

## Expanding Billing Opportunities and Finer Points

16 December 2014 1400 – 1500 EST

18 December 2014 0800 – 0900 EST

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- Understand different UBO rate structures and how they are applied
- Review rate structure and charging concepts for DoD-VA Resource sharing and available estimators
- Learn how to search for additional billing opportunities
- Assess how the Patient Protection and Affordable Care Act (PPACA) might impact MTFs
- Reduce lost revenue from pharmaceuticals requiring Pre-authorization

## Understanding Different UBO Rate Structures and How They Are Applied

- There are four widely used billing rate structures intended to recover costs in the fixed facilities of the Defense Health Program
  - Full or Third Party
  - Interagency
  - International Military Education and Training(IMEPT)
  - Department of Defense – Department of Veterans Affairs (DoD-VA) Sharing
- The DHA UBO Program Office also recommends billing rates for contractors and foreign nationals supporting deployed forces
- There are additional rate structures used to a lesser degree that will not be covered in this Webinar
- Patient Category (PATCAT) assignment drives the assignment of the applicable rate structure

- Full /TPC Billing rates are used synonymously
- Full/TPC rates are intended to recover the full cost of healthcare services provided
- Normally the highest UBO rate
- These rates are used for billing commercial insurance carriers and pay patients
  - Exception for DoD civilians overseas
  - Exception for cosmetic procedures
- Most UBO ambulatory/professional services Third Party Collection (TPC) rates are set to match TRICARE reimbursement (CMAC rates)
- Inpatient TPC rates are indexed to TRICARE percent (for the past four years, and are set to recover the full cost of inpatient care including professional services)
- Dental, Ambulance, Ambulatory Procedure Visit (APV), and a few Injectables TPC rates are set based on average Medical Expenses and Performance Reporting System (MEPRS) unit costs with adjustments for cost not reflected in MEPRS expenses

- Interagency rates begin with the full/TPC rates and are discounted to remove several cost factors for health care services
- Items such as durable medical equipment and pharmaceuticals, both retail pharmacy and clinician administered, are not discounted
- Costs removed from interagency charges include
  - Asset Use Charge - A charge applied by DoD for the use of its assets (facilities and/or equipment) to recoup depreciation and interest on investment
  - Government Share of Unfunded Retirement Costs – A charge applied by DoD to cover the cost of the unfunded civilian retirement, post retirement health benefits, and post retirement life insurance

- The IMET Program is a key funding component of U.S. security assistance that provides training on a grant basis to students from allied and friendly nations
  - Authority for the IMET program is found in Chapter 5, part II, Foreign Assistance Act of 1961
  - Funding is appropriated from the International Affairs budget of the Department of State
  - Not all foreign national patients participate in the IMET program
- IMET rates remove the same cost components as Interagency rates as well as military personnel cost

- The patient category (**PATCAT**) assignment is the key to determining whether there should be billing for a patient and, if so, who should be billed and under which rate structure

2014\_PATCAT\_Table 072914 Final.xlsx - Microsoft Excel

	A	B	C	K	L	M	N	V
1			<b>2014 PATCAT Table</b>					
2								
3	<b>Code</b>	<b>Subcat Name</b>		<b>Ipnt Indiv</b>	<b>Ipnt Agency</b>	<b>Opnt Indiv</b>	<b>Opnt Agency</b>	
185	K57	2 OTHER FEDERAL AGENCY OCC HEALTH		NC	IAR	NC	IOR	
186	K57	3 NAF EMPLOYEE OCC HEALTH CONUS		NC	IAR	NC	IOR	
187	K57	4 NAF EMPLOYEE OCC HEALTH OCONUS		NC	IAR	NC	IOR	
188	K57	5 DOD CIV EXP WRKF - OCC HEALTH/OWCP		NC	NC	NC	NC	
189	K57	6 OTH FED AGE CIV EXP WF - OCC HLT		NC	IAR	NC	IOR	
190	K57	7 UNPAID VOLUNTEER OCC HEALTH - NAVY		NC	NC	NC	NC	
191	K57	8 CIV SEAMAN MSTs/MSC OCC HLTH - NAVY		NC	NC	NC	NC	
192	K57	9 NAF EMPLOYEE OCC HLTH CONUS - NAVY		NC	NC	NC	NC	
193	K57	A NAF EMPLOYEE OCC HLTH OCONUS - NAVY		NC	NC	NC	NC	
194	K58	1 DISABILITY RET EXAM-DOD SPON		NC	NC	NC	NC	
195	K58	2 DISABILITY RET EXAM - NON-DOD SPON		NC	IAR	NC	IOR	
196	K59	2 FED GOVT EMPLOYEE IN REMOTE AREAS		NC	IAR	NC	IOR	
197	K59	3 FAM MBR FED EMPL IN REMOTE AREA US		NC	IAR	NC	IOR	
198	K61	1 VETERANS ADMIN BENEFICIARY		NC	IAR	NC	IOR	
199	K61	2 DOD/VA SHARING AGREEMENT		NC	FLEX	NC	FLXO	
200	K61	3 AIP & ATTENDANCE		NC	FLEX	NC	FLXO	



