows for two separate prescriptions to be filed on one claim form.

**Prescription/Service Reference Number, Required**

Prescription or service reference #

**(8) – Qualifier Code, Prescription/Service Reference Number Qualifier, Required**

Blank - Not specified

1 - Rx Billing (Default)

2 - Service Billing

**Date Written, Required**

Date prescription or service written

**Date of Service, Required**

Dispensed date

**Fill Number, Required, if applicable**

Fill number for the prescription

**(9) – Qualifier Code, Quantity Dispensed, Required, if applicable**

Quantity of prescription dispensed; expressed in metric decimal units

**Days Supply, Required, if applicable**

Number of days supplied in prescription

**Product Service ID, Required, if applicable**

Product/service ID number

Currently, will default to the NDC number

**(10) – Qualifier, Product Service ID Qualifier, Required**

Appropriate qualifier code

Blank - Not specified

00 - Not Specified

01 - Universal Product Code (UPC)

02 - Health Related Item (HRI)

03 - National Drug Code (NDC) (Default)

04 - Universal Product Number (UPN)

05 - Department of Defense (DoD)

06 - Drug Use Review/Professional Pharmacy Service (DUR/PPS)

07 - CPT4

08 - CPT5

09 - HCPCS

10 - Pharmacy Practice Activity Classification (PPAC)

11 - National Pharmaceutical Product Interface Code (NAPPI)

12 - International Article Numbering System (EAN)

13 - Drug Identification Number (DIN)

99 - Other

**Dispensed As Written (DAW) Code, Not Required (Blank)**

DAW code

**Prior Authorization Number Submitted, Conditional**

Prior authorization # submitted

**(11) – Qualifier Code, Prior Authorization Type, Conditional**

Enter the Prior Authorization Code

0 - Not Specified (Default)

1 - Prior Authorization

2 - Medical Certification

3 - EPSDT (Early Periodic Screening Diagnosis Treatment)

4 - Exemption from Co-pay

5 - Exemption from RX limit

6 - Family Planning Indicator

7 - Aid to Families with Dependent Children (AFDC)

8 - Payer Defined Exemption

**► Prescriber ID, Required**

Identification of the provider that prescribed the drug

**► (12) – Qualifier Code, Prescriber ID Qualifier, Required**

Enter the appropriate billing qualifier based on payer requirements (dropdown box)

Blank - Not specified  
00 - Not specified  
01 - DEA  
02 - State License  
03 - SSN  
04 - Name (Default)  
05 - National Provider ID (NPI)  
06 - Health Industry Number (HIN)  
07 - State Issued  
99 - Other

**(13) – Qualifier Code, DUR/PPS Codes, Conditional**

PPS codes—(Limit 1 set of DUR/PPS codes per claim)

A - Reason for Service  
B - Professional Service Code  
C - Result of Service

**(14) – Qualifier Code, Basis Cost, Required**

Basis Cost

Blank - Not specified  
00 - Not specified  
01 - Average Wholesale Price (AWP)  
02 - Local Wholesale  
03 - Direct (Default)  
04 - Estimated Acquisition Cost (EAC)  
05 - Acquisition  
06 - MAC (Maximum Allowable Cost)  
07 - Usual and Customary  
09 - Other

▶ **Provider ID (Registered Pharmacist, R.P.H.), Required**

Provider's ID- NPI Type 1 of the dispensing Provider

▶ **(15) – Qualifier Code, Provider ID Qualifier, Required**

**Use qualifier 05-National Provider ID**

Blank - Not specified  
00 - Not specified  
01 - DEA  
02 - State License  
03 - SSN  
04 - Name  
\*05 - National Provider ID (NPI)  
06 - Health Industry Number (HIN)  
07 - State Issued  
99 - Other (Default)

**Diagnosis Code, Conditional**

ICD9-CM diagnosis code

**(16) Qualifier Code, Diagnosis Code Qualifier, Conditional**

Report diagnosis code and qualifier related to prescription-limit: one per prescription

Blank - Not Specified  
00 - Not Specified  
01 - ICD-9 (Default)  
02 - ICD-10

- 03 - National Criteria Care Institute (NDCC)
- 04 - Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
- 05 - Common Dental Terminology
- 06 - Medi-Span Diagnosis Code
- 07 - American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)
- 99 - Other

**Other Payer Date, Conditional**

Other payer date

**Other Payer ID, Conditional**

ID for other payer

**(17) – Qualifier Code, Other Payer ID Qualifier, Conditional**

Blank - Not Specified

01 - National Payer ID (Default)

02 - Health Industry Number (HIN)

03 - Bank Information Number (BIN)

04 - National Association of Insurance Commissioners (NAIC)

05 - Coupon

99 - Other

**Other Payer Reject Codes, Conditional**

Reject codes from other payer

**Usual and Customary Charge, Required**

Usual and Customary Rate

**Ingredient Cost Submitted, Required**

Ingredient cost per unit

Total cost of the drug not including the dispensing fee

**Dispensing Fee Submitted, Required**

Dispensing is added into Basis Cost and not listed in field

**Incentive Amount Submitted, Conditional**

Incentive charges (Default = 0.00)

**Other Amount Submitted, Conditional**

Other charges submitted

**Gross Amount Due Submitted, Required**

Total due

Equals sum of Usual & Customary Charge, Ingredient Cost Submitted, Dispensing Fee Submitted, Incentive Amount Submitted, and Other Amount Submitted.

**Patient Paid Amount, Conditional**

Cost paid by the patient (Default =0.00)

**Other Payer Amount Paid, Conditional**

Total paid by the other payer

**Net Amount Due, Required**

Remaining balance due

Equals Gross amount due subtracted by sum of Patient Amount Paid and Other Payer Amount Paid.

**Compound Prescriptions, Not required**

Limit 1 compound prescription per claim if compound prescription used

Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area on the reverse side at the bottom of claim form. Use a separate claim form for each compound prescription.

