



DEFENSE HEALTH AGENCY  
UNIFORM BUSINESS OFFICE  
**USER GUIDE**

### Document Change History

Document Version	Posting Date	Description of Change	Affected Sections
1.0	18 January 2008	Updated section	Cosmetic Surgery
1.1	23 March 2009	Updated sections	Overview Air Evacuation Ambulance Services Claims Form Compliance Radiology Uniformed Services Family Health Plan Glossary
		New sections	Civilian Emergency Billing Third Party Collection Program (DD Form 2570)
1.2	10 July 2009	Updated sections	Accounts Receivable Dental Services Durable Medical Equipment and Supplies Pre-Authorizations/Pre-Certifications Revenue Codes
		New section	DD7/DD7A Process
		Deleted section	Report on Program Results (DD Form 2570). This information is covered in Third Party Collection Program Report.
1.3	1 July 2011	Replaced section	Observation
1.4	13 January 2012	Changed Revision date	Appendix C1
		Replaced Instruction Manual with link to current version	Appendix C3
		Changed UB-92 to UB-04	Throughout User Guide
		Updated section title	Glossary & Definitions
1.5	25 November 2013	Added sections	Help Desk Support (formerly Appendix A – Helpdesk & Hotline Support) Billing Inpatient Services Billing Outpatient Services U.S. Coast Guard Billing VA-DoD Resource Sharing Billing

Document Version	Posting Date	Description of Change	Affected Sections
			Appendix A – Procedure to Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate Files
		Revised sections	Overview Helpful Links Ambulatory Procedure Visits DD7/DD7A Reports Process Emergency Department Services File and Table Maintenance Laboratory Services (Codes 80048-89356) Patient Categories (formerly Patient Administration) Pharmaceuticals (formerly Pharmacy Services) Pre-Authorizations/Pre-Certifications Providers Rate Tables Third Party Collection Program – Report on Program Results (DD Form 2570) and UBO Metrics Report
		Changed TMA to DHA	All sections except those that were not revised in this version
		Deleted sections	Billable Encounters replaced with Billing Inpatient Services, Billing Outpatient Services Inpatient Fiscal Year Rates Outpatient Services Not Related to Inpatient Admissions Technicians, Nurses, and “Incident To”
1.6	29 April 2014	Added section	Medicare Claims
		Revised sections	Accounts Receivable Aeromedical Evacuation Coordination of Benefits Elective Cosmetic Procedures (replaces Cosmetic Surgery) Evaluation and Management Services

Document Version	Posting Date	Description of Change	Affected Sections
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		Deleted sections	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and DME/DMS Rate Table
1.7	29 August 2014	Added section	Appendix G – Invoice & Receipt Instructions
		Revised sections	Ambulance Services Ambulatory Data Module Ancillary Services and Hold Periods Antepartum/Postpartum Services (formerly Antepartum/Outpatient Obstetrical Services) Case Management Services Chemotherapy/Hydration/Infusions/Injection Services (formerly Chemotherapy) Civilian Emergency Billing Claim Formats (formerly Claim Forms (Paper)) Coding Compliance Editor (CCE) Compliance Dental Services Dialysis Electrocardiogram Services FEMA Reimbursement for Mission Assignment (formerly DoD Reimbursable Disaster Victim) Graduate Medical Education Health Insurance Portability and Accountability Act Immunization and Administration Services (formerly

Document	Posting Date	Description of Change	Affected Sections
			Immunization/Injection/ Infusion Services Itemized Posting of Receipts into TPOCS (formerly Itemized Posting of Receipts) Mental Health Services MHS Submission Forms (formerly System Change Requests (SCRs) and System Incident Reports (SIRs)) Modifiers National Disaster Medical System (NDMS) Billing Pulmonary Diagnostic Testing and Therapy Services (formerly Pulmonary Function) Radiology SIT/OHI (formerly Health Insurance)
		Deleted sections	Allergen Testing/Allergen Immunotherapy Bundling/Unbundling Services Diagnosis Pointers Education Services Ophthalmology, Optometry & Vision Services Otorhinolaryngology Services Pain Management Prolonged Services Rehabilitation Services
1.8	April 2018	Added Sections	Medicare Claims Staging Bill Errors

		<p>Revised Sections</p>	<p>Accounts Receivable  ADM  Aeromedical Evacuation  Allergy Testing  Ambulance Services  Ancillary Services  Anesthesia Provider Services  Antepartum Services  Appendix B,C,D,E,F, &amp; G  APVs  Billing Combined  Billing Inpatient  Billing Outpatient  Case Management Services  CCE  Chemotherapy Services  Civilian Emergency Billing  Claim Formats  Compliance  Coordination of Benefits  DD7  Denials Management  Dental Services  Dialysis  ED Services  Elective Cosmetic Surgery  Electrocardiogram Services  Evaluation &amp; Management  FEMA  File and Table Maintenance  Glossary  GME  HCPCS  Health Insurance  Help Desk  Helpful Links  HIPAA  ICD-10</p>
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		<p>Revised Sections</p>	<p>Immunization Services  Itemized Posting of Receipts  Laboratory Services  LaunchPad  MAC  Manual Billing  Modifiers  Mental Health Services  MHS Submission Forms  MSA  NDMS  Observation Services  OHI Discovery  Overview  PATCAT  Patient Centered Medical Home/Soldier Centered Medical Home  Pharmaceuticals  Pre-Authorizations  Providers  Pulmonary Testing  Radiology  Rate Tables  Refunds  Revenue Codes  SIT/OHI  System Change Request  Table of Contents  Telemedicine  TCP  TCP Pilot  USCG Billing  USFHP  VA-DoD Resource Sharing</p>
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Note: Each section has been reviewed as of April 2018, unless otherwise noted under the header of section.

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## Overview

1. General. This user guide provides functional guidance on data collection and Uniform Business Office (UBO) practices and billing procedures for Military Treatment Facilities (MTFs). This is a living document that is updated by the Defense Health Agency (DHA) UBO Program Office as necessary.

2. Background. MTF UBOs recover the cost of health care provided to patients seen in MTFs, as authorized by U.S. law. The DHA UBO Program Office is responsible for developing health care reimbursement rates, setting policy, and providing program oversight for the health care cost recovery programs: Medical Services Accounts (MSA), Third Party Collection (TPC), and Medical Affirmative Claims (MAC). The Services and the National Capital Region (NCR) Medical Directorate establish and operate UBOs at Defense Health Program (DHP) fixed MTFs throughout the world and administer these programs with the overall goal of optimizing the recovery of health care costs. The UBO focus is to: identify billable services and payer information; generate accurate and complete claims; and receive appropriate collections.

2.1. Medical Services Accounts (MSA) activities involve billing and collecting funds for medical, cosmetic, and dental treatment and services from: other government agencies (e.g., Department of Veterans Affairs (VA), U.S. Coast Guard (USCG), National Oceanic and Atmospheric Administration (NOAA), and U.S. Public Health Service (USPHS)); Department of Defense (DoD) beneficiaries; DoD civilians and contractors; Non-appropriated Fund (NAF) employees; authorized foreign military; DoD Dependents School employees; Army and Air Force Exchange Service (AAFES) employees; Secretarial Designees; and civilian emergency patients.

2.2. Third Party Collection (TPC) activities involve billing third-party payers, such as commercial health insurance carriers, on behalf of eligible DoD beneficiaries, excluding Active Duty (AD) members, for their treatment and services.

2.3. Medical Affirmative Claims (MAC) activities involve recovering the cost of furnishing health care to DoD beneficiaries, including AD members, who are injured or suffer an illness caused by a third party. MAC involves billing all areas of liability insurance, such as automobile, general casualty, homeowners and renters, medical malpractice (by civilian providers), and workers compensation (for persons other than federal employees).

3. Reimbursement. Healthcare providers document medical services based on current Military Health System (MHS) guidelines; medical coders use the documentation to assign specific codes to the services and supplies provided; billing systems assign charges to the codes and generate claims; and billing personnel verify accuracy and submit claims. Billing an encounter usually requires at least one International Classification of Diseases (ICD) diagnosis code and one Current Procedural Terminology (CPT<sup>1</sup>)/Healthcare Common Procedural Coding System (HCPCS) code.<sup>2</sup> Billable charges are recorded as line items on standard medical claim formats (e.g., Uniform Billing form (UB)-04/837I, Centers for Medicare & Medicaid Services (CMS) 1500/837P, National Council for Prescription Drug Programs (NCPDP) D.0, American Dental Association (ADA) claim forms), and MHS billing forms (e.g., Invoice and Receipt (I&R) and Department of Defense (DD) Forms 7 and 7A). Services and supplies are billed at rates according to the patient's category (PATCAT).

3.1. All three cost recovery programs use the same DHA UBO rates. The funds collected return directly to the operations and maintenance (O&M) budget of the MTF where the care was delivered and are used to improve the quality of healthcare. Often the funds allow the continuation of programs or purchasing of equipment at the facilities for which there would otherwise not be funding.

3.1.1 Outpatient Billing. Outpatient billable charges include the cost of clinic encounters and supplies, ambulatory procedure visits (APVs), emergency department (ED) visits, observation visits, dental services, and internally and externally ordered ancillary services (i.e., laboratory, radiology, and clinician administered pharmacy). These services and supplies: may be provided by MTF staff or purchased from outside the MHS; are coded with CPT<sup>2</sup>/HCPCS codes; and are billed as line-items. DHA UBO develops Outpatient Billing rates for these services and supplies.

3.1.2 Inpatient Billing. Inpatient billable charges include the costs for support staff, facility costs, ancillary services, pharmacy, and supplies. For TPC, MAC, and most MSA, the charges are based on the number of relative weighted products (RWP) associated with the Medicare Severity Diagnosis Related Group (MS-DRG) assigned to the encounter multiplied by Adjusted Standardized Amounts (ASA) rates. Due to MHS data system limitations, adjustments are made for length of stay (LOS) outliers, and the institutional charge is increased to include an allowance for professional services. Under VA-DoD resource sharing agreements, however, professional fees may be billed separately unless prohibited by local sharing agreements. ASA rates are MTF-specific and

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<sup>1</sup> CPT is a registered trademark of the American Hospital Association

<sup>2</sup> CPT is a registered trademark of the American Hospital Association

developed for full /Third Party Collections, Interagency Rate (IAR), and International Medical Education and Training (IMET) billing.

3.1.3 Pharmacy Billing. Pharmacy billable charges include the costs for pharmaceuticals provided by MTF pharmacies. For TPC, MAC, and most MSA, the charges are based on the rate of the pharmaceutical's National Drug Code (NDC), the quantity dispensed, and a dispensing fee. For VA-DoD resource sharing, there are separate NDC rate tables and pharmacy dispensing fees.

## Helpful Links

Note: These links may be accessed from this document by pressing CTRL + click (left mouse click over the link until you see the hand).

1. Armed Forces Health Longitudinal Technology Application (AHLTA): <http://www.ahlta.us/>
2. Air Force Medicine: <http://www.airforcemedicine.af.mil/>
3. Air Force E-Publishing (includes publications and forms): <http://www.e-publishing.af.mil/>
4. Army Medicine: <http://armymedicine.mil/pages/home.aspx>  
<http://armymedicine.mil/pages/home.aspx>
5. Army Publishing Directorate (includes publications and forms): <http://www.apd.army.mil/>
6. Code of Federal Regulations (CFR) (includes agency regulations):
7. <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>
8. Defense Health Agency (DHA): <https://health.mil/dha>
9. DHA ICD-10 Updates and Newsflash: <https://www.health.mil/Military-Health-Topics/Technology/Support-Areas/MHS-Specific-Coding-Guidelines/ICD-10-Activities>
10. DHA Manuals (i.e., Operations, Policy, System, and Reimbursement): <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance>
11. DHA Rates and Reimbursement: <https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement>  
DHA Uniform Business Office: <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office>  
<https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office>
12. Defense Health Services Systems (e.g., M2, MDR, CCE, TPOCS): <http://health.mil/DHSS/>
13. DoD Comptroller (includes DoD reimbursable rates): <http://www.dod.mil/comptroller/>
14. DoD Dictionary of Military Terms (Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms"): [http://www.dtic.mil/doctrine/new\\_pubs/dictionary.pdf](http://www.dtic.mil/doctrine/new_pubs/dictionary.pdf)
15. DoD Health Affairs Policies and Guidelines: <http://www.health.mil/HAPolicies.aspx>
16. DoD Issuances (i.e., Directives, Instructions, Publications, and Manuals): <http://www.dtic.mil/whs/directives/>
17. DoD Financial Management Regulations (FMR) 7000.14-R: <http://comptroller.defense.gov/fmr.aspx>
18. Defense Medical Information System [Facility] Identifier (DMIS ID) Table:

<https://www.health.mil/Military-Health-Topics/Technology/Support-Areas/Geographic-Reference-Information/DMIS-ID-Tables>

19. Embassy addresses and Web Sites: <https://www.usembassy.gov>

<https://www.usembassy.gov>

20.

Federal Register (includes agency rules, proposed rules and notices): <https://www.federalregister.gov>/Financial Management Service (FMS, U.S. Treasury) Intra-Governmental Payment and Collection System (IPAC): [https://www.fiscal.treasury.gov/fsservices/gov/acctg/ipac/ipac\\_home.htm](https://www.fiscal.treasury.gov/fsservices/gov/acctg/ipac/ipac_home.htm)

21. FMS forms and applications (i.e., IPAC, ARTIVA, OTCnet):

[http://www.fms.treas.gov/index\\_systems.html](http://www.fms.treas.gov/index_systems.html)

22. General Services Administration (GSA) Forms Library:

<http://www.gsa.gov/portal/forms/type/TOP>

23. Navy Medicine: <http://www.med.navy.mil/>

24. Navy Medicine Directives (includes directives, publications, and forms):

<http://www.med.navy.mil/directives/>

25. National Capital Region (NCR) Medical Directorate:

<http://www.capmed.mil/SitePages/Home.aspx>

26. DHA UBO User Guide - 11 - 29 August 2014 <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance> (still has Apr 2015 version) <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance> (still has Apr 2015 version)

27. Office of Management and Budget (OMB) (includes reports to Congress and President's budgets): <http://www.whitehouse.gov/omb/budget>

[http://www.whitehouse.gov/omb/legislative\\_reports](http://www.whitehouse.gov/omb/legislative_reports)

28. OTC Channel Application ("OTCNet", enables federal Agencies to integrate check capture and deposit reporting activities, consolidating management of all check and cash deposits through one web-based application.):

<http://www.fms.treas.gov/otcnet/index.html>

29. United States Code (USC) (for U.S. laws):

<http://www.gpo.gov/fdsys/browse/collectionUSCode.action?collectionCode=USCODE>

## Accounts Receivable Management

1. General. Accounts Receivable (ARs) are amounts due from the public (nonfederal) or U.S. government organizations or funds (intra-governmental). They must be recognized (i.e., established) and recorded (i.e., posted) for all health care related services and goods provided if they require payment from others. This must be done at the time the right to payment is established (i.e., when the health care is provided); however, public and intra-governmental ARs are recorded separately. Also, because of Military Health System (MHS) billing system limitations and requirements, ARs are recorded (i.e., posted) when a bill is generated, which may be months after the service was provided.

2. Authority and Guidance. The Department of Defense (DoD) Financial Management Regulation (FMR) 7000.14R directs statutory and regulatory financial management requirements, systems, and functions for all UBO activities and is available at <http://comptroller.defense.gov/fmr.aspx> . It consists of individual volumes by functional area, including:

1. GENERAL FINANCIAL MANAGEMENT INFORMATION, SYSTEMS AND REQUIREMENTS
4. ACCOUNTING POLICY AND PROCEDURES
5. DISBURSING POLICY
- 6A. REPORTING POLICY
- 6B. FORM AND CONTENT OF THE DEPARTMENT OF DEFENSE AUDITED FINANCIAL STATEMENTS
- 11A. REIMBURSABLE OPERATIONS, POLICY AND PROCEDURES
12. SPECIAL ACCOUNTS, FUNDS AND PROGRAMS
13. NONAPPROPRIATED FUNDS POLICY

DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," prescribes uniform billing procedures and accounting practices for managing and following up on patient accounts, including collecting, depositing, posting, and reconciliation. It is available at:

<https://info.health.mil/bus/brm/ubo/PolicyGuidance/UBO%20Manual%20dtd%20October%202017.pdf>

3. Types of ARs. ARs for medical services and goods include Medical Services Accounts (MSA), Third Party Collections (TPC), and Medical Affirmative Claims (MAC).
  - 3.1. MSA. MSA includes patient pay and interagency billing.
    - 3.1.1. Civilian Emergencies (CEs). MTF personnel may submit claims to third party payers on behalf of CEs, however the non-beneficiary patient is responsible for the entire claim, including all remaining balances if the payer does not pay in full. Thus, AR should be posted against the non-beneficiary patient.
      - 3.1.1.1. Refer to Service Guidelines for accurate billing guidance.
    - 3.1.2. Foreign military, including Foreign Military Sales (FMS) and International Military Education and Training (IMET). Foreign military, including FMS and IMET, claims are submitted to the individual or other government agency depending on the patient category. If no payment is received, follow your Service or National Capital Region Medical Directorate (NCR MD) specific guidance on processing the bad debt.
    - 3.1.3. Medicare. Medicare claims are submitted to the individual, or the Medicare Administrative Contractor (MAC) for the MTF Medicare Region, depending on Service or NCR MD guidance.. If no payment is received, follow your Service or NCR MD

guidance on processing the bad debt. Unpaid balances that are neither the responsibility of Medicare nor the patient will be closed in the billing system using the transaction code and sales (source) code identified in your Service or NCR MD-specific guidance. For more information on billing procedures see the “Medicare Claims” section of this User Guide.

- 3.1.4. Medicaid. Medicaid claims are submitted to the individual or the Medicaid fiscal agent or intermediary, depending on Service or NCR MD guidance. If no payment is received, follow your Service or NCR MD guidance on processing the bad debt. If the MTF chooses to participate in billing Medicaid for care provided to Medicaid patients, the MTF must have a current, signed agreement with its State Medicaid program. The agreement binds the MTF to accept the Medicaid payment as “payment in full,” with no balance billing to the patient for any amounts not covered. State Medicaid is billed at the full reimbursable rate (FRR). Unpaid balances that are neither the responsibility of the State nor the patient will be closed in the billing system using the transaction code and sales (source) code identified in your Service or NCR MD-specific guidance.
- 3.1.5. Elective cosmetic surgery. Elective cosmetic surgery procedures must be paid by the patient prior to scheduling the surgery (this includes active duty personnel). However, after the medical record is coded, additional procedures may be coded that were not indicated on the initial estimate provided to the patient. If this occurs, a bill is produced, generating an AR. The patient is billed on an Invoice and Receipt (I&R) statement; if this bill is not paid within 90 days, follow your Service or NCR MD-specific guidance for debt processing. For more information on billing procedures see the “Elective Cosmetic Surgery” section of this User Guide.
- 3.2. TPC. TPC includes billing private health care coverage payers for inpatient and outpatient care.
  - 3.2.1.1. Inpatient TPC Accounts
    - 3.2.1.1.1. TPC is on a “cash basis,” meaning the AR is not currently included in the Service and NCR MD accounting systems and is not created until receipt and posting of the funds to the system.
    - 3.2.1.1.2. As payments are received and posted, the AR is reduced. In ABACUS payments are posted to patient accounts. The TPC Inpatient AR is treated the same as the TPC Outpatient AR. If the claim is not paid in full but was paid correctly, the account is closed manually using the correct write-off code, which reduces the AR further. If the claim was not paid in full and was incorrectly discounted, follow Service or NCR MD guidance.
  - 3.2.1.2. Outpatient TPC Accounts

- 3.2.1.2.1. Outpatient claims may contain numerous line item charges for services rendered. Posting and follow-up may require accounting for and reconciliation of multiple service line item charges.
- 3.2.1.2.2. Posting payments, adjustments, and write-offs are itemized. If the claim is not paid in full but was paid correctly, the account is closed manually using the correct write-off code, which reduces the AR further. If the claim was not paid in full and was incorrectly discounted, follow Service or NCR MD guidance.

MAC. MAC includes billing tort liability or contractually based insurance. Coordinate claims with the MTF's Military Department–designated Recovery Judge Advocate (RJA) per the DHA-PM 6015.01.

4. Outstanding Accounts. Any account outstanding past 30 days must be followed up in accordance with procedures prescribed in the DHA-PM 6015.01-.
5. Delinquent Accounts. TPC accounts outstanding beyond 180 days and MSA accounts outstanding beyond 90 days are considered delinquent. Refer to the DHA-PM 6015.01, and Service or NCR MD guidance for additional instructions.
6. Depositing Collections. All TPC and most Non-Intra-governmental MSA collections for health care services are deposited in the year of receipt. Intra-governmental MSA collections, however, are deposited in the year services are rendered whether rendered in the current year or a prior year in order to liquidate the intra-governmental receivable established when the services were rendered. Collections for all Defense Health Program (DHP)-funded activities must be in compliance with Assistant Secretary of Defense for Health Affairs (ASD-HA) Memorandum, "Defense Health Program Accounts Receivable Policy," dated May 2, 2008.

### **Ambulatory Data Module (ADM)**

1. General. The ADM is the data collection module in the Composite Health Care System (CHCS) for both inpatient and outpatient professional services. Data entered by providers and collected in the AHLTA and the CHCS electronic documentation module for some outpatient encounters flow to ADM. Data may also be entered directly by MTF personnel in the ADM for specialties not in AHLTA.
2. Visit and Encounter Data Elements. Visit data elements that are collected and flow to ADM include schedules, appointments "kept", and telephone consultations, "cancelled". Encounter data elements that are collected and flow to ADM include: International Classification of Diseases (ICD), Current Procedural Terminology (CPT®), and Healthcare Common Procedure Coding System (HCPCS) coding, modifiers and units of service, Health Insurance Portability and Accountability Act (HIPAA) standard data elements (e.g., cause of injury, geographic location, pregnancy related and associated elements), HIPAA provider taxonomy, secondary providers, and encounter disposition types (inpatient or ambulatory).



3. Inpatient Professional Services. On admission, transfer to another service, and the census hour (i.e., 0015 each morning), an open/un- coded encounter will be generated in the ADM module.
  - 3.1. Ideally, inpatient professional encounters should be coded daily during the patient admission but not later than thirty (30) days from the date of discharge. Inpatient professional services provided to Department of Veterans Affairs (VA) beneficiaries under DoD - VA sharing agreements are billable apart from the inpatient institutional (Medicare Severity Diagnosis Related Group (MS - DRG)) charge.
  - 3.2. On transition to the Cerner Patient Accounting Module (CPAM), inpatient professional services will be billable separately from the inpatient institutional services for all billable patients. And, pending approval of changes to the Code of Federal Regulations, the MS - DRG charge for institutional services will be replaced an itemized bill based on resources used to treat the patient.
4. Data Flows. Selected CHCS ADM data flows to the Coding Compliance Editor (CCE), where it is reviewed, updated, and approved. CCE data flows back to CHCS, which feeds it to other systems including the MHS Data Repository (MDR) and the Armed Forces Billing and Collection Utilization Solution (ABACUS) legacy systems/solutions. Note not every data element or even every encounter record available in CHCS is provided to the other systems/solutions. Billing personnel may identify additional billing opportunities by going directly to ADM data and identifying encounters that do not automatically flow to the billing applications (e.g., Dental Care, Electrocardiography, Electroencephalography, Electroneuromyography, Pulmonary Function, Cardiac Catheterization, Anesthesiology, Hemodialysis, Peritoneal Dialysis, Inhalation/Respiratory Therapy, Nuclear Medicine, Area Reference Laboratories, Immunizations, Patient Transportation, Aeromedical Staging Facilities (Asf))
5. Coding Corrections. Although coding corrections are normally made in CCE, coders may correct coding in the ADM. To correct coding in AHLTA, the provider must amend the encounter in AHLTA. To correct or update coding data in MHS GENESIS the provider or the coder must use available tools in MHS GENESIS. CCE does not "write back" to MHS GENESIS.

## **Aeromedical Evacuation**

1. General. DHA UBO rates for aeromedical evacuation services represent the cost of providing medical care during aeromedical transport. The transportation charges of a patient per trip via air in-flight or ambulatory medical care. Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient per trip during a 24-hour period.
2. Appropriate charges are billed only by the Global Patient Movement Requirements Center (GPMRC). These charges are only for the cost of providing medical care, a separate charge for transportation may be generated by GPMRC.

For more information, see the annual DHA UBO Outpatient Medical Dental and cosmetic

Procedure Reimbursement Rates letter at:

<https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview>

## Allergy Testing

1. Allergen immunotherapy is the administration of allergenic extracts at periodic intervals, so individuals can be exposed to allergens while avoiding adverse reactions. It is a billable service when performed by a privileged provider. When performed by a technician, allergy testing is not currently billable due to the issues associated with technician coding accuracy.
2. CPT<sup>3</sup> codes for allergen immunotherapy include the professional services. There may be an Evaluation and Management (E/M) code for the first encounter as the allergist is obtaining the history and examination necessary to determine how to proceed. Except for the first encounter, the services are usually just the procedure and there is no separately identifiable E/M.

Allergy testing is not an ambulatory procedure visit. Patients should remain in the area for at least 20 minutes in case there is an allergic reaction, but this is not a “medically supervised recovery.”

3. **Billing Form:** The allergy testing as well as the antigen dispensing appears on the CMS 1500.

## Ambulance Services

1. Ambulance services are not part of the patient visit and will not be captured or coded on the same encounter as the emergency department (ED) visit or office visit.
2. Ambulance services provided to a patient for transportation to another facility for a service and returned to the hospital are not billed separately. This transport is part of the inpatient institutional encounter.
3. Identifying Billable Ambulance Services. The Billing Office can either check for coded encounters in MEPRS FEA or arrange to receive photocopies of ambulance transport sheets from the emergency department.
  1. Billing for ambulance transport is applicable to both emergency and non-emergency transports. MTF staff must determine whether the ambulance service is billable under the Third Party Collections Program (TPCP), Medical Services Accounts (MSA), or Medical Affirmative Claims (MAC).
  2. When an ambulance service is determined to be billable, request that a coder determine and document (on the run sheet) the appropriate ICD-10-CM diagnosis code, Current Procedural Terminology CPT code, and modifiers to use for billing.
4. Generating the Bill. Ambulance service bills must be created manually.

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4.1. Only the following Ambulance HCPCS codes; A0426, A0427, A0428, A0429 and A0999 have a DoD Rate assigned; however, claims with A0999 may be denied. On paper claims, manually change HCPCS code A0999 to the appropriate Ambulance HCPCS code documented on the run sheet by the coding department .

4.2 The biller can select the appropriate modifier to identify location of onload and offload if the coder did not document it on the run sheet. The most common combination is SH.Diagnostic or therapeutic site other than 'P' or 'H' when these codes are used as origin codes:

- E Residential, domiciliary, custodial facility
- G Hospital-based dialysis facility (hospital or hospital-related)
- H Hospital
- I Site of transfer (e.g., airport or helicopter pad) between types of ambulance
- J Non-hospital-based dialysis facility
- N Skilled nursing facility (SNF)
- P Physician's office (includes HMO non-hospital facility, clinic, etc)
- R Residence
- S Scene of accident or acute event
- X (Destination code only) intermediate stop at physician's office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

4.3. MHS Ambulance Billing Units. Currently, MHS ambulance charges are based on hours of service in 15-minute increments. The hourly charge for Ambulance Services is all-inclusive. Supplies and mileage are not billed separately. Billing Offices will calculate the charges based on the number of hours, fractions of an hour, that the ambulance is logged out on a patient run. Fractions of an hour are rounded up to the next 15-minute increment (e.g., 31 minutes are charged as 45 minutes). Refer to the Medical and Dental Services Rate Package for appropriate hourly charge rates. This rate package can be found on both the DHA UBO Website (<https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates>) and the Comptroller Website. Use ABACUS to create manual ambulance invoice.

4.4. Revenue Code. Ambulance Services code A0999 is mapped to revenue code 540 on the revenue mapping table.

4.5. Occurrence Code. If this transport is related to an injury/accident, use the appropriate occurrence code on the UB-04/837I. Occurrence codes can be found in the Uniform Business Editor or in appendix B-1 of this document.

5. Purchased Services. When a facility purchases ambulance services from a non-DoD source, the cost of the purchased services can be billed instead of the DoD rate. Obtain this information from the local Resource Management Division. Billing for the actual cost of purchased services requires either creating a "Passthrough" account in MSA or a bill created manually. If the

services are purchased or contracted on a flat fee per month/year instead of per run, use the DoD rate.

6. Ambulance Responds but No Transport. When an ambulance is dispatched to an incident, but no patient is transported, there is no appropriate coding or billing for this service.

### **Ancillary Services**

1. General. Ancillary services include laboratory and radiology services and pharmaceuticals dispensed to the patient. The diagnosis for laboratory or radiology services is required on all claims and is situational (i.e., the payer may or may not require it) for pharmacy claims. However, ancillary services will often flow to ABACUS without diagnosis codes. In those cases, do not bill until the appropriate diagnosis is matched to the service or pharmaceutical. To make this match, billing personnel will need to link the ancillary encounter with the encounter that generated it by reviewing the clinical encounter documentation or consulting with coding personnel for the diagnosis code(s) needed for billing, as explained below.
2. Hold Periods. When ancillary services are ordered within the MTF, a hold period on billing the ancillary services should allow the clinical encounter to catch up with the ancillary services thereby providing the required diagnosis. The hold also:
  1. allows finalization of associated services.
  2. reduces the number of claims produced. The linking of ancillary services with the clinical encounter may be accomplished with automated solution support, by manual review, or by a combination of both. Regardless of the specific method employed, the hold period lets the biller determine diagnosis data that may not have been present on the original encounter record.
- 2.1. Hold periods are set by the Services and the National Capital Region (NCR) Medical Directorate (MD) UBO Program Managers, and they are normally in the range of two weeks in addition to billing system or solution hold periods. In CHCS for example, a three-day hold period is standard for all eligible Ambulatory Data Module (ADM), Laboratory (LAB), Radiology (RAD), and Pharmacy (PHR) records. At the end of system or solution and the additional hold periods described below, encounters are transmitted to ABACUS.
  - 2.1.1. Usually an additional 7-day hold period is imposed for laboratory and radiology services, and, in the case of Medical Services Accounts (MSA), an additional 14-day hold period is imposed to allow finalization of associated services and to allow appending and excluding charges.
  - 2.1.2. An additional 14-day hold period is imposed on pharmacy services to give patients time to pick up their medications. The date of service for pharmacy services is the date the label was printed; however, the transaction cannot be closed until the medication is picked up. If pharmacy services have a corresponding clinical encounter, all pharmacy services will default to a pharmacy bill type (e.g., National Council for Prescription Drug Programs (NCPDP)) and

should be consistent with the associated diagnosis coding of the clinical encounter. If the medication is not picked up within 14 calendar days, the MTF pharmacy should re-stock the supply and send a Cancel Transaction to ABACUS.

- 2.2. Regardless of the length of the hold period, the hold period is an opportunity for billing personnel to conduct the following activities.
  - 2.2.1. DD Form 2569. During the hold period, if other health insurance (OHI) is identified at an encounter, billing personnel should verify and enter the DD Form 2569 data to have the encounter automatically flow to ABACUS.
  - 2.2.2. Pre-certifications/Pre-authorizations. During the hold period, billing personnel should work with radiology, pharmacy, and the operating room personnel to obtain pre-certifications and pre-authorizations. If billing personnel can receive a list of all patients receiving magnetic resonance images (MRIs) and computed tomography (CT) x-rays, high-cost pharmaceuticals, and ambulatory procedure visits (APVs), the lists can be checked to identify patients with OHI. Pre-certifications can then be obtained prior to billing.
  - 2.2.3. Staging Bill Errors (*see Staging Bill Errors section*). Billing personnel should use this opportunity to work their Staging Bill Errors. Staging Bill Errors is a que within ABACUS for billing personnel to correct errors prior to claim creation. Identifying and correcting claims that errored out due to unverified pre-authorization/pre-certification will ensure associated claims are corrected before flowing into ABACUS.
3. Linking Encounter Records. Care must be taken to ensure the correct diagnosis is linked from the clinical encounter to the ancillary service when the ancillary service encounter does not provide the diagnosis. Sometimes the first listed diagnosis is not the diagnosis that corresponds to the ancillary service. Attention to appropriate diagnosis code links is required to ensure that a potentially invalid claim is corrected before it is submitted.
  - 3.1. Although ABACUS may assist with linking encounter records, if an ancillary service cannot be linked, the diagnosis code needs further research. In those cases, if a diagnosis code is required by a payer for reimbursement of ancillary services, manual review of the encounter record is required to input the corresponding diagnosis.
  - 3.2. Do not enter a diagnosis that is not in the record. In the case of external prescriptions or referrals for ancillary services, contact the prescribing or referring provider and obtain the diagnosis.

### **Anesthesia Provider Services**

1. See the APV Section of this Guide for billing anesthesia services in the 0XXXXX range associated with an APV. The codes in the 0XXXXX range include the initial anesthesia consult prior to the surgical procedure, the anesthesia provided during the surgical procedure, and anesthesia care provided post operatively until care for the patient is transferred to the nurse in the post anesthesia care unit. Separately codable procedures not in the 0XXXXX range performed during an APV may be billed on a separate CMS 1500 from the surgeon.

- 1.1 For anesthesia services in non-MTFs (e.g., external resource sharing), the anesthesia will be billed on a CMS 1500/837P at the anesthesia rate.
  - 1.2 Services provided by anesthesia personnel that are not in the 0xxxx range should be billed on a separate CMS 1500/837P. For instance, when anesthesia personnel are providing outpatient pain management services, the services would be coded under the anesthesia provider's name in the "B" MEPRS.
2. Inpatient Anesthesia Services. Inpatient anesthesia services are part of the Adjusted Standardized Amount and not be billed separately. Inpatient post-operative pain management is part of the surgeon's responsibility and would not be furnished by anesthesia personnel unless there was a written request in the inpatient record.
3. 3.1 For inpatient anesthesia services in non-MTFs (e.g., if the MHS furnishes anesthesia professional services at a civilian hospital under an external resource sharing agreement and the MTF is not submitting and institutional DRG bill), the anesthesia services may be billed separately as professional charges. The surgeon's and anesthesia provider's services would be itemized on the CMS 1500/837P indicating "Inpatient Professional Service" billed at the anesthesia rate.

### **Antepartum Services**

1. General. Antepartum and postpartum professional services are not included in MHS inpatient obstetrical (OB) services diagnosis related groups (DRGs). The MHS uses Current Procedural Terminology (CPT<sup>4</sup>) Category II OB codes 0500F, 0502F, and 0503F for antepartum and postpartum professional services, however, these codes do not have rates and cannot be billed. CPT global maternity care codes 59400, 59410, 59425, 59426, 59510, 59515, 59610, 59614, 59618, 59622 also represent antepartum and postpartum services. If they are coded and have rates, then bill for these codes.

### **Ambulatory Procedure Visits (APV)**

1. General. An ambulatory procedure visit (APV) is a procedure or surgical intervention that requires pre- procedure care, an actual procedure to be performed, and immediate post-procedure care as directed by a qualified health care provider. Minor procedures that are performed in an outpatient clinic setting that do not require post-procedure care by a medical professional are not considered APVs. The nature of the procedure and the medical status of the patient combine as a short-term care requirement, but not for inpatient care. These procedures are appropriate for all types of patients (e.g., obstetrical, surgical, and non-surgical) who, by virtue of the procedure or anesthesia, require post-procedure care and/or monitoring by medical personnel. (Within this user guide, "provider" refers to a "physician or other qualified health care professional.")

- 1.1. Pre- and post-operative appointments are documented in the Ambulatory Data Module (ADM) of the Composite Health Care System (CHCS) as separate encounters.

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1.2. If the APV is scheduled in advance, the encounter during which the decision for the procedure is made, the pre-operative physical, and the procedure will be coded and billed as separate encounters.

1.3. If the procedure is emergent (e.g., dislocation of the shoulder), the encounter during which the decision for procedure is made may be the same day as the procedure. It is coded with a modifier -57 and it is also billed separately from the procedure.

1.4. Post-operative care after discharge is also coded separately as Current Procedural Terminology (CPT<sup>5</sup>) code 99024. There is no rate for this code.

2. Components. Typically, two major components of the APV are collected in the same ADM record: professional and institutional. The professional component may be submitted as a single claim or broken into separate ones on a Centers for Medicare & Medicaid Services (CMS) 1500 paper or 837P electronic claim. The institutional component is coded with CPT® code 99199 and is submitted on a Uniform Bill (UB)-04 paper or 837I electronic claim. Depending on the payer, claims may be paid if submitted as they are created by the billing system. Some payers will not permit the surgical procedure and the anesthesia to be on the same claim. In that case, cancel the original CMS 1500/837P claim where they were combined and generate two separate ones.

2.1. Professional Component. The professional component of an APV includes professional charges covering the pre-operative examination of the patient, the actual procedure(s) performed, and follow-up for the procedure. Identify all providers (e.g., anesthesiologist) for each procedure.

2.2. Institutional Component. The institutional component of an APV includes charges for the use of Military Health System (MHS) facilities, supplies, nursing and ancillary services, and anesthesia pharmaceuticals until the patient is discharged. In the MHS, per DoD Health Affairs Policy, "Use of CPT® Code 99199" (dated 14 Sept 2004), the institutional component of the APV is coded with CPT code 99199; submit this on a UB-04/837I claim.

3. Admission from an Ambulatory Patient Unit (APU). If an APV encounter leads directly to an inpatient admission, do not bill APV institutional or professional charges for Third Party Collections (TPC), Medical Affirmative Claims (MAC), and most Medical Services Accounts (MSA) encounters because those charges are included in the inpatient charge.

3.1 Exception: For Department of Veterans Affairs (VA)-DoD resource sharing agreement care, bill the professional charges for APVs unless prohibited by your local sharing agreement. (See the *VA-DoD Resource Sharing Billing* section of this User

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Guide for the menu path to identify professional charges.)

3.2 Exception: If the patient is admitted following the APV with a diagnosis unrelated to the APV pre-operative diagnosis, bill the APV and the inpatient admission separately.

4. Discontinued Procedures. Do not generate claims with modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) or modifier -74 (Discontinued Outpatient [Procedure] After Anesthesia Administration) as these are institutional modifiers, and the 99199 is a flat rate code. If there was a procedure, the entire 99199 fee will be charged.

5. Multiple Primary Providers. Modifier -62 added to a CPT code refers to two providers who worked as primary together performing distinct part(s) of a procedure. Modifier -66 refers to a surgical team of more than two providers. Billing personnel may create separate claims for each provider.

6. Assistant Providers. Modifier -80 identifies an assistant provider's services; modifier -81 identifies services of minimum assistant providers. Billing personnel may create separate claims for procedures coded with either of these modifiers.

7. Revenue Codes Applicable to APVs. Refer to the Defense Health Agency (DHA) UBO revenue mapping table available at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview> for revenue codes applicable to APVs.

### **Billing Combined Medically Necessary/Cosmetic Procedure When a Portion of the Procedure is Covered by Insurance**

1. The total procedure will be composed of:
  - 1.1. Medically necessary professional component
  - 1.2. Cosmetic professional component
  - 1.3. Institutional and anesthesia (I&A) components

NOTE: The patient is totally responsible for the I&A, but the insurer may pay some of the I&A as part of the medically necessary procedure. There are two different types of funds involved, third party and MSA.
2. The MHS is moving from flat rate institutional and anesthesia (I&A) billing for ambulatory procedure visits (APVs) to fee-for-service for institutional and anesthesia for APVs. MHS current cosmetic procedure billing is similar to fee-for-service. The current Third-Party Collections is a flat rate for institutional and anesthesia.
3. Professional Components. The medically necessary professional component will be paid by the insurance company. The cosmetic professional component will be paid by the patient.
4. Institutional and Anesthesia (I&A) Components. Both entities are responsible for the I&A components, but the MTF needs to recover the I&A costs just once. The patient is ultimately responsible for the entire cost of the cosmetic procedure (e.g., professional, institutional,



anesthesia, implants).

5. Steps to Determine the Institutional and Anesthesia (I&A) Amounts Due from the Insurance Company and the Patient.

5.1. Calculate the I&A cost for both the medically necessary procedure covered by the insurance company and the cosmetic procedure.

5.1.1. Example: A patient is having a bilateral blepharoplasty, upper eyelid; with excessive skin (CPT<sup>6</sup> code 15823), which is covered by insurance as it is medically necessary. During the same APV, the patient will also have a cosmetic bilateral blepharoplasty, lower eyelid, with excessive skin (CPT code 15821). It will be performed in a bedded MTF in the operating room with general anesthesia. NOTE: Be sure to obtain a pre-authorization for the medically necessary procedure from the insurance company.

