CHAPTER 12
SECTION 6

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - CLAIMS AND BILLING SUBMISSION UNDER HHA PPS

ISSUE DATE:

AUTHORITY: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)

I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

To describe the procedures involved in submitting Requests for Anticipated Payments and claims for 60-day episodes of care under the HHA PPS.

III. POLICY

A. Episode Payment. Payment for a 60-day episode of care will usually be made in two parts (initial and final), the first paid in response to a Request for Anticipated Payment, (RAP) and the last in response to a claim. Added together, the first and last payment will equal 100 percent of the established episode payment amount based upon patient severity and resource utilization. The following are billing procedure guidelines for RAPs and claims under the HHA PPS:

1. Requests for Anticipated Payments (RAPs). HHAs are required to submit the following data elements on a request for anticipated payment under the home health PPS. Effective for dates of service on or after the first day of health care delivery of the new contract, home health services under a plan of care will be paid based on a 60-day episode of care. To receive the first part of the HHA PPS split payment, HHAs must submit a request for anticipated payment (RAP) with coding as described below:

a. After assessment, and once a physician's verbal orders for home care have been received and documented, a plan of care has been established, and the first service visit under that plan has been delivered, the HHA can submit a request for anticipated payment, or RAP.

b. An episode will be opened on the system and visible in the automated authorization (on the expanded authorization screen) with the receipt and processing of the RAP.

c. RAPs, or in special cases, claims, must be submitted for initial HHA PPS episodes, subsequent HHA PPS episodes, or in transfer situations to start a new HHA PPS episode when another episode is already open at a different agency.

d. HHAs should submit the RAP as soon as possible after care begins in order to ensure prompt data entry into the contractor's authorization screen.

e. RAPs are submitted on the CMS 1450 UB-04 billing under Type of Bill (Form Locator 4) 0322.

f. RAPs incorporate the information output by Grouper for HHA PPS in addition to other claim elements. While TRICARE requires very limited information on RAPs, RAPs do not require charges for TRICARE. However, HHAs have the option of reporting service lines in addition to the TRICARE requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected reimbursement amount to aid balancing in accounts receivable systems. TRICARE will not use charges on a RAP to determine reimbursement, or for later data collection.

g. Once coding is complete, and at least one billable service has been provided in the episode, RAPs or claims are to be submitted to contractors processing TRICARE home health RAPs and claims.

h. Pricer software will determine the first of the two HHA PPS split percentage payments for the episode, which is made in response to the RAP.

i. Although submitted on a CMS 1450 UB-04 and resulting in TRICARE payment for home services, the RAP is not considered a TRICARE home health claim and is not subject to many of the stipulations applied to such claims in regulations. In particular, RAPs are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode, and these claims are still subject to the payment of interest if clean and delayed in processing. Each RAP must be based on a current Outcome and Assessment Information Set (OASIS)-based case mix. A RAP and a claim will usually be submitted for each episode period. Each claim must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode, or 60 days after the paid date of the RAP (whichever is greater), an offset recoupment will be initiated on future claims. A mess age will be placed on the RAP Explanation Of Benefits (EOB) that offset recoupment will occur if the claim is not received within 60 days of the RAP payment, recognizing that offset recoupment would ultimately depend on the HHA's claims volume (e.g., auto offset would not be feasible in low claims volume situations).

j. If care continues at the same provider for a second episode of care, HHAs may submit the RAP for the second episode even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, use the current mechanism of generating a debit and deducting it on the HHA's next remittance advice (RA) to recoup the overpaid amount.

k. Coding Required for a Request for Anticipated Payment (RAP) is as follows:

(1) From Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number Required. The minimum entry is the agency's name, city, state, and ZIP code. The post office number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the TRICARE provider number (FL 51) to verify provider identity.

(2) FL 2. (Untitled) Not required.

(3) FL 3. Patient Control Number Optional. The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

(4) FL 4. Type of Bill Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HHA PPS requests for anticipated payment are any combination of the codes listed below:

(a) 1st Digit -Type of Facility **3** - Home Health

(b) 2nd Digit - Bill Classification (Except Clinics and Special Facilities) 2 - Hospital Based or Inpatient. HHAs are encouraged to submit RAPs with bill classification 2.

(c) 3rd Digit-Frequency

1 2 - Interim-First Claim - use this code for the first of an expected series of bills of which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment. Use this code for original or replacement RAP.

2 8 - Void/Cancel of a Prior Claim - Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "2" bill (a replacement RAP) must be submitted for the episode to be paid. If a RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), use this code to cancel so that a corrected RAP can be submitted.

3 Allow only claims with the following frequency codes to process as an adjustment against RAPs: "8," "9" or "I" (accompanied by a cancel only code of

"C"). Do not allow claims with a frequency code of "7" to process as an adjustment against a RAP.

a 8 - Void/Cancel of Prior Claim

b 9 - Final Claim for a Home Health PPS Episode

c I - Intermediary Adjustment Claim (Other Than Provider)

(5) FL 5. Federal Tax Number Required.

(6) FL 6. Statement Covers Period (From-Through) Required. Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a requirement for payment for future services, however, the ending date may not be known. HHAs must submit the same date in both the "From" and "Through" date fields. On the first RAP in an admission, this date must be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (Day 61, 121, 181, etc.). All dates must be reported in the form of MM-DD-YYYY. Compare the provider effective date in the provider file to the "From" date to ensure that the "From" date is on or after the provider effective date. Reject claims which fail this edit.

(7) FL 7. Covered Days Not Required.

(8) FL 8. Non-covered Days Not Required.

(9) FL 9. Coinsurance Days Not Required.

(10) FL 10. Lifetime Reserve Days Not Required.

(11) FL 12. Patient's Name Required. Enter the patient's last name, first name, and middle initial.

