

Chapter 8

Section 6

Claim Development

Revision: C-19, January 24, 2018

1.0 GENERAL

1.1 Pursuant to National Defense Authorization Act for Fiscal Year 2007 (NDAA FY 2007), Section 731(b)(2) where services are covered by both Medicare and TRICARE, and medical necessity documentation is required for claims processing, the contractor shall require only the documentation as specified by the Medicare Indemnity Program, for example, the Centers for Medicare and Medicaid Services (CMS)-Certificates of Medical Necessity. No additional documentation for medical necessity is generally required if the care has been preauthorized.

1.2 The contractor shall retain all claims that contain sufficient information to allow processing to completion. The contractor shall also retain all claims that have missing information that can be obtained from in-house sources, including Defense Enrollment Eligibility Reporting System (DEERS) and contractor operated or maintained systems or files (both electronic and paper). If the claim has missing information that cannot be obtained from in-house sources, the contractor shall either return the claim to the sender or retain the claim and develop for the missing information from external sources (e.g., beneficiary or provider). If the claim is returned, the contractor shall return the claim to the sender with a letter stating that the claim is being returned, stating the reason and requesting the missing or required information. The letter shall request all known missing or required documentation. The contractor's system shall identify the claim as returned, not denied. Returned claims shall not be reported on TRICARE Encounter Data (TED) records. The Government reserves the right to audit returned claims, therefore the contractor shall retain sufficient information on returned claims to permit such audits.

1.3 If a claim is to be returned to a beneficiary who is under 18 years of age and involves venereal disease, substance or alcohol abuse, or abortion, the contractor shall contact the beneficiary to determine how he or she wishes to provide the missing information. See [Section 8, paragraph 6.0](#) regarding possible contact procedures and the need for both sensitivity and use of good judgment in the protection of patient privacy. **Mail development shall not be initiated on this type of claim without consent of the beneficiary irrespective of whether it is a network or non-network claim.**

2.0 AGREEMENT TO PARTICIPATE

2.1 If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of [32 CFR 199.8](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 4](#) will apply.

2.2 In all cases in which the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See the TRM for cases where double coverage is also involved.) If it comes to the contractor's attention that the terms of the participation agreement have been violated, the issue shall be resolved as outlined in [Chapter 13, Section 2, paragraph 2.4](#), under procedures for handling the violation of participation agreements. If the provider returns an adjustment check to the contractor indicating that payment had been made in full, an adjustment check shall be reissued to the beneficiary/sponsor. If the non-network provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

3.0 CLAIMS FOR CERTAIN ANCILLARY SERVICES

If laboratory tests billed by a non-network provider were performed outside the office of the non-network provider, the place where the laboratory tests were performed must be provided. The contractor shall approve arrangements for laboratory work submitted by network physicians. To be covered, the services must have been ordered by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and the laboratory must meet the requirements to provide the services as required under the 32 CFR 199, and Defense Health Agency (DHA) instructions.

4.0 INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, CLINICAL MODIFICATION (ICD-9-CM) "V" CODES

4.1 The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as **V** codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. **V** codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with dates of service or dates of discharge provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, with **V** codes as the primary diagnoses are to be processed as follows in the paragraphs below without development. Claims with dates of service or dates of discharge provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, are to be processed in accordance with ICD-10-CM **Z** codes.

4.2 **V** codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X (Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy), V25.2 (Sterilization), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

4.3 **V** codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a **V** code for radiologic exam, V72.5, followed by the code for 786.07 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the **V**-coded ancillary service and the diagnosis is not on file for the physician's office services, the claim is to be denied for insufficient diagnosis.

4.4 **V** codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to

the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., V76.11, V10.3, V15.89, and V163.0.
- Pap Smears, e.g., V72.3, V76.2, and V15.89.
- Screening for Fecal Occult Blood, e.g., V10.00, V10.05, and V10.06.

4.5 Claims with the only diagnoses being **V** codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be returned for insufficient diagnosis. This includes those **V** codes corresponding to the **V** codes for “Conditions not Attributable to a Mental Disorder” in the **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association (APA).

5.0 ICD-10-CM “Z” CODES

5.1 The codes listed in Chapter XXI of ICD-10-CM - Factors Influencing Health Status and Contact with Health Services (Z00-Z99), otherwise known as **Z** codes, will become effective on the mandated date, as directed by HHS, for ICD-10 implementation, and replace ICD-9-CM **V** codes. These **Z** codes deal with circumstances other than disease or injury classifiable to the ICD-10-CM categories A00-Y99. **Z** codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary encountering the health care system. Claims with **Z** codes as the primary diagnoses are to be processed as follows without development.

