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)

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 the TRICARE Management Activity (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 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 Chapter 13, Section 1, paragraph III.D.1.b.(5) 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 before May 1, 2009 (implementation of OPPS) 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.

3. Each line item on the 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.

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 013X effective for claims with dates of service on or after May 1, 2009 (implementation of OPPS).

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 CMS 1450 UB-04 claim form.

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 (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.

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 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 18-28 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:

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.

IV. EFFECTIVE DATE May 1, 2009.

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