I.D. \_\_\_\_\_ GROUP I.D. \_\_\_\_\_  
 NAME \_\_\_\_\_ PLAN NAME \_\_\_\_\_  
 PATIENT NAME: \_\_\_\_\_ OTHER COVERAGE CODE (1) \_\_\_\_\_ PERSON CODE (2) \_\_\_\_\_  
 PATIENT DATE OF BIRTH: MM DD CCYY \_\_\_\_\_ PATIENT (3) GENDER CODE \_\_\_\_\_ PATIENT (4) RELATIONSHIP CODE \_\_\_\_\_

PHARMACY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ SERVICE PROVIDER I.D. \_\_\_\_\_ QUAL (5) \_\_\_\_\_  
 CITY \_\_\_\_\_ PHONE NO. ( ) \_\_\_\_\_  
 STATE & ZIP CODE \_\_\_\_\_ FAX NO. ( ) \_\_\_\_\_

FOR OFFICE USE ONLY	

**WORKERS COMP. INFORMATION**  
 EMPLOYER NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 CARRIER I.D. (6) \_\_\_\_\_ EMPLOYER PHONE NO. \_\_\_\_\_  
 DATE OF INJURY: MM DD CCYY \_\_\_\_\_ CLAIM (7) REFERENCE I.D. \_\_\_\_\_

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.  
 PATIENT/AUTHORIZED REPRESENTATIVE \_\_\_\_\_

**ATTENTION RECIPIENT  
 PLEASE READ  
 CERTIFICATION  
 STATEMENT ON REVERSE  
 SIDE**

**1**

**1**

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	PHYSICIAN AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

PREScription / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAY CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PREScriBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

**2**

**2**

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	PHYSICIAN AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

PREScription / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAY CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PREScriBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

## APPENDIX D2 – Universal Claim Form Instructions

Revised: 01 October 2003

### Fields will be automatically populated by TPOCS.

**Patient Information** – This section of the Universal Claim Form provides patient and cardholder information.

**Cardholder I.D., Required**

Cardholder's I.D.

**Group I.D., Conditional**

Group I.D.

**Cardholder Name, Required**

Cardholder's name (last, first, middle initial)

**Plan Name, Required**

Plan name

**Patient Name, Required**

Patient's name (last, first, middle initial)

**(1) - Qualifier Code, Other Coverage Code, Required**

Other coverage codes, as applicable

0 - Not Specified (Default)

1 - No other coverage identified

2 - Other coverage exists-payment collected

3 - Other coverage exists-this claim not covered

4 - Other coverage exists-payment not collected

5 - Managed care plan-denial

6 - Other coverage denied-not a participating provider

7 - Other coverage exists-not in effect at this time

8 - Claim is billing for co-pay

**(2) - Qualifier Code, Person Code, Required**

Code assigned to specific person in the family

**Patient Date of Birth, Required**

Patient's DOB three spaces MMDDCCYY

**(3) - Qualifier Code, Patient Gender Code, Required**

0 - Not Specified

1 - Male

2 - Female

**(4) - Qualifier Code, Patient Relationship Code, Required**

Relationship code of patient to cardholder. (Drop down box)

0 - Not specified

1 - Cardholder

2 - Spouse

3 - Child

4 - Other

**Pharmacy Information** - This section of the UCF provides pharmacy information required for processing the claim.

**Pharmacy Name, Required**

Name of Pharmacy

For DoD, the name of the MTF that filled the prescription.

**(5) – Qualifier Code, Service Provider I.D., Required**

ID of the service provider/ followed by the following qualifier code

Blank - Not Specified

01 - National Provider Identifier (NPI)

02 - Blue Cross

03 - Blue Shield

04 - Medicare

05 - Medicaid

06 - UPIN

07 - NCPDP Provider ID

08 - State License

09 - CHAMPUS

10 - Health Industry Number

11 - Federal Tax ID

12 - DEA

**Address, Required**

Pharmacy street address

For DoD, the address of the MTF that filled the prescription.

**Phone Number, Required**

Pharmacy phone number

For DoD, enter the phone number of the MTF that filled the prescription.

**City, Required**

City for pharmacy address

For DoD, the city of the MTF that filled the prescription.

**Fax No., Required**

Fax # for the pharmacy.

For DoD, the fax number of the MTF that filled the prescription.

**State and Zip Code, Required**

State and Zip code for pharmacy

For DoD, the state and zip code of the MTF that filled the prescription.

**Workers Compensation Information** - This section provides information related to Worker Compensation claims.

**Employer Name, Conditional**

Employer's name for the patient

**Address, Conditional**

Employer's street address

**City, Conditional**

Employer's city

**State, Conditional**

Employer's state

**Zip Code, Required**

Employer's zip code

**Authorized Signature, Required**

Authorized signature of patient or legal guardian (handwritten)

**(6) – Qualifier Code, Carrier I.D., Required**

ID of the carrier

Code assigned to Worker's Compensation Program

Worker's Comp information is conditional and should be reported only for Workers Comp claims.

**Employer Phone Number, Required**

Employer's phone number

**Date of Injury, Required**

Date of injury

**(7) – Qualifier Code, Claim Reference I.D., Required**

Reference ID for the claim

Claim number assigned by Workers Compensation Program

**Prescription/Service Information** - Sections 1 and 2 of the Universal Claim Form require the same data. The form allows for two separate prescriptions to be filed on one claim form.

**Prescription/Service Reference Number, Required**

Prescription or service reference #

**(8) – Qualifier Code, Prescription/Service Reference Number Qualifier, Required**

Blank - Not specified

1 - Rx Billing (Default)

2 - Service Billing

**Date Written, Required**

Date prescription or service written

**Date of Service, Required**

Dispensed date

**Fill Number, Required, if applicable**

Fill number for the prescription

**(9) – Qualifier Code, Quantity Dispensed, Required, if applicable**

Quantity of prescription dispensed; expressed in metric decimal units

**Days Supply, Required, if applicable**

Number of days supplied in prescription

**Product Service ID, Required, if applicable**

Product/service ID number

Currently, will default to the NDC number

**(10) – Qualifier, Product Service ID Qualifier, Required**

Appropriate qualifier code

Blank - Not specified

- 00 - Not Specified
- 01 - Universal Product Code (UPC)
- 02 - Health Related Item (HRI)
- 03 - National Drug Code (NDC) (Default)
- 04 - Universal Product Number (UPN)
- 05 - Department of Defense (DoD)
- 06 - Drug Use Review/Professional Pharmacy Service (DUR/PPS)
- 07 - CPT4
- 08 - CPT5
- 09 - HCPCS
- 10 - Pharmacy Practice Activity Classification (PPAC)
- 11 - National Pharmaceutical Product Interface Code (NAPPI)
- 12 - International Article Numbering System (EAN)
- 13 - Drug Identification Number (DIN)
- 99 - Other

