Chapter 13 Section 4

Claims Submission And Processing Requirements

Issue Date: July 27, 2005
Authority: 10 USC 1079(j)(2) and 10 USC 1079(h)

1.0 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 the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

To describe additional claims submission and processing requirements.

3.0 POLICY

Appropriate bill types:

3.1 Bill Types Subject To Outpatient Prospective Payment System (OPPS)

All outpatient hospital bills (bill types 013X with Condition Code 41, 013X without Condition Code 41, 014X for diagnostic services), with the exception of bills from providers excluded under Section 1, paragraph 3.4.1.2.5 will be subject to the OPPS.

3.2 Reporting Requirements

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

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

3.2.3 Each line item on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 Claim Form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

3.3 Procedures for Submitting Late Charges

3.3.1 Hospitals may not submit a late charge bill (frequency 5 in the third position of the bill type) for bill types 013X.

3.3.2 They must submit an adjustment bill for any services required to be billed with Healthcare Common Procedure Coding System (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. Claims with bill type 0137 and 0138 should report the original claim number in Form Location (FL) 64 on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 Claim Form.

3.3.3 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 Outpatient Code Editor (OCE) under OPPS.

Note: The contractors will take appropriate action in those situations where either a replacement claim (Type of Bill (TOB) 0137)) or voided/cancelled claim (TOB 0138) is received without an initial claim (TOB 0131) being on file. Adjustments resulting in overpayments will be set for recoupment allowing an auto offset.

3.4 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 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.

3.5 Proper Reporting of Condition Code G0 (Zero)

Hospitals should report Condition Code **G0** when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. Refer to the Medicare Claims Processing Manual, Chapter 4, Section 180.4 for proper reporting of Condition Code **G0**.

3.6 Clinical Diagnostic Laboratory Services Furnished to Outpatients

3.6.1 Prior to January 1, 2014, payment for these services will be made under the CHAMPUS Maximum Allowable Charge (CMAC) System.

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

3.6.3 Beginning January 1, 2014, most laboratory tests will be packaged under OPPS. Laboratory tests should be reported on TOB 13X. Laboratory tests may be separately paid when billed on TOB 14X in the following circumstances:

3.6.3.1 Non-patient laboratory specimen tests.

3.6.3.2 When the hospital only provides laboratory tests (directly or under arrangement) and patient receives no other hospital outpatient services during the same encounter.

3.6.3.3 When the laboratory test is provided (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services.

3.6.4 Beginning January 1, 2016, laboratory tests (regardless of date of service) on a claim with a service that is assigned a Status Indicator (SI) of **S**, **T**, or **V**, unless an exception applies or the laboratory test is "unrelated" to the other service(s) on the claim, will be conditionally packaged and will be assigned SI of **Q4**. When laboratory tests are the only service(s) on a claim, a separate payment may be made.

3.7 OPPS Modifiers

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

4.0 EFFECTIVE DATE

May 1, 2009.

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