# Reviewing Charging Concepts For DoD-VA Resource Sharing And Available Estimators and Billing Guides

- DoD-VA Resource Sharing Agreements are very common, but not every MTF has an agreement
- The appropriate billing methodology for Veterans Affairs patients is dependent on the PATCAT assignment
- K61-1 is appropriate when the DoD treatment facility does not have a resource sharing agreement with VA
  - Normal UBO interagency charges apply
- K61-2 is appropriate when the DoD treatment facility does have a sharing agreement with VA
  - DoD-VA Resource Sharing National Agreement charges apply unless modified by local agreement
- There are additional PATCAT selections for VA patients for use in special cases
  - Primarily used at the James A. Lovell Federal Healthcare Center

- The Department of Veterans Affairs is DoD's largest payer
  - Payments
    - \$105, 659, 921 paid in FY13
    - United States Coast Guard paid \$80,000,000 in FY13
- Charges for health care services to VA beneficiaries under resource sharing agreements are governed by national agreements signed by the Assistant Secretary of Defense for Health Affairs and the Under Secretary for Health Department of Veterans Affairs
  - Inpatient
  - Outpatient
  - Pharmacy
  - Ancillary
- Current reimbursement model began in the first quarter of FY2003
- In general, these national agreements call for charging at the level TRICARE will allow minus 10%
- National Agreements are available on the DHA UBO Website
  - <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm>

- VA/DoD Health Executive Council Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology
  - Establishes the reimbursement methodology for direct sharing of healthcare resources between facilities of the VA and DoD
  - Both the VA and DoD will use CHAMPUS Maximum Allowable Charge (CMAC) rates less 10% as the reimbursement methodology for health care reimbursement between medical facilities, for institutional and professional charges
- Although waivers are generally discouraged, there are two scenarios under which a waiver from the standardized rate may be requested
  - If the standardized rate does not cover **marginal** costs
  - If the standardized rate is higher than local market rates **and both parties desire a larger discount from CMAC**

- Memorandum to the Surgeons General .... Department of Veterans Affairs (VA)-Department of Defense (DoD) Health Care Resource Sharing Rates-Billing Guidance Inpatient Services
  - Provides guidance on inpatient billing rates to be used for VA and DoD direct sharing agreements
- VA and DoD have agreed to a reimbursement methodology for billing of inpatient care which uses two components
  - Institutional – VA DoD reimbursement for a DRG will use the basic TRICARE DRG payment approach, applying a 10 % discount
  - Professional – Services and items **NOT** included in the DRG basic rate for the hospitalization will be billed separately
  - Professional services to include rounds, inpatient surgeries, and other inpatient procedures (e.g., reading an EKG) will be reimbursed at CMAC less 10%
  - Anesthesia professional services for each pre-intra-post anesthesia episode, including any anesthesia medical direction or supervision, will be reimbursed at CMAC less 10%
- Reimbursement level may be modified by local agreement

- The inpatient institutional reimbursement under DoD-VA Sharing is significantly lower than the inpatient institutional charging to Full/TPC payers
- Although the Diagnosis Related Group (DRG) assignments and case weights are consistent, the adjusted standardized amounts (ASAs) or charge per relative weighted product vary significantly

Rate Structure	IMET	Interagency	Full/TPC	DoD-VA Sharing
High Wage Index	\$7,184.50	\$10,851.33	\$11,448.97	\$5,780.77
Low Wage Index	\$7,559.03	\$11,199.19	\$11,856.01	\$5,780.77
Overseas	\$7,450.05	\$15,514.27	\$16,289.65	

- To recover the cost of care provided to VA beneficiaries, **it is necessary to bill for professional services** in addition to the institutional DRG charge