**Dispensed As Written (DAW) Code, Not Required (Blank)**

DAW code

**Prior Authorization Number Submitted, Conditional**

Prior authorization # submitted

**(11) – Qualifier Code, Prior Authorization Type, Conditional**

Enter the Prior Authorization Code

- 0 - Not Specified (Default)
- 1 - Prior Authorization
- 2 - Medical Certification
- 3 - EPSDT (Early Periodic Screening Diagnosis Treatment)
- 4 - Exemption from Co-pay
- 5 - Exemption from RX limit
- 6 - Family Planning Indicator
- 7 - Aid to Families with Dependent Children (AFDC)
- 8 - Payer Defined Exemption

**Prescriber ID, Required**

Name of the provider that prescribed the drug

**(12) – Qualifier Code, Prescriber ID Qualifier, Required**

Blank - Not specified

- 00 - Not specified
- 01 - DEA
- 02 - State License
- 03 - SSN
- 04 - Name (Default)
- 05 - National Provider ID (NPI)
- 06 - Health Industry Number (HIN)
- 07 - State Issued
- 99 - Other

**(13) – Qualifier Code, DUR/PPS Codes, Conditional**

PPS codes—(Limit 1 set of DUR/PPS codes per claim)

- A - Reason for Service
- B - Professional Service Code
- C - Result of Service

**(14) – Qualifier Code, Basis Cost, Required**

Basis Cost  
Blank - Not specified  
00 - Not specified  
01 - Average Wholesale Price (AWP)  
02 - Local Wholesale  
03 - Direct (Default)  
04 - Estimated Acquisition Cost (EAC)  
05 - Acquisition  
06 - MAC (Maximum Allowable Cost)  
07 - Usual and Customary  
09 - Other

**Provider ID (Registered Pharmacist, R.P.H.), Required**  
Provider's ID

**(15) – Qualifier Code, Provider ID Qualifier, Required**

Blank - Not specified  
00 - Not specified  
01 - DEA  
02 - State License  
03 - SSN  
04 - Name  
05 - National Provider ID (NPI)  
06 - Health Industry Number (HIN)  
07 - State Issued  
99 - Other (Default)

**Diagnosis Code, Conditional**

ICD9-CM diagnosis code

**(16) Qualifier Code, Diagnosis Code Qualifier, Conditional**

Report diagnosis code and qualifier related to prescription-limit: one per prescription

Blank - Not Specified  
00 - Not Specified  
01 - ICD-9 (Default)  
02 - ICD-10  
03 - National Criteria Care Institute (NDCC)  
04 - Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)  
05 - Common Dental Terminology  
06 - Medi-Span Diagnosis Code  
07 - American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)  
99 - Other

**Other Payer Date, Conditional**

Other payer date

**Other Payer ID, Conditional**

ID for other payer

**(17) – Qualifier Code, Other Payer ID Qualifier, Conditional**

Blank - Not Specified  
01 - National Payer ID (Default)  
02 - Health Industry Number (HIN)  
03 - Bank Information Number (BIN)  
04 - National Association of Insurance Commissioners (NAIC)  
05 - Coupon

99 - Other

**Other Payer Reject Codes, Conditional**

Reject codes from other payer

**Usual and Customary Charge, Required**

Usual and Customary Rate

**Ingredient Cost Submitted, Required**

Ingredient cost per unit

Total cost of the drug not including the dispensing fee

**Dispensing Fee Submitted, Required**

Dispensing is added into Basis Cost and not listed in field

**Incentive Amount Submitted, Conditional**

Incentive charges (Default = 0.00)

**Other Amount Submitted, Conditional**

Other charges submitted

**Gross Amount Due Submitted, Required**

Total due

Equals sum of Usual & Customary Charge, Ingredient Cost Submitted, Dispensing Fee Submitted, Incentive Amount Submitted, and Other Amount Submitted.

**Patient Paid Amount, Conditional**

Cost paid by the patient (Default =0.00)

**Other Payer Amount Paid, Conditional**

Total paid by the other payer

**Net Amount Due, Required**

Remaining balance due

Equals Gross amount due subtracted by sum of Patient Amount Paid and Other Payer Amount Paid.

**Compound Prescriptions, Not required**

Limit 1 compound prescription per claim if compound prescription used

Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area on the reverse side at the bottom of claim form. Use a separate claim form for each compound prescription.

## APPENDIX E – DD7A Instructions

Revised: 01 October 2003

Sections are automatically populated by CHCS.

### **Section 1: Required**

Installation Providing Hospitalization (name and address)

Name of medical activity, base and/or post, and Major Command as applicable providing medical care in continental United States. Name of medical activity, APO and Major Command outside continental United States (OCONUS).

### **Section 2: Required**

Month and Year Covered By This Report

Month and year covered by this report (9 character alpha month, 4-digit year).

### **Section 3: Required**

Category of Patients

Category of the patients.

### **Section 4: Required**

Authority for Treatment

Authority for the treatment.

### **Section 5: Required**

Name and SSN

Name (Last, First, Middle Initial) and SSN (9 digit numeric)

### **Section 6: Required**

Military Grade

Military grade or status of the individual (e.g., civilian, eligible family member).

### **Section 7: Requirement Not Available**

Organization

### **Section 8: Required**

Clinic associated with the Encounter

Clinic associated with the Encounter or Requesting MEPRS Code Location of service for each patient.

### **Section 9: Required**

Dates

List day, month and year (DDMMYYYY) as the Date of Service of the services/supplies furnished.

### **Section 10: Required**

Description of Services

Description of services provided, such as Encounter, Lab, Rad, Immunization, Pharmacy, etc., and corresponding dollar amount, for the Date of Service.

### **Section 11: Required**

Date of certification of report

Date of certification

### **Section 12: Required**

Authentication (signature, military grade, and organization of Commanding Officer)

Obtain the required signature of the MTF commander or authorized representative (on original only) including grade and organization.

**Section 13: Required, if applicable**

Total Amount per Patient Category and Total Billed To Date

Total amount for all patients listed for each Patient Category, Total Amount Billed this Fiscal Year, and any applicable adjustments for the period.

**Section 14: Required**

Date of Service

Date of Service

**Section 15 (New): Required**

CPT codes

This will only be available on the Detail per Patient.

HCPCS/CPT code for procedure.

**Section 16 (New): Required**

Description

This will only be available on the Detail per Patient.

30 Character AMA Short Name description for CPT/ HCPCS code.

**Section 17 (New): Required**

Cost

This will only be available on the Detail per Patient.

Cost of corresponding procedure.

**Section 18 (New): Required**

Total (Per Patient and Date of Service)

Total of all costs in section 18.

## APPENDIX F – I&R Instructions

Revised: 01 October 2003

Sections are automatically populated by CHCS.

### **Provider Name, Address: Required**

Medical activity, base and/or post, and Major Command as applicable providing medical care in continental United States. Name of medical activity, APO and Major Command outside continental United States.

