CHAPTER 1
SECTION 3

HEALTH CARE SERVICE RECORD SUBMISSION

1.0. GENERAL

1.1. Health Care Service Records (HCSR) provide detailed information for each treatment encounter and are required for TMA statistical and financial reporting. A Health Care Service Record consists of either an Institutional or non-institutional record. An institutional HCSR is defined as the submission of treatment encounter data created by the formal acceptance by a hospital or other authorized institutional provider of a beneficiary for the purpose of occupying a bed with the reasonable expectation that the patient will remain on inpatient status at least 24 hours with the registration and assignment of an inpatient number or designation.

1.2. All other treatment encounter data including institutional care in connection with ambulatory surgery must be reported on a non-institutional HCSR.

1.3. There are three types of HCSR:

1.3.1. Initial Submission

1.3.2. Adjustment Submission

1.3.3. Resubmission

1.4. These types of records are discussed briefly in the following paragraphs. Complete record layouts, data requirements by Element Locator Number (ELN), and edit criteria are detailed in Chapter 2 through Chapter 8. In the following text, the ELN will be provided in brackets directly following each data element.

1.5. The PROGRAM INDICATOR [1-030, 2-030] identifies the TRICARE Program on which the services that are being reported relate to that specific HCSR. The Drug Program Indicator is used when reporting drugs and medications obtained by prescription. The Handicapped Indicator is used when reporting the specific criteria as set forth under the TRICARE Program for Persons with Disabilities (PFPWD).

1.6. HCSRs within a day's cycle are processed by TMA first in Filing Date order, then by TYPE OF SUBMISSION (I, O, D, R first; A, B, C, E, F second).

2.0. INITIAL SUBMISSION OF HEALTH CARE SERVICE RECORDS

Initial submission applies only to the **first** submission of a **new** HCSR. Initial submissions are identified by TYPE OF SUBMISSION CODEs [1-175, 2-175] 'I', 'D', 'G' and 'O' on the HCSR.

2.1. All data indicated as "required" in the data element definition must be reported. If not received in the treatment encounter data, this data must be developed.

2.2. All signed numeric data elements on the initial submission must be reported as positive values.

2.3. Treatment encounter data must be reported on HCSRs using claim breakdown (multiple suffixes) under the following conditions:

2.3.1. Contains multiple providers, includes subidentifier code.

2.3.2. Crosses fiscal years and is a non-institutional HCSR with outpatient services.

2.3.3. Contains multiple kinds of services provided under more than one of the TMA programs (e.g., inpatient professional, outpatient professional, drug charges, institutional outpatient, ambulatory surgery, etc.)

2.3.4. Contains multiple, separate inpatient nonavailability statement issuances or when it contains a mixture of surgical procedure codes that require an outpatient nonavailability statement and surgical procedure codes that do not.

2.3.5. Covers a treatment period in which the sponsor's status changed from either leaving or entering active duty. All services received while the sponsor was on active duty will be reported separately (using the HCSR suffix) from those services received while the sponsor was not on active duty.

2.3.6. Covers a period during which a person was a spouse of an active duty member and changed to eligible former spouse status.

2.3.7. When there are indications that there may be third party liability for only a part of the services.

2.3.8. Multiple claims submitted together (shoebox claims), when there are claims that indicate third party liability.

2.3.9. Reimbursement of claims involving both regional and hospital-specific mental health per diem rates.

2.3.10. Covers a period during which different cost shares apply as the result of special programs (PFPWD, Basic Program, etc.).

2.3.11. Negotiated rates apply to some, but not all, treatment dates.

2.3.12. Contains services rendered in more than one locality, only if more than one is subject to pricing via CMAC and more than one locality code must be reported.

2.3.13. A hospital services claim covering a treatment period in which the patient's eligibility ended as determined by DEERS. All services received while the patient was eligible will be processed separately from those services received while the patient was

ineligible. The HCSR suffix containing the denied services will reflect the appropriate denial reason.

2.3.14. A suffix has been completely cancelled due to stale date check processing. The original ICN with a new suffix shall be used for reissuance of a stale dated check.

2.4. When doing a claim breakdown for treatment encounter data, report the same HCSR Indicator for each HCSR except, the first HCSR must be reported with a suffix = 'A', the next HCSR with suffix = 'B', and so on. If treatment data does not need a breakdown, the suffix must be A. Outpatient treatment encounter data for DME or global charges will be prorated for each fiscal year portion. When a claim breakdown is done all the HCSR suffixes that were created by that breakdown must be reported to TMA in the same batch. For claim splitting instructions, see OPM Part Two, Chapter 1.