# Billing for Inpatient Services Under DoD VA Sharing – Institutional Charge

Standard\_Modified\_VA-DoD\_Inp Inst Calculator\_FY15.xls [Compatibility Mode] - Microsoft Excel

File Home Insert Page Layout Formulas Data Review View Acrobat

Clipboard Font Alignment Number Styles Cells Editing

C4 fx 0

	A	B	C	D
1	<b>VA-DoD Resource Sharing - Inpatient Institutional Billing</b>			
2	<b>Modified TRICARE MS-DRG Payment Calculator - For Patients Discharged in FY15</b>			
3		LOS	0	
4	<b>Claim Information</b>	MS-DRG	000	Clear Worksheet
5		Disposition Status	0	
6	<b>Hospital-Specific Information</b>	Facility ZIP Code (5 digits)		Print Worksheets
7	<b>Policy Information</b>	VA-DoD Discount	10%	
8	<b>Payment Summary</b>	<b>Inpatient Institutional Charge</b>	\$ -	Export Worksheets
9				
10	<b>Instructions for use:</b>			
11	a. Enter Length of Stay (LOS) in Bed Days in cell C3 of Claim Information			
12	b. Enter Medicare Severity Diagnosis Related Group (MS-DRG) in cell C4 of Claim Information. The description of the MS-DRG number entered will display in the box below			
13	c. Enter Disposition Status in cell C5 of Claim Information			
14	d. Enter ZIP Code of your MTF in cell C6 of Hospital-Specific Information unless care was provided at an overseas MTF. Overseas MTFs enter 00000 in cell C6.			
15	e. VA-DoD Discount is fixed at 10%			
16	f. Inpatient Institutional Charge is displayed in cell C8 of Payment Summary			
17	<a href="#">Click here to access the complete VA-DoD Institutional Billing Calculator User Guide on the UBO Website</a>			
18		<b>MS-DRG Description</b>	Enter MS-DRG Above in cell C4.	
19				

Ready VA-DoD Inp. Inst. Calculator Inpatient Billing Guide 100%

# Billing for Inpatient Services Under DoD VA Sharing- Professional and Other Charges

Standard\_Modified\_VA-DoD\_Inp Inst Calculator\_FY15.xls [Compatibility Mode] - Microsoft Excel

VA-DoD Resource Sharing - Inpatient Billing Guide						
	Type of Service	CPT®/HCPCS Code or NDC	Billing Criteria	Cost	Discount %	VA Billable Amount
1	Inpatient Institutional Charge		VA-DoD Inp. Inst. Calculator			\$ -
2	Professional Services		TRICARE CMAC less Discount*	\$ -	10%	\$ -
3	Durable Medical Equipment		Cost	\$ -	0%	\$ -
4	Ambulance Services		CMS Ambulance less Discount*	\$ -	10%	\$ -
5	Anesthesia Professional Services		TRICARE CMAC less Discount*	\$ -	10%	\$ -
6	Purchased Care Services from Outside Facility		cost	\$ -	0%	\$ -
7	Pharmaceuticals		VA-DoD Resource Sharing PPE	\$ -	0%	\$ -
8	Pass-through Items		cost	\$ -	0%	\$ -
9	Other		cost	\$ -	0%	\$ -
10	<b>Total</b>					<b>\$ -</b>

\*TRICARE CMAC less discount, else CMS rate less discount, or negotiated rate.

- ☐ To identify inpatient professional services, use the following menu path in CHCS: FM\IFE\KG ADC DATA\PATIENT NAME\SELECT APPOINTMENT\STANDARD OUTPAT? FM\IFE\YES//CR. If you are not currently authorized to use the menu in CHCS, contact your system administrator to request access.
- ☐ For DoD MTF staff who work with VA-DoD Resource Sharing Agreement care, it is important to understand that the TRICARE CMAC rates are NOT the DHA UBO CMAC rates used in other UBO billing processes.
- ☐ Disclaimer: This is a guide to assist MTFs in generating a complete bill for all charges (e.g. institutional, professional, anesthesia, DME) relating to an inpatient episode of care. This guide does not substitute for any billing documents and cannot be sent to the VA for collection. Services must also follow their specific guidelines on how to bill the VA.