5.1.1.1. The I&A components for the medically necessary (insurance pays) procedure in a bedded MTF operating room will be:

Institutional (MHS CPT 99199) flat rate = \$819.18 Anesthesia MHS flat rate = \$749.00 Insurance I&A Total = \$1,568.18

5.1.1.2. The I&A components for the cosmetic (patient pays) procedure, in a bedded MTF operating room, will be:

CPT 15821 Institutional in bedded OR = \$875.01 CPT 15821 Anesthesia = \$236.99 Patient I&A Total = \$1,112.00.

5.2. The institutional/anesthesia “MTF I&A Amount to be Collected” will be the higher of the two amounts.

5.2.1. Example: In the above example, the medically necessary procedure has the higher I&A total cost so that will be the MTF I&A amount to be collected.

MTF I&A AMOUNT TO BE COLLECTED: \$1,568.18.

5.3. The patient must pay for the total cosmetic procedure in advance. Therefore, the patient will pay the professional, I&A and implant fees of the cosmetic procedure in advance.

5.3.1. Example: CPT 15821 Professional fee (first eye \$449.73 + bilateral \$224.87) = \$674.60 CPT 15821 I&A (CPT 15821 Institutional + CPT 15821 Anesthesia) in bedded operating room = \$875.01+ \$236.99 = \$1,112.00 CPT 15821 Implants = \$0 Patient Will Pay Total in Advance: \$1,786.60

5.4. Insurance will be billed:

5.4.1. Example: CPT 15823 Professional fee (first eye \$529.37 + bilateral \$264.69) = \$794.06 on the CMS 1500 Institutional (MHS CPT 99199) flat rate = \$819.18 on the UB-04 Anesthesia flat rate= \$749.00 on the CMS 1500 Bills to insurance company will total: \$2,362.24

5.5. The remittance will be received from the insurance company. The professional fee for the surgeon will be posted. The remittance from the institutional and anesthesia (I&A) portions will be added together. Subtract the institutional and anesthesia portions from the MTF I&A Amount to be Collected determined in step 5.2.1.

5.5.5. Example: Because the patient needed to satisfy the annual deductible of \$500, the insurance company remitted \$768.18 for the institutional component and \$300 for the anesthesia component, for a total of \$1,068.18. The MTF Amount to be Collected is \$1,568.18 from step 5.2.1. The insurance company reimbursement is less than the MTF I&A Amount to be Collected by \$500. NOTE: (Insurance institutional and anesthesia remittance + patient institutional and anesthesia payment) – MTF I&A Amount to be Collected = amount due back to patient.

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5.6. Determine if the I&A component paid by the patient for the cosmetic procedure is more than or less than the amount necessary to meet the MTF I&A Amount to be Collected.

5.6.1 When the total of the amounts received for I&A (from both insurance company and patient) exceed the MTF I&A Amount to be Collected, the patient will be refunded the overage.

5.6.1.1. Example: For the institutional and anesthesia, the patient had paid \$1,112.00. As the MTF only needs \$500 to meet the MTF I&A Amount to be Collected of \$1,568.18, the MTF will refund the patient \$612.00.

5.6.2. If the I&A payments combined are less than is necessary to meet the MTF I&A Amount to be Collected there will be no refund to the patient.

5.6.2.1. Example: The I&A payments exceed the MTF I&A Amount to be Collected, so this step does not apply.

## 6. ABACUS Instructions.

6.1. Generate the patient's bill using the amounts calculated by the Cosmetic Surgery Estimator tool.

6.1.1. Enter the amounts into the appropriate MSA Line of Business (LOB).

6.1.2. Collect the total amount from the patient.

6.2. ABACUS will generate a bill for the insurance company. Send the bill. Post the funds received.

6.3. If the total I&A received (from insurer and patient combined) exceeds the MTF I&A Amount to be Collected,

6.3.1. Go in to the MSA account for the surgery.

6.3.2. Generate a One-Time Charge for the new institutional amount (\$263.01, see below calculations).

6.3.3. Back out the original amount for the institutional (\$875.01).

6.3.4. This should create a credit balance (\$612.00). When you get the credit balance you will be given a notify message that a refund is due on the account. And you can produce the SF 1049 Public Voucher for Refund.

6.3.5. Refund the amount to the patient.

## 7. Calculations for updating the original MSA Bill.

7.1. MTF I&A Amount to be Collected = \$1,568.18

7.2. Insurance company I&A remitted \$1,068.18 (\$768.18 for the institutional and \$300 for the anesthesia)

7.3. The patient originally I&A paid \$1,112.00 (\$875.01 for the institutional and \$236.99 for the anesthesia)

7.4. New I&A amount owed by patient  $(\$1,568.18 - \$1,068.18) = \$500.00$

7.5. Excess Remittance  $(\$1,068.18 + \$1,112.00) - \$1,568.18 = \$612.00$

7.6. New I&A amount owed by patient to be entered into the account  $\$875.01 - \$612.00 = \$263.01$  for the institutional.

## Billing Inpatient

1. General. Inpatient bills are submitted on Uniform Bill 04 (UB-04) paper or the 837I electronic claim formats based on the Medicare Severity Diagnosis Related Group (MS-DRG) assigned to the episode of care. Each MS-DRG assignment translates to a number of relative weighted products (RWPs)—a common measure of inpatient workload. The number of RWPs associated with an episode of care may be adjusted upward based on the length of stay (LOS) when the LOS exceeds the long LOS outlier criteria for the MS-

DRG. MS-DRGs, associated RWPs, and LOS outlier criteria are established by TRICARE. The inpatient charge is computed by multiplying the total episode RWPs (base MS-DRG RWPs plus LOS adjustment, if any, by the appropriate Military Treatment Facility (MTF)-adjusted standardized amount (ASA)). The ASA is the MTF's approved charge per RWP.

- 1.1. The individual ASAs, including examples of how to calculate the reimbursement charge, are updated each fiscal year (FY) and published in the annual rates letters on the Defense Health Agency (DHA) UBO website (<https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview>).
  - 1.2. MS-DRG weight tables are updated in Military Health System (MHS) systems each fiscal year; hold inpatient billing beginning 1 October until the new weight tables are updated.
  - 1.3. Do not bill an inpatient service if there is no rate.
2. Third Party Collections (TPC), Medical Affirmative Claims (MAC), and most Medical Services Accounts (MSA). Charges are computed based on MTF-specific ASAs (e.g., the MTF's cost structure, including indirect medical education (IME) costs). ASAs include the cost of both inpatient institutional (93%) and professional (7%) services and apply to reimbursement from TPC, MAC, MSA, International Military Education and Training (IMET), and Interagency Rate (IAR) payers. Since the professional services reimbursement is bundled into the MS-DRG institutional claim, do not charge separately for professional services.
- 2.1. MTFs without inpatient services, but whose providers deliver inpatient care in a civilian facility, bill professional charges at the approved DHA UBO Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) rates for their locality.
  - 2.2. In the absence of an MTF-applied ASA rate for the facility, use the high, low, or overseas ASA rate based on the average for the type of core-based statistical areas (CBSA) in which the MTF is located. Contact the [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) to determine the applicable CBSA.
  - 2.3. For inpatient services provided under Department of Veterans Affairs (VA)-DoD resource sharing agreements, the MS-DRG payment is based on the TRICARE ASA—the level of reimbursement TRICARE will allow—rather than the DHA MTF cost-based ASA. (See the VA-DoD Billing section of this User Guide for instructions on billing Resource Sharing Agreement care.)
  - 2.4. For inpatient services provided to U.S. Coast Guard (USCG) beneficiaries at Army, Navy, and National Capital Region (NCR) Medical Directorate facilities, the USCG makes prospective payments to the DoD. Do not bill USCG for these

beneficiaries. These payments do not include reimbursement for other health insurance (OHI); bill payers if beneficiaries carry OHI. (See the USCG Billing section of this

5. User Guide for USCG billing instructions and for billing inpatient services provided at Air Force facilities).
3. Inpatient admissions from Emergency Department (ED). Do not bill the institutional charges incurred in the ED when the patient is admitted from the ED. For TPC, MAC, and most MSA patients, do not bill the professional charge because the inpatient institutional charge includes an allowance (7%) for professional services.
  - 3.1. For services provided under VA-DoD resource sharing agreements, bill professional services separately unless otherwise agreed to in local agreements. (See the VA-DoD Billing section of this User Guide for instructions on billing Resource Sharing Agreement care.)
  - 3.2. As with other inpatient and outpatient services, Army, Navy, and NCR Medical Directorate MTFs do not bill the USCG for ED services. (See the USCG Billing section of this User Guide for USCG billing instructions.)
4. Family Member Rate (FMR). In addition to billing inpatient charges as explained in this section, bill all DoD beneficiaries the FMR except: (a) family members of Active Duty personnel enrolled in TRICARE Prime, and (b) members whose OHI has been billed. The FMR is updated each fiscal year and is published in the ASA rates letter.

### **Billing Outpatient**

1. General. Services that are not related to a hospital admission are billed as outpatient services.
2. Outpatient Billing Rates. DHA UBO rates are generally developed on the modified calendar year 1 July to 30 June, are specific to an MTF's locality and the Provider Class, and are published in the annual rates letter on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview> . (See the *Rates Table* section of this User Guide for which outpatient rates tables to use.)
3. Outpatient Charges. To compute total charges, use the outpatient rates effective on the date of service assigned to the Current Procedural Terminology (CPT®1)/Healthcare Common Procedure Coding System (HCPCS) code. If the code includes modifiers, see the *Modifiers* section of this User Guide for additional billing guidance.
4. Non-Billable Services. For Third Party Collections (TPC), Medical Affirmative Claims (MAC), and most Medical Services Account (MSA) patients, do not bill services within the emergency department (ED) prior to an admission or outpatient services within three (3)

days prior to an admission if the diagnoses are the same in both cases. These services are considered “incident to” the admission, and the inpatient charge covers these services—both institutional and professional.

5. Department of Veterans Affairs (VA)-DoD Resource Sharing Agreements. Under VA-DoD Resource Sharing Agreement care, the institutional component of the ED visit is not billable if the patient is admitted. VA-DoD local resource sharing agreements may allow billing for professional charges, including those connected to an admission. (Refer to your local VA-DoD Resource Sharing Agreement(s)).
6. Billing for Services and Supplies Not in Standard Rate Files. Normally, an outpatient service cannot be billed if the Defense Health Agency (DHA) UBO has not established a rate for the item or service. However, under certain circumstances, if there is a TRICARE or Centers for Medicare & Medicaid Services (CMS) rate, the DHA UBO will review an out-of-cycle request. Follow the *Procedure To Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate* in Appendix A for submitting a request.

### **Case Management Services**

1. General. Case management services are coded with Current Procedural Terminology (CPT®) codes G9002–G9011, T1016, and T1017. Pursuant to Military Health System (MHS) policy, these codes are not billable. Thus, the Defense Health Agency (DHA) UBO does not establish rates for these codes.

### **Coding Compliance Editor**

1. General. The Coding Compliance Editor (CCE) system supports the Military Health System (MHS) with clinical decision logic and integrated references to enable consistent, accurate, and complete coding, in addition to editing and grouping software. All of this reduces errors in the revenue cycle. CCE is deployed at most MTFs and interfaces with Composite Health Care System (CHCS) (or future clinical systems) to receive patient encounter records, and it enhances coders’ ability to properly code services rendered. These records are returned to CHCS, which provides them to the billing systems and solutions. Procedures captured in the radiology and laboratory modules do not interface with CCE.

### **Chemotherapy Services**

1. General. Chemotherapy, hydration, infusion, and injection services are represented by Current Procedural Terminology (CPT®) codes 96360 through 96549. These services are performed by the nursing staff under the direct supervision of a physician and are billed on the Uniform Bill (UB)-04/837I facility claim format. Use revenue code 636 to report

Healthcare Common Procedural Coding System (HCPCS) J codes for drugs administered during chemotherapy for outpatient services.

2. Encounters. The encounters are collected in the Ambulatory Data Module (ADM) in the D\*\*\* MEPRS (Medical Expense and Performance Reporting System). As the D\*\*\* MEPRS currently do not flow automatically to ABACUS, these bills will need to be generated manually by finding these chemotherapy codes in ADM. Future systems may receive chemotherapy services recorded under D\*\*\* MEPRS accounts as well as have the ability to generate electronic transactions.
3. Charges. Charges for anesthesia, IV starts, subcutaneous catheters, flushing, and supplies are inherent in CPT codes for chemotherapy and should not be billed separately.

### **Civilian Emergency Billing**

1. General. A civilian emergency (CE) patient is generally defined as an individual who is not a beneficiary of the Military Healthcare System (MHS), and not otherwise entitled to care at an MTF, but who presents to the MTF for emergency treatment or for acute care. The CE patient should be treated only during the period of emergency and should be discharged or transferred to a civilian facility as soon as the emergency period ends. The CE patient has no entitlement to MTF care and is entirely responsible financially for the cost of any care provided. This includes ambulance services, ancillary services (i.e., radiology, pathology, pharmacy), and all medical care provided.
2. The Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA is the federal law that gives all individuals the right to be treated for an emergency medical condition regardless of their ability to pay and if the MTF is a Medicare participating provider. EMTALA does not preclude the MTF from billing the patient or OHI.
3. Other Health Insurance (OHI) Collection. The Emergency Room (ER) or admitting personnel should ensure the CE patient completes and signs a DD (Department of Defense) Form 2569, "Third Party Collection Program/Medical Services Account/Other Health Insurance," for billing information and also as authorization to release medical records in support of reimbursement. Intake personnel should also obtain copies of the patient's insurance cards, driver's license, and employment information to provide to the billing office.
4. Direct Patient Claims. MTFs may bill the patient directly at the appropriate full outpatient reimbursement rate (FOR) based on Military Department or National Capital Region (NCR) Medical Directorate (MD) guidance. Patient Category (PATCAT) K92 A, civilian emergency, should be assigned.
  - 4.1. Options. The MTF is not required to file a claim directly with the civilian patient's healthcare coverage payer but may do so as a courtesy to the patient at his/her request. However, the non-beneficiary patient is responsible for following up with his/her healthcare coverage payer to ensure timely payment. The patient is ultimately responsible for all charges incurred during the course of treatment at the MTF.
  - 4.2. Courtesy Claims. Billing offices may submit courtesy claims on behalf of CE

patients to healthcare coverage payers. Note the Composite Health Care System (CHCS) and the Defense Enrollment Eligibility Reporting System (DEERS) do not accept coverage policy information for non-beneficiaries. A further complication is that CHCS and DEERS also lack the ability to add carriers other than commercial payers (e.g., Medicare, Medicaid, VHA). However, coverage and payer information can be input into ABACUS. In addition, a manual claim can be created within ABACUS in the Billing Management Module.

4.3. Courtesy Claims Procedures. If the MTF files an insurance claims as a courtesy on the civilian patient's behalf, the following steps should be completed

4.3.1. Send a follow-up letter after 30 calendar days from the date the I&R was generated.

4.3.2. Advise the patient that he or she is personally liable for any amounts not paid by the third-party payer within 60 calendar days of the due date on the payer's I&R.

4.3.3. Transfer the account to the patient, upon completion of due process if no payment is received from the third-party payer. If payment is received from the third party payer after transfer, contact the appropriate office in accordance with Military Department or DHA-specific guidance to discuss reimbursement options.

### **Claim Formats**

1. General. Multiple claim formats are used in DoD billing; more than one may be generated for an encounter depending on services provided, payer requirements, and Service and National Capital Region Medical Directorate (NCR MD)–specific guidelines. Claim formats used in the Military Health System (MHS) include:

- 837I/Uniform Bill (UB)-04 (current version), institutional services claims

- 837P/Centers for Medicare & Medicaid Services (CMS) 1500 (current version), professional services claims

- Invoice and Receipt (I&R), claim for pay patients

- DD Form 7, Report of Treatment Furnished Pay Patients – Hospitalization Furnished (Part A)

- DD Form 7A, Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished (Part

B) National Council for Prescription Drug Programs (NCPDP) (current version), pharmaceutical claims

2. Third-Party Collection. The Armed Forces Billing and Collections Utilization Solution (ABACUS), is used for outpatient billing and is capable of generating institutional, professional, and pharmacy claims in electronic or paper format. ABACUS generates claims

in all industry standard formats (except dental). MTF dental services are restricted to active duty members.

3. Medical Services Account (MSA). ABACUS is used for inpatient and outpatient billing. It generates a DD Form 7 or 7A and Invoice and Receipt (I&R) claims. Until each MTF transitions to ABACUS, the new billing solution, billing offices need to create manual claims to submit to MSA payers that require industry-standard claims (e.g., Medicare, Department of Veterans Affairs (VA)). ABACUS generates claims in all industry-standard formats (except dental).
4. Medical Affirmative Claims (MAC). MAC does not have a system to generate claims. MAC offices may obtain fillable claim forms and complete them for MAC patients. See Service and NCR MD-specific guidelines. ABACUS generates claims in all industry-standard formats (except dental).
5. 837I/UB-04. This electronic or equivalent paper form is used for institutional services claims, including Medicare Severity Diagnosis Related Group (MS-DRG), Ambulatory Patient Classification (APC), Ambulatory Surgery Center (ASC), laboratory, pharmacy (unless billed on an NCPDP claim), Durable Medical Equipment (DME), and procedures that have separately priced technical components. See Appendix B in this User Guide for instructions on completing the 837I/UB-04.
6. 837P/CMS 1500. This electronic or equivalent paper form is used for professional services claims, including office visits, therapy, and procedures that have separately priced professional components. See Appendix C in this Guide for instructions on completing the 837P/CMS 1500.
7. Invoice and Receipt (I&R). The I&R is used for billing pay patients. See Appendix G in this User Guide for instructions on completing the I&R.
8. DD7/DD7A. The DD7 and DD7A forms are used for interagency billing, except where DoD and the agencies have agreed to a different form of billing. See the DD7/DD7A Reports Process section or Appendices E and F in this User Guide for instructions on completing the DD7/DD7A.
9. SF 1080. The Voucher for Transfers between Appropriations and/or Funds (SF 1080) is used to bill inpatient and outpatient medical charges for interagency patients. It is the equivalent of an invoice or bill, and it summarizes the DD7/7A reports. This form is available at <https://www.gsa.gov/portal/forms/download/115594>
10. National Council for Prescription Drug Programs. NCPDP is used to electronically bill pharmacy claims.

## **Compliance**

1. General. Compliance is the strict adherence to established laws, rules, regulations, and policies in an effort to reduce fraud, waste, abuse, and mismanagement. An effective compliance program helps ensure that the billing office is operating lawfully and ethically and at optimum efficiency. All billing offices must have a compliance program as stated in the 28 February 2002 Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) Memorandum, "Compliance Plan Implementation Policy," which is available at <https://www.health.mil/Policies/2002/02/28/Memorandum-Compliance-Plan-Implementation->



Policy.

The compliance program must be developed and the compliance officer must be designated in accordance with DHA-PM 6015.01, "Military Treatment Facility Uniform Business Office (UBO) Operations", which is available at:

<https://info.health.mil/bus/brm/ubo/PolicyGuidance/UBO%20Manual%20dtd%20October%202017.pdf>

The designated UBO compliance officer is responsible for all compliance activities.

2. Compliance Audit Checklist and Post-Submission Worksheets. The UBO compliance officer should use a Compliance Audit Checklist and Medical Services Account (MSA), Third Party Collections Program (TPCP), and Medical Affirmative Claims (MAC) Post-Submission Claims worksheets to perform quarterly audits. Examples of these documents that contain a minimum baseline of the items to be assessed are available at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance>. Billing personnel should review these documents to understand their program's audit requirements.

2.1. Compliance Officer. The MTF will provide the UBO compliance officer with requested information to complete the Compliance Audit Checklist and worksheets.

2.2. Corrections to Audit. The MTF must correct any errors or deficiencies identified during the Compliance Audit.

3. Questions. Questions concerning compliance should be directed to the MTF's UBO compliance officer or other designated point of contact in accordance with Service or National Capital Region Medical Directorate (NCR MD) specific guidelines.

**Coordination of Benefits**

1. General. Coordination of Benefits (COB) describes the steps used to determine the obligations of payers when a patient is covered under two or more separate healthcare benefit policies.
2. Verify the primary and secondary payers provided on the DD Form 2569.
3. The primary payer is billed initially, and, after payment is received, any remaining balance is forwarded to the secondary payer.
4. 3.1. If the patient is a subscriber of an employer's insurance plan, that insurance is considered primary. The coverage obtained through the health plan of a spouse's employer is secondary. For example: The spouse of a retiree received treatment at an MTF. The patient is employed and has an insurance policy with his or her employer. This insurance is considered "primary" Other Health Insurance (OHI). The retired member's policy is secondary. The MTF will submit a claim to the patient's insurance carrier for services rendered to the patient. The MTF, on receiving the remittance from the primary insurer, will bill the secondary insurer for the balance.
5. 3.2. If a patient is a dependent of two individuals with insurance through their employers, the parent with the birthday first in the calendar year will be considered the primary payer. For instance, if the mother's birthday is 2 February and the father's birthday is 3 November, the

mother's insurance is primary. This is called the "birthday rule."

### **DD7/DD7A Reports Process**

1. General. Department of Defense (DD) Form 7, "Report of Treatment Furnished Pay Patients – Hospitalization Furnished (Part A)" and DD Form 7A, "Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished (Part B)" when used, these reports are bills generated by ABACUS for inpatient and outpatient services. (See *Medical Services Account (MSA) Billing Forms* of this User Guide and Appendix E.) These reports are typically run monthly for interagency billing. Interagency billing uses a number of different forms which may or may not include DD7/DD7a forms (refer to Service specific guidance). The DD7/DD7a forms are an aggregation of services by Patient Category (PATCAT) (e.g., all Active Duty U.S. Public Health Service (P11) visits are printed on one report and all Family Members and Retirees of U.S. Public Health Service (P41) are printed on another). Note that this is different from the Medical Services Accounts (MSA) Invoice and Receipt (I&R), which is created for individual MSA billable patients.
2. DD Form 7. This report when used identifies non-DoD beneficiaries (e.g., National Oceanic and Atmospheric Administration (NOAA) and United States Public Health Service (USPHS)) who receive inpatient care at an MTF. Once coded and grouped in the Coding Compliance Editor (CCE) (which determines the Diagnosis Related Group (DRG)), ABACUS calculates the charge for the admission at the Interagency Rate (IAR). The DD7 report can be printed and submitted to the NOAA or USPHS with a Standard Form (SF) 1080 as the coversheet.
  - 2.1. As noted above, these reports are typically run monthly for interagency billing. Interagency billing uses a number of different forms which may or may not include DD7/DD7a forms; The ABACUS menu path is as follows: Account Management > MSA > SF 1080. Add Account Management>MSA>DD7/7A
  - 2.2. The MTF Commander, or authorized representative (e.g., MSA Officer), must sign each page of the report.
  - 2.3. The DD7 report may not reflect all the admissions for the month being billed.
    - 2.3.1. Line of Business (LOB) Billing Report DD7. A DD7 Billing Report can be generated for a specified LOB reflecting all PATCATs. The ABACUS menu path is as follows: Account Management > Recovery Reporting >DD Form 7A. This report when used identifies non-DoD beneficiaries who receive outpatient care at an MTF. Once coded and released by the Coding Compliance Editor (CCE) by the Outpatient Coders, the coding information is passed to ABACUS, which calculates the charge for each Current Procedural Terminology (CPT®), Healthcare Common Procedural Coding System (HCPCS), or Code of Dental Terminology (CDT) code at the IAR. Ancillary services are generated when the service is performed and entered into the laboratory (LAB),

radiology (RAD), or Pharmacy modules in ABACUS. At the same time, the information is passed to ABACUS, and charges are calculated at the IAR. A DD7A report can be printed and submitted to the interagency payer with an SF1080 as the coversheet.

3.1. The DD7A report must be run monthly. The ABACUS menu path to print the preview listing per treating Defense Medical Information System [facility] identifier (DMIS ID), Patient, and Date of Service for review prior to finalization is: Account Management > MSA > DD7 Invoices.

3.2. Review the listing and exclude or deselect accounts with a \$0.00 or duplicate balances or invalid charges (check the Defense Eligibility Enrollment System (DEERS) and verify the PATCATs for each patient). Prior to printing, it is important to check the DEERS Check Date. If the DEERS Check Date is blank or the date is over 90 days from the current date, the DEERS Check Date will need to be updated in Patient Demographics and OHI using the following menu path: Patients > Patient Account > Patient Demographics and OHI.

6. Editing DD7 Claims. Users have the ability to edit DD7 claims in Recovery by creating a new version of the bill. If a claim has been edited after the DD7 invoice has been linked to an SF 1080, the original invoice will be marked as “Old/Excluded” in the DD7 Invoices program and the SF 1080 will be updated.
7. Submission to Responsible Agency. Submit these reports along with the SF1080, “Voucher for Transfer between Appropriated and/or Funds” to the responsible agency†† for payment. (Note: Beginning in FY12, the DoD and U.S. Coast Guard implemented a prospective payment amount (PPA) reimbursement methodology to recover the cost of health care provided to USCG beneficiaries in Army, Navy, and National Capital Region (NCR) Medical Directorate MTFs. The Air Force joined the PPA in FY13. Thus, for USCG beneficiaries seen at these MTFs, do not send the SF1080 to the USCG; rather, follow the guidance in the *U.S. Coast Guard Billing* section of this User Guide.)

NOAA  
U.S. Dept. of Commerce – NMAO  
8403 Colesville Rd., Suite 500  
Silver Spring, MD 20910-3282

USPHS (Navy)  
U.S. Dept. of Health and Human Services – PHS  
8455 Colesville Rd., Suite 910

**Dental Services**

1. If the Ambulatory Data Module (ADM) is used to capture dental encounters associated with the Medical Expense and Performance Reporting System (MEPRS) Code C\*\*\*, accounts are generated in the UBO electronic billing solution) and Medical Services Accounts (MSA) in the same manner as B level MEPRS codes.

1.1. If ADM is not used, entries are hand-keyed into MSA and the DHA electronic billing solution from the supplied dental superbill.

2. Rates for dental procedures are calculated based on the DoD Dental Rate Table that originates from the American Dental Association Code on Dental Procedures and Nomenclature (CDT) codes.

2.1. CDT codes are alpha-numeric Healthcare Common Procedural Coding System (HCPCS) Level II codes ranging from D0100 to D9999.

2.2. The dental rate table is maintained in the UBO electronic billing solution.

2.3. The Dental Rate Table contains billing rates for the full reimbursement rate (FRR). The Interagency rates (IAR) and the International Military Education and Training (IMET) discounted rates are calculated based on expense and workload data across MTFs. The discounted services are calculated in THE UBO ELECTRONIC BILLING SOLUTION as a percentage of the FRR.

3. Dental Ambulatory Patient Visit (APV) Services.

3.1. All dental procedures are billable with a CDT code or a Current Procedural Terminology (CPT) code along with any ancillary service as a line-item charge representing procedures that were performed, regardless of the location where the procedure was performed.

3.2. CPT codes are used when billing for oral and maxillofacial surgery (OMS) such as surgical procedures or oral implants reconstruction.

3.3. A series of dental CDT (ADA) codes are located on the CHAMPUS Maximum Allowable Charge (CMAC) Rate Table with rates for billing dental and oral surgeries and procedures.

## **Dialysis**

1. General. Dialysis is usually billed monthly, at the beginning of the month following the services. Dialysis is an ancillary service performed by a nurse under the written orders of a physician.

2. Billing Professional Dialysis Services. The Current Procedural Terminology CPT<sup>®</sup>\*\*\* code range for professional dialysis services is 90935-90999. Hold them and bill monthly in addition to CPT Code 90999, as explained below in paragraph 3.

2.1. The encounters are collected in the ambulatory data module (ADM) under the DGB\* or DGD\* Medical Expense and Performance Reporting System (MEPRS)

workcenters.

2.2. For Medical Services Accounts (MSA), create an account and enter a one-time charge of the manually calculated appropriate rate.

2.3. Current and future billing solutions, including the Armed Forces Billing and Collections Utilization Solution (ABACUS) and MHS GENESIS, may receive dialysis services recorded under D\*\*\* MEPRS accounts as well as have the ability to generate electronic transactions.

3. Reporting the Urea Reduction Ratio (URR). With each monthly bill, add a separate line to the bill with the CPT code 90999. The code 90999 is a no-charge code and is reported to meet payer requirements for reporting the most recent URR result. The description will be "Unlisted dialysis procedure, inpatient or outpatient." Billing personnel must determine, with coding/clinical documentation support as needed, the latest blood urea nitrogen (BUN) test dialysis unit results and document the result with one of the modifiers listed below. The BUN tests are reported with laboratory CPT codes 84520–84525 and may contain modifiers G1–G6. If the modifier is not provided, billing personnel must contact coding personnel to obtain the URR reading and determine the correct modifier. The billing office then appends the appropriate modifier to 90999.

G1 – Most recent Urea Reduction Ratio (URR) reading of less than 60  
G2 – Most recent URR reading of 60–64.9

G3 – Most recent URR reading of 65–69.9  
G4 – Most recent URR reading of 70–74.9

G5 – Most recent URR reading of 75 or greater

G6 – End Stage Renal Disease patient for whom fewer than 7 dialysis sessions have been provided in a month

4. Revenue Code. The revenue code will be 820, 821, 826, or 829.

5. Additional Information. The explanation of benefits may identify other information needed including the codes below:

211 – date(s) of dialysis training provided to patient

212 – date of last routine dialysis

213 – date of first routine dialysis

### **Emergency Department Services**

1. General. Emergency department (ED) visits may include a visit involving only evaluation and

management (E&M) Current Procedure Terminology (CPT®) codes 99281 through 99285 and 99291 and 99292; or a visit involving an E&M CPT code and additionally coded services. The current Military Health System (MHS) billing systems are unable to store and use both the professional and institutional rates for the same code. Therefore, Defense Health Agency (DHA) UBO rates (TRICARE Ambulatory Payment Classification (APC) rates) for ED E&M 99281 – 99285 services are used to determine the DoD ED institutional charges; bill those E&M CPT codes on the institutional claim (Uniform Bill (UB)-04/837I). CPT codes 99291 and 99292 are currently mapped for MHS billing systems to professional claims Centers for Medicare & Medicaid Services (CMS) 1500/837P.

2. Inpatient Admission from ED. If the patient is admitted directly from the ED, either by the emergency services provider or by a referring provider, the discharge type from the ED should be “admitted.” In that case for Third Party Collection (TPC), Medical Affirmative Claims (MAC), and most Medical Services Account (MSA) patients, do not bill for institutional or professional ED services. However, in the case of Veterans Affairs (VA)-DoD Resource Sharing Agreement care, bill the professional charges, including CPT codes 99291 and 99292, unless precluded by the local sharing agreement.
  
3. Radiology and Laboratory with ED Admission. For TPC, MAC, and most MSA, radiology (RAD) and laboratory (LAB) services ordered during an encounter where the discharge status is “admitted” become part of the institutional component of the hospitalization. If these services generate a bill, the bill should be cancelled. Under VA-DoD Resource Sharing Agreement care, however, bill the professional components of ancillary services separately. (See *VA-DoD Billing* section of this User Guide for instructions.)
  
4. Billing Tips. The chief complaint (the patient’s reason for the visit) should be listed in Form Locator 70a-c on the institutional claim. The revenue code for the ED institutional claim is 450.

### **Elective Cosmetic Surgery**

1. General. Elective cosmetic procedures are not a covered benefit under TRICARE. These procedures are restricted to TRICARE-eligible beneficiaries, as defined in 10 United States Code (U.S.C.) Chapter 55. Elective cosmetic procedures are permitted in support of graduate medical education, board eligibility and certification, and skill maintenance for providers.
  - 1.1. Only privileged staff and residents in the specialties of plastic surgery, otorhinolaryngology, ophthalmology, dermatology, and oral-maxillofacial surgery may perform elective cosmetic surgery procedures.
  - 1.2. Cosmetic surgery procedures may be performed on a “space-available” basis only.

2. Patient Responsibility. Patients undergoing elective cosmetic surgery procedures accept responsibility for all procedure charges, including applicable professional, facility, and anesthesia fees plus the cost of any implants, pharmaceuticals, and other separately billable items provided by the MTF.

2.1. The Cosmetic Surgery Estimator (CSE) is used to generate elective cosmetic surgery procedure estimates. Rates for elective cosmetic procedures are updated annually by the Assistant Secretary of Defense for Health Affairs (ASD-HA).

2.2. Estimated charges are based on the Department of Defense (DoD) rates applicable at the time of payment. Rates cannot be guaranteed until estimated charges have been paid in full.

3. Reconstructive or Cosmetic Procedures. Some procedures can be considered reconstructive or cosmetic. Cosmetic surgery is “any elective plastic surgery performed to reshape normal structures of the body in order to improve the patient’s appearance or self-esteem.” Reconstructive surgery is “any plastic surgery performed on abnormal structures of the body which are caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive surgery is generally performed to improve function, but may also be done to approximate normal appearance.” The provider determines if the service is medically necessary (reconstructive) or elective cosmetic.

3.1. If the provider determines the procedure is elective cosmetic, then the first diagnosis code should indicate such.

3.2. If the provider determines the procedure to be medically necessary, then the first diagnosis code will not indicate cosmetic series and the procedure will be considered a covered benefit. Medically necessary procedures may be processed under the Third Party Collections Program (TPCP) if the DoD beneficiary has valid other health insurance (OHI) and the required documentation is presented to justify medical necessity. For medically necessary procedures, it may be necessary to obtain a pre-certification or pre-authorization number prior to treatment.

4. Included in the Cosmetic Surgery Program. Only the elective cosmetic procedures listed in the current year CSE are billable. In addition to the cost of elective cosmetic procedures, patients may be responsible for any applicable services, such as laboratory, radiology, and pharmacy.

5. Billable Elements of Elective Cosmetic Procedures. Elective cosmetic procedures are billed at the full reimbursement rate (FRR), regardless of the Patient Category (PATCAT). The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) national average (locality 300) rates are used for all procedure locations. Charges are not adjusted for the treating MTF’s geographic location. Professional Fees. Professional fees are based on Current Procedural Terminology® (CPT)

codes, which describe the type of procedures to be performed. Procedure rates are derived from the CMAC rate table, when available. When CMAC is not available, professional fees are determined based on estimates of the medical resources required relative to similar procedures that have CMAC pricing.

5.1. Institutional Fees. The institutional charge is based where (e.g., inpatient operating room, outpatient operating room, or provider's office) the procedure is performed.

5.1.1. CMAC non-facility physician allowable rates are used for services furnished in a provider's office. Location costs are included in the CMAC non-facility physician rate; therefore, no additional facility fees will be applied.

5.1.2. CMAC facility physician allowable rates are used for services furnished in a hospital operating room whether the patient is considered an inpatient or outpatient. If the procedure is performed in an inpatient operating room, the facility fees are included in the Diagnosis Related Group (DRG) rate. If the procedure is performed in an outpatient operating room, the facility fee is based on the TRICARE Ambulatory Payment Classification (APC) rate for the CPT code indicated.

5.2. Anesthesia Fees. Anesthesia fees associated with elective cosmetic procedures include the cost of anesthesia pharmaceuticals provider.

5.2.1. Topical and local anesthesia fees are included in the price of the procedure selected for all locations of service. The fee for moderate sedation is a flat fee based on the combined CMAC rates for CPT codes 99152 and 99153. Fees for General/Monitored Anesthesia Care are calculated using the TRICARE national average anesthesia conversion factor, multiplied by the sum of anesthesia base units and national average time units (measured in 15-minute increments) of the primary procedure. An additional anesthesia charge, based on additional minutes of service, is added for additional procedures performed during the same surgical encounter.

5.4. Additional Procedures During the Same Session. If multiple elective cosmetic procedures are performed during the same surgical encounter, a discount is applied. Professional, facility, and anesthesia fees are reduced by 50% from the initial charge.

5.5. Multiple Quantities and Sessions. Some procedures can be performed in multiple quantities during a single surgical encounter (quantitative procedures). Multiple quantity procedures are discounted by 50%. Other procedures generally require multiple sessions (separate surgical encounters) to achieve optimal results. There is no discount applied to procedures requiring additional sessions or multiple visits. Each session is priced at 100% whether it is listed as a primary or additional procedure.



5.6. Add-on Codes. Add-on codes are used to capture additional charges for secondary procedures that can only be done in conjunction with a specific primary procedure. They are performed by the same physician during the same surgical encounter as the primary procedure and must never be billed as a stand-alone procedure. Add-on codes are NOT subject to multiple-procedure discounting as they are inherently discounted codes.

5.7. Pharmaceuticals. Pharmaceuticals may be used for subcutaneous injection of filling material procedures (11950, 11951, 11952, and 11954) and chemodenervation procedures (64612, 64616, 64642, 64643, 64644, 64645, 64646, 64647, 64650, 64653). The cost of the fillers/injectables used for the elective cosmetic procedure(s) should be obtained from the MTF pharmacy. For chemodenervation procedures, three of the potential pharmaceuticals (Botox®, Dysport®, and Xeomin®) have TRICARE allowable prices. The prices applicable for the current version of the CSE are pre-populated in the pharmaceutical cost field. However, users are able to override the price of the pharmaceutical if the MTF pharmacy provides a purchase price for the pharmaceutical.

5.6. Implants. If the MTF provides implants/supplies to the patient, the patient is responsible for reimbursing the MTF for the cost of the implants/supplies.

6. Discounts. Discounts are available when: elective cosmetic procedures are performed in conjunction with a medically necessary procedure, a dermatology resident performs the procedure, and for bilateral procedures.

6.1. Medically Necessary Discount. If an elective cosmetic procedure is combined with a medically necessary procedure during the same surgical encounter, charges for the primary elective cosmetic procedure are discounted. Facility and anesthesia fees for an elective cosmetic procedure, when combined with a medically necessary procedure, are reduced by 50% from the initial charge.

6.1.1. Billing Elective Cosmetic and Medically Necessary Procedures Performed During the Same Session. The components of the service include the medically necessary professional component, the cosmetic professional component, institutional fees, anesthesia charges, pharmaceuticals, and implants/supplies.

6.1.2. The patient must pay for the entire cosmetic portion of the procedure prior to scheduling.

6.1.3. The medically necessary portion of the procedure should be billed to the patient's OHI.

6.2. Dermatology Resident Discount. A reduced professional flat rate per chemodenervation procedure is charged when performed by a Dermatology resident

physician. This discount is built into the CSE.

6.3. Bilateral Procedures. The bilateral discount is applied to the second half of the procedure. The first procedure is charged at 100% and the second at 50% of the initial fee. The total charge for a bilateral procedure is 150% of the initial fee.

7. Estimate Calculation. To calculate a charge, use the CSE in effect on the day the patient presents a completed Superbill to the Medical Services Account (MSA) office. To obtain the latest version of the CSE, contact your UBO Service or NCR MD Program Manager for log-in credentials. Note: The CSE is designed for MSA use only.

7.1. CSE Instructions. For step-by-step instructions on how to use the CSE, refer to the CSE User's Guide in effect on the estimate date. The CSE User Guide provides detailed instructions on how to generate an estimate in the CSE.

7.2. CSE Website. The CSE User Guide is posted on the ubocse.org website (password protected), health.mil the DHA UBO website under the MHS Rates-Cosmetic Surgery page. The User Guide can also be accessed by using F1 while in the CSE database.

8. Letter of Acknowledgment. Patients must sign a letter of acknowledgment accepting financial responsibility for costs associated with the procedure(s). Patients must agree that estimated charges are not final and additional charges (e.g., radiology, anesthesia, laboratory, pharmacy) may apply. Do not provide a receipt until the letter is signed and in the patient's file. Elective cosmetic procedures are not to be scheduled until a receipt is available.

9. MSA Bill Generation. The MSA Office must collect the estimated cost of the procedure in advance of treatment.

9.1 CSE Billing Process. Billing elective cosmetic procedures in MSA is a manual process. The MSA bill must be created in the ABACUS billing module. The initial procedure charge is posted and paid prior to treatment with additional charges billed once all services are complete. Payment for additional services is due within thirty (30) calendar days from the presentation of the final bill.

9.1.1. The MSA Office must also ensure that all charges associated with the cosmetic procedure are excluded from the DD7A billing menu for DD7A billable patients.

9.2. Post-Surgical Billing Adjustment. Until coding for the surgical procedure is complete, the full charges for the elective cosmetic procedure(s), including all ancillary services, will not be available. Consequently, the MSA Office may not be able to collect full payment in advance of services performed.