2.5. When institutional HCSRs are reported for other than the complete inpatient hospital stay, i.e. inpatient RTC care, the HCSRs must be reported to TMA in the sequence that the care was provided (FREQUENCY CODEs [1-255], 2-Initial, 3-Interim or 4-Final). If this reporting sequence is not followed, the HCSR(s) will not be accepted by TMA. Thus, the correct prior partial-stay HCSR must have passed TMA edits before the next sequential partial-stay HCSR can be reported.

3.0. ADJUSTMENT SUBMISSION OF HEALTH CARE SERVICE RECORDS

3.1. Adjustment submission applies to previously submitted and accepted HCSRs suffixes which require adjustment because of processing errors or the need to update prior data with more current/accurate information. Adjustments are absolutely not permitted when the type of submission on the initial HCSR was 'D' (Complete Contractor Denial).

3.2. Adjustment submissions are identified by TYPE OF SUBMISSION CODEs [1-175, 2-175] 'A', 'B', 'C', 'E', and 'F' on the HCSR. The use of the proper code is essential to accurate processing of adjustments.

3.3. Adjustment conditions include, but are not limited to, the following:

3.3.1. Error in information received from the provider or beneficiary

3.3.2. Late submission of data from providers

3.3.3. Error in processing by current or prior contractor (if applicable)

3.3.4. Deductible corrections

3.3.5. Successful recoupment of monies, or receipt of a refund from the provider, beneficiary, or third party

3.3.6. Stale dated payment checks

3.4. Adjustment submissions are **positive** (where additional monies are being paid by the contractor), **negative** (where monies are being credited back to the contractor), or **statistical** (serve to correct prior information but have no impact on payment amount).

NOTE: Adjustments to a complete denial HCSR are not permitted. Reopening of a previously denied HCSR must be submitted as a new initial submission HCSR. Determination of positive or negative adjustment submission is based on the **end result** of the adjustment activity on the individual HCSR AMOUNT PAID BY GOVERNMENT CONTRACTOR [1-155, 2-155]. If a negative adjustment results in complete cancellation of the amount paid by the government contractor, the adjustment must be reported with TYPE OF SUBMISSION [1-175, 2-175] code 'C' or 'E'. Complete cancellation of TYPE OF SUBMISSION 'O' (zero payment HCSR due to 100% reimbursement by other sources) is not permitted unless an adjustment HCSR(s) has been submitted with the net effect on AMOUNT PAID BY GOVERNMENT CONTRACTOR being greater than zero. Refer to "Examples" below for an example of a complete cancellation HCSR.

3.5. Examples of adjustment submissions are located below. Example paragraph 3.5.3.1. portrays a positive adjustment, Example paragraph 3.5.3.2. portrays a negative adjustment, and Example paragraph 3.5.3.3. portrays an adjustment correcting information without impact on payment amount.

3.5.1. All adjustment submissions must be reported using the HEALTH CARE SERVICE RECORD INDICATOR [1-005, 2-005] reported on the initial submission HCSR, regardless of the number of adjustments to the initial HCSR. Only the affected HCSR(s) should be reported. However, an adjustment that would result in submission of a different record category (e.g., change an institutional record, type 1, to a non-institutional record, type 2) is not permitted. In this instance, the initial HCSR must be completely cancelled (TYPE OF SUBMISSION code 'C'), and a new initial HCSR submitted with the correct data.

3.5.2. All data as reported on the initial HCSR must be resubmitted except for signed numeric fields, and those non-signed numeric fields requiring correction. Data contained within each occurrence in the variable portion of the adjustment HCSR must be reported in the same sequence, with the same Occurrence Number as on the initial HCSR. An adjustment HCSR can add additional detail occurrences. If the adjustment requires further breakdown of treatment encounter data (e.g., drug charges were processed in error as professional services with other professional services), the initial HCSR must be corrected and the 'new' data reported separately as TYPE OF SUBMISSION code 'F' with the next HCSR suffix assigned. All signed numeric fields and those non-signed numeric fields requiring correction must be reported according to the following:

3.5.2.1. All signed numeric data elements affected by the adjustment must reflect the **net difference** between what was **initially** reported and the **correct** amount. If adjustments were made in signed numeric fields prior to the current adjustment, the data elements must reflect the net amounts after combining the amounts in the initial and all prior adjustment submissions with this submission. Those signed numeric data elements that are unaffected by the adjustment netting process must be set to zero.