VA-DoD Inp. Inst. Calculator    Inpatient Billing Guide



- Outpatient billing guidance based on 2003 Memorandum of Agreement
- DoD and VA will bill:
  - Outpatient clinical services provided under direct sharing agreements at TRICARE CMAC minus 10%
  - Non-facility rates for outpatient visits
  - Facility rates for same day surgery procedures
  - Physical and occupational therapy services at CMAC minus 10%
  - Laboratory and radiology at TRICARE CMAC minus 10%
- DoD and VA agreed to use average wholesale price less 60% with a \$9.00 dispensing fee for pharmaceuticals
  - Not applicable to sharing agreements wherein VA participates as part of the TRICARE Retail Pharmacy

TRICARE CHAMPUS Maximum Allowable Charge (CMAC) rates are the basis of DoD VA billing rates for most professional and laboratory procedures. Charges are dependent on site of service and type of provider

- **Category 1** - Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and certified nurse midwives (CNMs) **provided in a facility** including hospitals (both inpatient and outpatient care), ambulances, ASCs, etc
- **Category 2** - Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and CNMs **provided in a non-facility** including provider offices and other non-facility settings
  - The non-facility CMAC rate applies to Occupational Therapy (OT), Physical Therapy (PT), or Speech Therapy (ST) regardless of the setting
- **Category 3** - Services, of all other providers not found in Category 1, **provided in a facility** including hospitals (both inpatient and outpatient care), ambulances, ASCs, etc
- **Category 4** - Services, of all other providers not found in Category 2, **provided in a non-facility** including provider offices and other non-facility settings

- Use the facility TRICARE CMAC rates, Categories 1 and 3, when there is a separate institutional charge for the patient encounter
  - DRG Charge
  - APV Charge
- Use the non-facility TRICARE CMAC rates, Categories 2 and 4, when there is no separate charge for the patient encounter
- Always use Category 2 for Occupational, Physical, and Speech Therapy
- Radiology procedures will typically not have different facility and non-facility rates
- Many lab procedures may only have one rate

- On the TRICARE website, enter zip code or CMAC locality code

ProcedurePricing - Windows Internet Explorer

http://www.tricare.mil/CMAC/ProcedurePricing/Proc

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## CMAC Procedure Pricing

The effective dates for differing localities are reflected at the procedure code detail level. If you are not sure what you are looking for, we have some [cross-reference utilities](#) to help you. Or view the [HELP](#) page for general questions concerning CMAC.

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Procedure pricing is calculated based on the **Locality Code**. Select a Locality Code for the geographic region you are querying, or you may look up locality codes by selecting a **State**, entering a **Catchment Area Code**, entering a **Zip Code**, or specifying a **Foreign Country**.

Locality Code:	Select
State:	Select
Catchment Area:	Select
Zip Code:	20889
Foreign Country:	Select

Search

NOTE: You may only search based on ONE of the fields listed above.

## Enter Procedure Code

SearchResults - Windows Internet Explorer

http://www.tricare.mil/CMAC/ProcedurePricing/Sear

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**Provider Resources**

CMAC Home **Procedure Pricing** Int'l Procedure Pricing Cross Reference Utilities Download All Current CMAC Pricing Download Current Individual Pricing Files

**CMAC Search Results**

**State: MARYLAND**

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DC + MD/VA SUBURBS

This is a list of localities associated with the search criteria you selected. Use your mouse to select a locality from the list, type in a procedure code and click on the "Show Pricing Information" button to retrieve CMAC pricing data:

Procedure Code: 99213

Use Appropriate Category Rate – Remember to discount 10%

CMAC Details - Windows Internet Explorer

http://www.tricare.mil/CMAC/ProcedurePricing/CMA

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CMAC Detail Screen for Procedure Code: **99213**  
 Locality Code: **317**  
 Locality Name: **DC + MD/VA SUBURBS**  
 State Code: **DC**  
 State Name: **DISTRICT OF COLUMBIA**  
 State Code: **MD**  
 State Name: **MARYLAND**  
 State Code: **VA**  
 State Name: **VIRGINIA**

Procedure Code	Description
99213	OFFICE/OUTPATIENT VISIT EST

Effective Date: 01-Apr-14 Correction Date: N/A Term Date: N/A

CMAC for Category [1](#) \$56.73  
 Category of Provider Facility Physician

CMAC for Category [2](#) \$82.57  
 Category of Provider Non-Facility Physician

CMAC for Category [3](#) \$48.21  
 Category of Provider Facility Non-Physician

CMAC for Category [4](#) \$70.18  
 Category of Provider Non-Facility Non-Physician