5.2 **Z** codes which provide descriptive information of the reason for the encounter based on the single code, e.g., Z23 (Encounter for Immunization), Z00.129 (Encounter for routine child health examination without abnormal findings), Z34.00 (Encounter for supervision of normal first pregnancy, unspecified trimester), Z30.011 (Encounter for initial prescription of contraceptive pills), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

5.3 **Z** codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, Z01.89, Encounter for the other specified (radiologic not associated with procedure) special examinations, followed by the code for R06.2 (wheezing) or R07.1 (chest pain on breathing) is acceptable. If the diagnosis or problem is not submitted with a claim for the **Z**-coded ancillary service and the diagnosis is not on file for the physician’s office services, the claim is to be denied for insufficient diagnosis.

5.4 **Z** codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., Z12.31, Z85.3, Z86.000, Z80.3, and Z91.89.
- Pap Smears, e.g., Z12.72, Z12.4, Z11.51, Z86.001, and Z91.89.
- Screening for Fecal Occult Blood, e.g., Z85.00 (Personal history of malignant).

5.5 Claims with the only diagnoses being **Z** codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be returned for insufficient diagnosis. This includes those **Z** codes corresponding to the **Z** codes for "Conditions not Attributable to a Mental Disorder" in the **Diagnostic and Statistical Manual of Mental Disorders** of the APA.

6.0 INDIVIDUAL PROVIDER SERVICES

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

- Identification of the provider of care;
- Dates of services;
- Place of service, if not evident from the service description or code, e.g., office, home, hospital, Skilled Nursing Facility (SNF), etc.;
- Charge for each service;
- Description of each service and/or a clearly identifiable/acceptable procedure code; and
- The number/frequency of each service.

7.0 UNDELIVERABLE/RETURNED MAIL

When a provider's/beneficiary's Explanation of Benefits (EOB), EOB and check, or letter is returned as undeliverable, the check shall be voided.

8.0 TED DETAIL LINE ITEM - COMBINED CHARGES

Combining charges for the same procedures having the same billed charges under the contractor's "financially underwritten" operation, for TED records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from March 25, 2015 to April 15, 2015 and surgery was performed on April 8, 2015, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between March 25th and March 31st, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month.

9.0 CLAIMS SPLITTING

A claim shall only be split under the following conditions. Unless a claim meets one of the following conditions, all services included on the claim shall be processed together and reported on one TED record.

9.1 A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under TEDs for different beneficiaries.

9.2 A claim for the lease/purchase of Durable Equipment (DE) and Durable Medical Equipment (DME) that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. These must be split under TEDs.

9.3 A claim that contains services, supplies or equipment covering more than one contractor's jurisdiction shall be split. See [Chapter 8, Section 2](#), for information on transferring partially out-of-jurisdiction claims.

9.4 An inpatient maternity claim which is subject to the TRICARE Diagnosis Related Group (DRG)-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the TRM, [Chapter 1, Section 31](#).

9.5 Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying Current Procedural Terminology (CPT) codes) shall be reported on a non-institutional format. See the TRM, [Chapter 11, Section 4](#).

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

- Charges for services which are included in the prospective group payment rate;
- Charges for services which are not included in the prospective group payment rate and are separately allowable; and
- Physician's fees which are allowable in addition to the facility charges. See the TRM, [Chapter 9, Section 1](#).

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

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

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

- Charges for services included in the Outpatient Prospective Payment System (OPPS); and
- Charges for professional services which are not included in the OPPS and are separately allowable.

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

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

10.0 PROVIDER NUMBERS

10.1 Claims received from covered entities with the provider's National Provider Identifier (NPI) (individual and organizational) shall be processed using the NPI. Electronic claim transactions received from covered entities without the requisite NPIs in accordance with Implementation Guide for the ASC X12N 837 transaction shall be denied. See [Chapter 19, Section 4](#) for further information.

10.2 Claims received (electronic, paper, or other acceptable medium) with provider's Medicare Provider Number (institutional and non-institutional) shall not be returned to the provider to obtain the TRICARE Provider Number. The contractor shall accept the claim for processing, develop the provider number internally, and report the TRICARE Provider Number as required by the TSM, [Chapter 2](#), on the TED records.

11.0 TRANSGENDERED BENEFICIARIES

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

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

12.0 DRUG SEEKING BENEFICIARIES

I Please refer to [Chapter 28](#) for current claims review and restriction program.

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