3.5.2.2. Non-signed numeric data elements requiring correction or update must reflect the most current information applicable to the service(s) being reported. All other non-signed numeric data elements must be reported as on the initial submission, or if prior adjustments corrected / updated the initial data, the data from the most recent submission must be reported. This does not apply to negative adjustments.

3.5.2.3. Adjustment and complete cancellation HCSRs are matched and applied to their corresponding initial submission HCSR and any other adjustment HCSRs at TMA. The resulting "net" HCSR is edited through the TMA edit system as if it were an initial submission HCSR. Thus, the original and any prior adjustments must have passed TMA edits before a new adjustment is reported.

3.5.3. Examples

3.5.3.1. Positive Adjustment

A HCSR was submitted by the contractor and processed by TMA with an amount billed of $200.00, amount allowed of $100.00, and $50.00 applied to the deductible. The amount allowed should have been $180.00 and no monies should have been applied to the deductible. The amount billed, however, was unchanged.

INITIAL HCSR POSITIVE ADJUSTMENT AMOUNTS

INITIAL HCSR	
Amount Billed	$200.00
Amount Allowed	100.00
Amount to Deductible	50.00
Amount Paid (75%)	37.50
ADJUSTMENT HCSR	
Amount Billed	0
Amount Allowed	80.00
Amount to Deductible	-50.00
Amount Paid (75%)	97.50
EFFECT AT TMA	
Amount Billed	200.00
Amount Allowed	180.00
Amount to Deductible	0
Amount Paid	135.00

3.5.3.2. Negative Adjustment

A HCSR was submitted by the contractor and processed by TMA with an amount billed of $500.00, an amount allowed of $500.00, and amount paid by the contractor of $500.00. However, other health insurance (OHI) was involved and their payment of $400.00 was recouped. The amounts billed and allowed were correct but the amount paid should have been $100.00.

HCSR NEGATIVE ADJUSTMENT AMOUNTS

INITIAL HCSR	
Amount Billed	$500.00
Amount Allowed	500.00
Amount to OHI	0
Amount Paid	500.00
ADJUSTMENT HCSR	
Amount Billed	0
Amount Allowed	0
Amount to OHI	400.00
Amount Paid	- 400.00
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Amount to OHI	400.00
Amount Paid	100.00

3.5.3.3. Statistical Adjustment

A HCSR was submitted by the contractor and processed by TMA for a hospitalization spanning twenty (20) bed days and $2000.00 in billed charges. Fifteen (15) of the days were considered authorized. Subsequently, the total number of bed days was found to be thirty (30) and billed charges were actually $3000.00. However, the allowable days and amount paid by the contractor remained unchanged.

HCSR STATISTICAL ADJUSTMENT

INITIAL HCSR	
Amount Billed	$2000.00
Amount Allowed	1500.00
Total Bed Days	20
Gov't Authorized Bed Days	15
Amount Paid (75%)	1125.00
ADJUSTMENT HCSR	
Amount Billed	1000.00
Amount Allowed	0
Total Bed Days	10
Gov't Authorized Bed Days	0

HCSR STATISTICAL ADJUSTMENT (CONTINUED)

Amount Paid	0
EFFECT AT TMA	
Amount Billed	3000.00
Amount Allowed	1500.00
Total Bed Days	30
Gov't Authorized Bed Days	15
Amount Paid	1125.00

3.5.3.4. Negative Adjustment (Complete Cancellation)

An HCSR was submitted by the contractor and processed by TMA with an amount billed of $500.00, allowed of $500.00, and amount paid by government contractor of $375.00. Subsequently, the contractor processed an adjustment to pay in full, reporting an increase of $125.00 in the amount paid by government contractor. The contractor then determined the care was processed in error and recouped the entire $500.00 payment.