- Under National Agreement, DoD bills VA at the TRICARE allowable amount minus 10%
- The anesthesia rate, also called a conversion factor, is charged per anesthesia unit. Each anesthesia procedure has a number of base units that is combined with individual encounter units of service to obtain total units.
- **The anesthesia charge recovers the cost of the anesthesia provider's professional services only**
- Anesthesia units are professional time units; they are not related to any pharmaceuticals or other supplies used during the procedures
  - The cost of pharmaceuticals and supplies as well as the operating room and nursing staff is recovered through other institutional billing
    - Ambulatory Procedure Visit charge
    - Diagnosis Related Group charge
    - Possible Ambulatory Payment Classification or Ambulatory Surgery Center charges in the future

On the TRICARE Website enter your zip code or CMAC locality code

Anesthesia Rates - Windows Internet Explorer

http://www.tricare.mil/anesthesia/default.aspx

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**Provider Resources**

Anesthesia Home Downloads

## Anesthesia Procedure Pricing

This release contains pricing effective April 1, 2014.

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Procedure pricing is calculated based on the **Locality Code**. Select a Locality Code for the geographic region you are querying, or you may look up locality codes by selecting a **State**, entering a **Catchment Area Code**, or entering a **Zip Code**

Zip Code:	<input type="text" value="20889"/>
National and State:	<input type="text" value="Select"/>
Locality Code:	<input type="text" value="Select"/>
Catchment Area:	<input type="text" value="Select"/>

NOTE: You may only search based on ONE of the fields listed above.



Enter provider class, anesthesia procedure, and minutes of service

RateSearch - Windows Internet Explorer

http://www.tricare.mil/anesthesia/default.aspx

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**Provider Resources**

Anesthesia Home Downloads

**Anesthesia Procedure Pricing**

Locality Code for Zip Code 20889: - 317 -

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Please select provider classification, procedure code, and enter the length of the procedure below.

Select Provider Classification:

☒ Class 1 (physician)

☐ Class 4 (non-physician)

Enter Procedure Code:

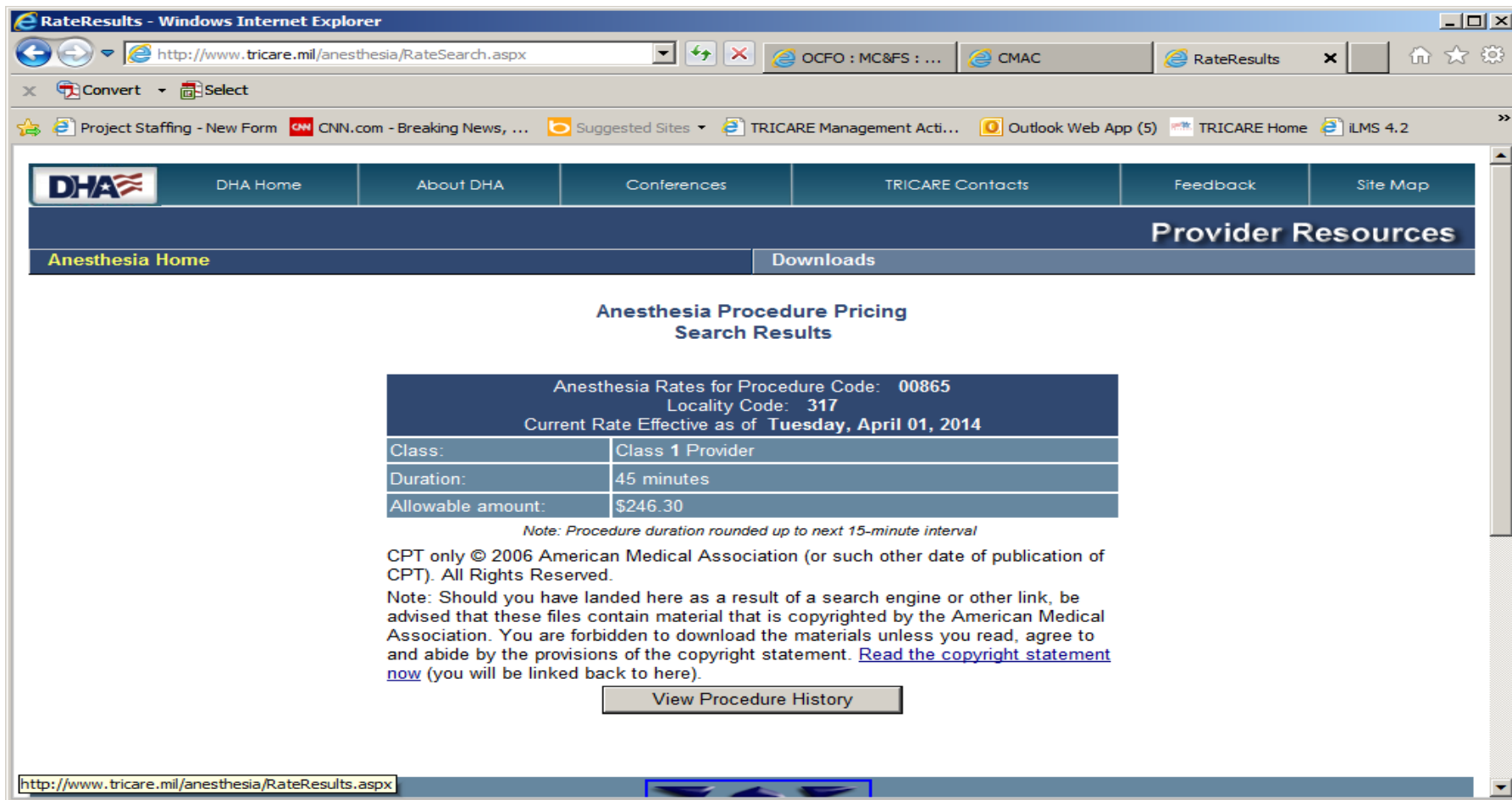
00865

Length of procedure, in minutes (ignored for codes 01953, 01996, 99100, 99116, 99135, 99140):

32

Submit for Calculations

TRICARE reimbursement is \$246.30, the discounted charge under VA sharing (10%) would be \$221.67



**RateResults - Windows Internet Explorer**

Address: <http://www.tricare.mil/anesthesia/RateSearch.aspx>

Navigation: Convert, Select

Project Staffing - New Form, CNN.com - Breaking News, Suggested Sites, TRICARE Management Act..., Outlook Web App (5), TRICARE Home, iLMS 4.2

**DHA** | DHA Home | About DHA | Conferences | TRICARE Contacts | Feedback | Site Map

**Provider Resources**

Anesthesia Home | Downloads

### Anesthesia Procedure Pricing Search Results

Anesthesia Rates for Procedure Code: 00865	
Locality Code: 317	
Current Rate Effective as of Tuesday, April 01, 2014	
Class:	Class 1 Provider
Duration:	45 minutes
Allowable amount:	\$246.30

*Note: Procedure duration rounded up to next 15-minute interval*

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[View Procedure History](#)

Address bar: <http://www.tricare.mil/anesthesia/RateResults.aspx>

The UBO Program Office provides a pharmaceutical calculator with DoD – VA Sharing Discounts Automatically Calculated

DoD VA Sharing Pharmacy Pricing Estimator ( as of October 1, 2014 )

File Home Clipboard Sort & Filter Records Find Window Text Formatting

Drug Information Input

☒ DRUG NAME ☐ NDC

Drug:  Qty:

DRUG(Generic Or Brand)	DRUG(Generic)	DOSAGE FORM	UNIT MEASURE	TOTAL PRICE
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$11.70
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$10.80
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$212.40
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$149.40
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$180.90
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$158.40
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$149.40
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$28.80
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$26.10
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	TABLET	EA	\$185.40

Total prices displayed in this estimator are based on the full reimbursement rates approved by the TRICARE Management Activity Uniform Business Office (TMA UBO) for the date of the request. If the user is not a TRICARE member, the prices may be different. The prices are subject to change without notice.

