CHAPTER 13
SECTION 4

CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

I. APPLICABILITY

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

II. ISSUE

To describe additional claims submission and processing requirements.

III. POLICY

Appropriate Bill Types:

A. Bill types subject to OPPS.

All outpatient hospital bills (bill types 13X with condition code 41, 13X without condition code 41), with the exception of bills from providers excluded under Section 1, paragraph III.D.1.b.(5) of this Chapter will be subject to the OPPS.

B. Reporting Requirements.

1. Payment of outpatient hospital claims will be based on the from date on the claim.

EXAMPLE: Claims with from dates prior to February 1, 2007 will not process as OPPS - this will also apply to version changes and pricing changes.

2. Hospitals should make every effort to report all services performed on the same day on the same claim to ensure proper payment under OPPS.

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C. Procedures for Submitting Late Charges.

1. Hospitals may not submit a late charge bill (frequency 5 in the third position of the bill type) for bill types 13X effective for claims with dates of service on or after February 1, 2007.

2. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 or 8 in the third position of the bill type. Separate bills containing only late charges will not be permitted.

3. The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing of OCE under OPPS.

D. Claim Adjustments. Adjustments to OPPS claims shall be priced based on the from date on the claim (using the rules and weights and rates in effect on that date) regardless of when the claim is submitted. Contractor's shall maintain at least three (3) years of APC relative weights, payment rates, wage indexes, etc., in their systems. If the claim filing deadline has been waived and the from date is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest APC weights and rates on the contractor's system.

E. Proper Reporting of Condition Code G0 (Zero).

1. Hospitals should report Condition Code G0 on FLs 24-30 when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

2. Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

3. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

4. Proper reporting of Condition Code G0 allows for proper payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

5. The following figure describes actions the OCE will take when multiple medical visits occur on the same day in the same revenue code center:

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FIGURE 13-4-1 ACTIONS TAKEN WHEN MULTIPLE MEDICAL VISITS OCCUR ON THE SAME DAY

EVALUATION & MANAGEMENT (E&M)	REVENUE CENTER	CONDITION CODE	OCE ACTION
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line item with E&M code

F. Clinical Diagnostic Laboratory Services Furnished to Outpatients.

1. Payment for clinical diagnostic laboratory services will not be paid under OPPS.

2. Payment for these services will be made under the CHAMPUS Maximum Allowable Charge (CMAC) System.

3. Hospitals should report HCPCS codes for clinical diagnostic laboratory services.

G. OPPS Modifiers.

TRICARE requires the reporting of HCPCS Level I and II modifiers for accuracy in reimbursement, coding consistency, and editing.

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