(12) FL 13. Patient's Address Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

(13) FL 14. Patient's Birth Date Required. Enter the month, day, and year of birth (MMDDYYYY) of patient. If the full correct date is not known, leave blank.

(14) FL 15. Patient's Sex Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

(15) FL 16. Patient's Marital Status Not Required.

(16) FL 17. Admission Date Required. Enter the date the patient was admitted to home health care (MMDDYYYY). On the first RAP in an admission, this date should match the statement covers "From" date in FL 6. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care.

(17) FL 18. Admission Hour Not Required.

(18) FL 19. Type of Admission Not Required.

(19) FL 20. Source of Admission Required. Enter a code indicating the source of this admission. Source of admission information will be used by TRICARE to correctly establish and track home health episodes.

CODE	DEFINITION
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer From a Hospital
5	Transfer From a SNF
6	Transfer From Another Health Care Facility
7	Emergency Room (Discontinued effective July 1, 2010)
8	Court/Law Enforcement
9	Information Not Available
A	Transfer From a Critical Access Hospital (CAH)
B	**Transfer From Another HHA** (Discontinued effective July 1, 2010)
C	**Readmission to the Same Home Health Agency** (Discontinued effective July 1, 2010)

NOTE: For dates of service on or after July 1, 2010 the National Uniform Billing Committee (NUBC) has retired codes 7 - Emergency Room, B - Transfer from Another HHA, and C - Readmission to the same HHA.

The NUBC has created a new condition code, code 47, to replace the point of origin code B. The title of this new code is "Transfer from another Home Health Agency." The definition is "The patient was admitted to this home health agency as a transfer from another home health agency." However, the Home Health Agency Prospective Payment System (HHA PPS) Pricer does not include the new code 47 in the Pricer logic (HHA PPS Pricer logic described in Section 7). When a condition code 47 is included on the claim, the contractor shall ensure correct reimbursement of the claim by changing the Pricer input

record to reflect a point of origin code B, although this code is no longer in use per the NUBC as described above. The NUBC will not replace point of origin C or 7.

(20) FL 21. Discharge Hour Not Required.

(21) FL 22. Patient Status Required. Enter the code indicating that patient's status as of the "Through" date of the billing period (FL 6). Since the "Through" date of the RAP will match the "From" date, the patient will never be discharged as of the "Through" date. As a result, only one patient status is possible on RAPs (i.e., Code 30 - Still Patient).

(22) FL 23. Medical Record Number Optional. The HHA enters the number assigned the patient's medical/health record. Carry the number the HHA enters through your system and return it to the HHA.

(23) FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes.

(a) Optional. Enter any NUBC approved code to describe conditions that apply to the RAP.

NOTE: See description of condition code 47 under paragraph (19).

(b) Required. If canceling the RAP (3x8), report one of the following:

CODE	TITLE	DEFINITION
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number. Use this code for most corrections to RAPs, including corrections to HIPPS codes.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate.

NOTE: Enter "Remarks" in FL 84, indicating the reason for cancellation.

(24) FL 32, 33, 34, and 35. Occurrence Codes and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY).

(a) Occurrence code 21 is not required on HHA PPS RAPs.

(b) Fields 32A-35A must be completed before fields 32B-35B.

(c) Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

(d) When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

(e) Other codes may be required by other payers, and while they are not used by TRICARE, they may be entered on the RAP if convenient. TRICARE systems do require that the dates associated with occurrence codes be within the statement covers period of the claim (FL 6).

(25) FL 36. Occurrence Span Code and Dates Not Required. Since the statement covers period (FL 6) of the RAP is a single day, occurrence spans cannot be reported.

(26) FL 37. Internal Control Number (ICN)/Document Control Number (DCN) Required. If canceling a RAP, HHAs must enter the control number assigned to the original RAP here. ICN/DCN is not required in any other case. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payers B and C on lines B and C, respectively, in FL 37.

(27) FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required.

(28) FLs 39-41. Value Codes and Amounts Required. Home Health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

(a) Code 61. Location Where Service is Furnished (HHA and Hospice). MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

(b) Since the value amount is a nine-position field, enter the four-digit MSA in the nine-position field in the following manner. Enter an MSA for Puerto Rico (9940) as 000994000, and the MSA for Abilene, TX (0040) as 000004000. Note that the two characters to the right of the assumed decimal point are always zeros.

(c) Optional. Enter any NUBC approved value code to describe other values that apply to the RAP.

1 Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollar and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

2 If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b". Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

(29) FL 42 and 43 Revenue Code and Revenue Description Required. One revenue code line is required on the RAP. This line is used to report a single Health Insurance Prospective Payment System (HIPPS) code (defined under FL44) which is the basis of the anticipated payment. The required revenue code and description for HHA PPS RAPs are as follows:

(a) Rev. Code 023. Home Health Services.

(b) Return the TRICARE reimbursement for the RAP in the total charges field (FL 47) of the 023 revenue code line. HHAs must zero fill FL 47.

(c) Optional. HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HHA PPS claims except another 023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

(d) Revenue codes 058X and 059X will no longer be accepted with covered charges on TRICARE home health RAPs under HHA PPS. Revenue code 0624 (investigational devices) will no longer be accepted at all on TRICARE home health RAPs under HHA PPS.

(e) HHAs may continue to report a "Total" line, with revenue care 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. However, the contractors' systems must overlay this amount with the total reimbursement for the RAP.

(30) FL 44. HCPCS/Rates Required. On the 022 revenue code line, HHAs must report the HIPPS code for which anticipated payment is being requested.