### **Organization: Required**

Military branch

### **Sponsor Name: Required**

Name of the patient's sponsor (Last, First, MI)

### **Service: Required**

Service code

### **Duty Address: Required**

Duty address of sponsor

### **Grade: Required**

Military grade or status of the individual (e.g. civilian, eligible family member).

### **Billing Name: Required**

Name of person to be billed (Last, First)

### **FMP/SSN: Required**

FMP and SSN of person to be billed

### **Billing Address: Required, if applicable**

Address of person to be billed

### **Patient Name: Required**

Name of patient (Last, First)

### **Account Number: Required**

Account number for bill

### **Date of Service: Required**

Date of admission or outpatient visit (DDMMYYYY).

### **Discharge Date: Required for inpatient services only**

Date of discharge. Inpatient services only (DDMMYYYY).

### **Total Charge: Required**

Sum of total inpatient or outpatient charges

### **Details of Service for Inpatient Invoice & Receipts**

#### **Beg Date: Required**

Date of admission

#### **End Date: Required**

Description of service

**Chg Days: Required**

Number of chargeable days

**Chg. Days: Required**

Number of non-chargeable days

**Rate: Required**

Per Diem rate charged per day for service (if a DRG calculated bill, system divides totals charges by number of chargeable days).

**Charge: Required**

Sum of total charges

**Details of Service for Outpatient Invoice & Receipts**

**Svc: Required**

Service charge category (e.g., OPE, LAB, RAD)

**Code: Required**

Procedure or product code (e.g., CPT, NDC)

**Description: Required**

Description of service

**Qty: Required**

Quantity of service rendered

**Svc Date: Required**

Date service provided

**Charges: Required**

Charge for service

**Date: Required**

Date of last transaction (e.g., date account generated, date of last payment)

**Payment: Required**

Payments made on account by date

**Type Pay: Required**

Form of payment (e.g., cash (C), check (K), credit card (E))

**Check No.: Required, if applicable**

Check number of payment

**Ctrl No.: Required**

Control number of transaction (auto assigned by CHCS)

**Balance: Required**

Balance calculated by subtracting Payment from Total Charges or previous balance.

## GLOSSARY & DEFINITIONS

Revised: 01 January 2009

The following information has been excerpted from the “Department of Defense Glossary of Healthcare Terminology” (DoD 6015.1-M), with additions.

ADA. American Dental Association.

ADDITIONAL DIAGNOSIS. Any diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the physician considers of sufficient significance to warrant inclusion for investigative medical studies.

ADMISSION. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day when the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. When reporting admission data, always exclude: total absent–sick patients, carded-for-record only (CRO) cases, and transient patients.

ADMISSION CERTIFICATION. Approval by a case manager or insurance company representative for a member to be admitted to a hospital or in-patient facility. Method of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under a certification program. The goal of pre-admission certification is to ensure appropriateness and medical necessity of hospitalization or other medical treatment. (Also called Pre-admission Certification).

ADM. Ambulatory Data Module.

AIS. Automated Information System. Computer hardware, computer software, telecommunications, information technology, personnel, and other resources that collect, record, process, store, communicate, retrieve, and display information. An AIS can include computer software only, computer hardware only, or a combination of the above.

ALLOWED AMOUNT. Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a Maximum Allowable.

AMBULATORY CARE. Health services provided without the patient being admitted. Also called Outpatient Care. The services of ambulatory care centers, hospital outpatient departments, physicians' offices, and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours.

ANCILLARY. Tests and procedures ordered by healthcare providers to assist in patient diagnosis or treatment (radiology, laboratory, pathology).

APV. Ambulatory Patient Visit. An APV provides pre-procedure and post-procedure care, observation, and assistance for patients requiring short-term care (less than 24 hours).

A/R. Accounts Receivable.

ASO (Administrative Services Only). An arrangement in which an employer hires a third party to deliver administrative services to the employer, such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans.

**ASSIGNMENT OF BENEFITS.** The payment of medical benefits directly to a provider of care rather than to a member. Generally requires either a contract between the health plan and the provider, or a written release from the subscriber to the provider allowing the provider to bill the health plan.

**ATTENDING PHYSICIAN.** The physician with defined clinical privileges that has the primary responsibility for diagnosis and treatment of the patient. A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case. There will always be only one primary physician; however, under very extraordinary circumstances, because of the presence of complex, serious and multiple, but related, medical conditions, a patient may have more than one attending physician providing treatment at the same time.

**BALANCE BILLING.** The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copays, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).

**BENEFIT.** Amount payable by the insurance company for covered medical expenses as specified by the plan to a claimant, assignee, or beneficiary.

**BENEFIT LIMITATIONS.** Any provision, other than an exclusion, which restricts coverage coverage, regardless of medical necessity. Limitations are often expressed in terms of dollar amounts, length of stay, diagnosis or treatment descriptions.

**BPR.** Business Process Reengineering. MHS Business Process Reengineering is a radical improvement approach that critically rethinks and redesigns product and service processes within a political environment to achieve dramatic MHS mission performance gains.

**BRAND-NAME DRUG.** Prescription drugs marketed with a specific brand name by the company that manufactures it. May cost insured individuals a higher co-pay than generic drugs on some health plans.

**BUNDLING.** Combining into one payment the charges for various medical services rendered during one health care encounter. Bundling often combines the payment from physician and hospital services into one reimbursement. Also called "package pricing."

**CARRIER.** An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health or other insurance programs.

**CASE MANAGEMENT.** A system embraced by employers and insurance companies to ensure that individuals receive appropriate, reasonable health care services.

**CATASTROPHIC HEALTH INSURANCE.** Policy that provides protection primarily against the higher costs of treating severe or lengthy illnesses or disabilities. Normally these are "add on" benefits that begin coverage once the primary insurance policy reaches its maximum.

**CERTIFICATE BOOKLET.** A printed description of the benefits and coverage provisions intended to explain the contractual arrangement between the carrier and the insured group or individual. May also be referred to as a policy booklet.

**CERTIFICATE OF COVERAGE (COC).** Outlines the terms of coverage and benefits available in a carrier's health plan.

**CHAMPUS.** Civilian Health and Medical Program of the Uniformed Services. An indemnity-like program called TRICARE Standard that is available as an option under DoD's TRICARE Program. There are deductibles and cost shares for care delivered by civilian health care providers to active duty family

members, retirees and their family members, certain survivors of deceased members, and certain former spouses of members of the seven Uniformed Services of the U.S.