9.3. MSA Office will complete a records reconciliation upon completion of the procedure and documentation process. Additional charges may be added to the payment amount or charges may be subtracted. ABACUS Unmatched Lines function should be used to correct the charges if necessary and eliminate the ADM bucket in Interface-Load Error Maintenance associated with each case.

10. Cosmetic Surgery Documentation. At a minimum, the patient's elective cosmetic procedure file must contain the following documentation prior to closing out the case:

10.1. Cosmetic Surgery Superbill. Original completed by the provider.

10.2. CSE Cost Report. Generated from the CSE.

10.3. Letter of Acknowledgment. A letter signed by the patient acknowledging financial responsibility for costs associated with the procedure(s), which may include additional charges associated with complications. These additional charges are due no later than 30 days after the final bill is presented.

10.4. Coding from the Surgical Encounter. If different from the initial invoice, a copy of the rebilling and payment/refund.

11. Cancellation. If the procedure was prepaid, and the procedure was cancelled:

11.1. Implant Refund. If the implants have not been opened and can be returned, the cost of the implants less the restocking fee will be refunded if the MTF paid for the implants. If implants cannot be returned, the cost of the implants will not be refunded.

11.2. Payment Refund Prior to Anesthesia. If the procedure is cancelled prior to the scheduled procedure date or administration of anesthesia, patients are entitled to a refund of all monies paid for the cancelled procedure(s).

11.3. Payment Refund Prior to Incision. If anesthesia administration begins, but there is no incision, funds will be refunded minus the costs of the implants and the anesthesia costs.

11.4. Payment Refund Once Surgery Begins. If anesthesia is administered and surgery begins, funds will not be refunded.

12. Cosmetic Surgery Complications. Complications of cosmetic surgery procedures are excluded from coverage under TRICARE. See TRICARE Policy Manual (TPM) Chapter 4, Section 1.1 (current version).

12.1. Patient Responsibility for Complication Charges. The patient is responsible for all charges related to the complications.

12.2. Patient Acknowledgment of Complication Charges. The patient must acknowledge this disclosure and a copy of the signed letter of acknowledgment must be filed in the patient's medical record.

12.3. Medical Services for Complications. Medical services may be provided by the MHS for cosmetic surgery complications when the complication represents a medical condition separate from the condition that the non-covered surgery was directed towards.

12.3.1. A complication may be considered a separate medical condition when it causes a systemic effect or occurs in a different body system from the non-covered treatment or is an unexpected complication. For example: Treatment for toxic shock syndrome (a systemic effect) following breast augmentation would be a covered benefit.

12.4. Benefit Exclusions. The patient is responsible for all costs associated with complications that occur in the same body system or the same anatomical area of the non-covered treatment and when the complication is one that commonly occurs. For example: In a breast augmentation procedure, a localized wound infection would be excluded and non-covered.

### **Electrocardiogram Services**

1. General. Electrocardiogram services are represented by Current Procedural Terminology (CPT®) codes 93000–93278 and 93799.
2. Encounters. The encounters may be collected in the Ambulatory Data Module (ADM) under the D\*\*\*MEPRS (Medical Expense and Performance Reporting System) work centers. As the D\*\*\* MEPRS, except lab and rad, currently do not flow automatically to billing these bills will need to be generated manually by finding these electrocardiogram codes in ADM. The Armed Forces Billing and Collections Utilization Solution (ABACUS), should receive electrocardiogram services recorded under D\*\*\* MEPRS accounts and have the ability to generate electronic transactions.

### **Evaluation & Management**

1. General. Modifiers are two-character descriptors added after the Current Procedural Terminology (CPT®)/Healthcare Common Procedural Coding System (HCPCS) code to indicate that a service or item was altered from the stated CPT/HCPCS description to represent the service or item rendered more accurately and specifically. CPT/HCPCS codes may have more than one modifier and, as with any code, modifiers must be supported by medical documentation. Billing personnel should not delete or add a modifier to a code.

- If more than one modifier is required and necessary on the claim, the modifiers should be sequenced by impact on reimbursement, i.e., those such as modifier 59 should be sequenced-distinct procedural service, before anatomical site modifiers such as modifier LT/RT-Left or Right, or TA- left foot great toe.
2. Use. Payers may deny claims as "unprocessable" for inappropriate modifier use or request additional supporting documentation. If the use of a procedure code/modifier combination is inappropriate, billing personnel should consult with their coding department to make the necessary corrections and resubmit the claim within the payer's timeline.
  3. Billing Examples. Common examples of modifiers that may impact billing are defined below. Refer to your CPT and HCPCS coding manuals for the complete list.

3.1. Modifier -24 – Unrelated Evaluation and Management Service by the Same Provider During a Postoperative Period. This modifier indicates that a provider has seen a patient for an unrelated issue during a postoperative period. For example, if a family practice provider performed a vasectomy on Monday (vasectomies have a 10-day postoperative period), then treated the patient as a walk-in for a sore throat on Friday, the provider would need to append modifier -24 to the office visit code. Without the modifier, the payer may not pay it thinking the office visit was part of the global follow-up for the procedure.

3.2. Modifier -25 – Separate E&M on the Same Day as Another E&M or Procedure by the Same Provider. This modifier indicates that the patient's condition on the day of the procedure required a significant, separately identifiable Evaluation and Management (E&M) service beyond the usual preoperative and post-operative care associated with the procedure or service performed. For example, a pediatrician performs a well-baby exam and also treats the child's conjunctivitis (pink eye) at the same visit. The pediatrician would code the physical (e.g., 99392) without a modifier and would code the office visit for the conjunctivitis with a modifier (e.g., 99212-25). The payer may decrement the payment for the code with the modifier (in this example, the 99212). The physician's documentation must clearly support the coding and billing of two visits for the same encounter, in this case the physical and the problem focused visit for conjunctivitis.

3.3. Modifier -26 – Professional Component. This modifier indicates that the service or item has separate professional and technical reimbursements. It is commonly used with radiology and some cardiology procedures. Billing personnel must make sure modifier -26 is included for procedures where they are only billing the professional component of an inpatient encounter.

3.4. Modifier -32 – Mandated Services. In the MHS, this modifier is used to mean –TC (technical component) because the Composite Health Care System (CHCS) does not allow alpha modifiers. If it is appended to a CPT code, billing personnel must change it to –TC. In the commercial sector this modifier indicates services mandated by an outside entity such as a payer, government agency, employer, etc. For example, a payer

requests an independent evaluation of a patient filing a workers compensation claim, or seeks a “second opinion” on a patient’s condition, prior to authorizing further testing and/or treatment.

3.5 Modifier -33 – Preventive Services. This modifier indicates when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force. PT modifier is required instead of Modifier 33 for Medicare in the event the government program is being billed for a denial in order for the secondary payer to be billed. Modifier 33 and PT are primarily utilized for screening colonoscopies converted to diagnostic colonoscopies. (USPSTF) A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory). Many payers will waive copays and deductibles. The current list of USPSTF A and B recommendations is available at <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

3.6. Modifier -50 – Bilateral. This modifier indicates that the same procedure was performed on both sides of the body during the same surgical session. For example, a patient has cataracts removed from both eyes during the same surgical session. Payers may decrement payment for the second procedure. Modifier 50 is not to be used on specific CPT codes that are inherently bilateral by virtue of the fact the title of the code describes a bilateral procedure or the title of the procedure includes the words “unilateral and/or bilateral.”

3.7. Modifier -51 – Multiple Procedures. This modifier indicates that more than one procedure, other than the E&M, was performed during the same session by the same provider. It is never appended to add on codes. Payers may decrement the professional fee for multiple procedures.

3.8. Modifier -52 – Reduced Services. This modifier indicates that a provider, at his or her discretion, reduced a service or procedure. Payers may request documentation of how the procedure was reduced and may decrement payment. Modifier 52 is not to be used if another CPT procedure code better outlines and describes the procedure performed as documented in the record.

3.9. Modifier -54 – Surgical Care Only. This modifier indicates that one provider performed the surgical procedure and another provided pre- or postoperative management. For example, a fracture is set in the Emergency Department, but after care will be done in Orthopedics.

3.10. Modifier -55 – Postoperative Management Only. This modifier indicates that one provider performed postoperative care and evaluation and another performed the surgical procedure. For instance, the orthopedic clinic does only the after care for a fracture treated in the Emergency Room at the downtown hospital. Payers may

decrement payment depending on the amount of the total global procedure is for the postoperative follow-up.

3.11. Modifier -56 – Preoperative Management Only. This modifier indicates that one provider performed preoperative care and evaluation and another performed the surgical procedure. For example, a primary care provider may do the preoperative component of the care for an open fracture reduction, and an orthopedic surgeon may perform the surgical procedure. Payers may decrement payment depending on the amount of the total global procedure is for the intraoperative and the postoperative follow-up.

3.12. Modifiers -62, -80, -81, and -82 – This modifier indicates multiple providers and assistants during the same surgical encounter. Payers may decrement payment. Modifier “-AS” indicates that the assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist. Technicians and operating room nurses should not be coded as assistant surgeons.

3.13. Modifier -RT or -LT – Location. Some codes require a location (informational) modifier. For example, a modifier is needed for a fracture of an arm to tell if it is the right (-RT) or left (-LT) arm. Claims may be returned if the location modifier is not provided. If location modifiers are used, payers may reimburse these as bilateral procedures (e.g., modifier -50) instead. Anatomical modifiers are not to be used if the description of the CPT<sup>7</sup> code does not indicate an anatomical site and the organ system/body area re not bilateral in nature.

## **Federal Emergency Management Agency**

1. General. Following a presidentially declared disaster or emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the “Stafford Act,” Public Law 93-288, as amended, 42 United States Code (U.S.C.) 5121-5207), MTFs may be authorized by the Federal Emergency Management Agency (FEMA) to provide medical assistance to victims of the disaster or emergency. In those cases, FEMA issues a Mission Assignment (MA), which is a work order directing a specified task and citing funding, other managerial controls, and guidance. Contact your UBO Service or National Capital Region (NCR) Medical Directorate (MD) -specific UBO Program Manager to determine if an applicable FEMA MA has been issued. The MA number should be on the MA document.
2. FEMA Reimbursable Costs. FEMA covers the costs of unreimbursed medical services including: transport of disaster victims, treatment and monitoring of disaster victims, vaccinations that prevent outbreaks of infectious and communicable diseases, and provision of health information.

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<sup>7</sup> CPT is a registered trademark of the American Hospital Association

- 3.1. Costs. Costs associated with emergency medical care must be reasonable and customary for the emergency medical services provided.
- 3.2. Cause of Injury or Illness. The patient must have received emergency medical care: (a) caused by or compounded by the disaster, (b) caused by the evacuation due to the disaster, or (c) received due to assisting with recovery from the disaster.
4. Non-Reimbursable FEMA Costs. Costs that cannot be reimbursed by FEMA include medical costs incurred once a disaster victim is admitted as an inpatient, follow-up treatment costs beyond 30 days after the declared disaster, administrative costs associated with treatment of disaster survivors due, and loss of revenue.
5. Direct Patient Claims. MTFs may bill patients who receive care pursuant to a MA directly, based on Service or NCR MD-specific guidance.

4.1. Option 1: FEMA Payment. Patients can then seek reimbursement from FEMA as determined by FEMA's case management. Under this option, charge the patient the full outpatient reimbursement rate (FOR) or full inpatient reimbursement rate (FRR). In these cases, Patient Category (PATCAT) K91-2 (Civilian Disaster, FEMA Referred) should be assigned. If the patient treated at the MTF is not a FEMA patient, assign PATCAT K92-A (Civilian Emergency Care) and charge the patient FOR/FRR.

4.2. Option 2: Other Health Insurance Payment. MTFs may submit claims to the patient's other health insurance (OHI) carrier or FEMA. However, OHI must be identified and billed first at the FOR/FRR rates before any claims are submitted to FEMA for reimbursement. If a claim is submitted to OHI, balance bill the patient for copays/deductibles and then balance bill FEMA at the outpatient Interagency/Other Federal Agency Sponsored Rate (IOR) and inpatient Interagency Rate (IAR) rates for the final difference. In the case of FEMA, the guidelines in paragraphs 5 through 10 apply.

6. Coverage Period. FEMA eligible costs will be limited to a period of up to 30 days after the date of the emergency or major disaster declaration.
7. Duplication of Benefits and Reimbursement Limitations. FEMA is prohibited from approving funds for reimbursement that are covered by another source of funding. Billing personnel must take reasonable steps to prevent such an occurrence and provide documentation patient by patient, verifying that insurance coverage or any other source of funding (including private insurance, Medicaid, or Medicare) has been pursued and does not exist. Also, for an MTF to receive reimbursement pursuant to an MA, the patient must not be either a DoD beneficiary or a National Disaster Medical System (NDMS)-regulated non-beneficiary inpatient (see NDMS section of the User Guide). Federal agencies providing disaster assistance under their own authorities independent of the Stafford Act are not eligible for FEMA reimbursement. (44 Code of Federal Regulations (CFR) 206,8).



8. **Timely Filing Limits.** The time limit and method for submitting reimbursement requests should be stipulated in the MA. Unless specified otherwise, claims and documentation should be sent to:

FEMA Finance Center

P.O. Box 9001 Winchester, VA 22604 FEMA-Disaster-Federal-Agencies-  
Payment@fema.dhs.gov

9. **Billing Instructions and Forms.** The MTF tasked with the MA is responsible for reviewing and submitting the bill along with supporting documentation to FEMA if that billing option is selected. Treasury Approved Forms include Standard Form (SF) 1080 (Voucher for Transfers Between Appropriations and/or Funds), SF1081 (Voucher and Schedule of Withdrawal and Credits), and 4445R (Voucher for Transfers Between Appropriations and/or Funds). These are available at <http://www.gsa.gov/portal/forms/type/SF>.
  - 9.1. **Mission Assignment Transmittal Form requirements.** Information required to be included on the form must include the MTF name and remittance address, fiscal point of contact, MA number, disaster number, State, agency bill number, billed amount, partial/final bill designation, and certifying official signature.
10. **Submissions.** Reimbursement requests can be submitted to FEMA monthly, regardless of the bill amount, and final bills should be submitted as soon as possible after completion of operational work or on termination of the MA. Separate reimbursement requests are required for each MA (44 CFR 206.8).
11. **Document Retention.** Source documents should be retained for 3 years after final submission.

### **File and Table Maintenance**

1. **General.** Files and tables are system components that are essential for accurate, up-to-date billing.
2. **Purpose.** Many files and tables must be correctly entered in Military Health System (MHS) applications so the correct data can be collected and flow to the billing systems (e.g., ABACUS, and future billing solutions). Incorrect or obsolete patient, provider, procedure, diagnosis, billing rate, health insurance payer, or other reference files can cause: billable encounters not to flow to the billing system; non-billable encounters to flow to the billing system; and billable encounters to flow but generate claims with incorrect or incomplete data.
3. **Non-UBO Tables.** While many reference tables (e.g., billing rate tables) are considered UBO tables, others that impact billing do not belong to the UBO. The Patient Category (PATCAT), Provider Specialty Code (PSC), International Classification of Diseases (ICD), and Current Procedural Terminology (CPT®/HCPCS)/Healthcare Common Procedural Coding System (HCPCS) tables belong to the Medical Coding Program Office (MCPO), but the UBO provides input to these tables. The Medical Expense and Reporting System (MEPRS) tables belong to the MEPRS Management Improvement Group (MMIG). The other health insurance (OHI) and the standard insurance table (SIT) are shared with

purchased care (PC) and pharmacy benefit managers (PBMs). §§ CPT® is a registered trademark of the American Medical Association.

3.1 The SIT is updated centrally in the Defense Enrollment Eligibility Reporting System (DEERS), with copies being downloaded to the Composite Health Care System (CHCS) through a subscription process. There are various sources of input to the SIT but the UBO Verification Point of Contact (VPOC) verifies the SIT. The VPOC also coordinates SIT input to MHS GENESIS. The UBO, PC, and PBMs update the OHI as new or updated OHI is gathered. Changes flow to DEERS and DEERS feeds the most current data to CHCS and MHS GENESIS when patient eligibility or OHI is queried. As OHI is updated in CHCS, and changes flow to DEERS. from CHCS to billing systems. There no OHI feed from MHS GENESIS to DEERS; users must enter OHI data into DEERS to share it outside MHS GENESIS.

3.2. Coding Compliance Editor (CCE), is updated with current diagnosis code tables, Medicare Severity Diagnosis Related Group (MS-DRG) grouping logic, and Relative Weighted Product (RWP) values assigned to each MS-DRG, at the beginning of every fiscal year. To ensure the most current MS-DRG/RWP-assignment codes, inpatient facilities should hold coding completion and billing for discharges with a date of discharge on or after 1 October of current year until the updates are made.

Tables Used for UBO Operations. The following files and tables contain the rates, costs, business rules, and mapping tables associated with procedures performed and supplies used.

CPT®-to-ABACUS Mapping Table  
CPT®-to-Modifier Mapping Table  
CPT®-to-Revenue Code Mapping Table  
CMAC Professional Services (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge)  
CMAC Component (procedures with separate technical and professional components)  
Defense Medical Information System [facility] identifier (DMIS ID)/CMAC–Locality Mapping Table (to match each MTF to the correct geographic location)  
Pharmacy National Drug Code (NDC) Rate (pharmacy ingredient unit measure charges)  
Pharmacy Dispensing Fee  
Immunization Rates  
Anesthesia Rates  
Dental Rates  
Ambulance Rates  
Durable Medical Equipment (DME)/Durable Medical Supplies (DMS) Rates  
International Medical Education and Training (IMET)/Interagency Rates (IAR) Rates  
Inpatient Adjusted Standardized Amount (ASA) Inpatient Rates  
CHSC Provider Specialty, CHCS Provider Class, and Health Insurance Portability and Accountability Act (HIPAA) Provider Taxonomy  
PATCAT Assignment to Rate Structure

4.1. The MTF UBO staff should ensure that their system administrator has received and downloaded the most current and updated version of the file and tables for appropriate billing.

4.2. Pharmacy Tables. Appropriate billing for pharmaceuticals depends on maintaining pharmacy files and tables.

4.2.1. Managed Care Pricing File (MCPF). This file lists over 100,000 NDCs with a number of important data elements, including NDC description, package size, unit of measure, dosage form, generic drug class, active ingredient(s), and pricing information. The NDCs that have unit measure prices listed in the UBO pharmacy rate files come from the MCPF. The CHCS Pharmacy module transmits the NDC and quantity dispensed to the billing system. Refer to the “DHA UBO Formulary and OTC Unit Rate–Biller’s Edition” file posted on the DHA UBO website to translate dosage and unit measures for pricing:

<https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates>.

4.2.2. New Pharmaceutical Items. Newly created NDCs may not be in the UBO rate file. An item or service cannot be billed if the UBO has not established a rate for the item or service. However, in the case of NDC-priced pharmaceuticals, if the MTF pharmacy has a cost, follow the *Procedure To Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate* in Appendix A for submitting a request.

4.2.3. Obsolete NDCs. NDCs tend to stay on the NDC rate table for some time after the manufacturer has stopped marketing the NDC because it can take time for the entire product supply to be dispensed. Eventually, the NDC will be dropped from the MCPF and hence the UBO NDC rate table. In most cases, when an MTF has an issue with this, it is because the pharmacy at the MTF is not updating its tables to reflect the new and obsolete NDCs being marketed. MTFs need to work with their pharmacies when obsolete NDCs are passed to the billing systems.

### **Graduate Medical Education (GME)**

1. General. Inpatient care provided by MTFs with Graduate Medical Education (GME) programs is billed at a higher rate to recover the extra costs associated with the indirect medical education program costs. The Indirect Medical Education (IDME) is the multiplier that represents these costs. See Billing Inpatient Services in this User Guide for more information.

### **Healthcare Common Procedure Coding System (HCPCS)**

1. HCPCS codes are grouped into three categories.

1.1. Category I: Current Procedural Terminology (CPT<sup>8</sup>). The CPT codes are primarily services by privileged providers, commonly called professional services. The codes matched to the nomenclature are copyrighted by the American Medical Association. TMA buys a site license for each MTF annually.

1.2. Category II HCPCS. These codes are listed in a book of the same name, HCPCS which stands for Health Care Procedural Coding System. They are not copyrighted. The list is maintained by the Centers for Medicaid and Medicare Services (CMS). National codes primarily cover services by individuals other than physicians (e.g., dentists, mental health/substance abuse services) and supplies. It also includes provider services, such as screenings, that will be reimbursed by CMS. For instance, if a physician performs an annual woman's exam, the CPT code 99395 would be coded. However, because CMS only pays for the screening and not the entire physical, there is a code just for the screening. It is important to note that these codes may not be used as a substitute for category I codes. These codes describe clinical components that may be typically included in evaluation and management services. Category II codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

1.2.1. When both CPT and HCPCS Category II codes have virtually identical narratives for a procedure or service, the CPT code is used. If, however, the narratives are not identical (e.g., the CPT code narrative is generic, whereas the HCPCS Category II code is specific) the Category II code is used.

1.2.2. HCPCS Category II codes begin with a single letter (A through V) followed by four numeric digits. They are grouped by the type of service or supply they represent. HCPCS Category II codes listed on the CMAC Rate Table (J, G, P and Q) and are billable.

1.2.3. Durable Medical Equipment and Durable Medical Supplies (DME/DMS) are billed based on the DME/DMS Rate Table. This is automated by systems to apply the correct rate.

## **Health Insurance**

See *Standard Health Insurance (SIT)* / *Other Health Insurance (OHI)*

## **Health Insurance Portability and Accountability Act (HIPAA)**

1. General. The 1996 Health Insurance Portability and Accountability Act (HIPAA), as amended, establishes standards and requirements for health plans, clearinghouses, and

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healthcare providers— including MTFs—that transmit health information electronically. This can be via claims, remittance, eligibility, and claims status requests and responses. Implementing regulations issued by the Department of Health and Human Services (HHS) have established requirements for: (a) standard transactions, code sets and identifiers to be used when transmitting HIPAA-compliant transactions; (b) information security guidance; and (c) protecting patient confidentiality. More information on HIPAA privacy and security requirements is available at: <https://tricare.mil/Privacy/HIPAA>

2. HIPAA Electronic Transaction Standards, Code Sets and Identifiers. In the HIPAA regulations, the Secretary of HHS adopted certain standard transactions, code sets and identifiers required for the electronic data interchange (EDI) of health care data.

2.1. Transactions. Transactions are exchanges involving the transfer of information between two parties (e.g., MTF and payer) for specific purposes. Under HIPAA, adopted EDI formats include the following:

- Health Care Institutional Claims (837I)
- Health Care Professional Claims (837P)
- Health Care Pharmaceutical Claims (NCPDP – National Council for Prescription Drug Programs)
- Remittance Advice (835)
- Claim Status Inquiry/Response (276/277)
- Eligibility Inquiry/Response (270/271)

UBO staff primarily deal with 837I, 837P, and NCPDP transactions but other transactions may be incorporated into UBO operations in the future including 835, 270, and 271 transactions.

More information on the current version for all HIPAA transactions is available at: <https://health.mil/About-MHS/Defense-Health-Agency/Resources-and-Management/HIPAA-Transactions-Code-Sets-and-Identifiers-Office>

2.2. Code Sets. Code sets define the content and format requirements of each transaction. Under HIPAA, the adopted code sets for procedures, diagnoses, and drugs are: Current Procedural; Terminology (CPT®-4 – Physicians Procedures), Healthcare Common Procedure Coding System (HCPCS – Ancillary Services/Procedures), Code on Dental Procedures and Nomenclature (CDT – Dental Terminology), International Classification of Diseases (ICD – Diagnosis and Hospital Inpatient Procedures), and National Drug Codes (NDC) codes. More information on the current version for all HIPAA code sets is available at <http://health.mil/Military-Health-Topics/Business-Support/HIPAA-Transactions-Code-Sets-Identifiers/Code-Sets>

2.3. Unique Identifiers. These identifiers provide required transaction information on employers, health plans, patients, and providers. Under HIPAA, the adopted unique identifiers are the: Employer Identifier Number (EIN, the standard unique employer identifier); National Provider Identifier (NPI, the standard unique health care provider identifier); Unique Health Plan Identifiers (HPID), the standard identifiers for health plans; and Other Entity Identifier (OEID) will function as an identifier for entities that are not health plans, health care providers, or individuals that need to be identified in standard transactions. More information on the current version for all HIPAA identifiers is available at: <https://health.mil/Frequently-Asked-Questions/HIPAA-Transaction-Code-Sets-and-Identifiers-Identifiers>

3. HIPAA-Compliant Electronic Claims. Electronic claims are transmitted in data “packets,” also referred to as loops and segments, from MTFs through clearinghouses to payers. Billing solutions first apply an initial set of edits, commonly known as front-end edits or pre-edits, to prepare claims for electronic clearinghouses. The clearinghouses ensure that the claims meet the basic format and content requirements of the HIPAA standards. If errors are detected at this level, a single claim or the entire batch would be rejected for correction and resubmission. Claims that pass through the clearinghouses are processed by the payers' claims-processing systems. Additional payer edits may include compliance with payer coverage and payment policy requirements. Edits at this level as well could result in rejection of individual claims for resubmission, determination of allowed amounts as well as payer and patient responsibility, or denial of the claim. In each case, the MTF should be sent a response that indicates the error to be corrected or the reason for payment adjustment or denial. After successful transmission, an acknowledgement report should be transmitted back to the MTF.

3.1. Legacy Billing Systems. The Composite Health Care System (CHCS) is not capable of electronic billing. However, it provides much of the data needed by other billing solutions to create HIPAA-compliant electronic billing transactions. Billing solutions typically perform a HIPAA edit check prior to the transmission of electronic claims to the clearinghouses. If the claim does not meet the HIPAA electronic transmission requirements, the biller will be required to obtain the missing information or attempt to bill the services on a paper claim. Outpatient visits and pharmacy claims are the primary types of services currently being electronically billed. Billing solutions may limit the types of claims that can be billed electronically.

3.2. Legacy billing solutions are limited on the types of claims that can be billed electronically.

3.1.2. The following types of claims require filing with paper format: ambulance, dental, electrocardiography, electroencephalography, electroneuromyography, pulmonary function, cardiac catheterization, anesthesiology, hemodialysis, peritoneal dialysis, inhalation/respiratory therapy, nuclear medicine, area reference laboratories, immunizations, patient transportation, aeromedical

staging facilities (ASF), inpatient Third Party Collections (TPC), Medical Services Accounts (MSA), Medical Affirmative Claims (MAC), pending implementation of future billing solutions.

3.3. Remittance Advice. Currently, remittances sent to the MTF by payers (e.g., Explanation of Benefits (EOBs) and payments), continue to be in the paper format. Future MHS billing solutions, including ABACUS, will have the ability to receive 835 HIPAA standard electronic remittance advice for all inpatient and outpatient services, supplies, and pharmaceuticals. The 835 remittance advice provides itemized information for each claim or line so the provider can associate the adjudication decisions with those claims/lines as submitted by the provider. It will report the reason for each adjustment and the value of each adjustment. Adjustments can happen at line, claim, or provider level.

### **Help Desk Support**

1. General. MTF personnel should first contact their MTF, Region, or Service/Defense Health Agency (DHA) Program Manager for assistance and guidance. Additional assistance is available from several resources regarding UBO functions and Military Health System (MHS) systems.
  - 1.1.1 SECURITY PRECAUTION: Review all e-mails prior to sending them to the Help Desks to ensure they do not contain PHI or PII. Remove and de-identify all unique person identifiers in your data before sending. Blocking or covering PHI or PII in a screen shot of encounter data is not sufficient.
2. DHA UBO Help Desk. Submit questions about UBO rates, processes, and policies to [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) or call (202)-741-1532. Replies are provided, in general, within one business day. Inquiries are routed to the appropriate DHA UBO Contract Support Subject Matter Expert for research and response. If resolved, the ticket is "closed." If necessary and as appropriate, the issue may be elevated to the Service UBO Program Manager or the DHA UBO Program Office for review and response.

Sample UBO Help Desk Topics:

  - Content of code and rate tables
  - Mapping of codes to the rate tables
  - Billing policy
  - SIT/OHI reporting issues

DHA UBO Verification Point of Contact (VPOC) Helpdesk.  
Address questions about the Standard Insurance Table (SIT) and Other Health Insurance (OHI) to the VPOC at

[VPOC.Helpdesk@altarum.org](mailto:VPOC.Helpdesk@altarum.org). Use this email as well to enter and update OHI and SIT information and to keep a subscription current in the master SIT, in addition to updating your local SIT.

DHA UBO Website. View UBO information and resources at <https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office>

DHA UBO Learning Center. View free, on demand, online, and archived DHA UBO webinars at:

<https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center>.

They provide current and topical DoD and industry medical billing and coding training to support the MHS's revenue cycle management and patient accounting activities. Submit recommendations for speakers and topics to

[UBO.LearningCenter@altarum.org](mailto:UBO.LearningCenter@altarum.org).

2. MHS Help. For assistance with MHS systems and applications, contact the following sources.
  - 2.1. Tier 1 application support analysts answer, document, and triage all inbound calls and email Incidents. Tier 2 application support analysts provide advanced software/systems support and assist Tier 1 analysts on supported MHS applications and escalated Incidents.
    - AHLTA (military electronic health record; Armed Forces Longitudinal Technology Application)
    - TOL (TRICARE Online)
    - DMHRSi (Defense Medical Human Resources System – Internet)
    - MHS Learn
    - DMLSS (Defense Medical Logistics Support System)
    - CHCS (Composite Health Care System)
    - MHS GENESIS

Global Service Center (GSC) Telephone Numbers:

CONUS (Continental U.S.) Toll Free: 1-800-600-9332

OCONUS (outside CONUS) Toll Free: Belgium: 0800-72115

Germany: 0800-1011129

Greece: 00800-12-5629

Guam: 1-866-637-8725

Italy: 800-782407

Japan: 00531-1-20743

Korea: 00798-14-800-5242



Netherlands: 0800-0228847  
Panama: 001-800-507-1669  
Portugal: 800-8-12305  
Turkey: 0-800-151-1005  
United Kingdom: 08-005871786  
Spain: 900-951895

DSN (Defense Switched Network): 510-421-3030

### **Immunization Services**

1. **General. Immunization and Administration services codes are represented by Current Procedural Terminology (CPT®) 16 codes 90281–90756 and HCPCS codes G0008–G0010.** When an immunization and the administration of the immunization are the only services provided, evaluation and management (E&M) code 99499 should be entered as a placeholder for an office visit. There should be a CPT or Healthcare Common Procedural Coding System (HCPCS) code for the actual injection and a separate code to reflect the vaccine product.
2. **Clinic Referral for Injections.** When a patient is seen in a clinic setting and then referred to an immunization clinic for injections, two encounters are generated. One encounter relates to the clinic visit, and the other relates to the immunization visit. This will generate two claims: one for the clinic visit, and one for the injection and administration.
3. **Same Visit for both Initial Clinic and Injection.** If the immunization is given during the initial clinic visit, the visit Should have a minimum of three codes: one E&M code with modifier -25 appended for the clinic visit; one administration code; and the vaccine code. It should also have multiple diagnosis codes: one for the reason for the visit, and separate code to explain the need for the vaccination, such as prophylactic vaccination for influenza. If not, consult with the coding department and have them correct the omission(s).

### **International Statistical Classification of Diseases and Related Health Problems: ICD-10**

1. **General.** ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses. The codes can be expanded to over 16,000 codes by using optional sub-classifications.
2. **Use.** Payers may deny claims as "unprocessable" for inappropriate ICD-10-CM and ICD-10-PCS use or request additional supporting documentation. If the use of a diagnosis code or procedure code combination is inappropriate, billing personnel should consult with their coding department to make the necessary corrections and resubmit the claim within the payer's timeline.

3. Resources. The MHS medical coding program encompasses review of documentation and other supporting reports to facilitate accurate assignment of medical codes (i.e., ICD, the American Medical Association's CPT, the Centers for Medicare and Medicaid Services' HCPCS, the American Dental Association's Current Dental Terminology codes, and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)).
4. The MCPO will publish MHS enterprise-wide coding and ethics guidelines and criteria, to include coding work force productivity standards, in coordination with the Military Departments. Coders must use published guidance to ensure accuracy and consistency of code assignment, proper code sequence, proper quantities, and valid data reporting. These criteria will be based on MHS enterprise-specific circumstances and current editions of ICD, CPT, HCPCS, and DSM codes.
5. Coding reference books, MHS enterprise-wide coding guidelines, and encoder software will be updated annually, or as necessary, as the classification systems are revised. The MTF will publish coding books, while the DHA will publish updated coding guidelines and provide software updates. Coding personnel must use these reference and coding tools, to include the full spectrum of encoder reports, to expedite the coding process and ensure all billable and non-billable events are coded in a timely manner.

### **Itemized Posting of Receipts**

1. General. As Explanations of Benefits (EOBs) are remitted reflecting a full or partial payment to the MTF, the user must post payments to the Ledger Posting Module. This program is used to post and track payments and write-offs from checks and EOBs received from third party payers. This information can be posted manually by a user or automatically via an electronic EOB.
2. EOB Reconciliation. Because many payers submit payments for multiple claims and multiple beneficiaries, all line-items on the EOB should be reconciled with Accounts Receivable (A/R) prior to posting payments and depositing funds.
3. Posting. Prior to posting payments, the user should at a minimum:
  - 3.1. Obtain the Control Number for each payment.
  - 3.2. Verify the amount paid against the amount billed.
  - 3.3. Determine amounts to be written off by applying DoD-approved closure reasons.

4. EOB/ERA Maintenance. Once an EOB has been received from the payer, users must use the EOB/ERA Maintenance posting program to post payment adjustments and any information regarding denials. This program contains the details of a particular check down to the line level.

5. If the EOB corresponds with a claim found within ABACUS, any payments, adjustments, and write-offs from that EOB should be entered into the Posting – Account Information window.

5.1. If the Control Number is known, the user can enter it into the Control Number field to open the claim in the “Posting – Account Lookup” window.

5.2. If the Control Number is not known, MTF staff can perform a search based on the first and last name of the patient.

5.3. Once the correct patient account is located, double-click to load the information into the Account Information screen to enter the EOB payment details.

6. Posting Account Information. On the Account Information screen, enter the Paid, Copay, Coinsurance, Deductible, or Other amounts listed on the EOB.

7. Write-Offs. If the user reaches the Other column and a balance remains, pressing Enter will display the listing of Other Write-Offs.

8. Special Account Transactions. Special accounts can be used to reconcile payments received on accounts intended for other facilities.

8.1. Select the Add Claim button within “Posting – EOB Claims.”

8.2. Search the Control Number field and select the Special Account drop-down.

8.3. Manually enter the payment information.

9. Flagging for Review. If an account appears to have been processed incorrectly by the payer, users can indicate that further follow-up is needed and check the Flag for Review button on the Posting – Account Information screen.

10. Entering Provider Adjustments. For accounts where either credits or debits have been applied to the check amount by a payer, these amounts can be captured by the Add Provider Adjustment button.

11. Editing Claims. To make changes to a previously saved EOB, choose the claim in question and select the Edit Claim button.

## **Laboratory Services**

1. General. Laboratory Services are billed based on the Current Procedural Terminology (CPT<sup>9</sup>) code assigned. The Defense Health Agency (DHA) Uniform Business Office assigns rates to the CPT® codes. Only DHA UBO–assigned rates can be used unless the tests were performed under supplemental care, MTF paid another entity, and the fee is a “pass-through.”
2. Billing for Tests Performed External to the MTF and Billed to the MTF by the External Laboratory. MTFs bill payers for laboratory services performed by external laboratories using the modifier -90, Reference (Outside) Laboratory. The charge will be the price paid by the MTF to the external laboratory. Billing personnel will need to obtain this price from Resource Management.
3. Billing for Tests Performed External to the MTF and NOT Billed to the MTF. The Military Health System (MHS) has reference laboratories, such as Armed Forces Institute of Pathology (AFIP) and the Wright-Patterson Medical Center Laboratory. There are also instances where a small MTF collects specimens that are tested at a larger MTF, and the results returned to the smaller MTF so that the patient can receive the results from his or her provider. Use DHA UBO rates when samples are collected at the (smaller) MTF and sent to an external laboratory, but the external laboratory does not bill the MTF. These tests should have the modifier -90, Reference (Outside) Laboratory, to indicate they were not done by the MTF.
4. Billing. DHA UBO rates provide separate professional and technical component rates for procedures where applicable and a single global rate when separate charging is not applicable for the procedure. When separate technical and professional rates are available, the global rate is the sum of the technical and professional component rates.
  - 4.1. A service that has a professional component in which the provider reads and interprets the results of a test performed by a technician is designated by a CPT®/Healthcare Common Procedure Coding System (HCPCS) code and modifier -26 on the professional claim.
  - 4.2. The technical component is reported on the institutional claim with the modifier -TC. In the CHCS Laboratory module, modifier -32 is used to indicate the technical component. When this modifier flows to the billing application, it is changed to -TC, which will appear on the bill.
  - 4.3. Procedures that have separate professional and technical component rates, but no -26 or -TC modifier indicate that the entire procedure was performed, and the global (combined) rate is applied.
5. Claim Forms. In general, laboratory services without modifiers and those with the modifier -TC will be reported on the institutional Uniform Bill 04 (UB-04) paper or 837I electronic claim. When only a professional component of a laboratory service is performed, the CPT with the

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<sup>9</sup> CPT is a registered trademark of the American Hospital Association

professional claim with modifier -26 should be reported on the professional Centers for Medicare & Medicaid Services (CMS) form 1500 paper or 837P electronic claim. Verify the assigned revenue code for each CPT/HCPCS code submitted. (See *Revenue Code* section in this User Guide for further guidance.) The number of outpatient laboratory tests for each CPT code is entered in Form Locator (FL) 46 “Service Units” on the institutional claim and Item Number (IN) 24.G “Days or Units” on the professional claim.

6. Pre-Admission Services. Diagnostic services performed for pre-admission are itemized and billed separately from the inpatient bill. Pre-admission services are normally not included in the inpatient Medicare Severity Diagnosis Related Group (MS-DRG) inpatient charge. However, if the patient is admitted from the emergency department, charges are bundled into the MS-DRG charge. For Third Party Collection (TPC), Medical Affirmative Claims (MAC), and most Medical Services Accounts (MSA) payers, there is no separate charging for emergency department services leading directly to an admission. Under Department of Veterans Affairs (VA)-DoD Resource Sharing Agreements, unless modified by a local agreement, professional services, including the professional components of procedures with separate rates, are billable in addition to the MS-DRG charge.

### **LaunchPad**

1. 1.General. The DHA UBO Launchpad site is an internal CAC-enabled site developed to provide easy access to files, rates tables, policy and guidance documents, and additional information useful to those involved with the medical care of beneficiaries.
2. 2.Use. The DHA UBO Launchpad site has valuable resources for reference and download such as UBO documents, policies, publications, calculators and archived webinars. Users can also find archived resources such as rate tables.

For questions related to Launchpad, please utilize the UBO Helpdesk by e-mailing [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) or by calling 202-741-1532 with questions or concerns.

### **Medical Affirmative Claims (MAC)**

1. General. The Federal Medical Care Recovery Act (FMCRA) authorizes MTFs to recover the cost of furnishing health care to DoD beneficiaries, including active duty beneficiaries, who are injured or suffer an illness caused by a third party. Medical Affirmative Claims (MAC) is the military program established to accomplish this activity. MAC activities involve billing all areas of liability insurance, such as automobile, homeowner and renter, general casualty, medical malpractice (by civilian providers), and workers compensation (for persons other than Federal employees).
2. Identifying MAC Cases. It is the billing personnel’s responsibility, working with patient administration personnel, provider(s), coder(s), and the MTF’s Recovery Judge Advocate (RJA) to identify MAC cases. For these cases, identify those services, items, and pharmaceuticals related to the accident or injury. Detailed encounter information for a potential MAC claim is retrieved from the inpatient, ambulatory, laboratory, radiology,

and pharmacy modules within Military Health System (MHS) clinical systems. Follow the MAC Enhancement Report menu path below or the Service or National Capital Region (NCR) Medical Directorate (MD)–specific guidelines to identify MAC claims.

**MAC Enhancement Report**

**1. CHCS Menu path: ADM Ambulatory Data Module ->2 Ambulatory Data Reports ->MAC Medical Affirmative Claims Services Report**

**2. Security Key: KG ADS MAC**

**If a user does not currently have access to the ADM menu, they can gain access through assignment of the new secondary menu option:**

**Secondary menu: KG ADS RPT INJURY REPORT**

*Medical Affirmative Claims Ser KG ADS RPT INJURY REPORT*

*Medical Affirmative Claims Services Report*

You may need to obtain the security key from your System Administrator.