(a) Definition. HIPPS rate codes represent specific patient characteristics (or case mix) on which TRICARE payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among various provider types. HIPPS codes are used in association with special revenue codes used on CMS 1450 UB-04 claim forms for institutional providers. One revenue code is defined for each prospective payment system that calls for HIPPS codes. Currently, revenue code 022 is reserved for the Skilled Nursing Facility Prospective Payment System (SNF PPS) and revenue code 023 is reserved for the HHA PPS.

(b) HIPPS codes are placed in Form Locator (FL) 44 ("HCPCS/rate") on the form itself. The associated revenue codes are placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim. HIPPS codes are alphanumeric codes of five digits.

(c) Under the home health prospective payment system, which requires the use of HIPPS codes, a case-mix adjusted payment for up to 60 days of care will be made using one of 80 Home Health Resource Groups (HHRG). On TRICARE claims these HHRGs will be represented as HIPPS codes. These HIPPS codes are determined based on assessment made using the OASIS. Grouper software run at the HHA site will use specific data elements from the OASIS data set and assign beneficiaries to a HIPPS code. The Grouper will output the HIPPS code which HHAs must enter in FL 44 on the claim.

(d) HHA HIPPS codes are five position alphanumeric codes: the first digit is a static "H" for home health, the second, third and fourth (alphabetical) positions represent the level of intensity respective to the clinical, functional and service domains of the OASIS. The fifth position (numeric) represents which of the three domains in the HIPPS code were either calculated from complete OASIS data or derived from incomplete OASIS data. A value of "1" in the fifth position should indicate a complete data set that will be accepted by the State Repository for OASIS data. Both HHA PPS RAPs and claims must be correct to reflect the HIPPS code accepted by the State repository. Lists of current HIPPS codes used for billing during a specific Federal fiscal year are published in the TRICARE Policy Manual.

(e) Optional. If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code.

(31) FL 45. Service Date Required. On the 023 revenue code line, HHAs report the date of the first billable service provided under the HIPPS code reported on that line.

(a) If the claim "From" date in FL 6 also matches the admission date in FL 17, edit to ensure that the service date on the 023 line of the RAP matches the claim "From" date.

(b) Optional. If additional revenue codes are submitted on the RAP, report service dates as appropriate to that revenue code.

(32) FL 46. Units of Service Optional. Units of service are not required (i.e., must be zero or blank) on the 023 revenue code line. If additional revenue codes are submitted on the RAP, HHAs report units of service as appropriate to the revenue code.

(33) FL 47. Total Charges Required. Zero charges must be reported on the 023 revenue line. TRICARE claims systems will place the reimbursement amount for the RAP in this field on the electronic claim record.

(a) Optional. If additional revenue codes are submitted on the RAP, report any necessary charge amounts to meet the requirements of other payers or your billing software.

(b) TRICARE claims systems will not make any payment determinations based upon submitted charge amounts.

(34) FL 48. Non-Covered Charges Not Required. Report non-covered charges only on HHA PPS claims, not RAPs.

Examples. The following provides examples of revenue code lines as HHAs should complete them, based on the reporting requirements above.

Report the required 023 line as follows:					
FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**	**FL 48**
023	HAEJ1	100101		0.00	
Report additional revenue code lines as follows:					
FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**	**FL 48**
550	G0154	100101	1	150.00	

(35) FL 49. (Untitled) Not Required.

(36) FLs 50A, B, and C. Payer Identification Required. If TRICARE is the primary payer, the HHA enters "TRICARE" on line A. When TRICARE is entered on line 50A, this indicates that the HHA has developed for other insurance coverage and has determined that TRICARE is the primary payer. All additional entries across the line (FLs 51-55) supply information needed by the payer named in FL 50A. If TRICARE is the secondary or tertiary payer, HHAs identify the primary payer on line A and enter TRICARE information on line B or C as appropriate. Do not make conditional payments for TRICARE Secondary Payer (MSP) situations based on the RAP.

(37) FL 51. TRICARE Provider Number Required. Enter the 9-18 position tax identification number assigned by TRICARE. It must be entered on the same line as "TRICARE" in FL 50.

(a) If a TRICARE provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number indicating patient status 06. This claim will be paid a PEP adjustment.

(b) Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases, report the new provider number in this field.

(38) FLs 52A, B, and C. Release of Information Certification Indicator Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

(39) FLs 53A, B, and C. Assignment of Benefits Certification Indicator Not Required.

(40) FLs 54A, B, and C. Prior Payments Not Required.

(41) FLs 55A, B, and C. Estimated Amount Due Not Required.

(42) FL 56. (Untitled) Not Required.

(43) FL 57. (Untitled) Not Required.

(44) FLs 58A, B, and C. Insured's Name Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information is shown in FLs 50-54, enter the patient's name as shown on his HI care or other TRICARE notice.

(45) FLs 59A, B, and C. Patient's Relationship to Insured Not Required.

(46) FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/ Identification Number Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information was shown on FLs 39-41, and 50-54, enter the patient's TRICARE health insurance claim number; i.e., if TRICARE is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of TRICARE Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

(47) FLs 61A, B, and C. Group Name Not Required.

(48) FLs 62A, B, and C. Insurance Group Number Not Required.

(49) FL 63. Treatment Authorization Code Required. HHAs must enter the claims-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). Verify that eighteen numeric values are reported in this field.

(a) The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen 1's.

(b) The investigational device (IDE) revenue code, 624, is not allowed on HHA PPS RAPs. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

(50) FL 64. Employment Status Code Not Required.

(51) FL 65. Employer Name Not Required.

(52) FL 66. Employer Location Not Required.

(53) FL 67. Principal Diagnosis Code Required. HHAs must enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, do not fill with zeros.

The ICD-9 codes and principle diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS from item M0230 (Primary Diagnosis), and on the CMS Form 485, from item 11 (ICD-9-CM/Principle Diagnosis).