CHCS. Composite Health Care System. Medical AIS that provides patient facility data management and communications capabilities. Specific areas supported include MTF health care (administration and care delivery), patient care process (integrates support--data collections and one-time entry at source), ad hoc reporting, patient registration, admission, disposition, and transfer, inpatient activity documentation, outpatient administrative data, appointment scheduling and coordination (clinics, providers, nurses and patients), laboratory orders (verifies and processes), drug and lab test interaction, quality control and test reports, radiology orders (verifies and processes), radiology test result identification, medication order processing (inpatient and outpatient), medicine inventory, inpatient diet orders, patient nutritional status data, clinical dietetics administration, nursing, order-entry, eligibility verification, provider registration, and the Managed Care Program.

CLAIM. A request by an individual (or provider) to an individual's insurance company for the insurance company to pay for services obtained from a health care professional. Types of claims and/or data records include Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug and Dental, and Program for the Handicapped.

CLAIM REIMBURSEMENT. The payment of the expenses actually incurred as a result of an accident or sickness, but not to exceed any amount specified in the policy.

CLAIMS REVIEW. The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

CLAIM STATUS CODES. A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction, and is maintained by the Health Care Code Maintenance Committee.

"CLEAN" CLAIM. A claim that is free of defect and impropriety, containing required substantiating documentation and also free of circumstances that require special treatment that may prevent timely payment.

CLINIC. A health treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and ambulatory services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, preventive medicine services, and health promotion activities to support a primary military mission. In some instances, a clinic may also routinely provide therapeutic services to hospitalized patients to achieve rehabilitation goals, (e.g., occupational therapy and physical therapy). A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital and for the care of cases that cannot be cared for on an outpatient status, but that do not require hospitalization. Such beds may not be considered when calculating occupied-bed days by MTFs.

CLINIC SERVICE. A functional division of a department of a Military Treatment Facility identified by a three-digit MEPRS code.

CLOSED ACCESS. Gatekeeper model health plan that requires covered persons to receive care from providers within the plan's coverage. Except for emergencies, the patient may only be referred to and treated by providers within the plan. A managed health care arrangement in which covered persons are required to select providers only from the plan's participating providers.

CMAC. CHAMPUS Maximum Allowable Charge.

CMS. Centers for Medicare & Medicaid Services (CMS). Formerly the Health Care Financing Administration (HCFA).

**CMS 1450.** Also known as UB-04 or UB-04. The common claim form used by hospitals to bill for services.

**CMS 1500.** A claim form used to bill for professional services. Required by Medicare and generally used by private insurance companies and managed care plans.

**CODE SET.** Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions.

**CODING.** A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "upcoded" which is considered fraud. A national certification exists for coding professionals and many compliance programs are raising standards of quality for their coding procedures.

**COINSURANCE.** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges. The individual could also be responsible for any charges in excess of what the insurer determines to be "usual, customary and reasonable. Coinsurance rates may differ if services are received from an network or non-network provider. In addition to overall coinsurance rates, rates may also differ for different types of services. Co-insurance is only required up to the plan's stop loss amount.

**COMPLIANCE.** Accurately following the government's rules on Medicare billing system requirements and other federal or state regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities.

**COMPREHENSIVE COVERAGE.** Insurance is either comprehensive or limited. Comprehensive means broader coverage and/or higher indemnity payments than limited coverage.

**COMPREHENSIVE MAJOR MEDICAL INSURANCE.** A policy designed to provide the protection offered by both a basic and major medical health insurance policy. It is generally characterized by a low deductible, a co-insurance feature, and high maximum benefits.

**CONCURRENT REVIEW.** Review of a procedure or hospital admission done by a health care professional, other than the one providing the care, during the same time frame that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay.

**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)** - Federal law that continues health care benefits for employees whose employment has been terminated. Employers are required to notify employees of these benefit continuation options, and, failure to do so can result in penalties and fines for the employer. An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment. COBRA imposes different restrictions on individuals who leave their jobs voluntarily versus involuntarily (Department of Labor, 2002).

**CONSULTATION.** A deliberation with a specialist concerning the diagnosis or treatment of a patient. To qualify as a consultation (for statistical measure) a written report to the requesting health care professional is required.

**CONTINUED STAY REVIEW.** A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

**CONTRACT.** A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation, and less formal agreements may be made.

**CONTRACT PROVIDER.** Any hospital, physician, skilled nursing facility, extended care facility, individual, organization, or agency licensed that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

**CONVENTIONAL INDEMNITY PLAN.** An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

**CONUS.** Continental United States. United States territory, including the adjacent territorial waters located within the North American continent between Canada and Mexico. Alaska and Hawaii are not part of the CONUS.

**COORDINATION OF BENEFITS (COB).** Provision regulating payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage. A coordination of benefits, or "nonduplication," clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pays its benefits in full and which becomes the supplementary payer on a claim.

**COPAYMENT.** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. There may be separate copayments for different services.

**COVERED SERVICE.** This term refers to all of the medical services the enrollee may receive at no additional charge or with incidental co-payments under the terms of the prepaid health care contract.

**COVERED BENEFIT.** A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

**CPT – CURRENT PROCEDURAL TERMINOLOGY.** A systematic listing and coding of procedures and services performed by a physician. Each procedure or service is identified with a five-digit code that simplifies the reporting of services.

**CPT MODIFIER.** A modifier is an addendum to procedure codes which indicates that a procedure has been altered by some specific circumstance but not changed in its definition.

**CREDIT FOR PRIOR COVERAGE.** Any pre-existing condition waiting period met under an employer's prior (qualifying) coverage will be credited to the current plan, if any interruption of coverage between the new and prior plans meets state guidelines.

**DEDUCTIBLE.** A fixed dollar amount during the benefit period, usually a year, that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For

example, a plan may have a hospitalization deductible per admission. □ Deductibles may differ if services are received from a network provider or if received from a non-network provider.

**DEDUCTIBLE CARRY OVER CREDIT.** Charge incurred during the last three months of a year that may be applied to the deductible and which may be carried over into the next year.

**DENIAL OF CLAIM.** Refusal by an insurance company to honor a request by an individual (or provider) to pay for health care services obtained from a health care professional.

**DIAGNOSIS.** A term used to identify a disease or problem from which an individual patient suffers or a condition for which the patient needs, seeks, or receives health care.

**DISALLOWANCE.** When a payer declines to pay for all or part of a claim submitted for payment.

**DME.** Durable Medical Equipment. Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. An area of increasing expense, particularly in conjunction with case management.