Follow Service or NCR MD–specific guidance to generate the actual form.

3. Claims. MAC claims are created similarly to commercial claims and as requested by the MTF's RJA. Follow Service or NCR MD–specific guidance to provide your RJA with MAC information and claims. Additional MTF responsibilities and procedures are available in *DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations,"* at

<https://info.health.mil/bus/brm/ubo/PolicyGuidance/UBO%20Manual%20dtd%20October%202017.pdf>

4. Rates. The rates used for MAC billing are the same as those included in the DHA UBO inpatient, outpatient, and pharmacy rate packages. However, inpatient and outpatient rates must be approved by the Office of Management and Budget (OMB) and published in the *Federal Register* before they can be used for MAC. Refer to the date of service to determine which inpatient or outpatient rate file applies. OMB-approved rates are published on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates>

Prescription drugs rates do not require OMB approval and thus are not affected by OMB publishing delays; use rates applicable on date of service <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates>

5. Automated MAC (AMAC) Program. Located within the Armed Forces Billing and Collections Solution (ABACUS) is the AMAC program which is designed to assist with the identification, creation, tracking, and closing of Third Party Liability cases. ABACUS allows users to create a MAC claim manually. AMAC pulls potential MAC cases from clinical systems based on diagnosis codes indicating injury. ABACUS receives files daily from CHCS for services rendered at a facility. Those services which have injury related indicators or injury related diagnosis codes are put into a daily candidate list for review. When a case is created, the AMAC program will allow for claims to be linked to the case and billed to the Third-Party Liability payer. Based on

Service Specific Guidelines, The case will remain open until a payment or settlement is reached with the MAC office. All financial transactions will be tracked in the AMAC program for reporting purposes.

5.1 ABACUS Manual. For specific guidance on performing AMAC activities such as entering a liability payer, checking the daily candidates list, working with MAC cases and vouchers, and payments and adjustments, please refer to the most current ABACUS Training and Operations Manual located on the ABACUS website under FAQ/Knowledge Base.

<https://www.abacusmhs.com/Home/FAQ>

5.2 ABACUS Computer Based Training. Also located on the ABACUS website is an AMAC training module which contains four programs:

3. Ignore Codes
4. Daily Candidate List
5. Work with MAC Cases
6. Work with MAC Vouchers

The AMAC module is mainly accessed by users that fall into either MAC Users, UBO Billers, and UBO Posters.

7. <https://www.abacusmhs.com/Home/Training>

## Manual Billing

1. General. MHS billing systems generate required claim formats in almost all cases. However, there may be instances where a manual claim must be created. Refer to the DHA UBO online training modules Data and Billing in Sync: UB-04/837I and [Centers for Medicare and Medicaid Services (CMS) form] 1500/837P available at <https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Online-Training-Courses>.

## Modifiers

1. General. Modifiers are two-character descriptors added after the Current Procedural Terminology (CPT®)/Healthcare Common Procedural Coding System (HCPCS) code to indicate that a service or item was altered from the stated CPT/HCPCS description to represent the service or item rendered more accurately and specifically. CPT/HCPCS codes may have more than one modifier and, as with any code, modifiers must be supported by medical documentation. Billing personnel should not delete or add a modifier to a code.

· If more than one modifier is required and necessary on the claim, the modifiers should be sequenced by impact on reimbursement, i.e., those such as modifier 59 should be sequenced-distinct procedural service, before anatomical site modifiers such as modifier LT/RT-Left or Right, or TA- left foot great toe.

2. Use. Payers may deny claims as "unprocessable" for inappropriate modifier use or request additional supporting documentation. If the use of a procedure code/modifier combination is inappropriate, billing personnel should consult with their coding department to make the necessary corrections and resubmit the claim within the payer's timeline.

3. Billing Examples. Common examples of modifiers that may impact billing are defined below. Refer to your CPT and HCPCS coding manuals for the complete list.

3.1. Modifier -24 – Unrelated Evaluation and Management Service by the Same Provider During a Postoperative Period. This modifier indicates that a provider has seen a patient for an unrelated issue during a postoperative period. For example, if a family practice provider performed a vasectomy on Monday (vasectomies have a 10-day postoperative period), then treated the patient as a walk-in for a sore throat on Friday, the provider would need to append modifier -24 to the office visit code. Without the modifier, the payer may not pay it thinking the office visit was part of the global follow-up for the procedure.

3.2. Modifier -25 – Separate E&M on the Same Day as Another E&M or Procedure by the Same Provider. This modifier indicates that the patient's condition on the day of the procedure required a significant, separately identifiable Evaluation and Management (E&M) service beyond the usual preoperative and post-operative care associated with the procedure or service performed. For example, a pediatrician performs a well-baby exam and also treats the child's conjunctivitis (pink eye) at the same visit. The pediatrician would code the physical (e.g., 99392) without a modifier and would code the office visit for the conjunctivitis with a modifier (e.g., 99212-25). The payer may decrement the payment for the code with the modifier (in this example, the 99212). The physician's documentation must clearly support the coding and billing of two visits for the same encounter, in this case the physical and the problem focused visit for conjunctivitis.

3.3. Modifier -26 – Professional Component. This modifier indicates that the service or item has separate professional and technical reimbursements. It is commonly used with radiology and some cardiology procedures. Billing personnel must make sure modifier -26 is included for procedures where they are only billing the professional component of an inpatient encounter.

3.4. Modifier -32 – Mandated Services. In the MHS, this modifier is used to mean –TC (technical component) because the Composite Health Care System (CHCS) does not allow alpha modifiers. If it is appended to a CPT code, billing personnel must change it to –TC. In the commercial sector this modifier indicates services mandated by an outside entity such as a payer, government agency, employer, etc. For example, a payer requests an independent evaluation of a patient filing a workers compensation claim, or seeks a "second opinion" on a patient's condition, prior to authorizing further testing and/or treatment.

3.5 Modifier -33 – Preventive Services. This modifier indicates when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force. PT modifier is required instead of Modifier 33 for Medicare in the event the government program is being billed for a denial in order for the secondary payer to be billed. Modifier 33 and PT are primarily utilized for screening colonoscopies converted to diagnostic colonoscopies. (USPSTF) A or B rating in effect



and other preventive services identified in preventive services mandates (legislative or regulatory). Many payers will waive copays and deductibles. The current list of USPSTF A and B recommendations is available at <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

3.6. Modifier -50 – Bilateral. This modifier indicates that the same procedure was performed on both sides of the body during the same surgical session. For example, a patient has cataracts

removed from both eyes during the same surgical session. Payers may decrement payment for the second procedure. Modifier 50 is not to be used on specific CPT codes that are inherently bilateral by virtue of the fact the title of the code describes a bilateral procedure or the title of the procedure includes the words “unilateral and/or bilateral.”

3.7. Modifier -51 – Multiple Procedures. This modifier indicates that more than one procedure, other than the E&M, was performed during the same session by the same provider. It is never appended to add on codes. Payers may decrement the professional fee for multiple procedures.

3.8. Modifier -52 – Reduced Services. This modifier indicates that a provider, at his or her discretion, reduced a service or procedure. Payers may request documentation of how the procedure was reduced and may decrement payment. Modifier 52 is not to be used if another CPT procedure code better outlines and describes the procedure performed as documented in the record.

3.9. Modifier -54 – Surgical Care Only. This modifier indicates that one provider performed the surgical procedure and another provided pre- or postoperative management. For example, a fracture is set in the Emergency Department, but after care will be done in Orthopedics.

3.10. Modifier -55 – Postoperative Management Only. This modifier indicates that one provider performed postoperative care and evaluation and another performed the surgical procedure. For instance, the orthopedic clinic does only the after care for a fracture treated in the Emergency Room at the downtown hospital. Payers may decrement payment depending on the amount of the total global procedure is for the postoperative follow-up.

3.11. Modifier -56 – Preoperative Management Only. This modifier indicates that one provider performed preoperative care and evaluation and another performed the surgical procedure. For example, a primary care provider may do the preoperative component of the care for an open fracture reduction, and an orthopedic surgeon may perform the surgical procedure. Payers may decrement payment depending on the amount of the total global procedure is for the intraoperative and the postoperative follow-up.

3.12. Modifiers -62, -80, -81, and -82 – This modifier indicates multiple providers and assistants during the same surgical encounter. Payers may decrement payment. Modifier “-AS” indicates that the assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist. Technicians and operating room nurses should not be coded as assistant surgeons.

3.13. Modifier -RT or -LT – Location. Some codes require a location (informational) modifier. For example, a modifier is needed for a fracture of an arm to tell if it is the right (-RT) or left (-LT) arm. Claims may be returned if the location modifier is not provided. If location modifiers are used, payers may reimburse these as bilateral procedures (e.g., modifier -50) instead. Anatomical modifiers are not to be used if the description of the CPT code does not indicate an anatomical site and the organ system/body area are not bilateral in nature.

## Medicare Claims

1. General. MTFs may bill non–Uniformed Services (“civilian”) Medicare enrollees directly for emergency treatment at the appropriate full outpatient reimbursement rate (FOR) or full (inpatient) reimbursement rate (FRR), based on Military Department or National Capital Region (NCR) Medical Directorate–specific guidance.

1.1. Options. MTFs may either participate in Medicare or elect to enroll as a nonparticipating provider for certain emergency care and submit claims to Medicare for care provided to civilian Medicare enrollees within the continental United States (CONUS), again based on Military Department or NCR Medical Directorate–specific guidance. In either case, whether participating or electing to submit claims to Medicare, the following guidelines apply.

1.1.1. The MTF must follow Medicare rules.

1.1.2. The MTF must bill Medicare at the interagency inpatient or outpatient rate (IAR or IOR).

1.1.3. The MTF may only submit Parts A (inpatient) and B (professional services and outpatient) claims<sup>19</sup> for emergency department (ED) care provided to these civilian Medicare enrollees within the continental United States (CONUS)<sup>20</sup>.

1.1.4. The MTF must submit all claims for Medicare patients to Medicare for the calendar year.

1.1.5. The MTF must agree to accept Medicare reimbursement as payment in full.

1.1.6. The MTF should bill the patient for any Medicare-authorized deductibles and co-payments identified in the remittance advice.

1.2. Direct Billing. If the MTF bills a civilian patient directly, the patient should be registered under Patient Category (PATCAT) K92 (Civilian Emergency) and must be charged the DHA UBO FOR or FRR. If the MTF bills Medicare on behalf of the civilian patient, whether the MTF is participating or nonparticipating, the patient should be registered under PATCAT K93 (Medicare Civilian Emergency), and Medicare is charged the DHA UBO interagency rates (IAR/IOR).

Billable Services/Items. Medicare covers different levels of ED care depending on whether

the claim is submitted by a participating or nonparticipating provider.

2. Participating Providers. Medicare will reimburse participating hospitals for ED and critical care visit codes if the services provided were medically necessary and match the code description. For further information see *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 12, Sections 30.6.11, “Emergency Department Visits (Codes 99281 – 99288),” and 30.6.12, “Critical Care Visits and Neonatal Intensive Care (Codes 99291 – 99292),” available at [CMS Internet-Only-Manuals](#).

2.1 Nonparticipating Providers. Claims submitted by nonparticipating providers must be supported with documentation that shows the services were “necessary to prevent the death or serious impairment on the CMS 1771. Use CMS form 1771 “Attending Physicians Statement and Documentation for Medicare Emergency” available at CMS Forms 1771.html. For more information, see Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 3, Section 110.2, “Establishing an Emergency”, available at CMS Internet-Only-Manuals. Review the Medicare Remittance Advice (MRA) for patient deductible and co- payment amounts and submit claims to the patient for those amounts; do not balance bill the patient except for amounts identified as the patient’s responsibility in the remittance advice.

2.1.1. Medicare will not pay federal hospitals for emergency items or services furnished to Veterans covered under a VA benefit, retired military personnel, or eligible dependents.

2.1.2. Provider documentation describing the emergency services and MTF location as most accessible and information indicating when the emergency ended<sup>22</sup> must be submitted with the claim.

2.1.3. MTFs may submit a copy of the patient’s chart or use CMS form 1771 (Attending Physicians Statement and Documentation for Medicare Emergency CMS) described in paragraph 6.

2.1.4. If Medicare determines provider documentation does not support this level of ED care and the claim is denied, the nonparticipating MTFs should re-register the civilian patient under PATCAT K92 (Civilian Emergency Care) and must charge the full reimbursement rate (FRR/FOR).

3. Assignment of Claims. For both participating and nonparticipating MTFs, collect and maintain on file the civilian patient’s Department of Defense (DD) Form 2569 (Third Party Collection Program/Medical Services Account/Other Health Insurance). This contains his or her assignment of benefits required to receive Medicare reimbursement.

4. Medicare Enrollment or Election. To submit claims as a participating provider, MTFs must enroll and update/revalidate enrollment in Medicare as explained in subparagraph 4.2. To submit claims as a nonparticipating provider, MTFs must file an election annually with Medicare also as explained in subparagraph 4.2. In either case, CMS requires that

providers and suppliers obtain their National Provider Identifier (NPI) prior to enrolling or updating their enrollment record with Medicare, and, once enrolled, MTFs will receive a Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN)—a Medicare provider number used in survey and certification, assessment-related activities, and communications.

4.1. Participating MTFs. Complete, submit, and periodically update (revalidate) an enrollment application to the CMS to submit claims to Medicare.

4.1.1. An enrollment/revalidation fee is required.<sup>23</sup>

4.1.2. Online enrollment and revalidation applications and additional guidance are available at the [CMS Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\)](#) webpage.

4.1.3. A paper enrollment application process (i.e., CMS Form 855A) is available at the [CMS Enrollment Applications](#) webpage.

MTFs choosing to participate in Medicare must also submit CMS Form 588, “Electronic Funds Transfer Authorization Agreement” (CMS-588) with their enrollment application. The form is available at the [CMS Forms](#) webpage. CMS requires that providers and suppliers who are enrolling in the Medicare program or making a change in their enrollment data receive payments via electronic funds transfer. Each section of the form must be completed, and the form must be signed by the authorized official who signed the Medicare enrollment application. Signatures must be original and in ink (blue preferable). Copied or stamped signatures will not be accepted.

4.2 Nonparticipating MTFs. To submit claims to Medicare for ED care provided to Medicare-eligible civilians, nonparticipating MTFs must file an election with Medicare.

4.2.1 To file an election, the MTF must use CMS Form 2628, "Foreign HI Claim or Emergency Services Accessibility Documentation and Determination," available at [CMS Forms 2628](#) webpage.

4.2.2 Alternatively, an authorized MTF official may sign a statement stating the MTF elects to receive reimbursement as a nonparticipating provider for all emergency services provided to Medicare beneficiaries during a calendar year.

4.2.3 Election to bill is on a calendar year basis and expires each December 31st.

4.2.4 An MTF may not file an election for the calendar year if it has already charged any Medicare beneficiary for covered services furnished in that year.

4.2.5 An election to bill cannot be withdrawn during the year; however, MTFs retain the right to elect to bill Medicare at any time during the coming year if, when the MTF makes its election, it has not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to them.

4.2.6 Once an MTF has filed an election to bill Medicare, it must submit claims

for emergency services furnished to Medicare beneficiaries throughout the year and may not submit claims to Medicare beneficiaries beyond deductibles, coinsurance, and non-covered services in the calendar year it has elected to bill Medicare.

- 4.2.7 For more information see *Medicare Claims Processing Manual*, CMS Pub. 100-04, Chapter 3, Section 110.11, "Elections to Bill for Services Rendered Nonparticipating Hospitals," available at [CMS Internet-Only-Manuals](#) webpage.

5. Medicare Administrative Contractors (MACs). Medicare operations are managed by designated MACs and fiscal intermediaries (FIs). They serve specific States or jurisdictions and can answer MTF questions about enrollment and claims processing. Contact and other information is available [CMS Contractor Directory-Interactive Map](#).

6. Claims. For both participating and nonparticipating MTFs, submit Medicare claims at the Interagency Rate (IAR) using the appropriate format (UB-04/837I or CMS 1500/837P) and to the appropriate MAC based on the MTF's geographical location.<sup>24</sup>

6.1. Electronic Claims. Electronic claim submissions are required if an MTF submits more than 10 per month. Review the patient's Medicare card for MAC information.

6.2. Institutional Claims. On the institutional claim, enter "hospital filed emergency admission" in Form Locator 80, "Remarks".

6.3. Nonparticipating Providers. Claims submitted by nonparticipating providers must be supported with documentation that shows the services were "necessary to prevent the death or serious impairment of the CMS 1771. Use CMS form 1771 "Attending Physicians Statement and Documentation for Medicare Emergency" available at [CMS Forms 1771.html](#). For more information, see *Medicare Claims Processing Manual*, CMS Pub. 100-04, Chapter 3, Section 110.2, "Establishing an Emergency", available at [CMS Internet-Only-Manuals](#). Review the Medicare Remittance Advice (MRA) for patient deductible and co-payment amounts and submit claims to the patient for those amounts; do not balance bill the patient except for amounts identified as the patient's responsibility in the remittance advice.

6.4. Time Limitations. In general, claims by both participating and nonparticipating providers must be filed to the appropriate Medicare claims processing contractor no later than 12 months, or one calendar year, after the date the services were furnished.

6.4.1. For claims that include span dates of service, claims filing timeliness is determined as follows: The "Through" date is used to determine the date of service for institutional claims; the "From" date is used to determine the date of service for professional claims.

6.5. Claims filed after the specified time will be denied with no appeal rights. Exceptions are provided in the Centers for Medicare and Medicaid Services (CMS) Manual below. For more information, see *Medicare Claims Processing Manual*, CMS Pub #100-04, Chapter 1, Section 70 - Time Limitations for Filing Part A and Part B Claims available at [CMS Internet-Only-Manuals](#).

6.6. CMS Instructions. Follow claim instructions for required and conditional information in Chapters 25 (Completing and Processing the Form CMS-1450 Data Set (includes information related to ASC X12 837 institutional claims) and 26 (Completing and Processing the Form CMS-1500 Data Set (related to ASC X12 837 professional claims) of the Medicare Claims Processing Manual available at [CMS Internet-Only- Manuals](#).

6.7. Incomplete or Invalid Claims Returned. Services not submitted in accordance with CMS instructions will be returned to the MTF billing provider.

6.7.1. The status of these data elements will affect whether or not an incomplete or invalid submission (hardcopy or electronic) will be returned to the MTF billing provider.

6.7.2. FIs should not deny claims and afford appeal rights for incomplete or invalid information as specified in the CMS Instructions.

6.7.3. Denials are subject to appeal, since a denial is a payment determination.

6.7.4. Rejections may be corrected and re-submitted.

7. Other Health Insurance (OHI). Generally, if the patient is insured by a third party payer in addition to Medicare (e.g., employer plans), that payer is primary and should be billed at the appropriate FOR or FRR before billing Medicare at the IAR.Medigap.

7.1. If the patient is also insured with a Medicare supplemental insurance (Medigap) plan, bill Medigap third.

7.2. Secondary Plans. If the patient has a plan that specifically applies as secondary after Medicare, bill Medicare first.

### **Mental Health Services**

1. General. Mental health services are represented by Current Procedural Terminology (CPT®) 25 codes 90785 through 90899. Evaluation and Management (E&M) code 99499 should be entered as a placeholder for an office visit when these CPT codes do not have an E&M component. There is no UBO charge for 99499.

## **MHS Submission Forms**

See *System Change Requests (SCRs)*

### **Medical Services Account (MSA) Claims**

1. General. MSA activities involve billing and collecting funds for medical and dental services provided in MTFs, including cosmetic procedures, from:

- a. Department of Defense (DoD) beneficiaries,
- b. Other government agencies,
- c. DoD civilians and contractors,
- d. Non-Appropriated Fund (NAF) employees,
- e. Authorized foreign military members,
- f. DoD Dependent School employees,
- g. Army and Air Force Exchange Services (AAFES) employees,
- h. Secretarial Designees,
- i. Civilian emergency patients, and
- j. Other non-DoD beneficiary patients authorized to receive treatment in MTFs.

2. Claims. MSA claim formats are used depending on the type of patient (i.e., Invoice and Receipt, DD7/7A, SF1080). See the *Claims Formats* section of this User Guide for more information.

3. Rates. The rates used for MSA billing are included in the Inpatient Adjusted Standardized Amounts (ASA) and Outpatient rate packages approved annually by the Assistant Secretary of Defense for Health Affairs. The billed amount is based on patient category (PATCAT) and eligibility at the time the care is rendered. The Defense Enrollment Eligibility Reporting System (DEERS) is the official site for determining eligibility for most patients.

4. Billing and Accounting Procedures. Follow DOD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual (available at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance> ) and Service or National Capital Region (NCR) Medical Directorate specific guidelines for 390billing and accounting procedures.

5. ABACUS. The Account Management Module within ABACUS provides users with a number of programs in order to track and reconcile various billing scenarios related to MSA. Those programs include the following:

- Accounts Receivable (AR) Management
- Bill Estimator
- Cash Collection Voucher (CCV)
- Debt Transfer
- Dining Hall
- DD7/DD7A and SF 1080
- Elective Cosmetic Surgery
- Invoice Payments
- Other Collections

- Payment Plan
- Refund Reconciliation
- VA Billing

5.1 MSA Reports. A standard set of reports is available in the MSA Reports folder in the Account Management module. MSA Reports provide visibility and analysis of MSA billing and collections and include the following:

- Aged AR by Control Number, Payment Plan, Responsible Party, and Active Non-Delinquent
- Dining Hall Collection and Statement of Subsistence in Kind (SIK)
- Exclusion Report
- MARS Report by Control Number and Line of Business (LOB)
- Payer Source Report
- Voucher Control Log
- Currently on Extension
- MEPRS Transaction Summary

5.2 Education and Training. For specific guidance on performing the MSA activities and reports listed in Section 5, please refer to the most current ABACUS Training and Operations Manual located on the ABACUS website under FAQ/Knowledge Base.

<https://www.abacusmhs.com/Home/FAQ>

Also located on the ABACUS website are MSA training modules covering the MSA activities and reports listed in Section 5.

<https://www.abacusmhs.com/Home/Training>

## Modifiers

1. General. Modifiers are two-character descriptors added after the Current Procedural Terminology (CPT®)/Healthcare Common Procedural Coding System (HCPCS) code to indicate that a service or item was altered from the stated CPT/HCPCS description to represent the service or item rendered more accurately and specifically. CPT/HCPCS codes may have more than one modifier and, as with any code, modifiers must be supported by medical documentation. Billing personnel should not delete or add a modifier to a code.

- If more than one modifier is required and necessary on the claim, the modifiers should be sequenced by impact on reimbursement, i.e., those such as modifier 59 should be sequenced-distinct procedural service, before anatomical site modifiers such as modifier LT/RT-Left or Right, or TA- left foot great toe.

2. Use. Payers may deny claims as "unprocessable" for inappropriate modifier use or request additional supporting documentation. If the use of a procedure code/modifier combination is inappropriate, billing personnel should consult with their coding department to make the necessary corrections and resubmit the claim within the payer's timeline.

3. Billing Examples. Common examples of modifiers that may impact billing are defined below. Refer to your CPT and HCPCS coding manuals for the complete list.



3.1. Modifier -24 – Unrelated Evaluation and Management Service by the Same Provider During a Postoperative Period. This modifier indicates that a provider has seen a patient for an unrelated issue during a postoperative period. For example, if a family practice provider performed a vasectomy on Monday (vasectomies have a 10-day postoperative period), then treated the patient as a walk-in for a sore throat on Friday, the provider would need to append modifier -24 to the office visit code. Without the modifier, the payer may not pay it thinking the office visit was part of the global follow-up for the procedure.

3.2. Modifier -25 – Separate E&M on the Same Day as Another E&M or Procedure by the Same Provider. This modifier indicates that the patient's condition on the day of the procedure required a significant, separately identifiable Evaluation and Management (E&M) service beyond the usual preoperative and post-operative care associated with the procedure or service performed. For example, a pediatrician performs a well-baby exam and also treats the child's conjunctivitis (pink eye) at the same visit. The pediatrician would code the physical (e.g., 99392) without a modifier and would code the office visit for the conjunctivitis with a modifier (e.g., 99212-25). The payer may decrement the payment for the code with the modifier (in this example, the 99212). The physician's documentation must clearly support the coding and billing of two visits for the same encounter, in this case the physical and the problem focused visit for conjunctivitis.

3.3. Modifier -26 – Professional Component. This modifier indicates that the service or item has separate professional and technical reimbursements. It is commonly used with radiology and some cardiology procedures. Billing personnel must make sure modifier -26 is included for procedures where they are only billing the professional component of an inpatient encounter.

3.4. Modifier -32 – Mandated Services. In the MHS, this modifier is used to mean –TC (technical component) because the Composite Health Care System (CHCS) does not allow alpha modifiers. If it is appended to a CPT code, billing personnel must change it to –TC. In the commercial sector this modifier indicates services mandated by an outside entity such as a payer, government agency, employer, etc. For example, a payer requests an independent evaluation of a patient filing a workers compensation claim, or seeks a "second opinion" on a patient's condition, prior to authorizing further testing and/or treatment.

3.5 Modifier -33 – Preventive Services. This modifier indicates when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force. PT modifier is required instead of Modifier 33 for Medicare in the event the government program is being billed for a denial in order for the secondary payer to be billed. Modifier 33 and PT are primarily utilized for screening colonoscopies converted to diagnostic colonoscopies. (USPSTF) A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory). Many payers will waive copays and deductibles. The current list of USPSTF A and B recommendations is available at <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

3.6. Modifier -50 – Bilateral. This modifier indicates that the same procedure was performed on both sides of the body during the same surgical session. For example, a patient has cataracts removed from both eyes during the same surgical session. Payers

may decrement payment for the second procedure. Modifier 50 is not to be used on specific CPT codes that are inherently bilateral by virtue of the fact the title of the code describes a bilateral procedure or the title of the procedure includes the words “unilateral and/or bilateral.”

3.7. Modifier -51 – Multiple Procedures. This modifier indicates that more than one procedure, other than the E&M, was performed during the same session by the same provider. It is never appended to add on codes. Payers may decrement the professional fee for multiple procedures.

3.8. Modifier -52 – Reduced Services. This modifier indicates that a provider, at his or her discretion, reduced a service or procedure. Payers may request documentation of how the procedure was reduced and may decrement payment. Modifier 52 is not to be used if another CPT procedure code better outlines and describes the procedure performed as documented in the record.

3.9. Modifier -54 – Surgical Care Only. This modifier indicates that one provider performed the surgical procedure and another provided pre- or postoperative management. For example, a fracture is set in the Emergency Department, but after care will be done in Orthopedics.

3.10. Modifier -55 – Postoperative Management Only. This modifier indicates that one provider performed postoperative care and evaluation and another performed the surgical procedure. For instance, the orthopedic clinic does only the after care for a fracture treated in the Emergency Room at the downtown hospital. Payers may decrement payment depending on the amount of the total global procedure is for the postoperative follow-up.

3.11. Modifier -56 – Preoperative Management Only. This modifier indicates that one provider performed preoperative care and evaluation and another performed the surgical procedure. For example, a primary care provider may do the preoperative component of the care for an open fracture reduction, and an orthopedic surgeon may perform the surgical procedure. Payers may decrement payment depending on the amount of the total global procedure is for the intraoperative and the postoperative follow-up.

3.12. Modifiers -62, -80, -81, and -82 – This modifier indicates multiple providers and assistants during the same surgical encounter. Payers may decrement payment. Modifier “-AS” indicates that the assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist. Technicians and operating room nurses should not be coded as assistant surgeons.

3.13. Modifier -RT or -LT – Location. Some codes require a location (informational) modifier. For example, a modifier is needed for a fracture of an arm to tell if it is the right (-RT) or left (-LT) arm. Claims may be returned if the location modifier is not provided. If location modifiers are used, payers may reimburse these as bilateral procedures (e.g., modifier -50) instead. Anatomical modifiers are not to be used if the description of the CPT code does not indicate an anatomical site and the organ system/body area re not bilateral in nature.

### **National Disaster Medical System (NDMS)**

1. General. The National Disaster Medical System (NDMS) serves a dual role of support in domestic emergencies, under the lead agency responsibility of the Department of Health and Human Services; and military health emergencies, under the lead agency responsibility of the Department of Defense.
  - 1.1 The DoD will provide available resources to support the NDMS during U.S. national emergencies or U.S. domestic disasters in accordance with Title 42, U.S.C., the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the NDMS Federal Partners Memorandum of Agreement, or as directed by the President.
  - 1.2 In accordance with Chapter 68 of Title 42, U.S.C. (also known and referred to in this issuance as "The Stafford Act") or Section 1535 of Title 31, U.S.C. (also known and referred to in this issuance as "The Economy Act"), requests for NDMS assistance will be processed in accordance with DoDD 3025.18 and the National Response Framework (NRF). Such assistance is provided on a reimbursable basis under these acts.
  - 1.3 DoD NDMS patient movement and reception pertains to patient evacuation from ports of embarkation to ports of debarkation via a Federal Coordinating Center (FCC) to an NDMS hospital.
  - 1.4 NDMS civilian hospitals serve as a backup to military treatment facilities when both DoD and Department of Veterans Affairs (VA) hospitals are at capacity during a military health emergency.
  - 1.5 The DoD medical evacuation system is organized, trained, and equipped for the evacuation of wartime casualties. This population is normally not synchronous with the types of patients generated from a civilian disaster scenario. DoD will provide medical evacuation for patients identified in the U.S. Transportation Command (USTRANSCOM) Patient Movement Automated Information System bed categories within the capacity of the evacuation system at execution.

### **Observation Services**

1. General Background. Observation (OBS) is an outpatient billable service. The Assistant Secretary of Defense for Health Affairs issued a memorandum titled "Policy for Billing for Observation Services in Fixed Military Treatment Facilities." This memorandum cancels policy titled "Policy for the Reporting and Billing of Observation Services," dated August 11, 2010, and implements new policy for billing for observation services in fixed MTFs. This section of the User Guide has been prepared to ensure correct billing for both TPC and MSA functions. prepared to ensure correct billing for both TPC and MSA functions.
  - 1.1. Under the policy referenced above, the use of MEPRS functional cost code B\*\*0 is no longer authorized.

1.2. Observation services shall only be provided in two locations: the hospital's Emergency Department (ED) or in a nursing unit/ward of the hospital.

1.2.1. Current MTF information systems can only support outpatient observation services for patients in the ED. Current systems allow capture the required billing data including ED MEPRS code and procedure codes for services rendered in the ED, including OBS.

1.2.1.1 Observation services (professional and facility) that are initiated in the ED following an ED evaluation, and result in the patient being discharged home (or to an external location outside the MTF) are captured in the Ambulatory Data Module (ADM) on the "B\*\*\*\*" ED Comprehensive Ambulatory/Professional Encounter Record (CAPER).

1.2.2. For continuity of care reasons, patients placed on a nursing unit/ward that require observation care will be "admitted" to the hospital via the UBO electronic billing solution.

## 2. Coding and Documentation Background to Billing.

2.1. There must be a separate medical observation record with proper documentation of the admitting orders, nursing notes and progress notes while in observation status. This record will be referenced by coders and billers as source validation of documentation to ensure correct coding and subsequent billing.

2.2. MTFs have the ability to code facility HCPCS codes (G0378 and if applicable, G0379) for each hour in observation status. This is in addition to the provider's professional E/M services and any other appropriate services reflecting all care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) during observation care, provided the patient is not subsequently converted to an inpatient.

2.3. A coding methodology was developed to identify or flag patients on the nursing unit/ward in OBS status who were discharged home (or to an external location outside the MTF) rather than converted to an inpatient status. These episodes of care are identified based on diagnosis code indicating observation on the SIDR and an MS-DRG assignment of 951.

2.4. For patients originally placed in observation status in the nursing unit/ward and subsequently converted to inpatient status, coding of the inpatient SIDR will be accomplished by sequencing an observation diagnosis code in the last-listed code on the SIDR. This allows for tracking of episodes of care where OBS status originated in the nursing unit/ward and converted to an acute care hospital admission.

2.5. All observation services rendered on the nursing unit/ward, both facility and

professional, will be captured on the associated "A" CAPER in the Rounds module in the CHCS.

### 3. Billing when the Patient is Not Converted to Inpatient Status

3.1. MTFs have the ability to bill facility, provider professional services, and other services reflecting all care provided during observation care, provided the patient is not subsequently converted to an inpatient.

3.2. Billing staff will review all inpatient claims/invoices to identify patients on the nursing unit/ward in OBS status, and who were discharged home (or to an external location outside the MTF) based on an observation diagnosis code will be the first-listed diagnosis code on the SIDR and an MS-DRG assignment of 951 to identify incorrect inpatient claims/invoices.

3.3. For those incorrect inpatient claims/invoices, billing staff will cancel the incorrect claim/invoice and manually generate appropriate outpatient claims/invoices for all services rendered during the OBS episode of care.

- Cancel the claim or write off charges in the UBO electronic billing solution to the appropriate closure code (as determined by each Service)
- Write off I&R charges generated in the UBO electronic billing solution (as determined by each Service).
- Pass information to outpatient or other designated billing staff

3.4. Facility HCPCS codes (G0378 and if applicable, G0379), provider professional services and any other services reflecting care provided (including ancillary services and supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) during observation care should be billed based on the patient category and outpatient itemized billing rates.

3.5. Review patient encounter data. Do admission and discharge date, or start and end times, etc., indicate less than a 24-hr. stay? If yes, flag claim/invoice as a possible Observation or other non-inpatient episode of care (e.g., post APV overnight stay).

Confer with HIM staff/Coding Guidelines for assistance in admission status determination Proceed with claim cancelation/invoice write-off followed by outpatient billing or inpatient billing as appropriate

### 4. Billing when the Patient is Converted to Inpatient Status.

4.1. Facility HCPCS codes (G0378 and if applicable, G0379), provider professional services and any other services reflecting care provided (including ancillary services and

supplies such as laboratory, radiology, pharmacy, minor procedures, etc.) are not billable when a subsequent “true” admission occurs.

Likewise, the attending provider’s professional services on the A\*\*\* Rounds SADR are not billable when a subsequent “true” admission occurs unless the patient is covered under a DoD-VA Resource Sharing agreement.

### **OHI Discovery/Intake**

1. General. Other Health Insurance (OHI) Discovery is the process by which beneficiaries with commercial insurance are proactively and accurately identified supplementing historical self-reporting methods. By law, TRICARE becomes the secondary payer for beneficiaries with both TRICARE and OHI for all services that are provided by the purchased care network. Furthermore, MTFs have the ability to recover the cost of care delivered to beneficiaries who carry OHI.
2. DD Form 2569. The DD Form 2569 is used to capture OHI and ensure the proper routing of health care claims. All DoD beneficiaries, excluding Active Duty, are required to complete this form on an annual basis or when coverage information changes. OHI discovery processes are intended to supplement but not replace the current self-reporting of OHI. Beneficiaries are still required to complete a DD Form 2569 with current OHI information.
3. OHI Discovery within ABACUS. The OHI Discovery function within ABACUS searches patients that meet the following criteria:
  - The patient is in a Line of Business (LOB) that could be billable to a third-party payer.
  - The patient has a transaction in ABACUS but no registered insurance.

Every two weeks, OHI Discovery searches patient transactions that are 21 days or older and generates a search file which is securely transferred to the clearinghouse for OHI Discovery, validated, and returned to ABACUS. For specific step by step instructions, please reference the OHI Discovery Job Aid on the ABACUS website.

[www.abacusmhs.com](http://www.abacusmhs.com)

### **PATCAT**

1. General. Patient categories (PATCATs) are codes used to identify a patient's level of eligibility for care in an MTF. PATCATs classify patients by:  
Sponsor Service  
Beneficiary Category  
Special Patient Groups  
PATCATs are directly linked to UBO billing and tell what reimbursable rate (if any) is applicable for health care services provided, what billing forms are used, and which cost recovery program is responsible for billing the encounter.
2. Assignment. Patient administration personnel assign PATCATs to patients during registration. Billing personnel are encouraged to work closely with patient administration personnel to ensure

correct PATCAT assignment. A patient's PATCAT is dynamic; he/she may have dual PATCAT assignment (e.g., retiree for one encounter and an occupational health patient for the next encounter). Patients should be registered according to their highest level of eligibility. For example, a patient should be registered as a dependent if he/she is both a military retiree and a family-member dependent (i.e., married to an active duty personnel). For questions contact your patient administration personnel.

3. Reference Materials. The PATCAT table, a Finder Guide, and a training module are available online at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Patient-Categories>. The PATCAT table lists the PATCAT codes, definitions, and billing structure for patients. The Finder Guide provides decision tree logic to classify the patient into the correct PATCAT. The training module provides an overview of what PATCATs are, how the table is structured, and how PATCATs should be assigned.

### **Patient Centered Medical Home/Soldier Centered Medical Home**

1. General. As of September 2016, all direct care system primary care clinics have transformed to the Patient Centered Medical Home (PCMH) model of primary care. In support of medical readiness, the Uniformed Services continue to implement operational medical homes through the Marine Centered, Soldier Centered, Fleet Centered, and Submarine Centered Medical Home programs.
2. Responsibilities. PCMH responsibilities in the direct care system are, but not limited to: supporting patients with serious or chronic diseases to achieve their health goals; giving patients 24-hour access to care and health information through secure messaging; delivering preventive care facilitated with embedded national screening guidelines; engaging patients and their families in their own care; and working together with hospitals and other clinicians, including traditional and PCMH-embedded specialists, to provide better coordinated care.
  - 2.1 TRICARE Prime beneficiaries are assigned to PCMBN (Primary Care Manager by name) and are encouraged to seek all nonemergency health care services from their PCMs.

### **Pharmaceuticals**

1. General. Pharmaceuticals are a significant opportunity for UBO revenue. To maximize reimbursement, MTF personnel need to understand the processes, concepts, and definitions that affect whether pharmacy claims will be paid. These include: internal and external prescriptions; initial fills and refills; the number of units that will be reimbursed; types of coverage; and claim forms.
2. Internal Prescriptions. An "internal prescription" is one prescribed by an MTF provider who saw the patient at the MTF. Internally ordered prescriptions are linked to an encounter feed to the billing applications via the pharmacy feed. If the prescription is filled and dispensed within the MTF and a holding-time is applied before the claim is created, the claim will pull in data from the encounter. This simplifies MTF personnel's task of obtaining all required data for the pharmaceutical claim including: the provider's National Provider Identifier (NPI), the name of the pharmaceutical, the National Drug Code (NDC) number, the quantity

dispensed, and the diagnosis code.

3. External Prescriptions. An “external prescription” is one prescribed by a civilian or other provider external to an MTF. External prescriptions are not tied to an MTF encounter and often do not include all required data for the pharmaceutical claim (required data listed above in paragraph 2). MTF personnel must follow up with the external provider to obtain this information.
4. Provider Information. Providers have a number of associated data elements including: name, Drug Enforcement Agency (DEA) Number, license number, Composite Health Care System (CHCS) Provider Specialty Code, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Provider Class, Health Insurance Portability and Accountability Act (HIPAA) Taxonomy, and National Provider Identifier (NPI) Type 1 that are needed for various claims and/or situational conditions. Military Health System (MHS) direct care billing systems build provider files that allow the look-up of provider data as required. These applications will, in most cases, automatically provide the information for providers working within the MTF. However, for an external provider, MTF personnel must contact the provider or search an external provider database, such as the National Plan and Provider Enumeration System (NPPES) and build a provider “profile” in the clinical or billing system. Billing applications can then pull in provider data as needed.
5. Diagnosis. The requirement to provide the diagnosis on a pharmacy claim is situational. A payer may require it if this field could result in: different coverage, pricing, patient financial responsibility, or drug utilization review outcome. When the diagnosis does not automatically flow to the billing system—this occurs frequently with external prescriptions—contact the prescribing provider to obtain the applicable diagnosis or consult the Coding Department for a Diagnosis Code that would be applicable. Civilian physician offices will not give diagnoses over the phone due to HIPAA Laws.
6. Quantity Limits. Many payers may limit initial fills, refills, and quantities of pharmaceuticals. Certain pharmaceuticals, such as narcotics, may have additional Food and Drug Administration (FDA) limits on the quantities that a pharmacy may dispense. Regardless of payer limits on payment, billing personnel must submit claims stating the correct quantity dispensed.
7. Refills. Normally, there are no visits associated with refills. There will be no associated diagnosis when the pharmacy refill claim feeds to the billing system. Obtain the diagnosis by researching it on the original prescription fill in the billing system or CHCS or contact the provider who prescribed the pharmaceutical to obtain it. The fill number is reported on the standard National Council for Prescription Drug Programs (NCPDP) electronic pharmacy claim. The Uniform Billing form (UB)-04 claim form does not have a form locator field in which to enter the refill information. Thus, MTF personnel must enter the term “refill” next to the NDC number in form locator 43 of the UB-04.
8. Pre-authorization/Pre-certification of Prescription Drugs. Many payers require pre-authorization of certain pharmaceuticals. Defense Health Agency (DHA) UBO includes a historical reference list of those for which payers commonly require pre-authorization in the Biller’s Edition Workbook. MTF personnel should review this list before submitting a claim and obtain pre-authorization, if necessary. If a pharmacy claim is denied due to lack of pre-



authorization, MTF personnel must submit an authorization request as follows:

- a. Create and maintain tracking lists of payer requirements.
- b. Obtain a blank pharmacy authorization request from the payer or its website.
- c. Submit completed authorization request to the payer.
- d. Some payers may have step-therapy guidelines; refer to the payer for requirements.
- e. If there are additional questions regarding how to accurately determine coverage, the MTF official or beneficiary can utilize the TRICARE Formulary Search Tool:

<https://www.express-scripts.com/static/formularySearch/2.8/#/formularySearch/drugSearch>.