(54) FLs 68-75. Other Diagnoses Codes Required. HHAs must enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. These codes must not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

(a) For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 67A-P must match the additional diagnoses reported on the OASIS, from item M0240 (Other Diagnoses), and on the CMS Form 485, from item 13 (ICD-9-CM/Other Pertinent Diagnoses).

(b) Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the CMS Form 485, from item 13, may be reported in FLs 67A-Q on the RAP if they are reported in the narrative from item 21 of the CMS Form 485.

(55) FL 69. Admitting Diagnosis Not Required.

(56) FL 72. E-Code Not Required.

(57) FL 73. (Untitled) Not Required.

(58) FL 74. Principal Procedure Code and Date Not Required.

(59) FL 74 a-e. Other Procedure Codes and Dates Not Required.

(60) FL 76. Attending/Requesting Physician I.D. Required. HHAs must enter the UPIN and name of the attending physician who has established the plan of care with verbal orders. Deny the RAP if the UPIN indicated in this field is on the sanctioned provider list.

NOTE: Medicare requires HHAs to enter the UPIN and name of the attending physician who has established the plan of care in FL 76 of the CMS 1450 UB-04. The UPIN information will be allowed on the RAP and claims but not stored until required.

(61) FL 78 Other Physician I.D. Not Required.

(62) FL 80. Remarks Required. Remarks are necessary when canceling a RAP, to indicate the reason for the cancellation.

(63) FL 86. Date Not Required. See FL 45, line 23.

2. Claims Submission and Processing. HHAs are required to submit the following claims detail for final payment under the HHA PPS:

a. The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier.

b. HHAs may not submit this claim until after all services provided in the episode are reflected on the claim and the plan of care and any subsequent verbal order have been signed by the physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

c. HH claims must be submitted with a new type of bill - 329.

d. NUBC approved "source of admission" and "patient status codes" are required on the claim.

e. The through date of the claim equals the date of the last service provided in the episode unless the patient status is 30, in which case the through date should be day 60.

f. Providers may submit claims earlier than the 60th day if the POC goals are met and the patient is discharged, or the beneficiary died. The episode will be paid in full unless there is a readmission of a discharged beneficiary, or a transfer to another HHA prior to the day after the HHA PPS period end date.

g. Providers may submit claims earlier than the 60th day if the beneficiary is discharged with the goals of the POC met; and if readmitted or if transferred to another HHA, the episode will be paid as a PEP.

h. If the beneficiary goes into the hospital through the end of the episode, the episode is paid in full whether the patient is discharged or not.

i. A PEP is given if a transfer situation, or if all treatment goals are reached with discharge and there is a readmission within the 60-day episode. PEPs are shown on the claim by patient status code 06.

j. Providers will report all SCICs occurring in one 60-day episode on the same claim.

k. The dates on 023 lines on all claims will be the date of the first service supplied at that level of care.

l. Late charge submissions are not allowed on claims under HHA PPS. Claims must be adjusted instead.

m. Claim will be paid as a LUPA if there are four or less visits total in an episode, regardless of changes in HIPPS code.

n. The HHA PPS claim will include elements submitted on the RAP, and all other line item detail for the episode, including, at a provider's option, any durable medical equipment, oxygen or prosthetics and orthotics provided, even though this equipment will be paid in addition to the episode payment. The only exception is billing of osteoporosis drugs, which will continue to be billed separately on 34X claims by providers with episodes open. Pricer will determine claim payment as well as RAP payment for all PPS.

o. The claim will be processed as a debit/credit adjustment against the record created by the RAP.

p. The related remittance advice will show the RAP payment was recouped in full and a 100% payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

q. Claims for episodes may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100% payment is made in the next calendar or fiscal year, at that year's rates. Claim payment rates are determined using the statement "through" date on the claim.

r. HHAs should be aware that HHA PPS claims will be processed in the TRICARE claims system as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims. As the claim is processed, the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net reimbursement on the claim can be easily understood.

s. Coding Required for a HHA PPS Claim is as follows:

(1) Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number Required. The minimum entry is the agency's name, city, state, and ZIP code. The post office number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the TRICARE provider number (FL 51) to verify provider identity.

(2) FL 2. (Untitled) Not Required.

(3) FL 3. Patient Control Number Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

(4) FL 4. Type of Bill Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bills accepted for HHA PPS requests for anticipated payment are any combination of the codes listed below:

(a) Code Structure (only codes used to bill TRICARE are shown).

1 1st Digit - Type of Facility 3 - Home Health

2 2nd Digit - Bill Classification (Except Clinics and Special Facilities) 2 - Hospital Based or Inpatient.

NOTE: While the bill classification of 3, defined as "Outpatient," may also be appropriate to a HHA PPS claim depending upon a beneficiary's eligibility, HHAs are encouraged to submit all claims with bill classification 2.

3 3rd Digit - Frequency

a 7 - Replacement of Prior Claim - Used to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims may be submitted at any point within the timely filing period after the payment of the original claim.

b 8 - Void/Cancel of a Prior Claim - Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP and claim must be submitted for the episode to be paid.

c 9 - Final Claim for a HHA PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7 or 8.

d HHA PPS claims are submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." Late charge bills, submitted with frequency "5," are not accepted under HHA PPS. To add services within the period of a paid HH claim, an adjustment must be submitted.

(5) FL 5. Federal Tax Number Required.

(6) FL 6. Statement Covers Period (From-Through) Required. The beginning and ending dates of the period covered by this claim. The "From" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "Through" date must be 59 days after the "From" date. The patient status code in FL 22 must be 30 in these cases. In cases where the beneficiary has been discharged or transferred within the 60-day episode period, report the date of discharge in accordance with your internal discharge procedures as the "Through" date. If a discharge claim is submitted due to change of intermediary, see FL 22 below. If the beneficiary has died, report the date of death in the

through date. Any NUBC approved patient status code may be used in these cases. You may submit claims for payment immediately after the claim "Through" date. You are not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care. Submit all dates in the format MMDDYYYY.

