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TRICARE
MANAGEMENT ACTIVITY
MB&RS

CHANGE 32
OCHAMPUS 6010.47-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE/CHAMPUS POLICY MANUAL

THE TRICARE MANAGEMENT ACTIVITY HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S):

CHAPTER 13 SECTION: 23.1

REMOVE PAGES: Chapter 13, Section 23.1, pages 1-2.

INSERT: Same pages as stated above.

SUMMARY OF ADDITIONS/REVISIONS: This revision provides the removal of the development of coding HCPCS claims. Instead of developing the claim, the contractor will follow the process used prior to the implementation of HCPCS. This may be returning the claim as unable to process due to improper coding. The contractor is not to code the claim with a dump code and pay as billed.

EFFECTIVE DATE AND IMPLEMENTATION: Upon direction of the Contracting Officer.

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Director, Program Development and Evaluation

ATTACHMENT(S): 1 PAGE
DISTRIBUTION: 6010.47-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

Subject: PROVIDER CODING OF NON-INSTITUTIONAL SERVICES USING HCPCS	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14,	Section: 23.1
	Issue Date: May 9, 1997

ISSUE

What is TRICARE/CHAMPUS' policy regarding provider reporting of non-institutional services by HCPCS?

BACKGROUND

The Health Care Financing Administration Common Procedure Coding System (HCPCS) includes three levels of codes as well as modifiers. Level I contains the AMA's numeric CPT codes. Level II contains alphanumeric codes for physician and other provider services not included in CPT, e.g., ambulance, DME, orthotics, prosthetics. Level II codes are maintained jointly by HCFA, Blue Cross and Blue Shield Association, the Health Insurance Association of America, and OCHAMPUS. Level III codes are for services not covered by a Level I or Level II code. For TRICARE/CHAMPUS' purposes, Level III codes are TRICARE/CHAMPUS established codes that cover a specific benefit that may not be coded by other organizations. OCHAMPUS can request code assignment, where appropriate, as described in paragraph D., under POLICY, below. For TRICARE/CHAMPUS, the hierarchy of the three levels is as follows: Level I, Level II, and Level III. Contractors are to use temporary codes only when permanent codes are not appropriate.

POLICY

All providers specialties and types of institutions except the following must report HCPCS codes on non-institutional claims (claims for which the contractors prepare a non-institutional HCSR):

Pharmacies - NDC codes

Residential Treatment Centers - Revenue codes

Skilled Nursing Centers - Revenue codes

Christian Science Sanatoria - Revenue codes

Dentists and Dental Services - ADA codes

POLICY CONSIDERATIONS

A. PROVIDER REQUIREMENTS - The following special considerations apply to the following specific provider types:

1. DME and Other Equipment and Devices. All durable medical equipment (DME) and prosthetic and orthotic devices must be reported using Level II alphanumeric codes whether furnished by individual professional providers, medical equipment companies, or institutions such as hospitals. The only exception is DME that is included in an inpatient

DRG or in an all-inclusive rate. HCPCS Level II codes beginning in E, K, and L describe DME and other equipment and devices. K codes are temporary codes established by Medicare carriers, but they may be used by contractors where they accurately describe the service. K codes may not be used if E or L codes describe the service.

2. Labs. Independent labs and labs based in facilities (e.g., hospitals) that provide outpatient services must report HCPCS. Most lab codes are found in Level I (80000-89999) of HCPCS. However, there are additional lab codes in Level II in the P and G series. The Level I codes are to be used prior to the Level II P series and the Level II P series are to be used prior to the Level II G series. Since the Level II G series are temporary codes, they should be used only when other Level I and Level II P series are not appropriate.

3. Drugs. HCPCS Level III codes are required for drugs, except for some hospital outpatient drugs. These are described in paragraph A.6., below. Drug injections must be coded in HCPCS Level II codes in the J series.

4. Radiology and Other Diagnostic Services. HCPCS must be reported for radiology services whether provided by individual professional providers, medical equipment companies, or institutions such as hospitals. The only exception is where the service is included in an inpatient DRG payment or in an all-inclusive rate. Special provisions for hospital outpatient reporting are described in paragraph A.6., below.

5. Ambulance Services. HCPCS are required for ambulance services and related supplies. Codes are in Level II in the A series.

6. Hospital Reporting of Outpatient Services on UB92. Hospitals should report the HCPCS code(s) that best describe the service(s) in column 44 of the UB92. HCPCS Level I and II codes are required for all services except supplies and most drugs. HCPCS Level II codes are required for drugs administered by injection or infusion, but not for other prescription drugs. There are situations where the best HCPCS code available does not describe hospital facility services, or includes professional and facility services. Improvements are gradually being made in HCPCS to include codes for appropriate hospital facility charges. Until such codes are available, hospitals should use the general facility charge code (HCPCS Level III Code 99088).

a. Units related to the HCPCS codes are reported in column 46. Related charges are shown in column 47.

b. Revenue codes are also required. Where the revenue code has no applicable HCPCS charge, the charges are shown for the revenue code in column 47. Otherwise, charges shown are for the HCPCS codes. There may be additional charges in the revenue center not related to the HCPCS code. In these cases, the revenue code is repeated on the bill with the additional charges for the other services shown separately.

c. A description follows when HCPCS codes are required for hospital outpatient services and unique situations requiring special procedures.

(1) Radiology and Other Diagnostic Procedures