8. Coverage Types. There are three principal types of insurance that may pay for prescriptions: medical, pharmacy, and comprehensive. If a pharmaceutical claim is denied based on invalid coverage type, MTF UBO personnel should follow up with the payer and then the patient to determine if he or she carries pharmaceutical coverage.
9. Claim Forms. Payers expect pharmacy claims from commercial pharmacies (e.g., Rite-Aid) or mail-order pharmacies in the UB-04/NCPDP format and may not recognize and thus reject other claim formats. In DoD MTFs, the billing system records pharmacy claims on the UB-04 and the NCPDP. For some MSA payers, pharmacy claims are created in the DD Form 77A or invoice and receipt (I&R) claim forms, depending on the patient's category (PATCAT). For other MSA claims submitted to payers (e.g., Medicare, Medicaid), MTF personnel must use the billing system to manually generate the UB-04/NCPDP claim.
10. Over-the-Counter (OTC) Medications. Most MTF pharmacies dispense OTC medications; however, they are normally not a covered benefit provided by payers. Some OTCs (e.g., diabetic supplies) are frequently covered. The DHA UBO Program Office (PO) provides a table in the Biller's Edition Workbook to identify OTCs at this link <https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates>.
11. Documentation Requirements. For some prescriptions, there are payer-specific requirements and supportive medical record documentation that must be submitted with the claim (e.g., medical necessity form, pre-authorization form). Obtain and provide this documentation if a payer requests it or a claim is denied.
12. Rates and Charges. Rates and charges are made up of a pharmaceutical ingredient charge and a dispensing fee. The DHA UBO Pharmacy Rate is based on a standard formula used to determine the beneficiary's final charge: Final Charge = [the NDC unit price multiplied by the quantity dispensed] + [the fixed DHA UBO dispensing fee] (effective on the script's fill date).
  - 12.1. Pharmaceutical Ingredient Charge. MTF billing systems automatically calculate the pharmaceutical ingredient charge by multiplying the number of units by the DHA UBO unit cost (rate) and adding a pharmacy dispensing fee for all prescriptions, both new and refills. DHA UBO rates are developed using the Managed Care Pricing File from Defense Supply Center Philadelphia (DSCP) and historical TRICARE purchased care reimbursement data. For some medications, this rate is lower than what the MTF may be paying to obtain the medication. MTF personnel must use and may not change the DHA UBO pharmaceutical rate.

12.2. Dispensing Fee. A dispensing fee representing the charge per prescription is updated and loaded into MTF billing systems along with the pharmacy ingredient rate updates. Add the dispensing fee to the ingredient charge to determine the total pharmaceutical charge. If there is no ingredient charge, submit the dispensing fee on the claim to the payer.

12.3. Unit of Measure. Units of measure are a critical aspect of determining the correct price calculation for prescriptions. The Biller's Edition Workbook provides descriptions of the Unit of Measure – ex: ml (milliliters) or gm (grams) - to calculate to total pharmacy charge.

12.4. Pharmacy Charge Calculation Example:

UBO Rx Rate File Fields to Use:

- NDC = 52959018790
- NDC Name/Description = IBOPROFEN 200 MG TABLET
- Dosage/Product Form Code = TA
- Unit of Measure (UM) = EA (Each)
- UBO Rx NDC Unit Price = \$0.01
- Quantity Dispensed: 30

Specific NDC Pricing Methodology:

$$\begin{aligned} &(\text{NDC Unit Measure} \times \text{Quantity Dispensed}) + \text{Dispense Fee} = \text{Total Rx Price} \\ &(\$0.01 \times 30) + \$2.00 = \$2.30 \end{aligned}$$

13. Medicare Supplemental Plans. MTFs can bill Medicare supplemental plans for prescription drugs in the same manner they bill other health insurance.

13.1. Medicare Parts A, B, and D as well as Medicare Advantage Plans are not billable for MHS Beneficiaries because the MTF is reimbursed through the MERHCF.

14. Revenue Codes. Revenue code 250 must be reported on UB-04 pharmacy claims. NCPDP claims do not require a revenue code.

15. Pharmacy Resources. Along with the Pharmacy Rate File, the UBO utilizes the DHA Pharmacy Pricing Estimator (PPE) and the DHA UBO Biller's Edition Excel Workbook.

16.1. The Biller's Edition Workbook provides the most recent NDC information, along with all updated NDC unite prices, Units of Measure,

16.2. The DHA Pharmacy Pricing Estimator (PPE) is an Access database that utilizes DHA pharmacy rates to calculate total prescription costs by factoring in drug codes, dosage, quantity dispensed, unit of measure, and the dispensing fee.

## **Pre-Authorizations**

1. General. Some payers require approval of an admission, a procedure, a drug, or supply before furnishing it or at the time of service before they will reimburse an MTF. The term pre-authorization can be used interchangeably with pre-certification and prior authorization. These are not to be confused with obtaining referrals, pre-determination, authorization for inpatient admissions or utilization review. Generally, payers request to see documentation of conservative treatment before a provider requests approval for more invasive procedures.

2. Admissions. A process must be in place for Admissions staff members to notify the UBO staff when a patient with other health insurance (OHI) is admitted (e.g., via email group, by providing Department of Defense (DD) Form 2569, or by phone call). A UBO staff member or a Utilization Review (UR) nurse should call the payer's pre-authorization phone number or use a secure online process to certify the admission. Verify pre-authorization prior to each patient admission, if possible.

2.1. The payer provides an authorization number if the reason for admission is approved. Enter the authorization number in the Patient Demographics and OHI - Authorizations Section in ABACUS. The Authorization Number can be manually entered on the claim once it is in "bill ready" in ABACUS.. Keep documentation of authorization for each admission or ambulatory procedure visit (APV) in the billing file. Failing to obtain pre-authorization may require additional "clinical review" and be subject to a reduction in reimbursement. In some cases, no authorization is needed for a diagnosis or where Medicare is considered the primary payer.

2.2. Payers may require a "clinical review," which may be facilitated by UBO staff or a UR nurse may verbally provide the medical documentation supporting the request. The payer may require follow-up documentation (e.g., a copy of the medical record).

3. Outpatient Surgery (i.e., APVs) and Diagnostic Imaging/Radiology Therapy. A process must be in place to obtain a copy of future appointments. Look for patients with insurance to see if there are any schedules, procedures, or visits that require pre-authorization.

3.1. Call for pre-authorization. Authorization may be given by telephone after providing a reason for procedure; however, additional information may be required from the medical record, and a clinical review may be necessary.

3.2. Enter the authorization number in the Patient Demographics and OHI - Authorizations Section in ABACUS. The Authorization Number can be manually entered on the claim once it is in "bill ready" in ABACUS..

4. Pharmacy Scripts. A process should be in place for UBO personnel to identify scripts that require pre-authorization; payer requirements may vary and may not be known until a denial is received. Prior to submitting the claim, check the Biller's Edition Workbook on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates> for a historical list of pharmaceuticals that commonly require pre-authorization. Additionally, MTF staff can enter the National Drug Code (NDC) or drug name into the TRICARE Formulary Search Tool, found at <https://www.express-scripts.com/static/formularySearch/2.7/#/formularySearch/drugSearch> , to determine if the drug requires a pre-authorization. An MTF staff member should reference these resources before submitting a claim and obtain pre-authorization, if necessary. If a pharmacy claim is denied due to lack of pre-authorization, an MTF staff member must submit an authorization request as follows.

4.1. Create and maintain tracking lists of payer requirements.

4.2. Obtain a blank authorization request from the payer or its website.

4.3. Submit completed authorization request to the payer.

4.4. Some payers may have step-therapy guidelines; refer to payer for requirements.

## Providers

1. General. Providers (e.g., physicians, nurse practitioners, nurses, medical technicians) in the Military Health System (MHS) are classified in several ways including Composite Health Care System (CHCS) Provider Class and Specialty Code, TRICARE Provider Category, and Health Insurance Portability and Accountability Act (HIPAA) Provider Taxonomy Code. The type of provider as well as the role of the provider for a given service affects the amount billed and may even determine if the services are billable.

2. CHCS Provider Classes. CHCS classifies providers into four Provider Classes based on the CHCS Provider Specialty Code(s), a schema for describing the provider's medical specialty, assigned to the provider by the MTF. TMA UBO rates for most professional services provided to Third Party Collection Program (TPCP), Medical Affirmative Claims (MAC) and most Medical Services Accounts (MSA) patients differ depending on the CHCS Provider Class.

Class 1 is the physician provider class (medical doctor (MD) and doctor of osteopathic medicine (DO)) Class 2 is the psychologist class (doctor of philosophy (PhD) and psychologist)

Class 3 is other mental health provider class (Certified Social Worker)

Class 4 is the extra medical provider (non-mental health only)

Rates are typically higher for Classes 1 and 2 than they are for Classes 3 and 4. The MHS maintains a table that maps each CHCS Provider Specialty Code to CHCS Provider Class as well as to the corresponding HIPAA Taxonomy. The HIPAA Taxonomy is the national standard schema for provider specialties. TPC, MAC, and billing applications maintain reference tables that tie the CHCS Provider Specialty to Provider Class and thereby calculate the correct charges for TPC, MAC and most MSA billing.

3. TRICARE Provider Categories. TRICARE Provider Categories are used to calculate charges for care provided to patients at MTFs operating under Department of Veterans Affairs (VA)-DoD resource sharing agreements. They classify providers into four categories that differ from CHCS Provider Classes. Whereas CHCS Provider Classes are determined solely by the CHCS Provider Specialty, TRICARE Provider Categories relate to a combination of the provider's HIPAA Taxonomy and the setting where the service was rendered (i.e., institutional setting versus provider's office). Correct VA-DoD resource sharing agreement billing is dependent on mapping the provider described in the encounter documentation to the correct TRICARE Provider Category show below.

Category 1 (Facility Physician): Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) provided in a facility setting.

Category 2 (Non-Facility Physician): Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and CNMs provided in a non-facility setting.

Category 3 (Facility Non-Physician): Services, of all other providers not found in Category 1, provided in a facility setting.

Category 4 (Non-Facility, Non-Physician): Services, of all other providers not found in Category 2, provided in a non-facility setting.

4. Provider Roles. HIPAA-claim filing standards require that provider roles are described relative to care provided. These roles include: referring, ordering, supervising, rendering, attending, operating, other operating and prescribing, depending on services provided and claim format. Provider roles within CHCS do not fully align with the HIPAA required claim roles. Therefore, billing applications map the CHCS DHA UBO User Guide - 100 - 29 August 2014 provider roles to the HIPAA-required claim roles.

5. "Incident To" Billing. "Incident to" billing refers to the billing of services and supplies that are performed by auxiliary personnel (e.g., physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, clinical psychologists, clinical social workers and physical and occupational therapists).

5.1. Supervision of Auxiliary Personnel. Auxiliary personnel act under the supervision of the provider after the provider has seen the patient, developed a plan of care, and initiated the course of treatment. The "incident to" service provided by the auxiliary personnel is then an incidental part of the patient's treatment. The services provided must be delivered under the provider's direct supervision; the provider must be in the area where care is delivered and be immediately available to provide assistance and supervision. The patient can see the auxiliary personnel for continued treatment of the initial problem that was presented to the provider. If a new problem is identified at a visit by the auxiliary personnel, the patient must be referred back to the provider for evaluation and development of a new plan of care.

5.2. Billing process. Submit claims based on the encounter information provided by the billing system. UBO personnel may bill "incident to" care under the supervising provider's identity if the conditions in 5.1 were met. In that case, review the encounter documentation and consult with the coding staff for verification.

## **Pulmonary Testing**

1. General. Pulmonary diagnostic testing and therapy services are represented by Current Procedural Terminology (CPT®) codes 94010–94799. These services include laboratory procedure(s) and the interpretation of test results. Charges for laboratory services or test results are inherent in CPT codes 94010–94799 and should not be billed separately when billing for pulmonary diagnostic testing and therapy services.

2. The encounters are collected in the Ambulatory Data Module (ADM) under the D\*\*\* MEPRS (Medical Expense and Performance Reporting System) work centers.

## **Radiology**

1. General. Radiology Current Procedural Terminology (CPT®) 28 codes are in the 70010–79999 range. Radiology services coded with no modifier or modifiers –TC or -32 should be

billed on the Uniform Bill (UB)-04/837I (institutional) claim format. Radiology services coded with modifier -26 reflect only professional services and should be billed on the Centers for Medicare & Medicaid Services (CMS) 1500/837P (professional) claim format.

## Rate Tables

1. General. DoD rates tables tell what rate to apply for each coded service, procedure, supply, and pharmaceutical provided to a patient. Each outpatient service and supply is identified with a Current Procedural Terminology (CPT®10)/Healthcare Common Procedural Coding system (HCPCS) code; each inpatient medical facility has adjusted standardized amounts (ASA); and pharmaceuticals are identified based on National Drug Code (NDC). Defense Health Agency (DHA) UBO rates are available on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview> . If there is no rate available, refer to Appendix A, *Procedure To Request DHA UBO Program Office-Approved Billing Rates for Services, Pharmaceuticals, or Durable Medical Equipment and Supplies Not Included in Standard Rate*.

2. Outpatient Billing Rates. The majority of rates are based on the TRICARE CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) Maximum Allowable Charge (CMAC) fee schedule, adjusted for MHS billing systems, and they include charges for additional services not reimbursed by TRICARE. If no TRICARE CMAC is available, rates may be developed based on Centers for Medicare & Medicaid Services (CMS) reimbursement rates, Purchased Care data, Medical Expense and Performance Reporting System (MEPRS), and other government rate tables. The annual Outpatient rates package includes MHS-adjusted Full Outpatient Reimbursable (FOR) CMAC rates and MHS standard rate tables for Dental, Immunizations/Injectables, Anesthesia, Durable Medical Equipment/Durable Medical Supplies (DME/DMS), and Ambulance. The package also includes government discounts for Interagency Outpatient Rates (IOR) and International Military Education and Training (IMET) services. For care provided to Department of Veterans Affairs (VA) patients under VA-DoD Resource Sharing Agreements, however, use TRICARE CMAC rates, and discounts apply.

### 2.1. UBO CMAC-based Rate Tables.

2.1.1. CHCS Provider Classes. UBO CMAC-based tables contain rates for each CMAC Provider Class applicable for each CPT/HCPCS code. Each billable provider is mapped to a CMAC Provider Class of 1 through 4. The four provider classes are: (1) Physicians, (2) Psychologists, (3) Other Mental Health Providers, and (4) Extra Medical Providers. (See the *Provider* section of this User Guide for more information on CMAC Provider Class and mapping information.)

2.1.2. Localities. UBO CMAC rates are calculated for 124 distinct “localities.” These localities recognize differences in local costs to provide health care services in the different geographic regions in which MTFs are located. Each MTF Defense Military Information System Identifier (DMIS ID) is mapped to its corresponding CMAC locality code to obtain the correct rates. For all MTFs located outside the continental United States and Hawaii, CMAC locality 300 is used. The complete DMIS ID-to-CMAC Locality table is available on the DHA

UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates>

2.1.3. CMAC and CMAC Component Tables. For each CMAC locality, the DHA UBO creates two sub-tables of rates: CMAC and Component. The CMAC rate table specifies the rates to use as payment for professional services and procedures identified by CPT and HCPCS codes, which cannot be separately provided as professional and technical component services. The Component rate table specifies which rates to use for CPT codes, which can be provided as distinct professional and technical components, or which are a combined professional and technical service. A separate rate is provided for each component. The professional component rates (for codes with modifier -26) are for services that are normally performed by a physician to interpret a diagnostic test. The technical component rates (for codes with modifier -TC) are institutional charges that are not normally billed separately (e.g., charges for DHA equipment, technician services, supplies and materials used during test). The global rate is equal to the sum of professional and technical charges.

2.2. Dental Rate Table. The Dental rate table provides full Third-Party Collection (TPC) rates for dental services based on American Dental Association (ADA) Current Dental Terminology (CDT) codes (HCPCS Level II codes). Discounted charges for IOR and IMET rates are calculated in the UBO billing solution.

2.3. Immunizations/Injectables Rate Table. The Immunization/Injectables rate table provides the full/TPC rates for vaccines and therapeutic medications (injections) administered other than by mouth as part of a clinic encounter, as identified by HCPCS Level II codes.

2.4. Anesthesia Rate Table. The Anesthesia rate table provides the Full/TPC rates for the professional portion of anesthesia services, based on the flat rate assigned to each anesthesia CPT code.

2.5. DME/DMS Rate Table. The DME/DMS rate table provides the full/TPC rate for DME/DMS based on HCPCS Level II codes and modifiers.

2.6. Ambulance Rate Table. The Ambulance rate table provides full/TPC rates for ambulance services, based on an all-inclusive hourly rate. Discounted charges for IOR and IMET rates are calculated in the UBO billing solution.

2.7. Government Discounted Services Rate Table. The government discounted services rate table (formerly known as the IOR/IMET rate table) provides the government discount or billing calculation factor (percentage discount) applied to the full/TPC rate when billing for IMET and IOR services, including ambulance and dental.

3. Inpatient ASA Rates. ASA rates are MTF-specific–based charges per relative weighted product (RWP) applied to inpatient encounters. They are adjusted for area wage differences and indirect medical education (IME) costs, if any, for the discharging hospital. The tables provide the full/TPC, IOR, and IMET rates.

4. Pharmaceuticals. Pharmacy rate tables provide full ingredient unit measure charges for pharmaceuticals based on their NDCs. For each rate table, there is a corresponding dispensing fee table.

5. Updating Rate Tables.

5.1. Outpatient. Billing system administrators must update outpatient rate tables as they are published (generally annually on a modified calendar year basis).

5.2. Inpatient. Billing system administrators must update outpatient rate tables as they are published (generally annually on a modified calendar year basis).

The ASA rates are updated by ABACUS Administrators.

5.3. Pharmacy. Billing system administrators must update Pharmacy rate tables as they are published (generally biannually).

### **Rate Request Procedure**

1. The billing office will identify the service's Current Procedural Terminology (CPT®14) procedure code, the pharmaceutical NDC, or the DME/DMS Healthcare Common Procedural Coding System (HCPCS) code that is not in the DHA UBO rates file.

a. In the case of a CPT procedure code that does not have a rate, the billing office will draft a written explanation telling the date(s) of service and the number of times and specific details of when or how the code is being used, including what documentation supports its use.

b. In the cases of a NDC or DME/DMS HCPCS code that does not have a rate, the billing office will contact its local procurement or supplies management activity to determine the actual price paid for the NDC or DME/DMS and obtain documentation or proof of purchase on the actual price paid ("the local proof of purchase"). The price paid is the government cost regardless of whether it is purchased from the MTF or central activity budget. If there is no local price, the billing office will draft a written explanation telling the dispense date and the number of times and specific details of when or how the NDC is being dispensed, including what documentation supports its use.

2. The billing office will forward the written explanation and supporting documentation or the local proof of purchase and quantity dispensed or number units and the service, dispense, or issue date to the DHA UBO Helpdesk at [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) with a request for pricing. Use the Subject line: "DHA UBO Special Price Request."

3. The DHA UBO Help Desk will forward the request and documentation to the pharmacy pricing subject matter expert (SME) or the Outpatient Services/DME/DMS pricing SME.

4. The pricing SME will verify that the service, NDC, or DME/DMS is not in the current rate file.

a. If the pricing SME confirms there is no DHA UBO current rate for a CPT® code, but there is a current TRICARE or CMS rate, he or she will review the written explanation and documentation to determine whether to recommend an out-of-cycle rates update. Factors considered include whether there is a TRICARE or CMS rate for the date of service, the number of times the new code is being used, and whether similar requests have been received from other billing offices. With PO approval, the SME may send a data call to the Services.

b. If the pricing SME confirms there is no DHA UBO current rate for an NDC or DME/DMS HCPCS code but there is a local proof of purchase, then he or she will verify the local proof of purchase. If verified, he or she will convert the actual price submitted into the unit measure price (rate). If there is no local proof of purchase, he or she will review the written explanation and documentation to determine whether to recommend an out-of-cycle rates update. Factors considered include the whether there is a TRICARE or CMS rate for the date of



service, the number of times the NDC or DME/DMS HCPCS code is being used, and whether similar requests have been received from other billing offices. The SME may send a data call to the Services. (The SME will determine the recommended charge by multiplying the quantity or number of units by the unit measure price and, in the case of pharmacy NDCs, adding the applicable dispensing fee.)

5. The pricing SME will submit the recommended charge and supporting justification and documentation (including no charge if insufficient justification and documentation) to the PO for review and approval.

6. The pricing SME will send the PO approved charge information (including if no charge) to the billing office that requested the pricing and copy the PO, the DHA UBO Help Desk, and the applicable Service Program Manager(s). Approval of a rate for services, NDCs, DME/DMS is MTF-specific or Activity-specific and cannot be used by other MTFs or Activities unless the PO states otherwise.

### **Refunds**

1. General. This section is applicable to ABACUS. Automated and manual procedures are used to correct accounting records. Manual procedures are provided when automated systems are not available. When performed manually, MTFs are responsible for tracking refunds and reconciling accounts for audit and compliance purposes. This does not pertain to Air Force billing operations; Air Force MTFs should follow Service guidance.

2. Refunds. When an overpayment is received for claims billed out of the Armed Forces Billing and Collection Utilization Solution (ABACUS), MTF staff should utilize the Refund Reconciliation program within the Account Management module. The Refund Reconciliation program allows users to locate and track accounts with a negative balance that may need to be refunded to the original source after approval from Defense Finance and Accounting Services (DFAS).

2.1. Identified accounts can be searched for in the Refund Reconciliation program to create a refund voucher which can then be used to print out a standard refund form. ABACUS provides the ability to produce three standard refund forms: SF 1034, SF 1049, and SF 1081.

2.2. For step by step instructions on properly performing a refund within ABACUS, please reference the *Refund Reconciliation* section of the ABACUS Training & Operations Manual located on the ABACUS website.

<https://www.abacusmhs.com/>

### **Revenue Codes**

1. General. Revenue codes (RCs) are used on the institutional claim (paper Uniform Bill (UB)-04 or the electronic 837I) to identify specific accommodations (inpatient) and ancillary services (outpatient). For additional information on institutional claims, view the DHA UBO

online training module Data and Billing in Sync: UB-04/8371, available at: <https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Online-Training-Courses>. Revenue codes are used to tell third party payers what service category was provided and in some instances where the service was provided. For instance, revenue code 450 indicates the service was provided in an Emergency Department, revenue code 490 indicates the service was provided in an ambulatory surgery center and revenue code 510 indicates the service was provided in a clinic. On the other hand, revenue code 636 indicates a drug was supplied and billed that is separately billable and payable as opposed to bundled into the drug administration code, revenue code indicates an X-ray was provided and billed, revenue code 402 indicates an ultrasound was performed and billed, and revenue code 434 indicates an occupational therapy evaluation or reevaluation was performed.

- 1.1 A revenue code corresponds to each narrative description or standard abbreviation that identifies a specific ancillary service.
  - 1.2 A revenue code must be assigned for each line item charge billed.
  - 1.3 A revenue code must be valid for the type of claim being billed. For example, Days Room & Board (e.g., 011X) is valid for inpatient claims only; it is not valid for outpatient claims.
2. Reference Materials. Reference materials, including use of revenue codes, are available from a number of sources. They provide information about the correlation between Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®30) codes, revenue codes, type of bill, etc. For more information, ask your Service or National Capital Region Medical Directorate (NCR MD) UBO Program Manager.
  3. Revenue Code Mapping Table. The Revenue Code to CPT Code Mapping Table is loaded annually each calendar year into the Composite Health Care System (CHCS) and billing and collections systems. For future billing solutions, this information may be distributed in a different manner.
    - 3.1 The mapping table lists most commonly used RCs per CPT/HCPCS codes. Changes to RCs listed in the mapping table will be considered by the Defense Health Agency (DHA) UBO Program Office on request. Send requests to your Service or NCR MD UBO Program Manager.
  4. Commonly Used Revenue Codes. Following is a list of the most common RCs for institutional claims:

Revenue Code	Description
0001	Total charge (paper only)
010X	All-Inclusive Rate
024X	All-Inclusive Ancillary
025X	Pharmacy
026X	IV Therapy
027X	Medical/Surgical Supplies and Devices

028X	Oncology
029X	Durable Medical Equipment (other than Renal)
030X	Laboratory
031X	Laboratory Pathology
032X	Radiology – Diagnostic
033X	Radiology – Therapeutic and/or Chemotherapy
034X	Nuclear Medicine
035X	CT Scan
036X	Operating Room Services
037X	Anesthesia
038X	Blood and Blood Products
040X	Other Imaging Services
041X	Respiratory Services
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech Therapy – Language Pathology
045X	Emergency Room
046X	Pulmonary Function
047X	Audiology
048X	Cardiology
049X	Ambulatory Surgical Care
051X	Clinic
053X	Osteopathic Services
054X	Ambulance
061X	Magnetic Resonance Imaging (MRI)
062X	Medical/Surgical Supplies
063X	Pharmacy
073X	EKG/ECG (Electrocardiogram)
074X	EEG (Electroencephalogram)
075X	Gastrointestinal Services
076X	Treatment or Observation Room
077X	Preventive Care Services
081X	Acquisition of Body Components
082X	Hemodialysis – Outpatient or Home
090X	Behavioral Health Treatments/Services
091X	Behavioral Health Treatments/Services
092X	Other Diagnostic Services
093X	Medical Rehabilitation Day Program
094X	Other Therapeutic Services
095X	Other Therapeutic Services
096X	Professional Fees
097X	Professional Fees
098X	Professional Fees

**Staging Bill Errors**

1. Staging Bill Errors. Billing personnel should use this opportunity to work their Staging Bill Errors. Staging Bill Errors is a que within ABACUS for billing personnel to correct errors prior to claim creation. Identifying and correcting claims that errored out due to data issues (e.g. unverified pre-authorization/pre-certification) will ensure associated claims are corrected before flowing into ABACUS.

**Standard Insurance Table (SIT) / Other Health Insurance (OHI)**

1. General. The DoD is authorized by federal law (10 United States Code (U.S.C.) 1095) to collect from third party payers “reasonable charges” for the cost of inpatient and outpatient services rendered to military retirees, all family members, and other eligible beneficiaries who have private health insurance.

1.1. The Standard Insurance Table (SIT) is the centralized Defense Enrollment Eligibility Reporting System (DEERS) database that contains information on Health Insurance Carriers (HICs) and the types of coverage (e.g., comprehensive, medical, pharmacy, dental, vision) that each HIC offers. The centralization of SIT data allows a payer’s address(es) for claims be shared throughout the Military Health System (MHS). To access the SIT, utilize the following menu path within CHCS or contact your activity CHCS Administrator for the correct CHCS path:

DAA > CFT > CFM > STM > SIT

Note the SIT is not available in MHS GENESIS.

1.2. Other Health Insurance (OHI) refers to other health insurance policies that a TRICARE beneficiary may carry, representing potential collections for the Third-Party Collection (TPC) Program. OHI excludes Medicare, Medicaid, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) supplemental plans, Tricare /Tricare supplemental plans and also civilian emergency patients and Uniformed Services Civilian employees who are not beneficiaries (they may be billed directly via the Medical Services Account (MSA) program). OHI data refers to information about a patient's policy, such as the policy name and number, coverage type, patient relationship to the insured person, and effective dates of coverage. This information is used to properly route a health care claim sent to the OHI carrier.

1.3. OHI Entry. To enter patient OHI data into CHCS, use one of the following menu paths:

- #1: CA -> PAD -> ROM -> PII -> enter Patient Name -> DEERS OHI query -> Screen 1
- #2: CA -> PAD -> ROM -> FRG or MRG -> Patient Name -> enter/edit registration information
- #3: CA -> PAD -> ADT -> ADM -> enter Patient Name -> enter/edit demographics -> DEERS OHI query -> Screen 2
- DD Form 2569 (Third Party Collection Program – Record of Other Health Insurance). MTF personnel should collect OHI information from all patients on Department of Defense (DD) Form 2569 annually and verify or update the form with the beneficiary at every visit. The feasibility of obtaining 2569 data without use of the actual paper form in MHS GENESIS is under review. The original (completed, signed, and dated) form can be placed in the patient’s medical record (e.g., inpatient, outpatient, and ambulatory procedure visit records) or stored electronically. The billing department should have access to the

electronically stored forms or a copy should be forwarded for verification and entry into the Composite Health Care System (CHCS) Patient Insurance Information (PII).

2.1 e2569. The e2569 program within ABACUS is used to track when DD 2569 forms need to be updated and to allow users to create and update electronic versions of the DD 2569s (e2569s). The data may then be transferred to ABACUS to update the Patient Demographics and OHI records. For specific instructions regarding searching updating, and finalizing an e2569 record, refer to the ABACUS Training and Operations Manual and computer based training found on the ABACUS website.

2. SIT/OHI DEERS Subscription. Authorized users enter SIT/OHI changes directly into local CHCS systems. CHCS automatically uploads data to DEERS to make the new information available to other system users. Similarly, DEERS OHI data is only downloaded to CHCS when the CHCS user queries the DEERS database for a specific DEERS OHI check for the individual. For this interface to work, the CHCS host must maintain a subscription with DEERS. Therefore, ensure the MTF's DEERS subscription is active so the most current SIT information will flow automatically from DEERS so that users will be able to pull the most current OHI information from DEERS. To request a full subscription, utilize the following CHCS menu path:

DAA > CFT > CFM > STM > SIT > Subscribe action

3. SIT/OHI Updates and Changes. Users must be assigned the SIT Security Key in CHCS (see site administrator) to add Temporary (Temp) SIT entries into their local systems. These temporary entries flow up to DEERS and are either verified or rejected by the Defense Health Agency (DHA) UBO Verification Point of Contact (VPOC). Prior to entering a temporary HIC, users should review the list of current HICs to ensure that the carrier with the appropriate coverage type and mailing address is not already in the SIT. Users should look up payers by their street address, Insurance Company Name, or Short Name fields before adding a Temp entry.

#### 4 Decision Tree for adding a new HIC ID:

Perform a partial lookup

- Consider any found carrier as a potential match

Do NOT add a new HIC ID if the partial lookup matches:

- Insurer Name, Address, City, State, and Zip
- If current telephone # differs, there may be more than one which is considered acceptable
- A variation in Insurer Name is acceptable
- Add a new HIC ID if differences in:

Insurer Name, Address, City, State, and Zip

3.1. Prior to adding a Temp entry to the SIT, the insurance company's claims address and contact information should be verified by calling the insurance company or checking its website.

3.2. Required data elements include the following. Enter them as accurately and completely as possible, and do not enter any placeholder information.

Insurance Company Name  
Coverage Type and Payer Type Code  
Street Address  
City, State, Zip Code  
At least one valid telephone number

3.3. The "Local Comment" field may be used as a free text field for site specific notes on each SIT entry (e.g., facsimile (fax) number).

3.4. The "Standard Comment" field is populated only by the DoD DHA VPOC and may be used to share information that may be useful to all sites in submitting claims to a certain payer.

3.5. Report any OHI the MTF previously entered that has been changed or incorrectly entered to VPOC.helpdesk@altarum.org. Include all data elements in question, and do not include any Protected Health Information or personally identifiable information (PHI/PII). If it is necessary to do so, advise the VPOC in advance so he/she can arrange a secure file transfer. The VPOC will review the issue with the DHA UBO Program Office and research and coordinate a solution if necessary with the activity (e.g., purchased care provider, Service contractor, UBO billing office) alleged to have submitted the incorrect OHI. Common issues with OHI data quality include:

- Incorrect OHI reactivation, which causes unbillable encounters to feed to billing system
- Incorrect OHI termination, which prevents billable encounters from feeding to the billing system
- Incorrect OHI rank assignment, causing initial billing to incorrect payer
- Entry of Placeholder Coverage identifier (ID)/Placeholder HIC ID, which causes unbillable encounters to flow to the billing system
- Misclassification of non-commercial payers. For example, inclusion of non-commercial payers and healthcare coverage in the TPCP SIT and OHI databases causing nonbillable/non-TPCP OHI (e.g., Medicare, Medicaid, Medicare Advantage, Medicare Part D) encounters to feed to the billing system
- Potentially billing non-billable payers or billing incorrect charges

## **System Change Request**

1. General. MHS information systems include legacy (e.g., the Armed Forces Billing and Collection Utilization Solution (ABACUS) and the Composite Health Care System (CHCS)). Submitting a System Change Request (SCR) through an MHS Submission Form is the vehicle

for submitting recommendations to a system's functional proponent that foster a change (addition, modification, or removal) to a capability, process, or application within an existing system that is in production. A SCR may be prepared by any stakeholder, but they are reviewed by its functional proponent, both the Defense Health Agency (DHA) UBO Program Office (PO) and Service and National Capital Region Medical Directorate (NCR MD) Program Managers as explained below. SCRs are not "trouble tickets" that identify that a current function is not working properly and that are submitted to the MHS Global Services Center. (See the Helpdesk section of this User Guide for more information on how to submit trouble tickets.)

2. Types of Requests. Examples of SCR request types include the following.

2.1. Change Request. A request that will result in a change to an existing system; for example, modification of a claim form to comply with a change in an industry standard.

2.2. New Functionality. Functionality that does not currently exist; for example, implementing an additional electronic transaction capability into an existing system.

2.3. Modernization. "Defense business system modernization" means any significant modification or enhancement of an existing Defense business system (other than necessary to maintain current services). Note: Modernization can be differentiated from a change request by the scale of the change requested; for example, a change request might refer to the addition of a drop-down menu, whereas a modernization might refer to modifying an existing local server-based solution to allow remote, web-based access from any location.

3. Priority Definitions.

3.1 Priority 1 (High). Affects patient safety, federal or congressional mandate, or significantly contributes to the accomplishment of DoD and MHS mission requirements.

3.2 Priority 2 (Medium). Moderately contributes to the accomplishment of DoD and MHS mission requirements or provides a significant improvement to the work process.

3.3 Priority 3 (Low). Minimally contributes to the accomplishment of DoD and MHS mission requirements.

4. DHA–UBO Developed Functional or Technical Change Requirements. The UBO Advisory Working Group (AWG) initiates or reviews, refines, and recommends approval of UBO-related system requirements.

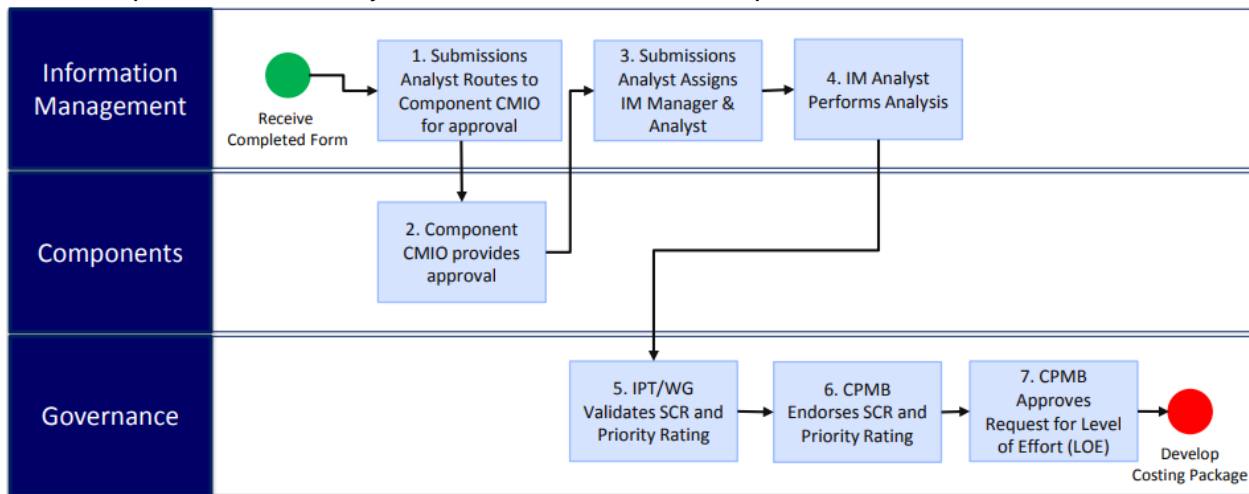
3.1. Requirement Description. These requirements are normally a functional description of a need that a solution is to be designed to meet. If approved by the AWG and the DHA UBO PO, an MHS Submission Form is sent to DHA Information Management (IM)/Information Technology (IT) Inbox ([dha.ncr.health-it.mbx.information-management-information-tech@mail.mil](mailto:dha.ncr.health-it.mbx.information-management-information-tech@mail.mil)) for review. Required form elements include: a problem statement, expected business outcome(s), current state ("as-is"), and desired future state ("to-be"). [dha.ncr.health-it.mbx.information-management-information-tech@mail.mil](mailto:dha.ncr.health-it.mbx.information-management-information-tech@mail.mil) for review. Required form elements include: a problem statement, expected business outcome(s), current state ("as-is"), and desired future state ("to-be").

5. Service or NCR MD-Level Developed Functional or Technical Change Requirements

5.1. Authorized Submitters. The Services, NCR MD, and MTFs may also directly submit a Clinical SCR pursuant to Service or NCR MD–specific guidance. MTF personnel should submit proposed improvements to systems to their Service or NCR

MD Program Managers. A SCR must then receive UBO AWG and UBO PO approval before being processed by IM/IT.

5.2. Process Flow for Requirements Submissions. DHA IM/IT receives requests for changes and facilitates the requests through the submissions process. This includes ensuring an understanding of the request and aiding in routing the request through the appropriate governance channels for approval. The status of the submission is communicated throughout the process. A tracking number and a point of contact is provided and used to communicate the status of the submission throughout the process. Requests are screened for duplication and existing functionality, evaluated by management, and either approved for implementation or returned to the user with an explanation as to why the submission was not adopted.



6.0 Additional Information. More information on the submission process, the submission form, and form instructions are available at <https://info.health.mil/hco/clinicsup/cim/cim/IMRL/SitePages/SCR.aspx>.

### Third Party Collections Program (TPCP)

1. General. The Department of Defense (DD) Form 2570, “Third Party Collection Program – Report on Program Results,” is used by individual UBOs to report claims and collections data for their Third Party Collection Program (TPCP) to the Defense Health Agency (DHA) UBO. The DD Form 2570, in almost all cases, has been replaced by automatic reporting in ABACUS. These reports are manually entered into the UBO Metrics Website where the data is aggregated for all MTFs across the DoD

MTF billing staff members enter Third Party Collection data, including the inpatient disposition and outpatient visit data collected, on this report into the DHA UBO Metrics Report (MR), an automated, Web-based, data collection application that facilitates capturing, consolidating, validating, and reporting DD Form 2570 TPCP results. The DHA UBO Metrics Reporting



website is available at <https://www.ubometrics.org>. Results are consolidated by MTF, Region, and Service in order to benchmark and trend claims and collection results.

1.1. Each UBO office can complete a DD 2570 on the first working day after the end of each quarter. The reporting quarters are: 1st = October – December; 2nd = January – March; 3rd = April – June; 4th = July – September.

1.2. Report data is cumulative. Prior Year (PY) 1 and PY2 will always be full cumulative fiscal year data. Cumulative Fiscal Year (CFY) will be cumulative through the quarter that is being reported.