(7) FL 7. Covered Days Not Required.

(8) FL 8. Non-covered Days Not Required.

(9) FL 9. Coinsurance Days Not Required.

(10) FL 10. Lifetime Reserve Days Not Required.

(11) FL 12. Patient's Name Required. Enter the patient's last name, first name, and middle initial.

(12) FL 13. Patient's Address Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

(13) FL 14. Patient's Birthdate Required. Enter the month, day, and year of birth (MMDDYYYY) of the patient. If the full correct date is not known, leave blank.

(14) FL 15. Patient's Sex Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

(15) FL 16. Patient's Marital Status Not Required.

(16) FL 17. Admission Date Required. Enter the same date of admission that was submitted on the RAP for the episode (MMDDYYYY).

(17) FL 18. Admission Hour Not Required.

(18) FL 19. Type of Admission Not Required.

(19) FL 20. Source of Admission Required. Enter the same source of admission code that was submitted on the RAP for the episode.

(20) FL 21. Discharge Hour Not Required.

(21) FL 22. Patient Status Required. Enter the code that most accurately describes the patient's status as of the "Through" date of the bill period (FL 6).

CODE STRUCTURE :	
CODE	DEFINITION
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of another organized home health service organization, or discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice or discontinued care
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility, such a hospital, SNF, ICF or freestanding hospice (hospice claims only)
42	Expired - place unknown (hospice claims only)
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharged/transferred with this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care.

(a) Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a Partial Episode Payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which a HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, TRICARE claims systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claim record to 06.

(b) In cases where an HHA is changing the contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "From" dates before the provider's termination date must be submitted to the contractor the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods - the "through" dates on or before the termination date. The provider must indicate that these claims will be partial payment (PEP) adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new intermediary.

(22) FL 23. Medical Record Number Optional. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

(23) FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes When Applicable. Enter any NUBC approved code to describe conditions and apply to the claim.

(a) Required. If adjusting a HHA PPS claim (TOB 3x7), report one of the following:

CODE	DEFINITION
D0	Change to Service Dates
D1	Change to Charges
D2	Change to Revenue Codes/HCPCS
D7	Change to Make TRICARE the Secondary Payer
D8	Change to Make TRICARE the Primary Payer
D9	Any other Change
E0	Change in Patient Status

(b) If adjusting the claim to correct a HIPPS code, report condition code D9. Enter "Remarks" in FL 84 indicating the reason for the HIPPS code change.

(c) Required. If canceling the claim (TOB 3x8), report one of the following:

CODE	DEFINITION
D5	Cancel to Correct HICH
D6	Cancel Only to Repay a Duplicate or OIG Overpayment. Use when D5 is not appropriate

(d) Enter "Remarks" in FL 84 indicating the reason for cancellation of the claim.

(24) FLs 32, 33, 34, and 35. Occurrence Codes and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27 is not required on HHA PPS RAPs.

(a) Fields 32A-35A must be completed before fields 32B-35B.

(b) Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

(c) When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

(d) Other codes may be required by other payers, and while they are not used by TRICARE, they may be entered on the bill if convenient.

(25) FL 36. Occurrence Span Code and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the claim.

(a) Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY.

(b) Reporting of occurrence span code 74 to show the date of an inpatient admission within an episode is not required.

(26) FL 37. Internal Control Number (ICN)/Document Control Number (DCN) Required. If submitting an adjustment (type of bill 3x7) to a previously paid HHA PPS claim, enter the control assigned to the original HHA PPS claim here. Insert the ICN/DCN of the claim to be adjusted here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payers B and C on lines B and C, respectively, in FL 37.

(a) Since HHA PPS claims are processed as adjustments to the RAP, TRICARE claims systems will match all HHA PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically.

(b) Providers do not need to submit an ICN/DCN on all HHA PPS claims, only on adjustments to paid claims.

(27) FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than TRICARE as defined in FP 58, the address of the other payer may be shown here or in 84 (Remarks).

(28) FLs 39-41. Value Codes and Amounts Required. Home Health episode payments must be based upon the site at which the beneficiary is served. Claims will not be processed with the following value code:

(a) Code 61. Location Where Service is furnished (HHA and Hospice). MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

(b) For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.

(c) Optional. Enter any NUBC approved value code to describe other values that apply to the claim. Code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollar and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

(d) If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b". Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

(29) FL 42 and 43 Revenue Code and Revenue Description Required. Claims must report a 023 revenue code line matching the one submitted on the RAP for the episode. If this matching 023 revenue code line is not found on the claim, TRICARE claims systems will reject the claim.

(a) If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), report one or more additional 023 revenue code lines to reflect each change. SCICs are determined by an additional OASIS assessment of the beneficiary, which changes the HIPPS code that applies to the episode and requires a change order from the physician to the plan of care. Each additional 023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care in FL 45 and zero changes in FL 47. In the rare instance when a beneficiary is assessed more than once in one day, report one 023 line for that date, indicating the HIPPS code derived from the assessment that occurred latest in the day.

(b) Claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 42X, 43X, 44X, 55X, 56X and 57X) must be reported as a separate line. Any of the following revenue codes may be used:

1 27X - Medical/Surgical Supplies (also see 62X, an extension of 27X). Code indicates the charges for supply items required for patient care.

a Rationale - Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4- Prosthetic/Orthotic Devices	PRSTH/ORTH DEV
5 - Pace Maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 - Oxygen-Take Home	O2/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

b Required detail: With the exception of revenue code 274, only service units and a charge must be reported with this revenue code. If also reporting revenue code 623 to separately identify wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for the 623 revenue code line and other supply revenue codes are mutually exclusive. Report only non-routine supply items in this revenue code or in 623. Revenue code 274 requires a HCPCS code, the date of service, service units and a charge amount.

