DHA UBO Webinar
Expanding Billing and Finer Points
Broadcast Dates: 16 and 18 December 2014
Participant questions reprinted as received during live
Webinar broadcasts and as answered by the Speaker
(Submit additional questions via e-mail to UBO.helpdesk@altarum.org)

1. Screen 5, bullet 4, should we be applying OTC rates to match insurance claims from TPOCS in CHCS for DoD Overseas employee's exceptions?

No, billing offices should follow the Patient Category (PATCAT) assignment which drives the assignment of the applicable rate structure. In most cases, DoD employees overseas should be billed at the interagency rates under PATCAT K53-S or K53-T. Exceptions would apply if the care is occupational health or worker's compensation where we would not expect any charge. For most services, the Third Party Outpatient Collection System (TPOCS) will generate higher charges because the TPOCS rate database is loaded with the full/third party collection rates which are typically about 6% higher than interagency billing rates.

2. Are we to bill VA for the parts that are not covered by the VA repay?

MTFs may bill for items not included in the definition of the services that are billed. For instance, the National "Inpatient Billing Reimbursement Methodology For Direct Sharing Agreements" allows additional billing for durable medical equipment items not included in the institutional DRG rate, such as crutches that go home with the patient (will be reimbursed at cost) and for professional services provided during the inpatient stay (e.g., rounds, inpatient surgeries, and other inpatient procedures such as reading an EKG).

3. The insurance is being billed the TPOCS rate, but after their determination, to make the patient portion match the EOB, we're adding the 6%. Is that the discount they should be getting?

If the patient is a DoD employee overseas he/she should be given the interagency discount rather than be charged the full TPC rate (see answer to Question 1 above). Although the interagency rate is typically around 6%, it can vary from year to year and the discount is dependent on the date of care. Charges should be calculated with the interagency discount, the amount paid by the third party payer should be subtracted, and patient should be billed the remaining amount.

4. When applying MS-DRG rates for inpatient procedures, such as total joint replacement, is the cost for the hardware required for the implant inclusive in the DRG rates?

Yes, the DRG reimbursement typically includes supplies (e.g., pacemakers, implantable devices) necessary for the treatment of the patient. For specifics refer to the TRICARE Reimbursement Manual.

5. In regards to PATCATs for patients who are dual eligible (i.e. VA and Retired Military), are there any plans to update CHCS to allow multiple PATCATs to be applied to those patients who are routinely referred to DoD facilities as VA Sharing Agreement patients?

The PATCAT assignment now needs to be manually changed based on the healthcare services provided to dual eligible patients. At this point, we do not expect CHCS to be modified. However, with the implementation of the Defense Healthcare Management System Modernization (DHMSM) Program we are hopeful that adjusting the patient category on an encounter by encounter basis will be easier.

6. I have a question on Itemized bills. We have come across some problems when sending the bill for inpatient care where we send it on a UB-04 form, then the payer denies the claim due to lack of Itemizing services. As a Military Installation, we don't itemize, so please advise us on this matter.

This sounds like the payer's adjudication process requires itemized services. It is correct that the MHS does not charge for itemized services for inpatient care and only charges the bundled institutional MS-DRG charge. We recommend contacting the payer and offering to provide it with the services provided from the completed encounter documentation. You may have to confirm with the providers that all the documentation has been entered in the patient's chart. However, we cannot itemize the charges for the individual services as the approved UBO rates are a single charge for the entire inpatient stay. If the payer refuses to process the claim even after being provided with the services, contact your UBO Service or NCR MD Program Manager and request further guidance.