HCSR NEGATIVE ADJUSTMENT

INITIAL HCSR	
Amount Billed	$500.00
Amount Allowed	500.00
Patient Coinsurance	125.00
Amount Paid	375.00
Total Bed Days	5
Gov't Authorized Bed Days	5
ADJUSTMENT HCSR	
Amount Billed	0
Amount Allowed	0
Patient Coinsurance	-125.00
Amount Paid	125.00
Total Bed Days	0
Gov't Authorized Bed Days	0
CANCELLATION HCSR	
Amount Billed	0
Amount Allowed	-500.00
Patient Coinsurance	0
Amount Paid	-500.00

HCSR NEGATIVE ADJUSTMENT (CONTINUED)

Total Bed Days	0
Gov't Authorized Bed Days	-5
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	0
Patient Coinsurance	0
Amount Paid	0
Total Bed Days	5
Gov't Authorized Bed Days	0

4.0. RESUBMISSION OF HEALTH CARE SERVICE RECORDS

Resubmission applies to initial and adjustment HCSRs which have failed to pass the TMA editing system. Failed records will be rejected and returned to the contractor for correction and resubmission. All rejected records within a batch or voucher must be returned by the contractor at the same time and balance to the outstanding Total Amount Paid and number of outstanding records at TMA. Upon resubmission, the records will again be processed through the TMA editing system. Resubmissions are identified by the RESUBMISSION NUMBER [0-045 or 0-100] in the Header Record.

4.1. Resubmissions must be reported using the HEALTH CARE SERVICE RECORD INDICATOR [1-005, 2-005] reported on the initial or adjustment HCSR, regardless of the number of times the HCSR is resubmitted.

4.2. All data as reported on the initial or adjustment HCSR must be resubmitted except for that data changed in order to correct the error(s).

4.3. If the rejected HCSR is TYPE OF SUBMISSION = 'I', report the correction HCSR with TYPE OF SUBMISSION ='R' (resubmission). All other HCSR types of submission retain their original code throughout the resubmission process.

4.4. To liquidate or "clear" a batch / voucher, both Total Amount Paid and the number of outstanding HCSRs must zero out through the edit error correction and resubmission process.

4.5. If TMA edits identify that the dollar amounts on the HCSR are incorrect, the contractor must:

Correct the related monetary data to balance to the AMOUNT PAID BY GOVERNMENT CONTRACTOR reported on the HCSR. **Do not change the AMOUNT PAID BY THE GOVERNMENT CONTRACTOR**. Correction of the payment error will be reflected through your processing and subsequent submission of the adjustment / cancellation HCSR.

5.0. INTERIM DRG PAYMENTS

In certain cases, providers can submit interim bills for DRG claims. (See the Policy Manual, Chapter 13, Section 6.1E) All HCSRs for interim DRG bills must be submitted with a SPECIAL PROCESSING CODE 'D', the SPECIAL RATE CODE must be 'G' or 'I', the Amount Billed must be greater than $90,000.00 on the initial and interim HCSRs, the Frequency Code must be Initial (2), Interim (3) or Final (4) as appropriate, and the Discharge Status must reflect the patient's status at the time the bill was submitted. Any additional DRG interim record after the initial interim record must be submitted as an adjustment record to the original submission, utilizing TYPE OF SUBMISSION code 'G' with REASON FOR ADJUSTMENT CODE 'A.' The requirement for TYPE OF SUBMISSION 'G' on all subsequent DRG Interim records applies, even if the conditions on the HCSR might apply to other TYPES OF SUBMISSION (e.g., 'O' and 'D').

EXAMPLE: Three (3) DRG interim billing are submitted for one stay:

	HCSR INDIC	SPEC PROC/ SPEC RATE	FREQUENCY/ DISCHARGE	AMOUNT BILLED	*	**
Bill #1	19883410600056A	D / G	2 / 30	$109,240.60	I	⅊
Bill #2	19883410600056B	D / G	3 / 30	98,691.20	G	A
Bill #3	19883410600056C	D / G	4 / 01	20,876.00	G	A
* TYPE OF SUBMISSION ** REASON FOR ADJUSTMENT						

6.0. PROCESS FOR REPORTING RESOURCE SHARING AND CAPITATED TREATMENT ENCOUNTERS TO TMA

The following process is to be used by claims processors to report data to TMA which relates to Resource Sharing or Capitated Treatment Encounters.

6.1. Special Processing Code

For Resource Sharing and / or Capitated claims / encounters, report a HCSR which includes the appropriate Special Processing Code, as defined in Chapter 2, for each patient encounter.