2 42X - Physical Therapy - Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

a Rationale - Permits identification of particular services.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

b Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3 43X - Occupational Therapy - Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore

an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

4 44X - Speech-Language Pathology - Charges for services provided to persons with impaired communications skills.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PATH

Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

5 55X - Skilled Nursing - Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR

SUBCATEGORY	STANDARD ABBREVIATION
9 - Other Skilled Nursing	SKILLED NURS/OTHER

Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

6 56X - Medical Social Services - Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

a Rationale: Necessary for TRICARE home health billing requirements. May be used at other times as required by hospital.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED SOCIAL SVS
1 - Visit charge	MED SOC SERV/VISIT
2 - Hourly charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Service	MED SOC SERV/OTHER

b Required detail: HCPCS code G0155 (service of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

7 57X - Home Health Aide (Home Health) - Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

a Rationale: Necessary for TRICARE home health billing requirements.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

b Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

NOTE: Revenue codes 58X and 59X may no longer be reported as covered on TRICARE home health claims under HHA PPS. If reporting these codes, report all charges as non-covered. Revenue code 624, investigational devices, may no longer be reported on TRICARE home health claims under HHA PPS.

8 Optional: Revenue codes for optional billing of DME: Billing Durable Medical Equipment (DME) provided in the episode is not required on the HHA PPS claim. Home health agencies retain the option to bill these services to their contractor or to have the service provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HHA PPS claims must use the revenue codes below.

a 29X - Durable Medical Equipment (DME) (Other Than Rental) - Code indicates the charges for medical equipment that can withstand repeated use (excluding rental equipment).

(1) Rationale: TRICARE requires a separate revenue center for billing.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of New DME	MED EQUIP/NEW
3 - Purchase of Used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

(2) Required detail: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and for service units of one.

b 60X - Oxygen (Home Health) - Code indicates charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment. If a beneficiary has purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply.

(1) Rationale: TRICARE required detailed revenue coding.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	02/HOME HEALTH
1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
2 - Oxygen - State/Equip/Suppl Under LPM	02/STATE EQUIP//UNDER 1 LPM
3 - Oxygen - State/Equip/Over 4 LPM	02/STATE EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	02/STATE EQUIP/PORT ADD-ON

(2) Required detail: The applicable HCPCS code for the item, a date of service, number of service units, and charge amount.

9 Revenue code for optional reporting of wound care supplies:

a 62X - Medical/Surgical Supplies - Extension of 27X - Code indicates charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed.

SUBCATEGORY	STANDARD ABBREVIATION
3 - Surgical Dressings	SURG DRESSING

(1) Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 27x to identify non-routine supplies other than those used for wound care, ensure that the change amounts for the two revenue code lines are mutually exclusive.

(2) HHA may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 623. Notwithstanding the standard abbreviation "surg dressing", use this item to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

(3) Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist TRICARE's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.

(4) You may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. TRICARE claims systems will assure this amount reflects charges associated with all revenue code lines, excluding any 023.

(30) FL 44. HCPCS/Rates Required. On the earliest dated 023 revenue code line, report the HIPPS code which was reported on the RAP. On claims reflecting a significant change in condition (SCIC), report on each additional 023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment.

(a) For revenue code lines other than 023, which detail all services within the episode period, report HCPCS codes as appropriate to that revenue code.

(b) Coding detail for each revenue code under HHA PPS is defined above under FL 43.

(31) FL 45. Service Date Required. On each 023 revenue code line, report the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, report services dates as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43.

(32) FL 46. Units of Service Required. Do not report units of service on 023 revenue code lines (the field may be zero or blank). For line items detailing all services within the episode period, report units of service as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), report as units of service the number of fifteen-minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit, and time spent updating medical records in the home as part of such a visit, may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15-minute increment.

(33) FL 47. Total Charges Required. Zero charges must be reported on the 023 revenue line. TRICARE claims systems will place the reimbursement amount for the RAP in this field on the electronic claim record.

(a) For other line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43.

(b) Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). TRICARE claims systems will not make any payment determinations based upon submitted charge amounts.

(34) FL 48. Non-Covered Charges Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here. Report all non-covered charges, including no-payment claims.

(a) Claims with Both Covered and Non-Covered Charges - Report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. On the CMS 1450 UB-04 flat file, use record type 61, Field No. 10 (total charges) and Field No. 11 (non-covered charges).

(b) Claims with ALL Non-Covered Charges - Submit claims when all of the charges on the claim are non-covered (no-payment claim). Complete all items on a no-payment claim in accordance with instructions for completing payment claims, with the exception that all charges are reported as non-covered.

(35) Examples of Completed FLs 42 through 48 - The following provides examples of revenue code lines as HHAs should complete them, based on the reporting requirements above.

Report the multiple 023 lines in a SCIC situation as follows:					
FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**	**FL 48**
023	HAEJ1	100101		0.00	
023	HAFM1	100101		0.00	
Report additional revenue code lines as follows:					
FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**	**FL 48**
270			8	84.73	
291	K0006	100101	1	120.00	
420	G0151	100501	3	155.00	
430	G0152	100701	4	160.00	
440	G0153	100901	4	175.00	
550	G0154	100201	1	140.00	
560	G0155	101401	8	200.00	
570	G0156	101601	3	65.00	
580		101801	3	0.00	75.00
623			5	47.75	

(36) FL 49. (Untitled) Not Required.