1.3. The DD 2570 report claims and summarizes adjustment transactions based on the date-of-service fiscal year (FY). Amounts collected are reported both based on the FY date-of-service and the year of collection. Follow Service-specific guidelines for validating report data.

2. Menu Paths for DD 2570 Data Fields. As explained below, obtain Outpatient DD 2570 data from the ABACUS, Inpatient DD 2570 data from ABACUS, and the number of non-Active Duty visits (NAD) from the CHCS Workload Assignment Module (WAM) or the Military Health System (MHS) Management Analysis and Reporting Tool (M2).

2.1. For Outpatient billing and collection data, use the following path in ABACUS: Account Management, Recovery Reporting, DD2570. Choose Line of Business and DMIS ID and click on the "Generate Report" button. Report can be saved or printed.

2.1.1. For NAD outpatient visits data:

2.1.1.1. Use the following WAM menu path to obtain the number of NAD outpatient appointments per month. The MEPRS Manager runs this report monthly.  Select 2 – Division  Select 1 – SAS #  Enter the month  Look for outpatient visit data by MEPRS (Medical Expense and Performance Reporting System) code

2.1.1.2. Use the following M2 menu path for a NAD report. Note the number of NAD visits displayed is cumulative throughout the FY (e.g., 1st Qtr + 2nd Qtr):  Choose DMIS ID (Defense Medical Information System [facility] identifier)  Identify Fiscal Year and Fiscal Month .  
 Select Beneficiary Category not equal to "4" (AD, Active Duty)  Set Compliance Status to "R"  Select clinic by 3- or 4-digit MEPRS code  Exclude telephone consultations (TCONS) (Appointment Status Code = 7)  
 Select Encounters  Run the Report

2.2. For NAD Inpatient billing and collection data, use the following MSA menu path in CHCS: IFM\QRP\PRR\current quarter.

2.3. Follow Service-specific guidelines to validate all TPCP data.

3. Training Module for Metrics Reports (Archived Webinars). View the MR training modules, "How to Pull DD 2570 Data and Combine for Accuracy and What It Means" and "Metrics Report" available on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Archived-Webinars>

3.1. User accounts are required to access the MR website. Only Service Program Managers may request new user accounts via email to [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org). Account access requests must include: User's First/Last Name, email address, commercial phone number, DMIS ID, and type/level of access (i.e., User, Region POC

(Point of Contact), Service POC, Read-Only). For Region POC access, requests must include the above information and specified Region (in lieu of DMIS ID).

3.2. Service Program Managers and Region Managers are responsible for informing the UBO MR Administrator at [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) of any account changes, including deactivation.

3.3. Enter DD 2570 data into the secure MR website at <https://www.ubometrics.org> as follows:  Log into the UBO MR website  Select “Add Report” tab at top of page  Go to facility block and select your facility  Choose Inpatient or Outpatient report  Select Fiscal Year  Select Quarter reporting  Click the “Add” button

3.3.1. Each section of the DD 2570 ABACUS or CHCS report correlates with a UBO metrics data requirement field.

3.3.2. The MR checks for accuracy of data input and displays system error prompts. Correct all errors and then select “save” report.

3.3.3. For assistance, contact your Service Program Manager or Region Manager. For additional assistance, submit a trouble ticket to the UBO Help Desk using the Help feature on the MR website or by calling 202-741-1532.

3.3.4. Each report must be validated by the Service Program Manager or Region Manager. Each Service establishes its own internal due dates and validation requirements.

3.3.5. The DHA UBO MR Administrator will roll up all reports four weeks after the end of each reporting quarter. This deadline may be extended by the DHA UBO Program Office.

3.3.6. Only Service Program Managers may submit requests for corrections or additions after the roll-up by contacting the [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) for DHA UBO Program Office review and approval.

3.4. The DHA UBO MR Administrator locks the validated reports until the final collections report is approved by the DHA UBO Program Office. Once approved, the reports (read-only format) are sent to the Service Program Managers and posted to the DHA UBO website.

### **United States Coast Guard (USCG) Billing**

1. General. Per Interagency Agreement (IAA), the U.S. Coast Guard (USCG) reimburses the Army, Navy, Air Force, and National Capital Region (NCR) Medical Directorate for inpatient and outpatient care provided to USCG-eligible beneficiaries at their MTFs annually on a prospective payment basis. Payments are calculated based on actual prior fiscal year encounter data and Defense Health Agency (DHA) UBO rates. They are normalized using the appropriate medical inflation factors, force structure adjustments, and other health insurance (OHI) adjustment (a discount). The Coast Guard directly distributes prospective payment amounts (PPAs) to Army, Navy, Air Force, and NCR Medical Directorate MTFs based on individual treatment Defense Medical Information System [facility] identifier (DMIS ID) PPA calculations; thus MTFs do not submit claims for these beneficiaries except as noted below in paragraphs 2 and 4. If in the future a Service or NCR Medical Directorate chooses not to participate in the IAA, their UBOs will resume submitting claims for USCG beneficiaries as noted in paragraph 3.

2. IAA claims. For Army, Navy, Air Force, and NCR Medical Directorate MTFs, cancel USCG DD7/DD7As and do not submit interagency claims to the USCG for inpatient or outpatient care provided to USCG beneficiaries (including dental and ancillary services, pharmaceuticals, and supplies). However, submit claims to USCG beneficiaries for patient pay services and other third party payers as follows.

2.1. The annual IAA PPA includes an adjustment for OHI. Thus, collect or update OHI information on a DD Form 2569 annually from each USCG beneficiary who receives care, and submit Third Party Collection (TPC) claims to the OHI payer if the USCG beneficiary carries OHI. "If the patient is a family member of an Active Duty and is enrolled in TRICARE Prime, do not bill FMR or subsistence charges to the patient. If the patient does not have OHI and is not enrolled in TRICARE Prime, bill subsistence and FMR charges to the patient using an invoice and receipt (I&R). If the patient is a family member of a Retiree, bill FMR charges to the patient no matter what Tricare they have. If the Dependent of a Retiree patient has OHI, there is no Family Medical Rate (FMR).. Also, if the patient is enrolled in TRICARE Prime, do not bill FMR or subsistence charges to the patient. If the patient does not have OHI and is not enrolled in TRICARE Prime, bill subsistence and FMR charges to the patient using an invoice and receipt (I&R).

2.2. The annual IAA PPA does not include reimbursement for elective cosmetic surgery (ECS). Submit a claim to and collect the full cost of ECS (including supplies and pharmaceuticals) from all eligible USCG beneficiaries in advance of the ECS service or procedure. (See the *Elective Cosmetic Surgery* section of this User Guide.)

2.3. The annual IAA PPA does not include reimbursement for individual billable care provided to USCG newborns of former service members (Patient Category (PATCAT) 28) or USCG newborns of sponsor's daughters (PATCAT 29). Bill both of these USCG beneficiaries the full reimbursement rate.

2.4. The IAA PPA includes the cost of care for injuries or diseases provided to USCG beneficiaries for which third party payers may be responsible due to tort liability (i.e., for Medical Affirmative Claims (MAC) billing). Forward any MAC claim information to the USCG for review and collections by the USCG. Request USCG MAC contact information from your Service or NCR Medical Directorate Program Manager.

3. Non-IAA claims. If in the future a Service or NCR Medical Directorate chooses to stop participating in the IAA, their UBOs will resume submitting claims to: the USCG, third-party payers, or USCG beneficiaries.

3.1. Follow Service or NCR Medical Directorate-specific guidance for forwarding information on services provided to Coast Guard patients for injuries or diseases for which third party payers may be responsible.

3.2. Submit claims for full reimbursement to USCG former Service members and newborns of sponsor's daughters for individual billable care provided (i.e., PATCATs 28 or 29).

4. Other Health Insurance (OHI). Follow the procedure described in section 2.1.

5. Exclusions from USCG Billing. Do not submit claims for USCG PATCAT C44 (USCG FAM MBR TRANSITIONAL COMP) or Medicare-eligible beneficiaries.

### **Uniformed Services Family Health Plan (USFHP)**

1. General. The Uniformed Services Family Health Plan (USFHP) is a TRICARE Prime option available to family members of active duty military, retirees, and retiree family members through not-for-profit health care systems in designated areas of the country. USFHP is not Other Health Insurance (OHI) under the Third Party Collections Program (TPCP), and any Health Insurance Carrier (HIC) identifier (ID) requests will be rejected.

2. Current USFHP Facilities. The current six facilities are listed below. For up-to-date information on authorized sponsoring organizations and covered regions, including contact information, visit the USFHP website at <http://www.usfhp.com/contact-us/>.

a. Martin's Point Health Care, Portland, Maine

b. Johns Hopkins Medicine, Baltimore, Maryland

c. Brighton Marine Health Center, Boston, Massachusetts

d. Saint Vincent Catholic Medical Centers, New York City, New York

e. CHRISTUS Health, Galveston, Texas

f. Pacific Medical Center (PacMed Clinics), Seattle, Washington

3. USFHP Enrollee Care at MTFs. USFHP enrollees are not eligible for care at MTFs. There are two exceptions to this limitation: (1) If there is an acute medical emergency, and the MTF is closest; or, (2) if care is not available through USFHP specialists, and the care is properly referred to an MTF pursuant to a Memorandum of Understanding (MOU) with the USFHP.

3.1. If an exception applies, the USFHP member should notify the USFHP of medical emergency care within 24 hours. The MTF should do so as well as soon as it learns about the encounter. The USFHP enrollee should be registered under Patient Category (PATCAT) K92B (USFHP Enrollee Authorized), and the MTF should manually bill the USFHP provider where the patient is enrolled. The appropriate USFHP billing address

can be found on the back of the USFHP membership ID card or on the USFHP website noted above in paragraph 2.1.

3.2. If an exception does not apply, the USFHP enrollee should be registered as PATCAT K92A (Civilian Emergency Care) and, the MTF must bill the patient manually.

## VA-DoD Resource Sharing

1. General. The Department of Veterans Affairs (VA) and DoD have entered into national resource sharing agreements that provide standardized reimbursement rates and policies for care provided in VA Medical Centers (VAMCs) and MTFs to the other's beneficiaries. These are available on the Defense Health Agency (DHA) UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Billing>. MTFs may have specific local resource sharing agreements as well. Although most sharing agreements will use the reimbursement methodology outlined in the VA/DoD Outpatient and Inpatient guidance, DoD and VA facilities are authorized to provide services in kind provided the exchange is clearly documented in the sharing agreement and can be expressed by a monetary value. Consult with your Service Program Manager for additional information. Care provided under VA-DoD resource sharing agreements is subject to specific business rules and rates that make submitting claims different from other interagency billing.

For patients assigned to patient category (PATCAT) K61-2 (DOD/VA SHARING AGREEMENT), follow the guidance in the national agreements as described in paragraphs 2 (Inpatient Services) and 3 (Outpatient Services) unless the terms of the local agreement differ.

1.2. MTFs that provide care to patients assigned PATCAT K61-1 (VETERANS ADMIN BENEFICIARY) are not covered under VA-DoD Resource Sharing Agreements. For billing guidance see *Inpatient* and *Outpatient Billing* sections of this User Guide.

2. Inpatient Services. To calculate inpatient institutional charges, see section 2.2. For charges for professional, ambulance, and anesthesia professional services and supplies, use the TRICARE Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (TRICARE CMAC) rates, less 10%. Calculate charges for durable medical equipment (DME), pharmaceuticals, services purchased from an outside facility, and pass-through items at cost. TRICARE CMAC rates are located at <https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement>. Use the "Facility Physician" rates (Category 1) and the "Facility Non-Physician" rate (Category 3) by mapping the provider described in the encounter documentation to the correct TRICARE Provider Category shown below.

□ Category 1 (Facility Physician): Services of medical doctors (MDs), doctors of osteopathic medicine (DOs), optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) provided in a facility setting.

- Category 3 (Facility Non-Physician): Services, of all other providers not found in Category 1, provided in a facility setting.

For additional guidance, view the Inpatient Billing Guidance for VA-DoD Resource Sharing Agreements at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Billing#VADoDInpatient>

2.1. Use the following menu path in the Composite Health Care System (CHCS) to identify inpatient professional services: *FM\FE\KG ADC DATA\PATIENT NAME\SELECT APPOINTMENT\STANDARD OUTPAT? FM\FE\YES//CR.*

2.2. To calculate inpatient charges to submit to VA, use the DHA UBO Inpatient Institutional Calculator package effective on the patient's date of service. There are two versions available for download on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Billing#VADoDInpatient>.

2.2.1. MTFs with standard VA-DoD direct care resource sharing agreements (i.e., charge TRICARE CMAC rates, less 10% discount) must use the "Standard\_Modified\_VA-DoD\_Inp Inst Calculator\_FYXX" version. The 10% discount percentages are pre-populated and cannot be altered in this version.

2.2.2. MTFs that have negotiated discounts other than the standard 10% discount or that have specific negotiated reimbursement amounts must use the "Variable\_Rate\_Modified\_VA-DoD\_Inp Inst DHA UBO Calculator\_FYXX" version. The discount percentages are pre-populated at zero and can be changed to reflect the negotiated discount.

2.3. Both versions include a Microsoft® Excel workbook with two worksheets (the Inpatient Institutional Calculator and Inpatient Billing Guide) and the portable document format (PDF) document, "FYXX VA-DoD Resource Sharing Inpatient Institutional Billing Modified TRICARE DRG Payment Calculator and Inpatient Billing Guide USER GUIDE." The USER GUIDE is a supplemental reference document available for download on the DHA UBO website with step-by-step instructions on how to use the Inpatient Institutional Calculator and Inpatient Billing Guide worksheets.

3. Outpatient Services. To calculate outpatient charges, use the TRICARE CMAC rate less 10% for the appropriate Current Procedural Terminology®33 (CPT)/Healthcare Common Procedural Coding System (HCPCS) code. If there is no TRICARE CMAC rate for a particular CPT/HCPCS code, the facility may substitute an agreed-on rate. TRICARE CMAC rates are located at <http://www.tricare.mil/cmac/>. Use the "Non-Facility Physician" rates (Category 2) and the "Non-Facility Non-Physician" rate (Category 4) by mapping the provider described in the encounter documentation to the correct TRICARE Provider Category shown below.

33 CPT is a registered trademark of the American Medical Association.

- Category 2 (Non-Facility Physician): Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and CNMs provided in a non-facility setting.
- Category 4 (Non-Facility, Non-Physician): Services, of all other providers not found in Category 2, provided in a non-facility setting.

For additional guidance, view the Outpatient Billing Guidance for VA-DoD Resource Sharing Agreements at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Billing#VADoDOutpatient> .

3.1. To calculate outpatient charges to submit to VA, use the DHA UBO Outpatient Billing Guide. There are two versions available for download on the DHA UBO website at <https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Billing#VADoDOutpatient> .

3.1.1. MTFs with standard VA-DoD direct care resource sharing agreements (i.e., charge TRICARE CMAC rates less 10% discount) must use the “Standard\_VA-DoD\_Outpatient\_Billing\_Guide\_FYXX” version. The 10% discount percentages are pre-populated and cannot be altered in this version.

3.1.2. MTFs that have negotiated discounts other than the standard 10% discount or that have specific negotiated reimbursement amounts must use the “Variable\_Rate\_VA-DoD\_Outpatient\_Billing\_Guide\_FYXX” version. The discount percentages are pre-populated at zero and can be changed to reflect the negotiated discount.

3.2. Both versions include a Microsoft® Excel workbook with one outpatient billing worksheet and the PDF document, “FYXX VA-DoD Outpatient Billing Guide USER GUIDE.” The USER GUIDE is a supplemental reference document available for download on the DHA UBO website with step-by-step instructions on how to use the Outpatient Billing Guide.

3.3. Institutional costs for ambulatory procedure visits, emergency room visits, and observation beds must be negotiated locally. 3.4. There is no TRICARE CMAC rate table for pharmaceuticals. For resource sharing agreement care, pharmaceuticals are charged at the average wholesale price (AWP) less 60% plus a \$9.00 dispensing fee. To calculate this charge, use the VA-DoD Sharing Pharmacy Price Estimator (PPE) effective on the pharmaceutical fill date. Current and archived VA-DoD PPEs are at <https://info.health.mil/bus/brm/ubo/SitePages/MHSUBORates.aspx>.

3.5. For outpatient durable medical equipment (DME), charge cost. If not available, MTFs can use the Centers for Medicare & Medicaid Services (CMS) DME fee schedule available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html> to obtain a DME charge or locally negotiate the DME charge.

4. Additional Resources. To learn more about VA-DoD resource sharing, reference current and archived material found at <https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Access-to-Healthcare/DoD-VA-Sharing-Initiatives/Joint-Resource-Sharing/Direct-Sharing-with-the-VA>.

## Appendix A

**BACKGROUND.** Title 32 of the Code of Federal Regulations (CFR) Part 220.8 requires that charges for outpatient services, pharmaceuticals, and durable medical equipment and supplies (DME/DMS) are based on TRICARE prevailing rates in cases where they are available. When they are not available, Centers for Medicare and Medicaid Services (CMS) reimbursement rates or actual military expense and workload data are used to determine Defense Health Agency (DHA) UBO Outpatient rates. If none of these rates or data is available for a service, no rate is assigned. However, in the cases of pharmaceuticals and DME/DMS, if TRICARE rates are not available, the CFR allows charges based on the average full cost of these items. TRICARE allowable rates and CMS reimbursement rates are updated and published quarterly; available pharmaceuticals may be updated at any time. DHA UBO Outpatient rate files are constructed annually on a modified calendar year basis to reflect TRICARE or CMS allowable rates for items listed at the time the DHA UBO rates files are created. DHA UBO pharmacy rate files are updated semiannually. In either case there may be a period during which a new code for a service, DME/DMS, or a new National Drug Code (NDC) does not have a DHA UBO rate. If there is no current rate, individual UBOs in general *cannot charge* for a service/NDC/DME/DMS. However, the DHA UBO Program Office (PO) will review a rate request if the billing office can provide sufficient justification and documentation for pricing the new service during an out-of-cycle update or documentation as to the actual cost of the pharmaceutical or DME/DMS. In those cases, the billing office may submit a rate request as follows.

## Appendix B

Revised: March 2014 Instructions for completing the institutional claim format are below. An online training module and reference guide, "Data and Billing in Sync: UB-04/8371" is available on the DHA UBO Learning Center at



[http://www.tricare.mil/ocfo/mcfs/ubo/learning\\_center/teleconferences.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/learning_center/teleconferences.cfm)

Demographics	Institutional Information	Additional Information	Services/Charging	Insurance Information	Diagnoses and Procedures	Provider Information	Reserved
1	3 a-b	18-28	42	50	66	56	7
2	4	29	43	51	67	57	30
8 a-b	5	30	44	52	67 a-d	76	37
9 a-e	6	31-37	45	53	68	77	49
10	12	38	46	54 a-c	69	78	[etc.]
11	13	39-41	47	55 a-c	70 a-c	79	
	14		48	58	71	80	
	15			59	72 a-c	81	
	16			60	73		
	17			61	74 a-e		
				62	75		
				63			
				64			
				65			

FL 1 Billing Provider Name, Address and Telephone Number (Required)

This FL lists the name and service location of the provider submitting the bill. Standard U.S. Postal Service (USPS) abbreviations should be used. Billing provider address must be a street address (not a PO Box or Lock Box). Use two-digit ISO (International Organization for Standardization) country codes for foreign addresses.

FL 2 Billing Provider's Designated Pay-to Address (Situational)

The address that the provider submitting the bill intends payment to be sent ***if different than FL 1.***

FL 3 a Patient Control Number (Required)

A unique number assigned by the provider to facilitate retrieval of the individual's account of services containing financial billing records and any postings of payment. Uniquely assigned by the MTF.

Keeps the patient's documentation and records for a date of service in one record.

Identifies which visit/encounter and date of service.

The 837I only holds 20 alphanumeric characters.

The UB-04 holds 24 alphanumeric characters.

FL 3 b Medical Health Record Number (Situational – UB-04/ Required – 837I)

Assigned by the billing solution. If generating a manual bill, contact the [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) for assistance.

FL 4 Type of Bill (Required)

Identifies the specific type of bill, such as a hospital or outpatient bill, replacement claim, or voided claim.

<b>Digit 1:</b>	Leading Zero (for paper UB-04 only; do not use leading zero for electronic)
<b>Digit 2: Type of Facility</b>	
	1 = Hospital
	2 = Skilled Nursing Facility
	3 = Home Health
	7 = Clinic
	8 = Special Facility
<b>Digit 3: Bill Classification</b>	
	1 = Inpatient
	3 = Outpatient
	4 = Other
<b>Digit 4: Frequency</b>	
	1 = Admit through Discharge
	2 = Interim – First Claim
	3 = Interim – Continuing Claim
	4 = Interim – Last Claim
	5 = Late Charge

Inpatient bills use 0111.  
 Outpatient bills use 0131.

FL 5 Federal Tax Number (Required)

Each MTF has a nine-digit federal tax identification number.  
 The 837I format is NNNNNNNNN. Example:

<p><b>REF EI 123456789</b></p> <p><b>KEY:</b>                  REF = Reference Information                  EI = Reference Identification Qualifier                  Reference Identification</p>
---

FL 6 Statement Covers Period (Required)

The beginning and ending service dates of the period included on the bill.

Inpatient: The “from” date is the date the patient was admitted to the hospital; the “through” date is date the patient was discharged.

· UB-04 format: MMDDYY (e.g., 070499 to 070699).

Electronic 837I claim format: CCYYMMDD (e.g., 19990704 to 19990704).

Outpatient: “from” date matches “through” date. Note: If treatment date extends (e.g., Observation), then use actual dates.

FL 7 Reserved

This field is reserved for assignment by NUBC.

FL 8 a-b Patient Name/Identifier (Required)

NM1	QC	1	DOE	SALLY	J
<b>Key:</b>					
NM1	=	Individual or Organizational Name			
QC	=	Entity ID Code			
1	=	Entity Type Qualifier			
Patient Last Name, First Name, Middle Initial					

Last name, first

name, middle initial

837I Example:

FL 9 a-e Patient Address (Required)

The mailing address of the patient.

Use standard USPS state abbreviations and ZIP codes.

Use two-digit ISO country codes for foreign addresses.

FL 10 Patient Birth Date (Required)

Use MMDDCCYY for the UB-04.

Use CCYYMMDD for the 837I. Example: 08122012

Must use 4-digit year.

Report zeroes for all 8 digits if birth date unknown.

FL 11 Patient Sex (Required)

The gender of the patient as recorded on the date of: admission, outpatient service, or start of care.

FL code structure:

M	Male
F	Female
U	Unknown

FL 12 Admission/Start of Care Date (Situational)

The start date for the episode of care.

Inpatient: Date patient was admitted.

Outpatient: Date of service.

Required for the UB-04.

UB-04 format: MMDDYY (e.g., 062911).

Electronic 837I claim format: CCYYMMDD (e.g., 19990704).

FL 13 Admission Hour (Required for UB-04)

The hour during which a patient is admitted for inpatient care (required for inpatient).

Use two-digit military time – 00 through 23. Round down to the nearest hour (e.g., if a patient is admitted any time between 0200 and 0259, enter “02”).

Two-Digit Military Hour and Corresponding Time

00	0000-0059	12	1200-1259
01	0101-0159	13	1300-1359
02	0200-0259	14	1400-1459
03	0300-0359	15	1500-1559
04	0400-0459	16	1600-1659
05	0500-0559	17	1700-1759
06	0600-0659	18	1800-1859
07	0700-0759	19	1900-1959
08	0800-0859	20	2000-2059
09	0900-0959	21	2100-2159
10	1000-1059	22	2200-2259
11	1100-1159	23	2300-2359

FL 14 Priority (Type) of Admission/Visit (Required for Inpatient Only)

The code showing the priority of the admission or visit.

Links the medical necessity to the care charged.

Code structure:

<b>01</b>	“Emergency” (requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions).
<b>02</b>	“Urgent” (requires immediate attention and treatment).
<b>03</b>	“Elective” (used if admission/visit is elective, allowing time to schedule accommodation).
<b>04</b>	“Newborn” (used for all newborns just born in the hospital facility).
<b>05</b>	“Trauma Activation” (must be a designated Trauma Center). <b>Note:</b> Not all payers recognize the additional cost when performing

FL 15 Point of Origin for Admission or Visit (Required)

Code for the source of the referral to the MTF for the admission or visit.

Codes vary for inpatient, outpatient, or newborn.

The point of origin is the DIRECT source for the particular facility.

Code structure:

<b>Code 1</b>	<b>Physician Referral – Non-healthcare Facility Point of</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility.</i>
<b>Outpatient</b>	<i>The patient presented to this facility for outpatient services.</i>
<b>Code 2</b>	<b>Clinic or Physician’s Office</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility.</i>
<b>Outpatient</b>	<i>The patient presented to this facility for outpatient services.</i>
<b>Code 4</b>	<b>Transfer from a Hospital (Different Facility)</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility as a hospital transfer from an acute care facility where he/she was an inpatient or</i>
<b>Outpatient</b>	<i>The patient was transferred to this facility as an outpatient from an acute care facility.</i>
<b>Code 5</b>	<b>Transfer from a Skilled Nursing Facility or Intermediate Care Facility or Assisted Living Facility</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility as a transfer from a SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), or ALF (Assisted Living Facility) where he/she was</i>
<b>Outpatient</b>	<i>The patient was referred to this facility for outpatient or referenced diagnostic services from a SNF, ICF, or ALF where he/she was a resident.</i>
<b>Code 6</b>	<b>Transfer from Another Health Care Facility</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility as a transfer from another type of health care facility (not defined elsewhere in</i>
<b>Outpatient</b>	<i>The patient presented to this facility for services from another health care facility (not defined elsewhere in this</i>
<b>Code 8</b>	<b>Court/Law Enforcement</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility upon the direction of a court of law or upon request of a law enforcement agency.</i>
<b>Outpatient</b>	<i>The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic</i>
<b>Code 9</b>	<b>Information Not Available</b>
<b>Inpatient</b>	<i>The patient’s Point of Origin is not known.</i>
<b>Outpatient</b>	<i>The patient’s Point of Origin is not known.</i>
<b>Code A</b>	<b>Reserved for Assignment by NUBC (National Uniform Billing Committee)</b>
<b>Code B</b>	<b>Transfer from Another Home Health Agency</b>
	<i>(Discontinued Effective 7/1/10.)</i>
	<i>(Replaced with Condition Code 47 FL 18-28.)</i>

	Reserved for assignment by the NUBC
<b>Code C</b>	<b>Discontinued Effective 7/1/10</b>
	Reserved for assignment by the NUBC
<b>Code D</b>	<b>Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate</i>
<b>Outpatient</b>	<i>The patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim</i>
<b>Code E</b>	<b>Transfer from Ambulatory Surgery Center</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility as a transfer from an ambulatory surgery center.</i>
<b>Outpatient</b>	<i>The patient presented to this facility for outpatient or referenced diagnostic services from an ambulatory surgery</i>
<b>Code F</b>	<b>Transfer from a Hospice Facility</b>
<b>Inpatient</b>	<i>The patient was admitted to this facility as a transfer from a hospice facility.</i>
<b>Outpatient</b>	<i>The patient presented to this facility for outpatient or referenced diagnostic services from a hospice facility.</i>

Code Structure for Newborns

<b>Code 5</b>	<b>Newborn, Born Inside this Hospital</b>
	<i>A baby born inside this Hospital.</i>
<b>Code 6</b>	<b>Newborn, Born Outside the Hospital</b>
	<i>A baby born outside of this Hospital.</i>

**FL 16 Discharge Hour (Situational)**

The hour the patient was discharged.

Use two-digit military time – 00 through 23.

Round down to the nearest hour (e.g., if a patient is admitted any time between 0200 and 0259, enter “02”).

Two-Digit Military Hour and Corresponding Time

00	0000-0059	12	1200-1259
01	0101-0159	13	1300-1359
02	0200-0259	14	1400-1459
03	0300-0359	15	1500-1559
04	0400-0459	16	1600-1659
05	0500-0559	17	1700-1759
06	0600-0659	18	1800-1859
07	0700-0759	19	1900-1959
08	0800-0859	20	2000-2059
09	0900-0959	21	2100-2159
10	1000-1059	22	2200-2259

11	1100-1159	23	2300-2359
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**FL 17 Patient Discharge Status (Required)**

Code indicating the patient’s discharge status or disposition as of the “through” date of the period covered on the bill (FL 6).

Patient Status Codes

<b>01</b>	Discharged to home or self-care (routine discharge).
<b>02</b>	Discharged/transferred to a short-term general hospital for inpatient care.
<b>03</b>	Discharged/transferred to skilled nursing facility with Medicare Certification in anticipation of Skilled Care.
<b>04</b>	Discharged/transferred to a facility that provides custodial or supportive care.
<b>05</b>	Discharged/transferred to a designated cancer center or children’s hospital.
<b>06</b>	Discharged/transferred to home under care of organized home health service organization in anticipation of covered
<b>07</b>	Left against medical advice or discontinued care.
<b>20</b>	Expired.
<b>43</b>	Discharged/transferred to a federal health care facility.

**FL 18-28 Condition Codes (Situational)**

Codes used to identify conditions that may affect payer processing of the bill.  
May enter up to 11 codes. Leave blank if no codes are being used.  
If there is more than one applicable code, list the codes in an alphanumeric sequence.

Code Structure

02	Condition is employment related.
03	Patient is covered by insurance not reflected here.
05	Lien has been filed.
44	Inpatient Admission Changed to Outpatient
77	Provider accepts or is obligated/required due to a contractual agreement of law to accept payment by primary payer as payment in
A0	TRICARE External Partnership Program
A4	Family Planning
A5	Disability
A9	Second Opinion Surgery
AA	Abortion Performed Due to Rape
B3	Pregnancy Indicator
C4	Admission/Services Denied
C6	Admission Pre-authorization
C7	Extended Authorization
X2	Medicare EOB (Explanation of Benefits) on File
X4	Medicare Denial on File

X5	Third-party Payment on File
X6	Restricted Recipient Referral Form
B3	Pregnancy
Y6	Third-party Denial on File

837I Example:

<p><b>HI BG:17 BG:67</b></p> <p><b>KEY:</b>                  HI = Health Care Information Codes                  BG = Condition Code</p>
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FL 29 Accident State (Situational)

Required only when the claim is related to an auto accident.  
 Identifies the two-character abbreviation of where the accident occurred.  
 Use the ISO country code for OCONUS (outside the continental United States) locations.

FL 30 Reserved

Leave this form locator blank

FL 31-34 Occurrence Codes and Dates (Situational)

Required if event has occurred that may affect payer processing.  
 Enter the occurrence code and associated date to tell about a significant event relating to the claim that may affect payer processing.  
 Report codes in alphanumeric sequence.  
 UB-04 format: MMDDYY.  
 837I format: CCYYMMDD.

Occurrence Codes

01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of the
02	No-Fault Insurance Involved – Including Auto	Code indicating the date of an accident including auto or other where state has applicable no-fault liability laws.
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third-party's action that may involve a civil court process in an attempt to require payment by the third party other than
04	Accident/Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Accident/No Medical or Liability Coverage	Code indicating accident or injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury.
06	Crime Victim	Code indicating the date on which the patient's medical condition resulted from an alleged criminal action committed by one or more parties. Provide the date of the occurrence.
07-08		Reserved for assignment by the NUBC.
09	Start of Infertility Treatment Cycle	Code indicating the start date of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity-related



11	Onset of Symptoms/Illness	Code indicating the date the patient first became aware of the symptoms/illness.
12	Date of Onset for a Chronically Dependent	Code indicating the date the patient first became a CDI. Home Health Agency (HHA claims only)
13-15		Reserved for assignment by the NUBC.
16	Date of Last Therapy	Denotes last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).
17	Date Outpatient Occupational Therapy Plan Established or Last	Code denotes date an occupational therapy plan was established or last reviewed.
18	Date of Retirement – Patient/Beneficiary	The date of retirement for the patient/beneficiary.
19	Date of Retirement - Spouse	The date of retirement for the patient's spouse.
20	Guarantee of Payment Began	Code indicates date on which the provider began claiming Medicare payment under the guarantee of payment
21	UR Notice Received	Code indicating the date the SNF and hospital received the Utilization Review (UR) Committee's finding that the admission or future stay was not medically necessary.
22	Date Active Care Ended	Code indicates the date covered level of care ended in a skilled nursing facility (SNF) or general hospital, or date on which active care ended in a psychiatric or tuberculosis (TB) hospital, or date on which patient was released on trial.
23	Date of Cancellation of Hospice Election Period	Code indicating when a hospice period of election is cancelled by the intermediary as opposed to revocation by
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the health care facility from any insurer.
25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Workers Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Became Available (Inpatient)	Code indicating the date on which a SNF bed became available to hospital inpatient who requires only SNF level of
27	Date of Hospice Certification or Re-Certification	Code indicating the date of certification or re-certification of the hospice benefit periods.
28	Date Comprehensive Outpatient Rehabilitation Plan Was Established or	Code indicating the date the Comprehensive outpatient rehabilitation plan was established or last reviewed.
29	Date Outpatient Physical Therapy Plan Established or Last Reviewed	Code indicating the date an outpatient physical therapy plan was established or last reviewed.
30	Date Outpatient Speech-language Pathology Plan Established or Last	Code indicating the date an outpatient speech-language pathology plan was established or last reviewed.
31	Date Beneficiary Notified of Intent to Bill	Code indicating the date the beneficiary was notified by the hospital that a covered level of inpatient care was no longer
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	Code indicating the date the beneficiary was notified by the hospital that the requested care (diagnostic procedures or treatments) may not be considered reasonable or
33	First Day of the Coordination Period for End-stage Renal Disease (ESRD) Beneficiaries Covered by an	Code indicating the first day of the coordination period for end-stage renal disease (ESRD) beneficiaries covered by an employee group health plan.
34	Date of Election of Extended Care Services	Code indicating the date of election of extended care services.

35	Date Treatment Started for Physical Therapy	Code indicating the date services were initiated for physical therapy.
36	Date of Inpatient Hospital Discharge for Covered Transplant Patient	Code indicating the date of inpatient hospital discharge for a covered transplant patient.
37	Date of Inpatient Hospital Discharge for Non-covered Transplant Patient	Code indicating the date of inpatient hospital discharge for a non-covered transplant patient.
38	Date Treatment Started for Home IV Therapy	Code indicating the date treatment started for home IV therapy.
39	Date Discharged on a Continuous Course of IV Therapy	Code indicating the date discharged on a continuous course of IV therapy.
40	Scheduled Date of Admission	Code indicating scheduled date of admission.
41	Date of First Test for Pre-admission Testing	Code indicating date of first outpatient diagnostic test for pre-admission testing.
42	Date of Discharge	Code indicating date of discharge.
43	Scheduled Date of Cancelled Surgery	Code indicating scheduled date of cancelled surgery.
44	Date Treatment Started for Occupational Therapy	Code indicating date when services were initiated for occupational therapy.
45	Date Treatment Started for Speech-language Therapy	Code indicating date when services were initiated for speech-language therapy.
46	Date Treatment Started for Cardiac Rehabilitation	Code indicating date when services were initiated for cardiac rehabilitation.
47	Date Cost Outlier Status	Code indicating the first date the cost outlier threshold is
A1	Birth Date – Insured A	Code indicating birth date – Insured A.
B1	Birth Date – Insured B	Code indicating birth date – Insured B.
C1	Birth Date – Insured C	Code indicating birth date – Insured C.
G1		Reserved for assignment by the NUBC.
A2	Effective Date – insured A	Code indicating effective date – insured A policy.
B2	Effective Date – insured B	Code indicating effective date – insured B policy.
C2	Effective Date – insured C	Code indicating effective date – insured C policy.
A3	Benefits Exhausted – Payer A	Code indicating benefits exhausted – payer A.
B3	Benefits Exhausted – Payer B	Code indicating benefits exhausted – payer B.
C3	Benefits Exhausted – Payer C	Code indicates benefits exhausted – payer C.
A4	Split Bill Date	Code indicates the date the patient became Medicaid eligible due to medically needy spend-down.

**FL 35-36 Occurrence Span Codes and Dates (Situational)**

The MHS uses these codes when associated with a diagnosis that indicates an accident and when requested by the payer.

Enter the codes and associated dates that define a significant event that relates to the bill in alphanumeric order UB-04 format: MMDDYY.

837I format: CCYYMMDD.

Up to 12 codes may be appended.

FL 37 Reserved for Future Use

Leave this form locator blank.

FL 38 Responsible Party Name and Address (Situational)

UB-04: Enter the name and address of the party responsible for the bill if not the subscriber or patient.

837I: Not required for claim submissions.

FL 39-41 Value Codes and Amounts (Situational)

Enter the applicable codes, if any, and their related dollar amounts or values that identify elements needed for the health plan to process the claim.

Up to 12 codes may be appended in numerical sequence.

The MHS uses these codes when the payer requests them.

Value codes range from 01 to 99, including those listed below. See your Service Manager or NCR MD, or contact the UBO Help Desk for a complete list.

Value Codes

23	Recurring Monthly Income
25	Offset to the Patient-Payment Amount – Prescription Drugs
31	Patient Liability Amount
34	Offset to the Patient-Payment Amount – Other Medical Services
35	Offset to the Patient-Payment Amount – Health Insurance
66	Medicaid Spend Down Amount
80	Covered Days
81	Non-covered Days
82	Coinsurance Day

**FL 42 Revenue Codes (Required)**

Represents all billable services and indicates which department provided the treatment and can bill for it.

Enter the appropriate numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation or ancillary service.

Must be listed in ascending, numbered order.

Inpatient bills: Assign the revenue code category for each inpatient service.

Outpatient bills: Assign the revenue code for each line item charged in FL47.

The 837I does not require the description field.

Commonly Used Revenue Codes

Revenue	Description
0001	Total Charge (paper only)
010X	# Days All-Inclusive Rate
024X	All-Inclusive Ancillary
025X	Pharmacy
026X	IV Therapy
027X	# Items Medical/Surgical Supplies and Devices

<b>Revenue</b>	<b>Description</b>
028X	Oncology
029X	# Items Durable Medical Equipment (Other Than Renal)
030X	# Tests Laboratory
031X	# Tests Laboratory Pathology
032X	# Tests Radiology - Diagnostic
033X	# Tests Radiology – Therapeutic and/or Chemotherapy
034X	# Tests Nuclear Medicine
035X	# Scans CT Scan
036X	Operating Room Services
037X	Anesthesia
038X	# Pints Blood and Blood Components
040X	# Tests Other Imaging Services
041X	# Treatments Respiratory Services
042X	# Treatments Physical Therapy
043X	# Treatments Occupational Therapy
044X	# Treatments Speech Therapy – Language Therapy Pathology
045X	# Visits Emergency Room
046X	# Tests Pulmonary Function
047X	# Tests Audiology
048X	# Tests Cardiology
049X	Ambulatory Surgical Care
051X	# Visits Clinic
053X	# Visits Osteopathic Services
054X	# Miles Ambulance
061X	# Tests Magnetic Resonance Technology (MRI)
062X	# Days Medical/Surgical Supplies
063X	# Units Pharmacy
073X	# Tests EKG/ECG (Electrocardiogram)
074X	# Tests EEG (Electroencephalogram)
075X	# Tests Gastrointestinal Services
076X	Specialty Services
077X	Preventive Care Services
081X	Acquisition of Body Components
082X	# Sessions Hemodialysis – Outpatient or Home
090X	# Visits Behavioral Health Treatments/Services
091X	# Visits Behavioral Health Treatments/Services
092X	# Visits Other Diagnostic Services
093X	Medical Rehabilitation Day Program
094X	# Visits Other Therapeutic Services
095X	Other Therapeutic Services
096X	Professional Fees
097X	Professional Fees
098X	Professional Fees

**FL 43 Revenue Description/IDE Number/Medicaid Drug Rebate (Required)**

Enter the narrative description or standard abbreviation for each revenue code reported, including Investigational Device Exception (IDE) and Medicaid Drug Rebate.

Inpatient: This form locator is used to report MS-DRG (Medicare Severity Diagnosis Related Group) information and all NDC (National Drug Code) information (pharmacy) information-use the 11-digit NDC number (without hyphens).

The next two positions immediately following the last digit of the NDC number is the unit qualifier. Report the appropriate unit modifier from the following list.

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

The 9-digit quantity immediately follows the unit qualifier. The decimal point is floating and the numbers to the right of the decimal point are restricted to three.

**12345012312UN000030000**

Example: 30 units of product with NDC 12345-123-12 is entered on the UB-04 claim as follows:

Outpatient: This form locator is used to report an itemized list of all services, including ancillary services.