**DMIS ID.** Defense Medical Information System Identification Code. The Defense Medical Information System identification code for fixed medical and dental treatment facilities for the Tri-Services, and the U.S. Coast Guard. In addition, DMIS IDs are given for non-catchment areas, administrative units such as the Surgeon General's Office of each of the Tri-Services, and other miscellaneous entities.

**DRG.** Diagnosis Related Group. Patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed. It provides a framework for specifying hospital case mix and identifies classifications of illnesses and injuries for which payment is made under prospective pricing programs. It is used to determine the payment the hospital will receive for the admission of that type of patient. **E/M.** Evaluation and Management.

**ED.** Emergency Department.

**EDI - ELECTRONIC DATA INTERCHANGE.** The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization. Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

**EDI TRANSLATOR.** Used in electronic claims and medical record transmissions, this is a software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

**EFFECTIVE DATE.** The date on which a policy's coverage of a risk goes into effect.

**ELECTIVE CARE.** Medical, surgical, or dental care that, in the opinion of professional authority, could be performed at another time or place without jeopardizing the patient's life, limb, health, or well-being. Examples are surgery for cosmetic purposes, vitamins without a therapeutic basis, sterilization procedures, elective abortions, procedures for dental prosthesis, prosthetic appliances, and so on.

**ELECTRONIC CLAIM.** A digital representation of a medical bill generated by a provider or by the provider's billing agent for submission using telecommunications to a health insurance payer.

**ELECTRONIC MEDIA CLAIMS.** A flat file format used to transmit or transport claims.

**ELECTRONIC REMITTANCE ADVICE.** Any of several electronic formats for explaining the payments of health care claims.

**EMERGENCY.** Situation that requires immediate intervention to prevent the loss of life, limb, sight or body tissue or to prevent undue suffering.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA).** Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. ERISA exempts most large self-funded plans from State regulation.

**ENCOUNTER.** A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment.

**ENROLLED GROUP.** Persons with the same employer or with membership in an organization in common, who are enrolled collectively in a health plan.

**EXCLUSIONS.** Specified illnesses, injuries, or conditions listed in the policy that are not covered. Experimental therapies, cosmetic surgery, and eyeglasses are common exclusions.

**EXCLUSIVE PROVIDER ARRANGEMENT (EPA).** An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

**EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN.** A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

**EXPLANATION OF BENEFITS (EOB).** A carrier's written response to a claim for benefits. Sometimes accompanied by a benefits check.

**FAMILY MEMBER PREFIX (FMP).** A two-digit number used to identify a sponsor or prime beneficiary or the relationship of the patient to the sponsor.

**FEE-FOR-SERVICE PLAN.** Fee-for-service health insurance plans typically allow patients to obtain care from doctors or hospitals of their choosing, but in return for this flexibility they may pay higher copayments or deductibles.

**FISCAL INTERMEDIARY.** The agent that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs. This entity may also be referred to as TPA or third party administrator.

**FLEXIBLE BENEFITS PLAN (CAFETERIA PLAN) (IRS 125 PLAN).** A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

**FLEXIBLE SPENDING ACCOUNTS OR ARRANGEMENTS (FSA).** Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health

plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. See also Medical Spending Account.

FORMULARY. An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care.

FRR. Full Reimbursable Rate.

FY. Fiscal Year.

GME. Graduate Medical Education. Full-time, structured medically related training, accredited by a national body (e.g., the Accreditation Council for Graduate Medical Education) approved by the commissioner of education and obtained after receipt of the appropriate doctoral degree.

GATEKEEPER. A primary care physician, utilization review, case management, local agency or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for. An arrangement in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone that makes the decision of where a patient will receive services.

GENERIC DRUG. The chemical equivalent to a "brand name drug."

GLOBAL FEE. A total charge for a specific set of services, such as obstetrical services that encompass prenatal, delivery and post-natal care.

GROUP INSURANCE. Any insurance policy or health services contract by which groups of employees (and their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

HCPCS. CMS's Healthcare Common Procedural Coding System. A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes, but also has codes for services not included in CPT, such as ambulance. While HCPCS is nationally defined, there is provision for local use of certain codes.

HEALTHCARE PROVIDER. A healthcare professional who provides health services to patients; examples include a physician, dentist, nurse, or allied health professional.

HEALTHCARE PROVIDER TAXONOMY CODES. An administrative code set that classifies health care providers by type and area of specialization. A provider may have more than one Healthcare Provider Taxonomy Code.

HEALTH INSURANCE. Financial protection against the health care costs of the insured person. May be obtained in a group or individual policy.

HEALTH MAINTENANCE ORGANIZATION (HMO). An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The members of an HMO are required to use participating or approved providers for all health services except for emergencies and generally all services need approval by the HMO through its utilization program.

I&R. Invoice & Receipt.

IAR. Interagency Rate.

ICD-9-CM. International Classification of Diseases, 9th Revision, Clinical Modification. A coding system for classifying diseases and operations to facilitate collection of uniform and comparable health information.

IMET. International Military Education and Training.

IMMUNIZATION. Protection of susceptible individuals from communicable diseases by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.

IMMUNIZATION PROCEDURE. The process of injecting a single dose of an immunizing substance. For a detailed discussion on counting immunization procedures, see DoD 6010.13-M (reference (a)).

INDEMNITY INSURANCE/PLAN. Traditional insurance that reimburses the patient and/or provider as expenses are incurred.

INDIVIDUAL HEALTH INSURANCE PLAN. A type of insurance plan for individuals and their dependents who are not eligible for coverage through employer group coverage.

IN-NETWORK. Describes a provider or health care facility which is part of a health plan's network. When applicable, insured individuals usually pay less when using an in-network provider.

INSOLVENCY. A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

J-CODES. A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items.

LIFETIME MAXIMUM BENEFIT. The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

LIMITATIONS. A restriction on the amount of benefits paid out for a particular covered expense.

LONG-TERM CARE POLICY. Insurance policies that cover specified services for a specified period of time. Covered services usually include nursing care, home health care services, and custodial care.

LONG-TERM DISABILITY (LTD). Insurance which pays employees a percentage of monthly earnings in the event of disability.

LOS – LENGTH OF STAY. A term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

MAC. Medical Affirmative Claims.

MAJOR MEDICAL EXPENSE INSURANCE. Policies designed to offset medical expenses resulting from catastrophic or prolonged illness or injury. They generally provide benefits payments for 75 to 80 percent of most types of medical expenses above a deductible paid by the insured.