(37) FLs 50A, B, and C. Payer Identification Required. If TRICARE is the primary payer, the HHA enters "TRICARE" on line A. When TRICARE is entered on line 50A, this indicates that the HHA has developed for other insurance coverage and has determined that TRICARE is the primary payer. All additional entries across the line (FLs 51-55) supply information needed by the payer named in FL 50A. If TRICARE is the secondary or tertiary payer, HHAs identify the primary payer on line A and enter TRICARE information on line B or C as appropriate. Conditional and other payments for TRICARE Secondary Payer (MSP) situations will be made based on the HHA PPS claim.

(38) FL 51. TRICARE Provider Number Required. Enter the 9-18 position tax identification number assigned by TRICARE. It must be entered on the same line as "TRICARE" in FL 50.

(a) If the TRICARE provider number changes within a 60-day episode, reflect this by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number.

(b) In this case, report the original provider number in this field.

(39) FLs 52A, B, and C. Release of Information Certification Indicator Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

(40) FLs 53A, B, and C. Assignment of Benefits Certification Indicator Not Required.

(41) FLs 54A, B, and C. Prior Payments Not Required.

(42) FLs 55A, B, and C. Estimated Amount Due Not Required.

(43) FL 56. (Untitled) Not Required.

(44) FL 57. (Untitled) Not Required.

(45) FLs 58A, B, and C. Insured's Name Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information is shown in FLs 50-54, enter the patient's name as shown on his HI card or other TRICARE notice. Enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than TRICARE and you are requesting payment because:

(a) Another payer paid some of the charges and TRICARE is secondarily liable for the remainder;

(b) Another payer denied the claim; or

(c) You are requesting conditional payment. If that person is the patient, enter "Patient." Payers of higher priority than TRICARE include:

1 EGHPs for employed beneficiaries and their spouses;

2 EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a TRICARE Coordination Period;

3 An auto-medical, no-fault, or liability insurer;

4 Lisps for disabled beneficiaries; or

5 WC including BL.

(46) FLs 59A, B, and C. Patient's Relationship to Insured Required. If claiming payment under any of the circumstances described under FLs 58A, B, or C, enter the code indicating the relationship of the patient to the identified insured.

CODE STRUCTURE :		
CODE	TITLE	DEFINITION
01	Patient is the Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured Financial Responsibility	Self-explanatory

CODE STRUCTURE (CONTINUED):		
CODE	TITLE	DEFINITION
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.

(47) FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/ Identification Number Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information was shown on FLs 39-41, and 50-54, enter the patient's TRICARE health insurance claim number; i.e., if TRICARE is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of TRICARE Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office. If claiming a conditional payment under any of the circumstances described under FLs 58A, B, or C, enter the involved claim number for that coverage on the appropriate line.

(48) FLs 61A, B, and C. Group Name Required. Where you are claiming a payment under the circumstances described in FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the name of the group or plan through which that insurance is provided.

(49) FLs 62A, B, and C. Insurance Group Number Required. Where you are claiming a payment under the circumstance described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter identification number, control number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

(50) FL 63. Treatment Authorization Code Required. Enter the claims-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). Copy these OASIS items exactly as they appear on the OASIS assessment, matching the date formats used on the assessment.

(a) In most cases, the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must

correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

(b) The investigational device (IDE) revenue code, 624, is not allowed on HHA PPS RAPs. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

(51) FL 64. Employment Status Code Required. Where you are claiming payment under the circumstances described in the second paragraphs of FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified, if the information is readily available.

CODE STRUCTURE :		
CODE	TITLE	DEFINITION
1	Employed Full Time	Individual claimed full time employment.
2	Employed Part Time	Individual claimed part time employment.
3	Not Employed	Individual states that he or she is not employed full time or part time.
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for national assignment.
9	Unknown	Individual's employment status is unknown

(52) FL 65. Employer Name Required. Where you are claiming a payment under the circumstance described under FLs 58A, B, or C, and there is involvement of WC or EGHP, enter the name of the employer that provides health care coverage for the individual.

(53) FL 66. Employer Location Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual. A specific location is the city, plant, etc., in which the employer is located.

(54) FL 67. Principal Diagnosis Code Required. Enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, do not fill with zeros.

(a) The ICD-9 codes and principal diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS from item M0230 (Primary Diagnosis), and on the CMS Form 485, from item 11 (ICD-9-CM/Principle Diagnosis).

(b) In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principle diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

(55) FLs 68-75. Other Diagnoses Codes Required. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

(a) For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 67A-Q must match the additional diagnoses reported on the OASIS, from item M0240 (Other Diagnoses), and on the CMS Form 485, from item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields from M0240 on the OASIS, or on the CMS Form 485, from item 13, may be reported in FLs 67A-Q on the claim if they are reported in the narrative from item 21 of the CMS Form 485.

(b) In most cases, the other diagnoses codes on the claim will match those submitted on the RAP. In SCIC cases, however, the other diagnoses codes reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

(56) FL 69. Admitting Diagnosis Not Required.

(57) FL 72. E-Code Not Required.

(58) FL 73. (Untitled) Not Required.

(59) FL 74. Principal Procedure Code and Date Not Required.

(60) FL 74 a-e. Other Procedure Codes and Dates Not Required.

(61) FL 76. Attending/Requesting Physician I.D. Required. Enter the UPIN and name of the attending physician who has signed the plan of care.

NOTE: Medicare requires HHAs to enter the UPIN and name of the attending physician who has established the plan of care in FL 76 of the CMS 1450 UB-04. The UPIN information will be allowed on the RAP and claims but not stored until required.

(62) FL 77. Other Physician I.D. Not Required.