**FL 44 HCPCS/Accommodation Rates/HIPPS Rate Codes (Situational)**

Enter the HCPCS (Healthcare Common Procedural Coding System) codes and modifiers (if any) applicable to outpatient and ancillary services.

HCPCS codes are five alphanumeric characters.

Use up to four alphanumeric modifiers.

Multiple services with accompanying codes can be appended to describe all of the services and supplies used during the patient's encounter.

Examples of modifiers: (RT, LT, 50).

Inpatient: Contains the accommodation description for inpatient claims.

Outpatient: Each HCPCS code must have an individual related revenue code.

Home Health HIPPS (Health Insurance Prospective Payment System) codes are 5- position alphanumeric codes.

**FL 45 Service Date (Situational)**

Enter the date the outpatient service was provided for every revenue code.

Not listed on inpatient claims.

UB-04 format: MMDDYY.

837I format: CCYYMMDD.

Must match the data in FL 06 – Statement Covers Period.

FL 46 Service Units (Situational – UB-04/Required – 837I)

Enter the unit or quantity of the services provided; this can include: the number of accommodation days, miles, pints of blood, or number of treatments/tests.

Situational for UB-04.

Required for 837I.

Situational for UB-04; report where appropriate and defined by Revenue Code requirements.

FL 47 Total Charges (Required)

Represents the total charges for this episode of care.

This is the sum of the first through last line in FL 47.

FL 48 Non-Covered Charges (Situational)

Enter any non-covered charges from this episode of care.

FL 49 Reserved for Future Use

Leave this form locator blank.

FL 50 Payer Name (Required)

Enter up to three payers or health insurance plan names from which the MTF expects payments for the claim.

Line A is required; lines B and C are situational (depending on whether there are other potential payers).

List names in order of priority for billing.

FL 51 Health Plan Identification Number (Required)

Enter the number used by the health plan to identify itself.

Line A is the primary payer – required for inpatient and outpatient.

Lines B and C are situational (used only when you have additional payers).

Note: When mandated by HIPAA (Health Insurance Portability and Accountability Act), you must use the payer's National Plan Identifier (NPI) in this FL.

FL 52 Release of Information Certification Indicator (Required)

Enter the code that indicates whether the provider has a signed statement from the patient or the patient's legal representative (e.g., mother of a child) permitting the provider to release health information so that the claim may be paid.

Code Structure

"Y" =	Yes, provider has a signed statement permitting release of medical billing data related to a claim. – Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature to be collected.
"I" =	For informed consent to release medical information for conditions or diagnoses regulated

by federal statutes. (Note: "I" is required when the signature has not been collected and the state and federal laws do not supersede the HIPAA Privacy Rule by requiring a signature to be collected).

**FL 53 Assignment of Benefits Certification Indicator (Situational – UB-04/Required – 837I)**

Enter the code that indicates whether or not the provider has a signed statement from the patient or the patient's responsible party authorizing the payer to directly pay the provider (versus sending the payment directly to the patient).

Code structure

"Y" = Yes – Benefits assigned  
"N" = No – Benefits not assigned  
"W" = Not applicable – Used when the patient refuses to assign benefits

**FL 54 Prior Payments – Payer (Situational)**

Enter the dollar amount (including decimals) paid to date and received from the payer(s) indicated in FL 50 – Payer Name, Lines A, B, and C.

This is used in the MHS when the primary payer has paid an amount and is sending the claim to the secondary payer

**FL 55 Estimated Amount Due – Payer (Situational)**

Enter the amount the MTF believes to be due (with no decimal point) from the health plan(s) listed in FL 50 – Payer Name, Lines A, B, and C.

This amount is the total charges on the claim (listed under FL 47).

**FL 56 National Provider Identifier – Billing Provider (Required)**

Enter the MTF's unique 10-digit numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES).

This is the MTF's standard unique identifier for all payers.

**Note:** It is NOT the NPI of the physician; it is NOT an employer tax identification or Social Security number.

**FL 57 Other (Billing) Provider Identifier (Situational)**

This legacy number has been replaced with the NPPES in FL 56.

Check with your specific Service guidelines for how to fill out this FL for pharmacy.

**FL 58 Insured's Name (Required)**

Enter the name of the person under whose name the insurance benefit is held (subscriber name). Line A is required.

Lines B and C are situational.

If FL 50 – Payer Name – A, B, and C are filled in, then FL 58 – Insured's Name – A, B, and C must also be filled in.

A comma or space may be used between first and last name.

Use a hyphen, with no space, between hyphenated names.

Leave a space between last name and suffix, and then write the first name.

Do not use titles (e.g., Sir, Dr., or Mr.).

FL 59 Patient's Relationship to the Insured (Required)

Enter the code that explains the relationship of the patient to the insured identified in FL 58 – Insured's Name.

9 options are available:

01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

FL 60 Insured's Unique Identifier (Required)

Enter the identification number assigned to the insured (subscriber number) by the payer/health plan on the ID card.

Social Security numbers used to be entered here, but those numbers are no longer used for billing and reimbursement.

Example: AAA888000111

FL 61 Insured's Group Name (Required)

Enter the insured's group or plan name assigned by the insurance company, if available (usually found on the ID card).

This field links to FL 58, which lists the name of the person who holds the insurance.

This is required when the group name and number are available.

FL 62 Insurance Group Number (Required)

Enter the insured's group or plan number assigned by the insurance company, if available.

This field links to FL 58, which lists the name of the person who holds the insurance.

This is required when the group name and number are available.



FL 63 Authorization Code/Referral Number (Required)

Enter authorization/referral number for the treatment if assigned by the payer. Designates that the services on the bill have been authorized by the payer or indicates that a referral is involved. The current MHS system limitations may prevent this FL from being filled in. This FL is required if the payer assigns an authorization or pre-authorization number. Follow your Service guidance if they recommend typing in PRECERT for inpatient claims or other specific guidance.

FL 64 Document Control Number (Situational)

Enter the internal or document control number (ICN/DCN) assigned to the original claim by the health plan, if any, as part of its internal control process. In the MHS, this FL may be left blank.

FL 65 Employer Name (of the Insured) (Situational)

Enter the name of the employer who provides health care coverage for the insured person listed in FL 58 – Insured’s Name. Not used for 837I submission.

FL 66 Diagnosis and Procedure Code Qualifier (Required)

Outpatient – The code in this FL identifies the reason for the patient encounter. Enter the version of the ICD reported. Do not use decimals. They will be rejected per HIPAA 5010 transaction standard requirements.

FL 67 Principal Diagnosis Code (Required)

Outpatient – The code in this FL identifies the reason for the patient encounter. Enter the seven digits of the ICD-9 CM (International Classification of Diseases, Ninth Revision, Clinical Modification) code that describe the principal diagnosis or the chief condition that caused the patient to receive care. The eighth digit contains the POA (Present on Admission) indicator (for use on inpatient claims only). The Coding Department provides POA information based on documentation. POA Indicators:

Y	Yes –The diagnosis was present at the time of the inpatient admission.
N	No – The diagnosis was not present at time of the inpatient admission.
U	Unknown –The documentation is insufficient to determine if the condition was present.
W	Clinically undetermined – The provider is unable to clinically determine whether the condition was present at the time of the admission.

FL 67 a-q Other Diagnosis Codes (Situational)

These FLs are situational, but they are required when other conditions are present or develop. Use fields A-Q to list ICD-9 CM codes for conditions that coexist at the time of admission, develop subsequently, or affect the treatment received or length of stay. Additional diagnoses are sequenced in order of priority assigned by the coding staff. Do not use decimals because they are implied.

FL 68 Reserved

Leave this form locator blank

FL 69 Admitting Diagnosis (Required)

Required for inpatient.  
Enter the ICD-9-CM diagnosis code describing the patient's diagnosis at the time of admission, including fourth and fifth digits, when appropriate.

FL 70 a-c Patient's Reason for Visit (Required for UB-04/Situational for 837I)

Situational for outpatient visits.  
Required for observation and ER (emergency room) visits.  
Not required for ancillaries: laboratory, radiology, and pharmacy.  
Enter up to three ICD-9-CM diagnosis codes that describe the patient's reason for the visit at the time of the outpatient registration, including the fourth and fifth digits, when appropriate.

FL 71 Prospective Payment System (PPS) Code (Situational)

Not used in the MHS.

FL 72 a-c External Cause of Injury (E-Code) (Situational)

Expressed as an E-code.  
Required in cases when any diagnosis is related to injury (including due to motor vehicle traffic accidents involving collision with another vehicle), poisoning or adverse effect.  
Enter the three "E" ICD-9 CM codes that indicate the external cause, if any, of an injury, poisoning, or adverse effect.  
These codes are assigned by the coding department.

FL 73 Reserved

Leave this form locator blank

FL 74 Principal Procedure Code and Date (Situational)

Required on inpatient claims when a procedure was performed; not required for outpatient. Enter the ICD-9 CM Volume 3 codes and dates for the inpatient principal procedure performed, if any, and the corresponding date on which the principal procedure was performed.

Per HIPAA 5010 transaction standard requirements, do not use ICD-9 CM procedure codes on outpatient claims.

The procedure code dates must fall within the dates provided in FL 06 – Statement Covers Period.

UB-04 format: Use MMDDYY.

837I format: Use CCYYMMDD.

FL 74 a-e Other Procedure Codes and Dates (Situational)

Enter up to five additional ICD-9 CM Volume 3 codes and dates for any additional inpatient procedures.

The procedure code dates must fall within the dates provided in FL 06 – Statement Covers Period.

UB-04 format: Use MMDDYY.

837I format: Use CCYYMMDD.

FL 75 Reserved

Leave this form locator blank.

FL 76 Attending Provider Name and Identifiers (Required)

Enter the name and identifying number of the attending provider.

The top line captures the ID number (NPI) of the provider as well as the Qualifier field.

The bottom line lists the provider's last name followed by first name.

For inpatient bills, FL 76 lists the attending physician.

For outpatient diagnostic services or outpatient therapy claims, this FL lists the physician who requested the service.

In the MHS, the primary physician for the case is listed in this FL.

FL 77 Operating Physician Name and Identifiers (Situational)

Enter the identification number and name of the physician (last, first) who has the primary responsibility for performing a surgical procedure.

The top line captures the ID number (NPI) of the provider as well as the Qualifier field.

The bottom line lists the provider's last name followed by the first name.

This FL is left blank if a procedure is not performed.

FL 78-79 Other Provider Names and Identifiers (Situational)

Enter the identification numbers and names of other providers or health care professional involved in the care of the patient.

The top line captures the ID number (NPI) of the provider as well as the Qualifier field.

The bottom line lists the provider’s last name followed by the first name.

Use the NPI and qualifier code, indicating the provider type.

FL 80 Remarks (Situational)

Enter any remarks needed to provide information not shown elsewhere on the bill but necessary for proper payment.

Assignment of benefits is assumed under Title 10 USC (United States Code) 1095.

Optional – not all Services use this on their (paper) UB-04 claims.

FL 81 Code-Code (Situational)

Enter overflow or additional condition, value, occurrence span, or occurrence codes related to the form locators.

This is not used for the 837I.

This is not used in the MHS.

**Appendix C**

Revised: March 2014

Instructions for completing the professional claim format follow. An online training module and reference guide, “Data and Billing in Sync: CMS 1500 (02/12)/837P” is available on the DHA UBO Learning Center: [http://www.tricare.mil/ocfo/mcfs/ubo/learning\\_center/teleconferences.cfm](http://www.tricare.mil/ocfo/mcfs/ubo/learning_center/teleconferences.cfm).

For more information go to the website of the National Uniform Claim Committee ([nucc.org](http://nucc.org)).

Grouping of Item Numbers

<b>Insurance Information</b>	<b>Patient Demographic</b>	<b>Additional Information</b>	<b>Diagnosis &amp; Procedures</b>	<b>Provider Information</b>
Carrier	<i>Item Numbers</i>	<i>Item Numbers</i>	<i>Item Numbers</i>	<i>Item Numbers</i>
<i>Item Numbers</i>	2	10a-10c	21	17
1	3	10d	21A-L	17a
1a	5	14	24A-H	17b
4	12	15	24A	24I
6	13	16	24B	24J
7		18	24C	25
9		19	24D	26
9a		20	24E	27
9d		22	24F	31
11			24G	32
11a			24H	32A
11b			28	32B
11c			29	33
11d				33A
23				33B

NOTE: Item Numbers 8, 9b, 9c, and 30 are reserved for NUCC use.

Carrier (Required)

The top section of the 1500 Claim Form; contains payer name and address.

To distinguish this version of the form from other versions, the top left side of the margin has the Quick Response (QR) code symbol (e.g., machine-readable matrix barcode) and NUCC approval date (02/12).

Do not use punctuation or symbols (e.g., comma, #) in any portion of the address.

- Exception: When entering a nine-digit ZIP code, include the hyphen.

The payer is the carrier, health plan, third-party administrator, or other payer that will handle the claim.

In the top center, white open area, enter the payer’s name and address, as follows:

1 <sup>st</sup> Line	Payer Name
2 <sup>nd</sup> Line	Payer Address Line 1
3 <sup>rd</sup> Line	Payer Address Line 2 (situational)
4 <sup>th</sup> Line	Payer City, State (2-character state abbreviation) and ZIP Code (if 9-digit zip, include hyphen)

**Item Number 1 – Medicare, Medicaid, TRICARE, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), Group Health Plan, FECA (Federal Employees’ Compensation Act), Black Lung, Other (Required)**

Describes the type of health insurance coverage and establishes the insurance type to which the claim is being submitted.

Only one box may be marked.

Check "Other" if the applicable payer is a health maintenance organization (HMO), commercial, automobile accident, liability, or workers' compensation.

DoD military treatment facilities (MTFs) do not submit claims to TRICARE (TRICARE may be an option for other providers).

#### **Item Number 1a – Insured's ID Number (Required)**

Identifies the insured to the payer.

Enter the insurance ID Number, as displayed on the insurance card, for the coverage identified in Item Number 1 (Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other).

This may be the patient's Insurance ID Number or the unique Member ID number the payer has assigned to the patient (even though the patient may not be the insured).

For workers' compensation claims, enter the Employee ID.

For other property and casualty claims, enter the Federal Tax ID or SSN of the insured person or entity.

#### **Item Number 2 – Patient's Name (Situational)**

Identifies the name of the person who received treatment or supplies.

Enter the name of the patient using the following format:

Last Name, First Name, Middle Initial (include commas).

Enter name suffixes after the last name preceded by a space, followed by a comma and a space, then the first name (e.g., Smith Jr, John).

Do not use: periods, professional suffixes (e.g., PhD, Esq), titles (e.g., Dr, Sgt.).

Capitalize both names in hyphenated names (e.g., Smith-Jones).

If the patient name is the same as the insured's name - meaning that the patient is also the insured—it is not necessary to report the patient's name in this field.

#### **Item Number 3 – Patient's Birth Date, Sex (Required)**

Contains identifying information about the patient.

Enter the date of birth of the patient and enter "X" in the appropriate gender box.

Format for 1500: MMDDYYYY.

Format for 837P: YYYYMMDD.

If gender is unknown, leave blank.

#### **Item Number 4 – Patient's Name (Required)**

Identifies the person who holds the policy.

Format: Last name, first name, middle initial (include commas).

Enter name suffixes after the last name preceded by a space, followed by a comma and a space, then the first name (e.g., Smith Jr, John).

Do not use periods, professional suffixes (e.g., PhD, Esq.), or titles (e.g., Dr., Sgt.).

Capitalize the first letter of both names in hyphenated names (e.g., Smith-Jones).

For workers' compensation claims, enter the name of the employer.

For other property and casualty claims, enter the name of insured person or entity.

**Item Number 5 – Patient’s Address (Situational)**

Contains the patient’s permanent address.

Enter the address using the format below; do not enter temporary address or school address.

1st line	Street Address
2nd line	City, State (2 character state abbreviation)
3rd line	ZIP Code (if 9 digit zip, include hyphen)

Do not use punctuation (i.e., commas, periods) or symbols (e.g., #).

For foreign addresses, contact payer for specific reporting instructions.

If the patient’s address is the same as the insured, these fields may be left blank.

Telephone – situational.

For electronic claims, leave blank.

**Item Number 6 – Patient Relationship to Insured (Situational)**

Indicates how the patient is related to the policyholder.

Identified in Item Number 4 (Insured’s Name) when a name is entered.

Enter “X” in the appropriate box; only one box may be checked.

For electronic claims, leave blank.

Relationship to Insured

Self	Insured is the patient; may also be a family member, but has a unique member ID number.
Spouse	Insured is the husband, wife or partner, as defined by the payer, of the patient.
Child	The insured is the parent of the patient who is a minor family member, as defined by the payer.
Other	Use if the patient’s relationship to the insured is not self, spouse, or child; “Other” may include employee, ward, or family member, as defined by the payer.

**Item Number 7 – Insured’s Address (Required)**

Identifies the insured’s permanent residence.

Enter the address using the indicated format; do not enter temporary address or school address.

Do not use punctuation (e.g., commas, periods) or symbols (e.g., #) unless otherwise noted.

For foreign addresses, contact payer for specific reporting instructions.

Telephone – situational (do not use a hyphen or space as a separator within the telephone number).

For electronic 837P claims, leave blank.

Item Number 8 – Reserved for NUCC use.

**Item Number 9 – Other Insured’s Name (Situational)**

Identifies the name of the person who has other insurance and indicates that there is another policy that may cover the patient.

Complete only if Item Number 11d (Is there another Health Benefit Plan?) is marked “Yes.”

Format: Last name, First name, Middle initial (include commas).

Enter name suffixes (e.g., Jr or III) preceded by a space after the last name, followed by a comma and a space, then the first name (e.g., Smith Jr, John).

Do not use periods, professional suffixes (e.g., PhD or Esq.) or titles (e.g., Dr. or Sgt.).

Capitalize the first letter of both names in hyphenated names (e.g., Smith-Jones).

**Item Number 9a – Other Insured’s Policy Or Group Number (Situational)**

Identifies the policy or group number of the other insurance policy.

Complete only if Item Number 9 (Other Insured’s Name) has been completed.

Enter the insured’s policy or group number as it appears on the insurance card.

Do not include space or hyphen.

Item Number 9b – Reserved for NUCC use Item Number 9c – Reserved for NUCC use

**Item Number 9d – Insurance Plan Name or Program Name (Situational)**

Identifies the name of the plan or program of the other insured.

Complete only if Item Number 9 (Other Insured’s Name) is completed.

Enter the plan name of the payer identified in Item Number 9a (Other Insured’s Policy or Group Number).

Usage varies depending on the payer.

**Item Number 10 – Is Patient’s Condition Related To:**

**Item Number 10a-10c (Situational)**

Indicates whether the patient’s illness or injury is related to employment or other type of accident.

Mark only one box in each line to indicate whether the services reported on this claim relate to employment, auto accident, or other type of accident.

If auto accident is marked with “YES,” enter the state abbreviation of where the accident took place.

**Item Number 10d – Claim Codes (Designated by NUCC)(Situational)**

A sub-set of Condition Codes.

Codes identify additional information about the patient’s condition or the claim.

Use as required by payers.

Multiple codes may be reported; separate each code by 3 blank spaces.



**Item Number 11 – Insured’s Policy Group or FECA Number (Situational)**

Refers to the alpha-numeric identifier for health, auto, or other insurance plan coverage.  
If Item Number 4 (Insured’s Name) is completed, enter the insured’s policy or group number as it appears on the insurance card.  
For auto accident claims, enter the auto insurance policy number.  
For workers’ compensation claims, enter the 9-digit alphanumeric FECA (Federal Employees’ Compensation Act) identifier assigned to the patient.  
Do not include space or hyphen.

**Item Number 11a – Insured’s Date of Birth, Sex (Situational)**

Enter the date of birth of the insured identified in Item Number 1a (Insured’s ID Number) and enter “X” in the appropriate gender box.  
Format for 1500: MMDDYYYY.  
Format for 837P: YYYYMMDD.  
If gender is unknown, leave blank.

**Item Number 11b – Other Claim ID (Designated by NUCC) (Situational)**

Use only for workers’ compensation or property and casualty claims Enter “Y4” in the first two positions to the left of the vertical, dotted line followed by the claim ID on the right side of the vertical, dotted line  
Do not enter any other identifiers  
“Y4” is the NUCC-defined identifier for Property Casualty Claim Number  
FOR WORKERS’ COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.  
Leave blank for all other claim types

**Item Number 11c – Insurance Plan or Program Name (Situational)**

Identifies the name of the plan or program of the insured.  
Enter the plan name of the payer identified in Item 1a (Insured’s ID Number).  
Usage varies depending on the payer.

**Item Number 11d – Is There Another Health Benefit Plan? (Required)**

Indicates that the patient has insurance coverage other than the plan identified in Item Number 1 (Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other).  
Enter “X” in the appropriate box; only one box may be marked.  
If the “YES” box is marked, complete the following Item Numbers:  
9 – Other Insured’s Name  
9a – Other Insured’s Policy or Group Number  
9d – Insurance Plan Name or Program Name

**Item Number 12 – Patient’s Or Authorized Person’s Signature (Required)**

Indicates that there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

Enter "Signature on File," "SOF," or a legal signature.

If entering a legal signature, enter the corresponding date.

Format for 1500: MM DD YYYY or MM DD YY.

If there is no signature on file, leave blank or enter "No Signature on File."

**Item Number 13 – Insured’s Or Authorized Person’s Signature(Required)**

Indicates that there is a legal signature or a signature on file authorizing payment of medical benefits.

Enter "Signature on File," "SOF," or a legal signature.

If entering a legal signature, enter the corresponding date.

If there is no signature on file, leave blank or enter "No Signature on File."

**Item Number 14 – Date of Current Illness, Injury, or Pregnancy (LMP) (Required)**

Identifies the first date of onset of illness, the actual date of injury or first day of last menstrual period (LMP).

Enter the date in the designated spaces using the following format:

MM DD YYYY or MM DD YY.

To the right of the date, enter the qualifier that identifies the date being reported.

Qualifier Values

431	Onset of Current Symptoms or Illness
484	Last Menstrual Period

**Item Number 15 – Other Date (Situational)**

Identifies additional date information about the patient’s condition or treatment.

Enter the qualifier identifying the reported date in the first space.

Enter the date in the subsequent spaces using the following format: MMDDYYYY or MMDDYY.

Qualifier Values

454	Initial Treatment
304	Latest Visit or Consultation
453	Acute Manifestation of a Chronic Condition
439	Accident
455	Last X-ray
471	Prescription
090	Report Start (Assumed Care Date)
091	Report End (Relinquished Care Date)
444	First Visit or Consultation

**Item Number 16 – Dates Patient Unable to Work in Current Occupation (Situational)**

Identifies the date span the patient is unable to work in his/her current occupation because of this medical condition.

Complete only if the patient was employed at the onset of the medical condition.  
 Enter the "FROM" and "TO" dates the patient is unable to work.  
 Format for 1500: MM DD YYYY or MM DD YY.  
 Format for 837P: YYYYMMDD.

**Item Number 17 – Name of Referring Provider or Other Source (Required)**

Displays the referring, ordering, or supervising provider, as indicated by the qualifier, who referred, ordered, or supervised the service(s) or supply(ies) on the claim.  
 If more than one provider is involved, enter only one based on the role of the provider being reported, using the following priority: referring (first), ordering (second), and supervising (third).  
 To the left of the vertical line, enter the qualifier that indicates the type of provider being entered.

0B	State License Number
1G	Provider UPIN Number (Unique Physician Identification
G2	Provider Commercial Number
LU	Location Number

To the right of the vertical line, enter the name of the provider followed by their credentials, using the following format: First Name, Middle Initial, Last Name, Credential(s).  
 Do not use periods or commas.  
 Hyphen may be used if name contains a hyphen.

**Item Number 17a – Other ID# (Situational)**

Identifies and lists the type of non-National Provider Identifier (NPI) number of the referring, ordering, or supervising provider identified in Item Number 17 (Name of Referring Provider or Other Source) and is the unique identifier of the professional- or provider-designated taxonomy code.  
 Use this Item Number only if the provider does not have an NPI number or there is a payer requirement to provide another identifier.  
 On the left side of the field, enter the qualifier.

Qualifiers

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number

On the right side of the field, enter the provider's other identification number.

**Item Number 17b – NPI# (Situational)**

Contains the NPI number of the referring, ordering, or supervising provider identified in Item Number 17 (Name of Referring Provider or Other Source).  
 Enter the provider's 10-digit NPI number.

**Item Number 18 – Hospitalization Dates Related To Current Services (Situational)**

Refers to an inpatient stay associated with the services on this claim.

Enter the inpatient admission and discharge dates for the related hospitalization. If the patient has not been discharged, leave the "TO" field blank.  
 Format for 1500: MM DD YYYY or MM DD YY.  
 Format for 837P: YYYYMMDD.

**Item Number 19 – Additional Claim Information (Situational)**

This field may contain two different types of claim information: provider and workers' compensation.

**Provider** – Enter a provider identifier as required by the payer preceded by a qualifier that describes it. Identifiers are assigned to the provider by the payer or a third party to uniquely identify the provider. Identifiers may also include taxonomy code that identifies the provider type, classification and/or specialty.

**NUCC-defined Qualifiers**

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (used for Supervising
N5	Provider Plan Network Identification Number
SY	Social Security Number
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy (5010A1 = PXC; Paper = ZZ)

Format for 1500: qualifier/identifier; if entering a second identifier, include 3 blank spaces before enter the next qualifier.

Do not enter space, hyphen, or other separator between the qualifier code and the data.

**Workers' Compensation**

Usage based on state guidelines.

Format for 1500: Qualifier/Report Type Code/Transmission Type Code/Attachment Control Number.

Do not enter space, hyphen or other separator between the qualifier code and the data.

Qualifier: Use only PWK.

**Transmission Type Codes**

AA	Available on Request at Provider Site
BM	By Mail

**Item Number 20 – Outside Lab? \$Charges (Situational)**

Indicates that the services were provided by an independent provider.

Enter an "X" in the YES box to indicate that the reported service was provided by an entity other than the billing provider.

Enter an "X" in the NO box to indicate that there are no purchased services on the claim.

If "YES" is marked, enter the purchase price in the \$ Charges section of the item number.

Enter the entire amount, including cents, to the left of the vertical line.

Enter 00 for cents if the amount is a whole number.

Do not include dollar signs, commas, or decimal points in the amount.

Only one charge for a purchased service may be entered per claim.

**Item Number 21 – Diagnosis or Nature of Illness or Injury (Required)**

Contains the diagnosis pertaining to the patient’s condition.  
 May be either ICD-9-CM or ICD-10-CM based on what is indicated in the ICD Indicator.  
 Enter the indicator between the vertical, dotted lines in the upper right portion of this field.

Indicator Codes

9	ICD-9-CM
0	ICD-10-CM

**Item Number 21A-L – Diagnosis or Nature of Illness or Injury (Required)**

In Item Numbers 21A-L, enter up to 12 diagnosis codes  
 These diagnosis codes are linked to the procedure codes in Item Number 24E (Procedures, Services, or Supplies)

**Item Number 22 – Resubmission Code and/or Original Reference Number (Situational)**

Refers to the reference number assigned by the payer to indicate a previously submitted claim.  
 Select the appropriate resubmission (bill frequency) code if this claim is either a replacement or a void of a prior claim.

7	Replacement of prior claim
8	Void/cancel of prior claim

Enter the original reference number of the prior claim on the right of the vertical solid line (e.g., 12345358X).

**Item Number 23 – Prior Authorization Number (Situational)**

Refers to the payer-assigned number authorizing these services.  
 Enter any of the following that relates to this claim: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.  
 Do not enter hyphens.

**Item Number 24, Section 24A – H**

Required.  
 Enter up to 6 services or supplies, with corresponding information, that the patient received.

**Item Number 24A – Dates of Service [Lines 1–6] (Required)**

Identifies the date(s) the service or supply was provided.  
 Enter the “From” and “To” dates that the service or supply was provided.  
 If there is only one date of service, enter that date under “From” and leave the “To” field blank or re-enter the “From” date.

If grouping multiple dates of services into one line, the services must have been provided on consecutive days and Item Number 24G (Days or Units) must correspond to the number of days identified in the “From” and “To” dates (e.g., dates of service from 07 01 13 to 07 03 13 equate to 3 days).

The following item numbers must be identical for that service line: place of service, Current Procedural Terminology/Healthcare Common Procedural Coding System (CPT/HCPCS), charges, and provider.

Format for 1500: MMDDYY

Format for 837P: YYYYMMDD

**Item Number 24B – Place of Service [Lines 1–6] (Required)**

Identifies the location where each service was provided or item was used. Enter the Place of Service code for each line item.

Commonly Used Places of Service

Place of Service Code(s)	Place of Service Name	Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided
11	Office, Clinic	Location other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF) where the health professional routinely provides health examinations, <del>diagnosis, and treatment of illness or injury</del>
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by, or under, the <u>supervision of physicians to patients</u>
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is <del>provided</del>
24	Ambulatory Surgical Center	A freestanding facility, other than a physician’s office, where surgical and diagnostic services are provided on an
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services.

Place of Service Code(s)	Place of Service Name	Description
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	Outpatient ancillary laboratory and radiology services at non-bedded facility.
99	Other Place of Service	Other place of service not identified above.

**Item Number 24C – EMG [Lines 1–6] (Situational)**

Identifies whether the service was an emergency.  
 Emergency services are indicated with the Medical Expense and Performance Reporting System (MEPRS) code BIA.  
 Enter “Y” for Yes if the service was an emergency; leave blank if the service was not an emergency.

**Item Number 24D – Procedures, Services, or Supplies [Lines 1–6] (Required)**

Identifies the procedures, services, or supplies provided to the patient.  
 Enter the CPT/HCPCS code(s) and modifier(s), if applicable.  
 Up to four two-digit, modifiers may be entered.

**Item Number 24E – Diagnosis Pointer [Lines 1–6] (Required)**

Links the diagnosis code(s) listed in Item Number 21A-L (Diagnosis or Nature of Illness or Injury) to the procedure, service or supply identified in this line item; the diagnosis code is the reason why the service was performed or the supply given.  
 Enter up to 4 letters (A-L), which are the diagnosis codes listed in Item Number 21A-L (Diagnosis or Nature of Illness or Injury).

**Item Number 24F – \$Charges [Lines 1–6] (Required)**

Indicates the total billed amount for each service line.  
 Enter the dollar amount right justified, to the left of the vertical line for the listed service or supply.  
 Do not enter: commas, dollar symbol or negative amounts.  
 Enter cents to the right of the vertical line.  
 If cents is zero, enter 00; do not leave blank.

**Item Number 24G – Days or Units [Lines 1–6] (Required)**

Displays the number of days corresponding to the dates entered in Item Number 24A (Date(s) of Service) or units as defined in CPT or HCPCS coding manual(s).

Enter the number that corresponds to the service or supply being provided.  
 Must be right justified with no leading zeros.  
 Anesthesia services must be reported in minutes; if hours are provided, they must be converted to minutes.  
 If reporting one unit, enter 1.  
 If reporting a fraction of a unit, use a decimal point (e.g., 2.5).

**Item Number 24H – EPSDT/Family Plan [Lines 1–6] (Required)**

Identifies whether the services provided under Medicaid are EPSDT (Early & Periodic Screening, Diagnosis and Treatment).  
 If your MTF provides Medicaid services and the billed services are provided under the EPSDT program, enter Y for “YES” in the shaded portion; otherwise, enter “N” for “NO.”  
 If the payer is not Medicaid, leave this field blank.  
 If your state requires a reason code, enter a reason code in the non-shaded portion of the field.

Reason Codes

AV	Available – Not used (patient refused referral)
S2	Under Treatment (patient is currently under treatment for referred diagnostic or corrective health problem)
ST	New Service Requested
NU	Not Used (used when no EPSDT patient referral was given)

**Item Number 24I – ID Qual (Lines 1-6) (Situational)**

Identifies the qualifier that describes the type of provider identification number being reported and the corresponding identification number of the provider.  
 Use this qualifier when a provider does not have an NPI number.  
 Enter the qualifier in the top (shaded) portion of the field.

ID Qualifiers

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number
ZZ	Provider Taxonomy
PXC	Provider Taxonomy for electronic submission

**Item Number 24J – Rendering Provider ID # [Lines 1–6] (Required)**

Identifies, by NPI number, the provider, or an individual or a company (laboratory or other facility), that provided the service  
 Enter the 10-digit NPI number in the bottom, white portion of the field  
 Report the provider ID in this field only when it is different from the billing provider identifier reported in Item Numbers 33a (NPI#) and 33b (Other ID#)

**Item Number 25 – Federal Tax ID # SSN EIN (Required)**



Enter the Federal Tax ID Number – either the employer ID number (EIN) or the Social Security number (SSN) of the billing provider identified in Item Number 33 (Billing Provider Info & Ph #). The Federal Tax ID Number is a unique identifier assigned by a federal agency used for 1099 reporting purposes.

Enter “X” in the appropriate box to indicate whether EIN or SSN is being reported.

Only one box may be checked.

Do not enter hyphens with number.

**Item Number 26 – Patient’s Account No. (Required)**

Enter the account number assigned to the patient by the provider.

Do not enter hyphens with number.

**Item Number 27 – Accept Assignment (Required)**

Indicates that the provider agrees to accept assignment (receive payment) under the terms of the payer’s program.

Enter “X” in the YES box to indicate that the provider accepts assignment. Note: The YES box should be checked for all providers; otherwise, the provider is not going to receive payment.

**Item Number 28 – Total Charge (Required)**

Displays the total billed amount for all services entered in Item Number 24F (\$ Charges), lines 1 – 6.

Enter the total dollar amount of all the charges listed for the services and items provided.

The dollar amount is right justified to the left of the vertical line.

Do not enter commas, dollar symbol, or negative amounts.

Enter cents to the right of the vertical line.

If cents is zero, enter 00; do not leave blank

Reason Codes

AV	Available – Not used (patient refused referral)
S2	Under Treatment (patient is currently under treatment for referred diagnostic or corrective health problem)
ST	New Service Requested
NU	Not Used (used when no EPSDT patient referral was given)

**Item Number 29 – Amount Paid (Situational)**

Displays the total payment amount received by the patient and/or another payer for the covered services only.

Leave blank if no payment has been received.

Item Number 30 – Reserved for NUCC use.

**Item Number 31 – Signature of Physician or Supplier Including Degrees or Credentials(Required)**

Refers to the authorized or accountable person who provided the service(s) or supply(ies) and his/her degree, credentials, or title.

Enter one of the following: the legal signature of the practitioner or supplier or their representative, "Signature on File" or "SOF."

Enter the date the form was signed in any of the following formats: MMDDYY, MMDDYYYY or alphanumeric (June 1, 2013).

For electronic claims, leave this field blank.

Contact payer for specific reporting guidelines.

**Item Number 32 – Service Facility Location Information (Situational)**

Refers to the facility that provided other services, such as diagnostic tests, and is different from the Billing Provider identified in Item Numbers 33 (Billing Provider Info & Ph #) and 33a (NPI#).

The billing office must check the DMIS ID table to determine whether the service facility (treatment DMIS ID) has a Type 2 NPI.

If the service facility has a Type 2 NPI, complete this item number; otherwise, leave blank.

Enter the name and address information of the facility, using the following format:

1 <sup>st</sup> line	Name
2 <sup>nd</sup> line	Payer Address (do not use punctuation or symbols; e.g., 1 W End St 101)
3 <sup>rd</sup> line	Payer City, State (enter space between town name and state; do not include common, use two-character state abbreviation and use a nine-digit ZIP code, including the hyphen)
Foreign address	Contact payer for specific formatting guidelines

Item Number 32A – NPI# (Situational)

Enter the 10-digit NPI number of the facility identified in Item Number 32 (Service Facility Location Information)

Item Number 32B – Other ID# (Situational)

Contains an additional facility identification number that may be reported.

Enter the qualifier that identifies the type of identification number being reported, followed by the identification number.

Other ID# Qualifier

0B	State License Number
G2	Provider Commercial Number
LU	Location Number

Do not enter a space, hyphen or other separator between the qualifier and the number

Item Number 33 – Billing Provider Info & PH # (Required)

Contains the name, address and telephone number of the provider who provided the services or supplies identified in Item Number 25 (Federal Tax ID Number); this is the entity requesting payment for the services or supplies listed on the claim.

Enter the name and address information of the facility (must be the physical location, not a P.O. Box) using the following format:

1 <sup>st</sup> line	Name
2 <sup>nd</sup> line	Payer Address (do not use punctuation or symbols; e.g., 1 W End St 101)
3 <sup>rd</sup> line	Payer City, State (enter space between town name and state; do not include comma, use two-character state abbreviation and use a nine-digit ZIP code, including the

For format of foreign addresses, contact payer for specific formatting guidelines  
 Enter the billing provider phone number in the upper right hand side of the field  
 Do not use hyphens or spaces

**Item Number 33A – NPI (Situational)**

Enter the 10-digit NPI number of the provider identified in Item Number 33 (Billing Provider Info & Ph #)

**Item Number 33B – Other ID# (Situational)**

Contains an additional provider identification number that may be reported.  
 Enter the qualifier that identifies the type of provider identification number being reported, followed by the identification number.

Qualifiers to Identify Provider Number

0B	State License Number
G2	Provider Commercial Number
LU	Location Number

Do not enter a space, hyphen or other separator between the qualifier and the number.

**Appendix D**

Revised: August 2014

**NOTE:** All Pharmacy/Bill Types-2 generated in Third Party Outpatient Collection System (TPOCS) should include; National Provider Identifier (NPI) Type 2 for the facility and NPI Type 1 for the Dispensing provider (data elements for the Prescriber I.D. will be based on payer requirements).

**Patient Information** – This section of the Universal Claim Form (UCF) provides patient and cardholder information.

Cardholder I.D. – Required  
 Cardholder’s I.D.

Group I.D., – Conditional  
Group I.D.

Cardholder Name – Required  
Cardholder's name (last, first, middle initial)

Plan Name – Required  
Plan name

Patient Name – Required  
Patient's name (last, first, middle initial)

– Qualifier Code, Other Coverage Code – Required  
Other coverage codes, as applicable 0 - Not Specified (Default)  
- No other coverage identified  
- Other coverage exists-payment collected  
- Other coverage exists-this claim not covered 4 - Other coverage exists-payment not collected 5 -  
Managed care plan-denial  
6 - Other coverage denied-not a participating provider 7 - Other coverage exists-not in effect at  
this time  
8 - Claim is billing for co-pay

– Qualifier Code, Person Code – Required  
Code assigned to specific person in the family

Patient Date of Birth – Required  
Patient's DOB three spaces MMDDCCYY

– Qualifier Code, Patient Gender Code – Required  
0 - Not Specified 1 - Male  
2 - Female

– Qualifier Code, Patient Relationship Code – Required  
Relationship code of patient to cardholder (Drop down box) 0 - Not specified  
- Cardholder  
- Spouse

- Child
- Other

**Pharmacy Information** - This section of the UCF provides pharmacy information required for processing the claim. Note: NPI Type 2 of the treatment/dispensing MTF will be used for all pharmacy claims generated in TPOCS.

Pharmacy Name – Required

Name of Pharmacy

For DoD, the name of the MTF that filled the prescription.

– Qualifier Code, Service Provider I.D. – Required

ID of the service provider/ followed by the following qualifier code

TPOCS will now assign qualifier **01-NPI Type 2** based on the **Dispensing DMIS ID (Defense Medical Information System Identifier)**.

Blank - Not Specified

- National Provider Identifier (NPI)

- Blue Cross 03 - Blue Shield 04 - Medicare

- Medicaid

- UPIN

- NCPDP Provider ID 08 - State License

- CHAMPUS

- Health Industry Number 11 - Federal Tax ID

12 - DEA

Address – Required

Pharmacy street address

For DoD, the address of the MTF that filled the prescription.

Phone Number – Required

Pharmacy phone number

For DoD, enter the phone number of the MTF that filled the prescription.

City – Required

City for pharmacy address

For DoD, the city of the MTF that filled the prescription.

Fax No. – Required

Fax # for the pharmacy

For DoD, the fax number of the MTF that filled the prescription.

State and Zip Code – Required

State and Zip code for pharmacy

For DoD, the state and Zip code of the MTF that filled the prescription.

**Workers' Compensation Information** – This section provides information related to Workers' Compensation claims.

Employer Name – Conditional  
Employer's name for the patient

Address – Conditional  
Employer's street address

City – Conditional  
Employer's city

State – Conditional  
Employer's state

Zip Code – Required  
Employer's Zip code

Authorized Signature, Required  
Authorized signature of patient or legal guardian (handwritten)

– Qualifier Code, Carrier I.D. – Required  
ID of the carrier  
Code assigned to Workers' Compensation Program  
Worker's Compensation information is conditional and should be reported only for Workers' Compensation claims.