MANAGED BEHAVIORAL HEALTH PROGRAM. A program of managed care specific to psychiatric or behavioral health care.

MANAGED CARE. The coordination of health care services in the attempt to produce high quality health care for the lowest possible cost. Examples are the use of primary care physicians as gatekeepers in HMO plans and pre-certification of care.

MANAGED CARE PLANS. Managed care plans generally provide comprehensive health

services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), and Point of Service Plans (POS).

**MANAGED CARE PROVISIONS.** Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members.

Examples of managed care provisions include:

- Preadmission certification – An authorization for hospital admission given by a case manager or insurer prior to a member’s hospitalization. Failure to obtain a preadmission certification in non-emergency situations may reduce or eliminate the insurer’s obligation to pay for services rendered.
- Utilization review – The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
- Preadmission testing – A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- Non-emergency weekend admission restriction – A requirement that imposes limits on reimbursement for non-emergency weekend hospital admissions.
- Second surgical opinion – A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed.

**MAXIMUM OUT-OF-POCKET EXPENSE.** See Out-of-Pocket Maximum.

**MAXIMUM PLAN DOLLAR LIMIT.** The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. Plans can have a yearly and/or a lifetime maximum dollar limit. The most typical of maximums is a lifetime amount of \$1 million per individual.

**MEDICAL CODE SETS.** Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations.

**MEDICALLY NECESSITY SERVICES.** Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and They are the most appropriate level or supply of service which can safely be provided.

**MEDICAL SAVINGS ACCOUNTS (MSA).** Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

**MEDICARE PART A.** Inpatient portion of benefits under the Medicare Program. Covers inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and co-payments.

**MEDICARE PART B.** Outpatient portion of benefits under the Medicare Program. Covers physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, co-payments, deductibles, and balance billing.

**MEDICARE PART C (MEDICARE ADVANTAGE PLAN/MEDICARE REPLACEMENT).** Medicare Advantage plans are private health plans that generally provide all the coverage of Original Medicare and more. Many Medicare Advantage plans provide benefits and services not covered by Original Medicare. Some plans may also include Part D, or prescription drug coverage. These plans are referred to as Medicare Advantage with Prescription Drug (MAPD) coverage. Types of Medicare Advantage Plans include: Medicare Health Maintenance Organization (HMOs), Preferred Provider Organizations (PPO), Private Fee-for-Service Plans, Medicare Special Needs Plans. Patient must have Medicare Part A and Part B to enroll in Medicare Part C. SecureHorizons is an example of an insurer that offers Medicare Advantage Plans.

**MEDICARE PART D.** Medicare Part D plans prescription drug coverage plans offered by private companies. Everyone with Medicare can get this optional coverage. Medicare Part D covers both brand-name and generic prescription drugs at participating pharmacies. There are two types of Medicare Part D coverage: Stand-alone plans, also referred to as Prescription Drug Plans (or PDP plans), which solely offer prescription drug coverage. Medicare Advantage plus Prescription Drug (or MAPD) plans that offer prescription drug coverage as well as medical coverage for doctor visits and hospital expenses.

**MEDICARE REMITTANCE ADVICE REMARK CODES.** A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transactions.

**MEDICARE SUPPLEMENTAL POLICY/MEDIGAP.** Private health insurance plans that pay for the cost of services not covered by Medicare, such as coinsurance and deductibles. Insurance companies are allowed to sell patients only one Medigap policy. Different standardized plans are referred to as A, B, C, D, E, F, F+, G, H, I, J, J+, K and L. Because the policies are standardized, the benefits for a particular plan are the same for each insurance company that offers this type of coverage.

**MEPRS.** Medical Expense and Performance Reporting System. A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions and requirements for accounting and reporting of expense, manpower, and performance data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.

**MSA.** Medical Services Account.

**MTF.** Military Treatment Facility. A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

**NATIONAL DRUG CODE (NDC).** A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. This code set was adopted as the standard for reporting drugs and biologics on standard transactions.

**NATIONAL PROVIDER IDENTIFIER.** A system for uniquely identifying all providers of health care services, supplies, and equipment.

**NETWORK.** A group of doctors, hospitals and other health care providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

**NON-PARTICIPATING/NON-PLAN PROVIDER.** See Out-of-Network Provider.

**OCCASION OF SERVICE.** A specific identifiable act or service involved in the medical care of a patient that does not require the assessment of the patient's condition nor the exercising of independent judgment as to the patient's care, such as a technician drawing blood, taking an x-ray, administering an immunization, issuance of medical supplies and equipment; i.e., colostomy bags, hearing aid batteries, wheel chairs or hemodialysis supplies, applying or removing a cast and issuing orthotics. Pharmacy, pathology, radiology and special procedures services are also occasion of service and not counted as visits.

**OCONUS.** Outside the Continental United States.

**OPEN ACCESS.** A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor.

**OPEN-ENDED HMOS.** HMOs which allow enrolled individuals to use out-of-plan providers and still receive partial or full coverage and payment for the professional's services under a traditional indemnity plan.

**OUT-OF-AREA BENEFITS.** Benefits supplied to a patient by a payer or managed care organization when the patient needs services while outside the geographic area of the network.

**OUT-OF-NETWORK BENEFITS.** Typically, HMOs will not reimburse for services provided by a hospital or doctor who is not in their network, except for emergencies or if the HMO offers Out-of-Plan/Open ended benefits. With PPOs and other managed care plan, there may exist a provision to reimbursement at out-of-network/out-of-plan benefits. Usually this will involve higher copay or a lower reimbursement. Also referred to as opt-out benefits.

**OUT-OF-NETWORK PROVIDER.** A provider, doctor or hospital that does not have a contract to participate in a health plan network. Out-of-Network providers are also called non-participating, non-plan, or out-of-plan providers/physicians.

**OUT-OF-PLAN/OUT-OF-PLAN PROVIDER.** See Out-of-Network Benefits/Out-of-Network Provider.

**OUT-OF-POCKET EXPENSES.** Costs borne by the member that are not covered by health care plan. Portion of health services or health costs that must be paid for by the plan member, including deductibles, co-payments and co-insurance.

**OUT-OF-POCKET MAXIMUM/LIMIT.** The maximum dollar amount a member is required to pay out of pocket during a year. Until this maximum is met, the plan and member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. Also referred to as Stop Loss.

**OUTPATIENT.** An individual receiving health care services for an actual or potential disease, injury or life style related problem that does not require admission to a medical treatment facility for inpatient care.

**OUTPATIENT PROFESSIONAL SERVICES.** Ambulatory professional services. See discussion on Inpatient Professional Services.