Form View Num Lock

## Learning How To Search For Additional Billing Opportunities

- Not all billable encounters will automatically flow to billing solutions

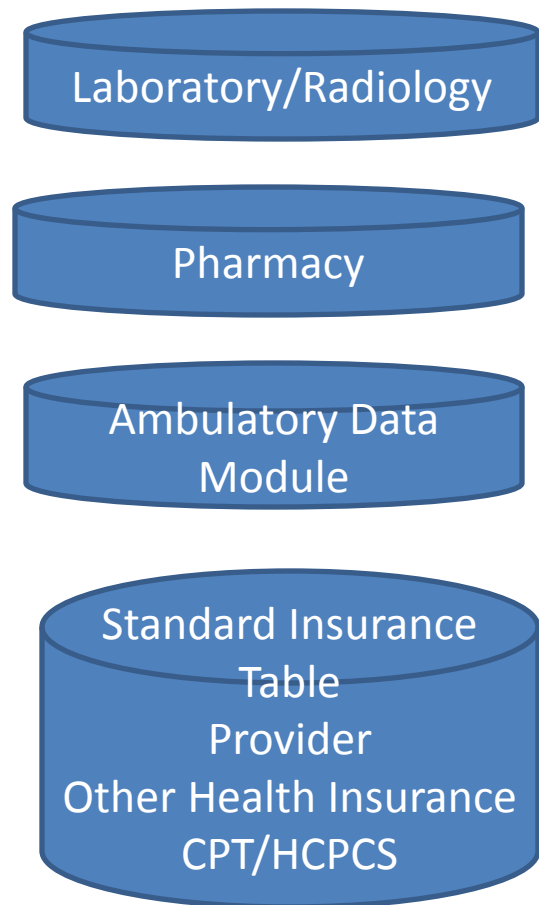


- UBO staff may be able to identify, bill, and collect for additional services

- A      Inpatient Care
  - Example Cardiology: AAB
- B      Ambulatory Care
  - Example Primary Care Clinic: BHA
- C      Dental Care
  - Example Dental Care: CAA
- D      Ancillary Services
  - Examples Pharmacy: DAA, Clinical Pathology: DBA, Diagnostic Radiology: DCA, **Other Ancillary Services**
- E      Support Services
  - Example Third Party Collection Administration: EBH
- F      Special Programs
  - Example Ambulance Services: FEA
- G      Readiness
  - Example Deployment Planning and Administration: GAA

- Charges for procedures and services billed by TPOCS, CHCS MSA and Monthly DD7/DD7A are captured as a by-product of day-to-day operations using:
  - CHCS Registration (Mini and Full Registration)
  - CHCS Patient Insurance Information (PII)
  - CHCS Admissions, Discharge, Transfer (ADT)
  - **CHCS Ambulatory Data Module (ADM)**
  - CHCS Laboratory (LAB)
  - CHCS Radiology (RAD)
  - CHCS Pharmacy (PHR)
- **CHCS Ambulatory Data Module (ADM)** prepares a **daily** batch extract ASCII (text) file for each MTF on the CHCS host that contains patient level data for:
  - Ambulatory Clinic Encounters
  - Ambulatory Procedure Visits (APV) Encounters
  - Inpatient Consults (Not associated with the Attending Clinical Service)
  - Inpatient Professional Services Record

Each File is an ASCII formatted file and will be “pushed” to the Third Party Outpatient Collection System (TPOCS) via Composite Healthcare System (CHCS) Electronic Transfer Utility (ETU)



Ambulatory Data Module Message  
Definition/Field 23 - ADM will only send “B”  
Level MEPRS Code and “FBI\*” Immunization  
Clinic encounters



- Electrocardiography (EKG): DDA
- Electroencephalography (EEG): DDB
- Electroneuromyography (EMG): DDC
- Pulmonary Function: DDD
- Cardiac Catheterization: DDE
- Anesthesiology: DFA
- Hemodialysis: DGB
- Peritoneal Dialysis: DGD
- Inhalation and Respiratory Therapy: DHA
- Nuclear Medicine Clinic: DIA

- Outpatient care (all UBO healthcare cost recovery programs and DoD VA resource sharing)
  - Billing office staff may bill for all coded ambulance, non-pharmacy, laboratory, radiology ancillary services even if they do not automatically flow to TPOCS
  - Billing office staff will need to query CHCS ADM for billable patients to identify
- Inpatient care (excludes DoD VA resource sharing)
  - UBO adjusted standardized amount rates include both institutional and professional component

## Assessing How The Patient Protection and Affordable Care Act (PPACA) Might Affect MTFs



- All Marketplace plans and many other plans must cover certain preventive services without charging the patient a copayment even if the deductible has not been met
- This applies only when these services are delivered by a network provider
- This could provide additional revenue for MTFs as copayments and deductible amounts are not charged to MHS beneficiaries

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Diabetes (Type 2) screening or adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A, Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users

- Anemia screening on a routine basis for pregnant women
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
- Breast Cancer Mammography screenings for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling and access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures; This does not apply to health plans sponsored by certain exempt “religious employers”
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Urinary tract or other infection screening for pregnant women
- Well-woman visits to get recommended services for women under 65