6.2. "Amount" Field Reporting

The "amount" fields must contain the following:

6.2.1. Amount Billed

The Amount Billed Field shall be the amount (institutional or noninstitutional charges) that the capitated provider would charge a patient outside the plan; e.g., a patient is seen on an emergency basis or not on a capitated basis. If a Resource Sharing provider is

being reimbursed on a fee-for-service basis with negotiated / discounted rates, , report these amounts.

6.2.2. Amount Allowed

The Amount Allowed Field must contain the appropriate DRG or per diem for institutional services or the CHAMPUS Maximum Allowable Charge (CMAC) for noninstitutional services.

6.2.3. Amount Paid By Government Contractor

The Amount Paid By Government Contractor Field must equal the "lesser" of the amount allowed minus (patient copayment plus patient coinsurance plus amount applied toward deductible) or amount allowed minus (amount of OHI plus amount of TPL). If the "Lesser" computed amount is negative, amount paid by government contractor must = $0.00.

7.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA

The following process is to be used by claims processors to report claim-related data to TMA which contain charges for blood clotting factor.

7.1. Blood Clotting Factor

Data is to be reported on the Institutional Health Care Service Record, even though they are to be reimbursed separately from the DRG methodology.

7.2. Calculation of Charge

Charges will be calculated in a two-step process, as described below.

7.2.1. First Step

The DRG-reimbursable hospital charges will be calculated in the normal way. All related financial data will be stored for later use (see below).

7.2.2. Second Step

The blood clotting factor financial data will be calculated based on the reimbursement methodology described in the Policy Manual, Chapter 13, Section 6.1D. All related financial data will be stored for later use. Revenue Code 636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor only. All other drugs are to be reported using the appropriate Revenue Codes in the 25X series.

7.2.2.1. The number to be coded in the "Units of Service" field is the number of units billed on the claim, not the number of payment units (which is 100 times the number of units billed).

7.2.2.2. The billed charges for blood clotting factor are to be reported in the "Total Charge by Revenue Code" field of the payment record.

NOTE: While blood clotting factor charges will be priced separately, the "Denial Reason Code" cannot be 'F' (DRG non-reimbursables).

7.2.3. Data Reporting

From the two steps above, merge the financial data as follows, and enter them into the appropriate cost fields:

7.2.3.1. Amount Billed

This is the sum of all billed charges **including** those for blood clotting factor.

7.2.3.2. Amount Allowed

This is the sum of the two separate amounts allowed resulting from the calculations in step 2 above.

7.2.3.3. Amount of Other Health Insurance

This is the amount paid by other primary sources of reimbursement, if applicable.

7.2.3.4. Amount of Third Party Liability

Enter an amount, if applicable.

7.2.3.5. Patient Cost-Share

Enter in the appropriate field based on the Category of Beneficiary:

7.2.3.5.1. Patient Co-Insurance (For Other Than Family Members of Active Duty)

This is the amount based on either 25% of the billed charges (including those for blood clotting factor) or the per diem amount times the number of days in the hospital stay.

7.2.3.5.2. Patient Co-Payment (For Family Members of Active Duty)

This is the amount based on the inpatient hospital daily rate times the number of days in the hospital stay.

7.2.3.6. Amount Paid by Government Contractor

This is the sum of the two separate amounts resulting from the calculations in step 2 above.

8.0. ADMINISTRATIVE CLAIM PAYMENTS

8.1. Administrative reimbursement is based only upon initial types of Health Care Service Record submission (see paragraph 2.0.):

INITIAL TYPES OF SUBMISSION	
D	Complete contractor denial of an initial HCSR submission
I	Initial HCSR submission
O	Zero payment HCSR due to 100% OHI/Third Party Liability payment
R	Resubmission of an initial HCSR that was rejected due to errors
G	DRG interim billings (for Institutional HCSRs only)

8.2. None of the other types of submission will receive administrative reimbursement.

8.3. No administrative reimbursements will be made until all initial HCSRs making up a claim have passed the TMA edit system.

8.4. Only one administrative reimbursement per ICN will be made irrespective of the combination of initial submissions. Even if an initial submission HCSR has multiple suffixes and contains a combination of initial submissions that normally qualify for an administrative reimbursement, i.e., suffix A has a TYPE OF SUBMISSION 'I' and suffix B has a TYPE OF SUBMISSION 'D', only one administrative reimbursement will be paid.