**OUTPATIENT SERVICE.** Care center providing treatment to patients who do not require admission as inpatients.

**PARTICIPATING PROVIDER.** A provider contracted with an insurer. Usually refers to providers who are part of a network.

**PATIENT.** A sick, injured, wounded, or other person requiring medical or dental care or treatment.

**PATIENT LIABILITY.** The dollar amount that an insured is legally obligated to pay for services rendered by a provider. These may include co-payments, deductibles and payments for uncovered services.

**PCM. Primary Care Manager.** An individual (military or civilian) primary care provider, a group of providers, or an institution (clinic, hospital, or other site) who or which is responsible for assessing the health needs of a patient, and scheduling the patient for appropriate appointments (example: pediatric, family practice, ob-gyn) with a primary health care provider within the local MHS network.

**PCP. Primary Care Physician.** Generally applies to internists, pediatricians, family physicians and general practitioners and occasionally to obstetrician/gynecologists.

**PCP - PRIMARY CARE PROVIDER.** A health care professional who serves as a member's primary contact within a health plan. In a managed care plan, the primary care provider provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals. Sometimes referred to as the gatekeeper. Some plans will pay out-of-network benefits if services are not provided by or referred by the member's PCP.

**PHARMACY BENEFIT MANAGER (PBM).** Third party administrators of prescription drug benefits.

**PLAN SPONSOR.** An entity that sponsors a health plan. This can be an employer, a union, or some other entity.

**POINT-OF-SERVICE (POS) PLANS.** Managed care plans that give the insured the option of seeing providers within the plan's network and paying the co-payment amount only, or seeing providers out of the network and getting reimbursed as you would under an conventional indemnity policy.

**PRE-ADMISSION CERTIFICATION.** See Admission Certification.

**PRE-ADMISSION TESTING.** Medical tests that are completed for an individual prior to being admitted to a hospital or inpatient health care facility.

**PRE-EXISTING CONDITION.** A medical condition that is excluded from coverage by an insurance company, because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company.

**PREFERRED PROVIDER ORGANIZATION (PPO).** PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans, in that they will pay a higher percentage for care provided by providers in the network.

**PRIMARY COVERAGE.** Plan that pays its expenses without consideration of other plans, under coordination of benefits rules.

**PRINCIPAL DIAGNOSIS.** The condition established after study to be chiefly responsible for the patient's admission. This should be coded as the first diagnosis in the completed record.

**PRINCIPAL PROCEDURE.** The procedure that was therapeutic rather than diagnostic, most related to the principal diagnosis, or necessary to take care of a complication. This should be coded as the first procedure in the completed record.

**PRIVILEGED PROVIDER.** Independent practitioners who are granted permission to provide medical, dental and other patient care in the granting facility within defined limits based on the individual's education, professional license, experience, competence, ability, health and judgment. The provider has his/her qualifications reviewed by the credentialing review board, a scope of practice defined and a request for privileges approved by the privileging authority.

**PROFESSIONAL SERVICES.** Any service or care rendered to an individual to include an office visit, X-ray, laboratory services, physical or occupational therapy, medical transportation, etc. Also, any

procedure or service that is definable as an authorized procedure from the CPT coding system or the CHAMPUS manuals.

**PROVIDER.** Person or entity, such as physicians, nurse practitioners, chiropractors, physical therapists, hospitals, home health agencies, nursing homes, providing health care services to patients.

**RATE.** Regular fee charged to all persons of the same patient category for the same service or care.

**REFERRAL.** Transfer of patient's care to specialty physician or specialty care by a primary care provider/physician.

**REVENUE CODE.** Identifies a specific accommodation and/or ancillary service performed.

**RETROSPECTIVE REVIEW PROCESS.** A review that is conducted after services are provided to a patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of health care services provided.

**SECONDARY COVERAGE.** Health plan that pays costs not covered by primary coverage under coordination of benefits rules.

**SELF-FUNDED/SELF-INSURED PLAN.** Employer or organization assumes complete responsibility for health care losses of its covered employees. Funds are set up against which claim payments are drawn. Claims processing is typically handled by a third party administrator or through an insurance carrier who acts as a third party administrator rather than an insurer.

**SUBROGATION.** Procedure where insurance company recovers from a third party when the action resulting in medical expense (e.g. auto accident) was the fault of another person. The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable.

**SUBSCRIBER.** Employment group or individual that contracts with an insurer for medical services. Usually synonymous with enrollee, covered individual or member.

**SHORT-TERM DISABILITY.** An injury or illness that keeps a person from working for a short time. Short-term disability insurance coverage is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working.

**SMALL EMPLOYER GROUP.** Generally means groups with 1 - 99 employees. The definition may vary between states.

**TRIPLE-OPTION.** Insurance plans that offer three options from which an individual may choose. Usually, the three options are traditional indemnity, an HMO, and a PPO.

**THIRD PARTY ADMINISTRATOR (TPA).** An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

**TPCP.** Third Party Collection Program.

**TPOCS.** Third Party Outpatient Collection System. Compiles outpatient visit information from Ambulatory Data System (ADM), and ancillary testing or services information from the Composite Health Care System (CHCS). Using rate tables for billing services from DoD Comptroller, the system generates a billing for accounts receivable, refunds or other health care insurance purposes.

**TELEHEALTH, TELEMEDICINE, E-HEALTH.** The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education and/or medical learning.

**TERMINATION DATE.** Date that a group contract expires or an individual is no longer eligible for benefits.

**THIRD PARTY PAYMENT.** Payment by a financial agent, rather than direct payment by a patient, for medical care services.

**THIRD PARTY PAYER.** Any organization, public or private that pays or insures health or medical expenses on behalf of beneficiaries or recipients. The payer organization pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

**UBU.** Unified Biostatistical Utility. The part of CEIS responsible for capturing and standardizing biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses and algorithms across the MHS.

**UCF.** Universal Claim Form. A paper claim form used to bill pharmacy claims only.

**UNBUNDLING.** The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.

**USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES.** The average fee charged by a particular type of health care provider within a geographic area for a particular medical procedure. The term is often used by medical plans as the amount they will approve for a specific test or procedure. Also referred to as Reasonable and Customary Fees.

**VISIT.** Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.

**WORKLOAD.** An expression of the amount of work, identified by the number of work units or volume of a workload factor that a work center has on hand at any given time or performs during a specified period of time.

**WAITING PERIODS.** The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

**WORKERS COMPENSATION INSURANCE.** Insurance coverage for work-related illness and injury. All states require employers to carry this insurance.