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments
- Blood Pressure screening
- Cervical Dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under age 3
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements
- Hematocrit or Hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Immunization vaccines for children from birth to age 18
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis and Vision Screening

# Limitation on Coverage for Preventive Services Without Patient Copayment

- General limitation on ACA plan coverage without application of copayment or deductible requirements – Services must be delivered by a **network** provider
- However, under statute this may not be used to reduce third party payment
- **32 CFR §220.3 Statutory obligation of third party payer to pay**
  - (a) Statutory requirement. Under 10 U.S.C. 1095(b), no provision of any third party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in a facility of the uniformed services shall operate to prevent collection by the United States.
  - (b) General rules. Based on the statutory requirement, the following are general rules for the administration of 10 U.S.C. 1095 and this part
    - (4) No objection, precondition or limitation may be asserted that is contrary to the basic nature of facilities of the uniformed services
  - (c) Specific examples of impermissible exclusion
    - (4) No participation agreement. The lack of a **participation agreement** or the absence of privity of contract between a third party payer and a facility of the uniformed services **is not a permissible ground for refusing or reducing third party payment**



- **32 CFR §220.4 Reasonable terms and conditions of health plan permissible**

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the ***third party payer must provide appropriate documentation*** to the facility of the Uniformed Services.

- ***This includes***, when applicable, ***copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms.***
- It also includes ***copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy*** or plan coverage benefit information.

REQUEST THIS INFORMATION FROM PAYERS TO ENSURE THE MTF AND THE PAYER ARE MEETING THE REQUIREMENTS OF THE PLAN INCLUDING COVERAGE OF APPROPRIATE SERVICES WITHOUT APPLICATION OF COPAYMENTS AND DEDUCTIBLES

# Reducing Lost Revenue from Pharmaceuticals Requiring Pre-Authorization



- Prior Authorization is a cost-savings feature of pharmacy benefit plans that are intended to help ensure the appropriate use of selected prescription drugs
  - encourages safe and cost-effective medication use; generally applies to certain high-cost drugs that have the potential for misuse.
  - Drugs needing prior authorization may:
    - Have dangerous side effects or can be harmful when combined with other drugs
    - Be used only for certain health conditions
    - Be often misused or abused
    - Be prescribed when less expensive drugs might work better
- The provider must provide documentation to meet the payer's criteria for that particular medication
- The list of drugs requiring prior authorization differs by payer

The Formulary and OTC Unit Rates – Biller's Edition available on the DHA UBO Website provides a listing of the drugs that TRICARE requires prior authorization

FY14 DHA UBO Rx Billers Edition Workbook Effect081814.xlsx [Read-Only] - Microsoft Excel

B33		TESTOSTERONE
1	<b>DHA UBO Rx Release Notes:</b>	
2	1) Payers require prior authorization for certain prescription pharmaceuticals	
3	2) Below is a list of DHA pharmaceuticals which commonly require prior authorization	
4		
5	<b>Brand Name</b>	<b>Generic Name</b>
27	AMERGE	NARATRIPTAN HCL
28	AMETHIA	LEVONORGESTREL-ETH ESTRA/ETHINYL ESTRADIOL
29	AMETHIA LO	LEVONORGESTREL-ETH ESTRA/ETHINYL ESTRADIOL
30	AMETHYST	LEVONORGESTREL-ETHINYL ESTRADIOL
31	AMTURNIDE	ALISKIREN HEMIFUMARATE/AMLODIPINE/HYDROCHLOROTHIAZIDE
32	ANDRODERM	TESTOSTERONE
33	ANDROGEL	TESTOSTERONE
34	ANTARA	FENOFIBRATE, MICRONIZED
35	ANZEMET	DOLASETRON MESYLATE
36	APLENZIN	BUPROPION HBR
37	ARICEPT	DONEPEZIL HCL
38	ASSURE 4	BLOOD SUGAR DIAGNOSTIC
39	ASSURE PLATINUM	BLOOD SUGAR DIAGNOSTIC

UBO Rx OTC List Effect 081814    DHA PriorAuthorization NDCs    M2 Product Form Codes & Descrip    DMLSS Dosage Cod

- If you receive a denial due to a lack of prior authorization:
  - Verify that the pharmaceutical is on the payer's list of drugs requiring prior authorizations
  - Contact the payer if necessary to determine what information they require to review the prescription
  - Consult with your billing office manager to determine if contacting the prescribing provider to provide the required information is feasible



**Questions?**

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