Employer Phone Number – Required  
Employer's phone number

Date of Injury – Required  
Date of injury

– Qualifier Code, Claim Reference I.D. – Required  
Reference ID for the claim  
Claim number assigned by Workers' Compensation Program

**Prescription/Service Information** – Sections 1 and 2 of the Universal Claim Form require the same data. The form allows for two separate prescriptions to be filed on one claim form.

Prescription/Service Reference Number – Required  
Prescription or service reference #

– Qualifier Code, Prescription/Service Reference Number Qualifier – Required  
Blank - Not specified 1 - Rx Billing (Default) 2 - Service Billing

Date Written – Required  
Date prescription or service written

Date of Service – Required  
Dispensed date

Fill Number – Required, if applicable

Fill number for the prescription

– Qualifier Code, Quantity Dispensed – Required, if applicable

Quantity of prescription dispensed; expressed in metric decimal units

Days Supply – Required, if applicable

Number of days supplied in prescription

Product Service ID – Required, if applicable

Product/service ID number

Currently, will default to the NDC number

– Qualifier, Product Service ID Qualifier – Required

Appropriate qualifier code Blank - Not specified 00 - Not Specified

01 - Universal Product Code (UPC) 02 - Health Related Item (HRI)

03 - National Drug Code (NDC) (Default) 04 - Universal Product Number (UPN) 05 - Department of Defense (DoD)

06 - Drug Use Review/Professional Pharmacy Service (DUR/PPS) 07 - CPT4

- CPT5

- HCPCS

- Pharmacy Practice Activity Classification (PPAC)

- National Pharmaceutical Product Interface Code (NAPPI) 12 - International Article Numbering System (EAN)

13 - Drug Identification Number (DIN) 99 - Other

Dispensed As Written (DAW) Code – Not Required (Blank)

DAW code

Prior Authorization Number Submitted – Conditional

Prior authorization # submitted

– Qualifier Code, Prior Authorization Type – Conditional

Enter the Prior Authorization Code 0 - Not Specified (Default)

1 - Prior Authorization 2 - Medical Certification

3 - EPSDT (Early Periodic Screening Diagnosis Treatment) 4 - Exemption from Co-pay

5 - Exemption from Rx limit 6 - Family Planning Indicator

7 - Aid to Families with Dependent Children (AFDC) 8 - Payer Defined Exemption

Prescriber ID – Required

Identification of the provider that prescribed the drug

– Qualifier Code, Prescriber ID Qualifier – Required

Enter the appropriate billing qualifier based on payer requirements (Drop-down box)

Blank - Not specified 00 - Not specified 01 - DEA  
02 - State License 03 - SSN  
- Name (Default)  
- National Provider ID (NPI)  
- Health Industry Number (HIN) 07 - State Issued  
99 - Other

– Qualifier Code, DUR/PPS Codes – Conditional  
PPS codes—(Limit 1 set of DUR/PPS codes per claim) A - Reason for Service  
B - Professional Service Code C - Result of Service

– Qualifier Code, Basis Cost – Required  
Basis Cost  
Blank - Not specified 00 - Not specified  
01 - Average Wholesale Price (AWP) 02 - Local Wholesale  
- Direct (Default)  
- Estimated Acquisition Cost (EAC) 05 - Acquisition  
06 - MAC (Maximum Allowable Cost) 07 - Usual and Customary  
09 - Other

Provider ID (Registered Pharmacist, R.P.H.) – Required  
Provider's ID- NPI Type 1 of the dispensing Provider

– Qualifier Code, Provider ID Qualifier – Required  
Use qualifier 05 - National Provider ID Blank - Not specified  
00 - Not specified 01 - DEA  
02 - State License 03 - SSN  
04 - Name  
\*05 - National Provider ID (NPI) 06 - Health Industry Number (HIN) 07 - State Issued  
99 - Other (Default)

Diagnosis Code – Conditional  
ICD9-CM diagnosis code

– Qualifier Code, Diagnosis Code Qualifier – Conditional  
Report diagnosis code and qualifier related to prescription-limit: one per prescription Blank - Not Specified  
00 - Not Specified 01 - ICD-9 (Default) 02 - ICD-10  
- National Criteria Care Institute (NDCC)



- Systemized Nomenclature of Human and Veterinary Medicine (SNOMED) 05 - Common Dental Terminology
- Medi-Span Diagnosis Code
- American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)
- 99 - Other

Other Payer Date – Conditional  
Other payer date

Other Payer ID – Conditional  
ID for other payer

- Qualifier Code, Other Payer ID Qualifier – Conditional
- Blank - Not Specified
- 01 - National Payer ID (Default) 02 - Health Industry Number (HIN)
- Bank Information Number (BIN)
- National Association of Insurance Commissioners (NAIC) 05 - Coupon
- 99 - Other

Other Payer Reject Codes – Conditional  
Reject codes from other payer

Usual and Customary Charge – Required  
Usual and Customary Rate

Ingredient Cost Submitted – Required  
Ingredient cost per unit  
Total cost of the drug not including the dispensing fee

Dispensing Fee Submitted – Required  
Dispensing is added into Basis Cost and not listed in field

Incentive Amount Submitted – Conditional  
Incentive charges (Default = 0.00)

Other Amount Submitted – Conditional  
Other charges submitted

Gross Amount Due Submitted – Required  
Total due  
Equals sum of Usual & Customary Charge, Ingredient Cost Submitted, Dispensing Fee Submitted, Incentive Amount Submitted, and Other Amount Submitted.

Patient Paid Amount – Conditional  
Cost paid by the patient (Default = 0.00)

Other Payer Amount Paid – Conditional  
Total paid by the other payer

Net Amount Due – Required  
Remaining balance due  
Equals Gross amount due subtracted by sum of Patient Amount Paid and Other Payer Amount Paid.

Compound Prescriptions – Not required

Limit 1 compound prescription per claim if compound prescription used

Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area on the reverse side at the bottom of claim form. Use a separate claim form for each compound prescription.

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**PERF** **UNIVERSAL CLAIM FORM (UCF)** **PERF**

**TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES**

**ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE**

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE

**1**

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN	DATE OF SERVICE	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
MM DD CCYY		MM DD CCYY	MM DD CCYY			

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS CODE (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
MM DD CCYY				

**2**

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN	DATE OF SERVICE	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
MM DD CCYY		MM DD CCYY	MM DD CCYY			

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS CODE (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
MM DD CCYY				

INGREDIENT COST SUBMITTED
DISPENSING FEE SUBMITTED
INCENTIVE AMOUNT SUBMITTED
OTHER AMOUNT SUBMITTED
SALES TAX SUBMITTED
GROSS AMOUNT DUE SUBMITTED
PATIENT PAID AMOUNT
OTHER PAYER AMOUNT PAID
NET AMOUNT DUE

FOR OFFICE USE ONLY

QUAL (5)

SCREENS: BOX 10%, TEXT 11%.

Appendix E

Revised: June 2014

DD7 form available at <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd0007.pdf>

DD7 sections are automatically populated by the government billing solution, but must be reviewed for accuracy.

Section 1: Required

Installation Providing Hospitalization (name and address)

Name of medical activity, base and/or post, and Major Command as applicable providing medical care in the continental United States. Name of medical activity, APO and Major Command outside the continental United States (OCONUS).

Section 2: Required

Month and Year Covered by This Report

Month and year covered by this report (9-character alpha month, 4-digit year).

**Section 3: Required** Category of Patients Category of the patients.

**Section 4: Required** Authority for Admission Authority for the admission.

Section 5: Required

Name and SSN

Name (Last, First, Middle Initial) and Social Security Number (SSN) (9-digit numeric).

Section 6: Required

Military Grade

Military grade or status of the individual (e.g., civilian, eligible family member).

Section 7: Requirement Not Available

Organization

Section 8: Required

Diagnosis Diagnosis

Section 9: Required

Admission

List 4 digit year of admission, 2 digit month, 2 digit day, no separators.

Section 10: Required

Discharge

List day, 4 digit year, 2 digit month, 2 digit day of discharge.

Section 11: Required

Total

Total number of days hospitalized. Section 12: Required

Date of Authentication

4 digit year, 2 digit month, 2 digit day

**Section 13: Required**

Authentication (signature, military grade, and organization of Commanding Officer)

Obtain the required signature of the MTF commander or authorized representative (on original only) including grade and organization.

**Section 14: Required**

Total Days Hospitalized

Enter the total number of days hospitalized.

**Appendix F**

Revised: June 2014

DD7A form available at

<http://www.dtic.mil/whs/directives/infomgt/forms/forminfo/forminforpage4.html>

DD7A sections are automatically populated by the government billing solution, but should be reviewed for accuracy prior to submitting to payer.

**Section 1: Required**

Installation Providing Hospitalization (name and address)

Name of medical activity, base and/or post, and Major Command, as applicable, providing medical care in the continental United States (CONUS). Name of medical activity, APO (Army Post Office, or FPO, Fleet Post Office, or MPO, Military Post Office), and Major Command outside the continental United States (OCONUS).

**Section 2: Required**

Month and Year Covered By This Report

Month and year covered by this report (9-character alpha month, 2-digit year; e.g., 30-Jul-04).

**Section 3: Required**

Category of Patients

Category of the patients, PATCATs.

**Section 4: Required** Authority for Admission Authority for the admission.

**Section 5: Required**

Name and SSN

Name (Last, First, Middle Initial) and Social Security Number (SSN) (9-digit numeric).

**Section 6: Required**

Military Grade

Military grade or status of the individual (e.g., civilian, eligible family member).

**Section 7: Requirement Not Available**

Organization

**Section 8: Required**

Diagnosis

The MEPRS Clinic/Services diagnosis; e.g., BDBA (OPE [Outpatient Emergency]).

Section 9: Required  
Treatment Dates

List day, month, and year (DDMMCCYY) as the Date of Service of the services/supplies furnished.

**Section 10: Required** Treatment Number Number of days treated.

Section 11: Required  
Date

Date of certification of rep

Section 12: Required

Authentication (signature, military grade, and organization of Commanding Officer)  
Obtain the required signature of the MTF commander or authorized representative (on original only), including grade and organization.

Section 13: Required, if applicable

Total

Total amount for all patients listed for each Patient Category (PATCAT), Total Amount Billed this Fiscal Year, and any applicable adjustments for the period.

**Appendix G**

Revised: June 2014

Invoice and Receipt (I&R) sections are automatically populated by the government billing solution, but they must be reviewed for accuracy.

Provider Name, Address: Required

Medical activity, base and/or post, and Major Command as applicable providing medical care in continental United States. Name of medical activity, Army or Navy Post Office (APO/FPO), and Major Command outside the continental United States.

Organization: Required

Military branch

Sponsor Name: Required

Name of the patient's sponsor (Last, First)

Service: Required

Service code

Duty Address: Required

Duty address of sponsor

Grade: Required

Military grade or status of the individual (e.g. civilian, eligible family member)

Billing Name: Required

Name of person to be billed (Last, First)

FMP/SSN: Required

Family member prefix (FMP) and Social Security number of person to be billed

Billing Address: Required, if applicable

Address of person to be billed

Patient Name: Required

Name of patient (Last, First)

Account Number: Required

Account number for bill

Date of Service: Required

Date of admission or outpatient visit (DDMMYYYY)

Discharge Date: Required for inpatient services only

Date of discharge. Inpatient services only (DDMMYYYY).

Total Charge: Required

Sum of total inpatient or outpatient charges

Details of Service for Inpatient I&R Beg Date: Required

Date of admission

End Date: Required Date of discharge

Chg Days: Required

Number of chargeable days

NChg. Days: Required

Number of non-chargeable days

Rate: Required

Per diem rate charged per day for service (if a Diagnosis Related Group (DRG)-calculated bill, system divides totals charges by number of chargeable days)

Charge: Required

Sum of total charges

Details of Service for Outpatient I&R Svc: Required

Service charge category (e.g., OPE (Outpatient Emergency), LAB (Laboratory), RAD (Radiology))

Code: Required

Procedure or product code (e.g., CPT (Current Procedural Terminology), NDC (National Drug Code))

Description: Required

Description of service

Qty: Required

Quantity of service rendered

Svc Date: Required

Date service provided

Charges: Required  
Charge for service

Date: Required  
Date of last transaction (e.g., date account generated, date of last payment)

Payment: Required  
Payments made on account by date

Type Pay: Required  
Form of payment (e.g., cash (C), check (K), credit card (E))

Check No.: Required, if applicable  
Check number of payment

Ctrl No.: Required  
Control number of transaction (auto assigned by government billing solution)

Balance: Required  
Balance calculated by subtracting Payment from Total Charges or previous balance

## **Glossary**

Revised: August 2014

The following information has been excerpted from the "Department of Defense Glossary of Healthcare Terminology" (DoD 6015.1-M), with additions.

A/R. Accounts Receivable. Amounts due from the public (nonfederal) or US. Government organizations or funds (intra-governmental).

ABACUS. Armed Forces Billing and Collection Utilization Solution. A joint shared Service (Army, Navy, Air Force and NCR MD) medical billing solution that initially will interface with the Composite Health Care System (CHCS) to execute billing and collection functions on behalf of the MHS. It provides clearinghouse services to transmit electronic HIPAA standard claims to payers and receive responses/remittance remarks.

ADA. American Dental Association. The nation's largest dental association representing more than 157,000 dentist members.

ASA. Adjusted Standardized Amount. The ASA represents the adjusted average operating cost for treating all TRICARE beneficiaries in all DRGs during the database period.

ADM. Ambulatory Data Module. The data collection module in Composite Health Care System (CHCS) for both inpatient and outpatient professional services.

ADMISSION. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day when the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight.

When reporting admission data, always exclude: total absent–sick patients, carded-for-record only (CRO) cases, and transient patients.

**AIS.** Automated Information System. Computer hardware, computer software, telecommunications, information technology, and other resources that collect, record, process, store, communicate, retrieve, and display information. An AIS can include computer software only, computer hardware only, or a combination of the above.

**ALLOWED AMOUNT.** Maximum dollar amount assigned for a procedure based on various pricing mechanisms.

**AMBULATORY CARE.** Health services provided without the patient being admitted. The services of ambulatory care centers, hospital outpatient departments, physicians' offices, and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours.

**ANCILLARY.** Tests and procedures ordered by healthcare providers to assist in patient diagnosis or treatment (radiology, laboratory, pathology).

**APC.** Ambulatory Patient Classification. System for reimbursing acute care facilities for outpatient services using a prospective payment system. Services are assigned to various APC categories and providers receive fixed payments for individual services.

**APV.** Ambulatory Procedure Visit. An APV is a procedure or surgical intervention that requires pre- procedure care, an actual procedure to be performed, and immediate post-procedure care as directed by a qualified health care provider.

**ASSIGNMENT OF BENEFITS.** The payment of medical benefits directly to a care provider rather than to a member. Generally requires either a contract between the health plan and the provider, or a written release from the subscriber to the provider allowing the provider to bill the health plan.

**ATTENDING PHYSICIAN.** A physician with privileges to practice the specialty independently and who has the primary responsibility for diagnosis and treatment of the patient. The physician may have either primary or consulting responsibilities depending on the case. There will always be only one primary physician; however, under very extraordinary circumstances, because of the presence of complex, serious and multiple, but related, medical conditions, a patient may have more than one attending physician providing treatment at the same time.

**BAD DEBT.** Amounts considered to be uncollectable from patient accounts. Bad debt must be written off or placed in the hands of a professional debt collector.

**BALANCE BILLING.** The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's usual, customary and reasonable or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copays, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).

**BENEFIT.** Amount payable by the insurance company for covered medical expenses as specified by the plan to a claimant, assignee, or beneficiary.

**BUNDLING.** Combining into one payment the charges for various medical services rendered during one health care encounter. Bundling often combines the payment from physician and



hospital services into one reimbursement.

**CARRIER.** An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health or other insurance programs.

**CASE MANAGEMENT.** A system embraced by employers and insurance companies to ensure that individuals receive appropriate, reasonable health care services through effective resource coordination.

**CATASTROPHIC HEALTH INSURANCE.** Policy that provides protection primarily against the higher costs of treating severe or lengthy illnesses or disabilities. Normally these are "add-on" benefits that begin coverage once the primary insurance policy reaches its maximum.

**CBER.** Central Billing Events Repository. A subset/extract of the MHS Data Repository (MDR) and a potential DHA future billing capability that together with ABACUS will allow MTFs to adopt more standard commercial practices.

**CCE.** Coding Compliance Editor. A software suite solution focused on coding, compliance, and data management. The CCE assign and audit medical code sets and abstract data required by the MHS.

**CHAMPUS.** Civilian Health and Medical Program of the Uniformed Services. An indemnity-like program called TRICARE Standard that is available as an option under DoD's TRICARE Program. There are deductibles and cost shares for care delivered by civilian health care providers to active duty family members, retirees and their family members, certain survivors of deceased members, and certain former spouses of members of the seven Uniformed Services of the U.S.

**CHCS.** Composite Health Care System. Medical AIS that provides patient facility data management and communications capabilities. Specific areas supported include MTF health care (administration and care delivery), patient care process (integrates support--data collections and one-time entry at source), ad hoc reporting, patient registration, admission, disposition, and transfer, inpatient activity documentation, outpatient administrative data, appointment scheduling and coordination (clinics, providers, nurses and patients), laboratory orders (verifies and processes), drug and lab test interaction, quality control and test reports, radiology orders (verifies and processes), radiology test result identification, medication order processing (inpatient and outpatient), medicine inventory, inpatient diet orders, patient nutritional status data, clinical dietetics administration, nursing, order-entry, eligibility verification, provider registration, and the Managed Care Program.

**CIVILIAN EMERGENCY.** An individual who is not a beneficiary of the MHS, and not otherwise entitled to care at a military treatment facility (MTF), but who presents to the MTF for emergency treatment or for acute care.

**CLAIM.** A request by an individual (or provider) to an individual's insurance company for the insurance company to pay for services obtained from a health care professional. Types of claims and/or data records include Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug and Dental, and Program for the Handicapped.

**CLEARINGHOUSE.** A public or private entity that facilitates the processing of health information received from another entity.

**CLINIC.** A health treatment facility primarily intended and appropriately staffed and equipped to

provide emergency treatment and ambulatory services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, preventive medicine services, and health promotion activities to support a primary military mission. In some instances, a clinic may also routinely provide therapeutic services to hospitalized patients to achieve rehabilitation goals, (e.g., occupational therapy and physical therapy). A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital and for the care of cases that cannot be cared for on an outpatient status, but that do not require hospitalization. Such beds may not be considered when calculating occupied-bed days by MTFs.

**CLINIC SERVICE.** A functional division of an MTF department identified by a three-digit MEPRS code. **CMAC.** CHAMPUS Maximum Allowable Charge. **TRICARE** reimbursement rates. **CMS.** Centers for Medicare & Medicaid Services. Formerly the Health Care Financing Administration (HCFA).

**CMS 1450.** The standard claim form used by hospitals to bill for services.

**CMS 1500.** A claim form used to bill for professional services. Required by Medicare and generally used by private insurance companies and managed care plans.

**COB.** Coordination of Benefits. Describes the steps used to determine the obligations of payers when a patient is covered under two or more separate healthcare benefit policies.

**CODE SET.** Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions.

**CODING.** A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "upcoded," which is considered fraud. A national certification exists for coding professionals and many compliance programs are raising standards of quality for their coding procedures.

**COINSURANCE.** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges. The individual could also be responsible for any charges in excess of what the insurer determines to be "usual, customary and reasonable".

Coinsurance rates may differ if services are received from a network or non-network provider. In addition to overall coinsurance rates, rates may also differ for different types of services. Coinsurance is only required up to the plan's stop loss amount.

**COMPLIANCE.** The strict adherence to established laws, rules, regulations, and policies in an effort to reduce fraud, waste, abuse, and mismanagement.

**CONSULTATION.** A deliberation with a specialist concerning the diagnosis or treatment of a patient. To qualify as a consultation (for statistical measure), a written report to the requesting health care professional is required.

**CONTRACT.** A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation and less formal agreements may be made.

**CONUS.** Continental United States. United States territory, including the adjacent territorial waters located within the North American continent between Canada and Mexico. Alaska and Hawaii are not part of the CONUS.

**COPAYMENT.** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the remainder of the reimbursement. There may be separate copayments for different services. Some plans require that a deductible first be met for some specific services before a copayment applies.

**CORE-BASED STATISTICAL AREA.** A concept developed by the federal Office of Management and Budget in order to standardize geographic and population descriptions so that data from one federal agency may be reliably related to data from another federal agency without having to recheck definitions used by each agency.

**COVERED BENEFIT.** A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

**COVERED SERVICE.** This term refers to all of the medical services the enrollee may receive at no additional charge or with incidental co-payments under the terms of the prepaid health care contract.

**CPT.** Current Procedural Terminology. A systematic listing and coding of procedures and services performed by a physician. Each procedure or service is identified with a five-digit code that simplifies the reporting of services.

**CSE.** Cosmetic Surgery Estimator. A Microsoft Access-based software application to help MSA clerks estimate the cost of a cosmetic procedure before it is performed.

**DEDUCTIBLE.** A fixed dollar amount during the benefit period, usually a year, that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from a network provider or if received from a non-network provider.

**DEERS.** Defense Enrollment Eligibility System. A data repository that contains all Department of Defense beneficiaries plus the capability to store information for people who are not eligible for DoD benefits.

**DIAGNOSIS.** A term used to identify a disease or problem from which an individual patient suffers or a condition for which the patient needs, seeks, or receives health care.

**DME.** Durable Medical Equipment. Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. An area of increasing expense, particularly in conjunction with case management.

**DMIS ID.** Defense Medical Information System Identification Code. The DMIS ID is an identification code for fixed medical and dental treatment facilities for the Tri-Services and the U.S. Coast Guard. In addition, DMIS IDs are given for non-catchment areas, administrative units such as the Surgeon General's Office of each of the Tri-Services, and other miscellaneous entities.

**DRG.** Diagnosis Related Group. Patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed. It provides a framework for specifying hospital case mix and identifies classifications of illnesses and injuries for which payment is made under prospective pricing programs. It is used to determine the payment the hospital will receive for the admission of that type of patient.

**E/M.** Evaluation and Management. Visits furnished by physicians and the following qualified NPPs: nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants.

**ED.** Emergency Department. The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care.

**EDI.** Electronic Data Interchange. The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization.

**EFFECTIVE DATE.** The date on which a policy's coverage of a risk goes into effect.

**EFT.** Electronic Funds Transfer. Any transfer of funds that is initiated through an electronic terminal, telephone, computer, or magnetic tape, for the purpose of ordering, instructing, or authorizing a financial institution to debit or credit an account.

**ELECTRONIC CLAIM.** A digital representation of a medical bill generated by a provider or by the provider's billing agent for submission using telecommunications to a health insurance payer.

**ERA.** Electronic Remittance Advice. Any of several electronic formats for explaining the payments of health care claims.

**EMERGENCY.** Situation that requires immediate intervention to prevent the loss of life, limb, sight or body tissue or to prevent undue suffering.

**EMTALA.** The Emergency Medical Treatment and Active Labor Act. The federal law that gives all individuals the right to be treated for an emergency medical condition regardless of their ability to pay.

**ENCOUNTER.** Face-to-face contact between patient and the provider with primary responsibility for assessing and treating the patient at a given contact.

**ENROLLEE.** See Subscriber.

**EOB.** Explanation of Benefits. A carrier's written response to a claim for benefits. Sometimes accompanied by a benefit check.

**EXCLUSIONS.** Specified illnesses, injuries, or conditions listed in a policy that are not covered. Experimental therapies, cosmetic surgery, and eyeglasses are common exclusions.

**FEE-FOR-SERVICE PLAN.** In fee-for-service plans, a premium is paid to a private insurance carrier to provide a specific package of health benefits. The insurance carrier reimburses hospitals, physicians, and other service providers, at a rate determined by the plan on a fee-for-service basis. Fee for service health insurance plans typically allow patients to obtain care from doctors or hospitals of their choosing, often paying higher copayments or deductibles.

**FEMA.** Federal Emergency Management Agency. An agency of the United States Department of Homeland Security whose mission is to reduce the loss of life and property and protect communities nationwide from all hazards, including natural disasters, acts of terrorism, and other man-made disasters. FEMA leads and supports the nation in a risk-based, comprehensive emergency management system of preparedness, protection, response, recovery, and mitigation.

**FMCRA.** The Federal Medical Care Recovery Act. Authorizes MTFs to recover the cost of furnishing health care to DoD beneficiaries, including active duty beneficiaries, who are injured or suffer an illness caused by a third party.

**FMP.** Family Member Prefix. A two-digit number used to identify a sponsor, prime beneficiary, or the relationship of the patient to the sponsor.

**FMS.** Foreign Military Sales. The FMS program is a form of security assistance authorized by the Arms Export Control Act (AECA). Under FMS, the US Government and a foreign government enter into a government-to-government sales agreement.

**FORMULARY.** An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care.

**FRR.** Full Reimbursable Rate. The Full Outpatient Rate (FOR) or Full Inpatient Reimbursement Rate (FRR), when appropriate, is used for claims submission to third-party payers and to all other applicable payers not included within International Military Education and Training (IMET) and Interagency/Other Federal Agency Sponsored Rate (IOR) billing guidance.

**FSA.** Flexible Spending Account. Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. See also Health Savings Account.

**FY.** Fiscal Year. A 12-month period used by a government, business, or organization to calculate how much money is being earned, spent.

**GENERIC DRUG.** A drug product that is comparable to a brand name drug in dosage form, strength, route of administration, quality and performance characteristics, and intended use.

**GME.** Graduate Medical Education. Full-time, structured medically related training, accredited by a national body (e.g., the Accreditation Council for Graduate Medical Education) approved by the commissioner of education and obtained after receipt of the appropriate doctoral degree.

**GPMRC.** Global Patient Movement Requirements Center. A joint activity for the regulation of movement of uniformed services patients. The GPMRC authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs.

**GATEKEEPER.** A primary care physician, utilization review, case management, local agency or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for. An arrangement in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone that makes the decision of where a patient will receive services.

**HCPCS.** Healthcare Common Procedural Coding System. A set of codes used by Medicare that describe services and procedures. HCPCS includes CPT codes, but also has codes for services not included in CPT, such as ambulance. While HCPCS is nationally defined, there is provision for local use of certain codes.

**HEALTH INSURANCE.** Financial protection against the health care costs of the insured person. May be obtained in a group or individual policy.

**HEALTHCARE PROVIDER.** A healthcare professional who provides health services to patients; examples include a physician, dentist, nurse, or allied health professional.

**HIPAA.** Health Insurance Portability and Accountability Act. Establishes standards and requirements for health plans, clearinghouses, and healthcare providers that transmit health information electronically.

**HITECH ACT.** Health Information Technology for Economic and Clinical Health Act. Legislation created to stimulate the adoption of electronic health records (EHR) and supporting technology in the United States. The act also addresses the privacy and security concerns associated with the electronic transmission of health information.

**HMO.** Health Maintenance Organization. An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The members of an HMO are required to use participating or approved providers for all health services except for emergencies and generally all services need approval by the HMO through its utilization program.

**HOLD PERIOD.** A period of time between when services are ordered within the MTF and when the services are billed. A hold period is an opportunity for billing personnel to conduct activities such as verifying OHI and obtaining pre-certifications and pre-authorizations.

**HPID.** Health Plan Identifiers. A unique set of numbers and letters used by a health plan to identify members.

**HSA.** Health Savings Account. Savings accounts designated for out-of-pocket medical expenses. In an HSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and an HSA is the ability to carry over the unused funds for use

in a future year, instead of losing unused funds at the end of the year. Most HSAs allow unused balances and earnings to accumulate. Unlike FSAs, most HSAs are combined with a high deductible or catastrophic health insurance plan.

**I&R. Invoice & Receipt.** A paper form used in the MHS for MSA billable patients.

**IAR. Interagency Rate.** Billing rate charged to other federal agencies: Inpatient Interagency Rate (IAR); Interagency/Other Federal Agency Sponsored Outpatient Rate (IOR).

**ICD-9-CM. International Classification of Diseases, 9th Revision, Clinical Modification.** A coding system for classifying diseases and operations to facilitate collection of uniform and comparable health information.

**IMET. International Military Education and Training.** A program that provides training and education on a grant basis to students from allied and friendly nations.

**IMMUNIZATION.** Protection of susceptible individuals from communicable diseases by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.

**INDEMNITY INSURANCE/PLAN.** Traditional insurance that reimburses the patient and/or provider as expenses are incurred.

**J-CODE.** A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items.

**LIMITATIONS.** A restriction on the amount of benefits paid out for a particular covered expense.

**LOS. Length of Stay.** A term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or inpatient facility.

**MAC. Medicare Administrative Contractor.** Contractors used by the Centers for Medicare and Medicaid Services (CMS) to process Medicare claims, enroll healthcare providers in the Medicare program, and educate providers on Medicare billing requirements.

**MAC. Medical Affirmative Claims.** The military program established to accomplish the activity of recovering health care costs under FMCRA. MAC activities involve billing all areas of liability insurance, such as automobile, homeowner and renter, general casualty, medical malpractice (by civilian providers), and workers compensation (for persons other than Federal employees).

**MANAGED CARE.** The coordination of health care services in the attempt to produce high quality health care for the lowest possible cost. Examples are the use of primary care physicians as gatekeepers in HMO plans and pre-certification of care.

**MANAGED CARE PLANS.** Managed care plans generally provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), and Point of Service Plans (POS).

**MANAGED CARE PRICING FILE.** A monthly pharmacy data file that is developed by the Defense Supply Center in Philadelphia (DSC-P) and is the basis for current pharmacy rates.

**MAXIMUM ALLOWABLE.** See Allowed Amount.

**MEDICALLY NECESSARY SERVICES.** Services or supplies which meet the following tests: appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; provided for the diagnosis or direct care and treatment of the medical condition; meet the standards of good medical practice within the medical community in the service area; are not primarily for the convenience of the plan member or a plan provider; are the most appropriate level or supply of service which can safely be provided.

**MEDICARE PART A.** Inpatient portion of benefits under the Medicare Program. Covers inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and co-payments.

**MEDICARE PART B.** Outpatient portion of benefits under the Medicare Program. Covers physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, co-payments, deductibles, and balance billing.

**MEDICARE PART C (MEDICARE ADVANTAGE PLAN/MEDICARE REPLACEMENT).** Medicare Advantage plans are private health plans that generally provide all the coverage of Original Medicare and more. Many Medicare Advantage plans provide benefits and services not covered by Original Medicare. Some plans may also include Part D, or prescription drug coverage. These plans are referred to as Medicare Advantage with Prescription Drug (MAPD) coverage. Types of Medicare Advantage Plans include: Medicare Health Maintenance Organization (HMOs), Preferred Provider Organizations (PPO), PRIVATE FEE-FOR-SERVICE PLANS, MEDICARE SPECIAL NEEDS PLANS. Patient must have Medicare Part A and Part B to enroll in Medicare Part C. SecureHorizons is an example of an insurer that offers Medicare Advantage Plans.

**MEDICARE PART D.** Medicare Part D plans are prescription drug coverage plans offered by private companies. Everyone with Medicare can obtain this optional coverage. Medicare Part D covers both brand-name and generic prescription drugs at participating pharmacies. There are two types of Medicare Part D coverage: Stand-alone plans, (Prescription Drug Plans-PDP plans) which offer only prescription drug coverage and Medicare Advantage plus Prescription Drug (or MAPD) plans that offer prescription drug coverage as well as medical coverage for doctor visits and hospital expenses.

**MEDICARE SUPPLEMENTAL POLICY/MEDIGAP.** Private health insurance plans that pay for the cost of services not covered by Medicare, such as coinsurance and deductibles. Insurance companies are allowed to sell patients only one Medigap policy. Different standardized plans are referred to as A, B, C, D, E, F, F+, G, H, I, J, J+, K and L. Because the policies are standardized, the benefits for a particular plan are the same for each insurance company that offers this type of coverage.

**MEMBER.** See Subscriber.

**MEPRS.** Medical Expense and Performance Reporting System. A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions and requirements for accounting and reporting of expense, manpower, and performance data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.

**MMIG.** MEPRS Management Improvement Group. The senior staff level body responsible for the functional oversight of the Department of Defense (DoD) MEPRS Program and a uniform Military



Health System (MHS) Financial Management Accounts Structure (FMAS) for the TRICARE Management Activity (TMA) and each of the Military Medical Departments.

MODIFIER. Codes that are appended to procedure codes and/or HCPCS codes to provide additional information about the billed procedure.

MSA. Medical Services Account. Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. Most MSAs are combined with a high deductible or catastrophic health insurance plan.

MS-DRG. Medicare Severity Diagnosis Related Group. A Medicare payment system that assigns a level of severity to each episode of care.

MTF. Military Treatment Facility. A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

NDC. National Drug Code. A medical code set maintained by the Food and Drug Administration (FDA) that contains codes for drugs that are FDA-approved. This code set was adopted as the standard for reporting drugs and biologics on standard transactions.

NDMS. National Disaster Medical System. A federal system that supplements the nation's medical response capacity by assisting state and local authorities during major disasters.

NETWORK. A group of doctors, hospitals and other health care providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

NPI. National Provider Identifier. A unique 10-digit identification number used to identify all providers of health care services, supplies, and equipment.

NPPES. National Plan and Provider Enumeration System. Individuals or organizations apply for NPIs through the CMS National Plan and Provider Enumeration System (NPPES)

OCONUS. Outside the Continental United States.

OHI. Other Health Insurance. Any health insurance other than TRICARE.

OUT-OF-NETWORK BENEFITS. Typically, HMOs will not reimburse for services provided by a hospital or doctor who is not in their network, except for emergencies or if the HMO offers Out-of-Plan/Open ended benefits. With PPOs and other managed care plans, there may be a provision to reimbursement at out-of-network/out-of-plan benefits. Usually this will involve higher copays or a lower reimbursement.

OUT-OF-NETWORK PROVIDER. A provider, doctor or hospital that does not have a contract to participate in a health plan network.

OUTPATIENT. An individual receiving health care services for an actual or potential disease, injury or life style related problem that does not require admission to a medical treatment facility for inpatient care.

**OUTPATIENT CARE.** See Ambulatory Care.

**OUTPATIENT PROFESSIONAL SERVICES.** Ambulatory professional services. See discussion on Inpatient Professional Services.

**OUTPATIENT SERVICE.** Care center providing treatment to patients who do not require admission as inpatients.

**PARTICIPATING PROVIDER.** A provider contracted with an insurer. Usually refers to providers who are part of a network.

**PATCAT.** Patient Category. Codes used to identify a patient's level of eligibility of care in a Military Treatment Facility (MTF). PATCATs are directly linked to UBO billing and tell what reimbursable rate is applicable for the healthcare services provided, what billing forms are used, and which cost recovery program is responsible for billing the encounter.

**PATIENT.** A sick, injured, wounded, or other person requiring medical or dental care or treatment.

**PATIENT LIABILITY.** The dollar amount that an insured is legally obligated to pay for services rendered by a provider. These may include co-payments, deductibles and payments for uncovered services.

**PBM.** Pharmacy Benefit Manager. Third party administrator of prescription drug benefits.

**PCP.** Primary Care Physician. A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the PCP provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals. Generally applies to internists, pediatricians, family physicians and general practitioners and occasionally to obstetrician/gynecologists.

**PCP.** Primary Care Provider. A health care professional who serves as a member's primary contact within a health plan. In a managed care plan, the primary care provider provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals. Some plans will pay out-of-network benefits if services are not provided by or referred by the member's PCP. See Gatekeeper.

**POS.** Point-of-Service Plans. Managed care plans that give the insured the option of seeing providers within the plan's network and paying the co-payment amount only, or seeing providers out of the network and getting reimbursed as you would under an conventional indemnity policy.

**PPO.** Preferred Provider Organization. An indemnity plan where coverage is provided to participants through a network of selected health care providers. PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans, in that they will pay a higher percentage for care provided by providers in the network.

**PRE-ADMISSION TESTING.** Medical tests that are completed for an individual prior to being admitted to a hospital or inpatient health care facility.

**PRINCIPAL DIAGNOSIS.** The condition established after study to be chiefly responsible for the patient's admission. This should be coded as the first diagnosis in the completed record.

**PRINCIPAL PROCEDURE.** The procedure that was therapeutic rather than diagnostic, most

related to the principal diagnosis, or necessary to take care of a complication. This should be coded as the first procedure in the completed record.

**PRIVILEGED PROVIDER.** Independent practitioners who are granted permission to provide medical, dental and other patient care in the granting facility within defined limits based on the individual's education, professional license, experience, competence, ability, health and judgment. The provider has his/her qualifications reviewed by the credentialing review board, a scope of practice defined and a request for privileges approved by the privileging authority.

**PROFESSIONAL SERVICE.** Any service or care rendered to an individual to include an office visit, X- ray, laboratory services, physical or occupational therapy, medical transportation, etc. Also, any procedure or service that is definable as an authorized procedure from the CPT coding system or the CHAMPUS manuals.

**PROVIDER.** Person or entity, such as physicians, nurse practitioners, chiropractors, physical therapists, hospitals, home health agencies, nursing homes, providing health care services to patients.

**RATE.** Regular fee charged to all persons of the same patient category for the same service or care. **REASONABLE AND CUSTOMARY FEES.** See Usual, Customary, and Reasonable Fees. **REDUCED SERVICES.** When a physician, at his or her discretion, reduces or eliminates a portion of a service or procedure, or when the work required to perform the service or procedure is significantly less than usually required.

**REFERRAL.** Transfer of patient's care to specialty physician or specialty care by a primary care provider/physician.

**REVENUE CODE.** Identifies a specific accommodation and/or ancillary service performed.

**RWP.** Relative Weighted Product. A DoD measure of workload that represents the relative resource consumption of a patient's hospitalization as compared to that of other inpatients.

**SIT.** Standard Insurance Table. A database of Health Insurance Carriers (HIC) and their claim's addresses.

**STOP LOSS.** A form of reinsurance that limits the amount an employer will have to pay for each person's health care. Under this kind of policy, the insurer becomes liable for losses that exceed certain limits.

**SUBSCRIBER.** Employment group or individual that contracts with an insurer for medical services.

**SUPERVISING PHYSICIAN.** A licensed physician who, pursuant to state regulations, engages in direct supervision of physician assistants and nurse practitioners whose duties are encompassed by the supervising physician's scope of practice.

**THIRD PARTY PAYER.** Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. The payer organization pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

**TPA.** Third Party Administrator. An individual or firm hired by an employer to handle claims

processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

TPCP. Third Party Collection Program. A program used to report claims and collections data to the Defense Health Agency (DHA) UBO.

TPOCS. Third Party Outpatient Collection System. Compiles outpatient visit information from Ambulatory Data System (ADM), and ancillary testing or services information from the Composite Health Care System (CHCS). Using rate tables for billing services from DoD Comptroller, the system generates a bill for accounts receivable, refunds or other health care insurance purposes.

UB-04. See CMS 1450.

UBU. Unified Biostatistical Utility. DHA's Joint Coding Governance Work Group (JCGWG), formerly the Unified Biostatistical Utility (UBU) group, is responsible for the detailed work of the analysis required to standardize biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses and algorithms across the Military Health System.

UCF. Universal Claim Form. A paper claim form used to bill pharmacy claims only.

UCR. Usual, Customary, and Reasonable Charges. The average fee charged by a particular type of health care provider within a geographic area for a particular medical procedure. The term is often used by medical plans as the amount they will approve for a specific test or procedure. Also referred to as Reasonable and Customary Fees.

UNBUNDLING. The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.

UNIT OF SERVICE. The number of times a procedure is performed (e.g., multiple biopsies), amount of time (e.g., 15-minute intervals for most physical therapy procedures), supplies (e.g., number of shoe inserts), or days that a particular CPT HCPCS code is performed or supplied.

USFHP. United States Family Health Plan. A TRICARE prime option available to family members of active duty military, retirees, and retiree family members through not-for-profit health care systems in designated areas of the country.

VISIT. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.

WAITING PERIOD. The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

WORKERS COMPENSATION INSURANCE. Insurance coverage for work-related illness and injury. All states require employers to carry this insurance.

WORKLOAD. An expression of the amount of work, identified by the number of work units or volume of a workload factor that a work center has on hand at any given time or performs during a specified period of time.

WORKLOAD ASSIGNMENT MODULE. A CHCS subsystem that interfaces with the Expense Account System (EAS) and Standard Accounting and Reporting System/Field Level (STARS/FL) systems to provide a means for automated workload reporting.