(63) FL 80. Remarks Not Required

(64) FL 86. Date Not Required. See FL 45, line 23.

t. Examples of Claims Submission Under the HHA PPS. The following types of claims submissions can be viewed in Addendum J:

(1) RAP - non-transfer situation

(2) RAP - non-transfer situation with line item service added

(3) RAP - transfer situation

(4) RAP - discharge/re-admit

(5) RAP - cancellation

(6) Claim - non-transfer situation

(7) Claim - transfer situation

(8) Claim - SCIC

(9) Claim - no-RAP-LUPA claim

(10) Claim - adjustment

(11) Claim - cancellation

u. Claims Adjustments and Cancellations.

(1) Both RAPs and claims may be canceled by HHAs if a mistake is made in billing (TOB 328); episodes will be canceled in the system, as well.

(2) Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment.

(3) RAPs can only be canceled, and then re-billed, not adjusted.

(4) HHRGs can be changed mid-episode if there is a significant change in the patient's condition (SCIC adjustment).

(5) Partial Episode Payment Adjustments. Episodes can be truncated and given partial episode payments (PEP adjustment) if the beneficiaries choose to transfer among HHAs or if a patient is discharged and subsequently readmitted during the same 60-day period.

(a) In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called PEPs. When either the agency the beneficiary is transferring from is preparing the claim for the episode, or an agency that has discharged a patient knows when preparing the claim that the same patient will be readmitted in the same

60 days, the claim should contain patient status code 06 in FL 17 (Patient Status) of the CMS 1450 UB-04.

(b) Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service, to and including the day of the last billable service.

(c) Transfers. Transfer describes when a single beneficiary chooses to change HHAs during the same 60-day period. By law under the HHA PPS system, beneficiaries must be able to transfer among HHAs, and episode payments must be pro-rated to reflect these changes.

1 To accommodate this requirement, HHAs will be allowed to submit a RAP with a transfer indicator in FL 15 (Source of Admission) of CMS 1450 UB-04 even when an episode may already be open for the same beneficiary at another HHA.

2 In such cases, the previously open episode will be automatically closed in TRICARE systems as of the date services began at the HHA the beneficiary transferred to, and the new episode for the "transfer to" agency will begin on that same date.

3 Payment will be pro-rated for the shortened episode of the "transferred from" agency, adjusted to a period less than 60 days, whether according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency. The HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

(d) Discharge and Readmission Situation Under HHA PPS. HHAs may discharge beneficiaries before the 60-day episode has closed if all treatment goals of the plan of care have been met, or if the beneficiary ends care by transferring to another home health agency. Cases may occur in which an HHA has discharged a beneficiary during a 60-day episode, but the beneficiary is readmitted to the same agency in the same 60 days.

1 Since no portion of the 60-day episode can be paid twice, the payment for the first episode must be pro-rated to reflect the shortened period: 60 days less the number of days after the date of delivery of the last billable service until what would have been the 60th day.

2 The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock").

3 As with transfers, FL 15 (Source of Admission) of CMS 1450 UB-04 can be used to send "a transfer to same HHA" indicator on a RAP, so that the new episode can be opened by the HHA.

4 Beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases.

a When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same 60-day period.

b Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA.

(e) Payment When Death Occurs During an HHA PPS Episode. If a beneficiary's death occurs during an episode, the full payment due for the episode will be made.

1 This means that PEP adjustments will not apply to the claim, but all other payment adjustments apply.

2 The "Through" date on the claim (FL 6) of CMS 1450 UB-04, closing the episode in which the beneficiary died, should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

(f) Low Utilization Payment Adjustment (LUPAs). If an HHA provides 4 visits or less, it will be reimbursed on a standardized per-visit payment instead of an episode payment for a 60-day period. Such payment adjustments, and the episodes themselves, are called LUPAs.

1 On LUPA claims, non-routine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates.

2 Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history.

3 If the claim for the LUPA is later adjusted such that the number of visits becomes 5 or more, payments will be adjusted to an episode basis, rather than a visit basis.

(g) Special Submission Case: "No-RAP" LUPAs. There are also reducing adjustments in payments when the number of visits provided during the episode fall below a certain threshold (low utilization payment adjustments: LUPAs).

1 Normally, there will be two percentage payments (initial and final) paid for an HHA PPS episode - the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which an HHA knows that an

episode will be four visits or less even before the episode begins, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment.

2 In such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage that otherwise would likely have been largely recouped automatically against other payments.

3 However, HHAs may submit both a RAP and claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in recoupment of funds when the claim is submitted. HHAs should also be aware that receipt of the RAP or a "No-RAP LUPA" claim causes the creation of an episode record in the system and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk for that period of not being established as the primary HHA.

4 Physician orders must be signed when these claims are submitted.

5 If an HHA later needs to add visits to the claim, so that the claim will have more than 4 visits and no longer be a LUPA, the HHA should submit an adjustment claim so the intermediary may issue full payment based on the HIPPS code.

(h) Therapy Threshold Adjustment. There are downward adjustments in HHRs if the number of therapy services delivered during an episode does not meet anticipated thresholds - therapy threshold.

1 The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode.

2 The number of therapy hours projected on the OASIS assessment at the start of the episode, will be confirmed by the visit information submitted in line-item detail on the claim for the episode.

3 Because the advent of 15-minute increment reporting on home health claims only recently preceded HHA PPS, therapy hours will be proxied from visits at the start of HHA PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent 8 hours of therapy.

4 Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational or speech therapy combined).

5 Logic is inherent in HIPPS coding so that there are essentially two HIPPS representing the same payment group:

a One if a beneficiary does not receive the therapy hours projected, and

b Another if he or she does meet the "therapy threshold".

c Therefore, when the therapy threshold is not met, there is an automatic "fall back" HIPPS code, and TRICARE systems will correct payment without access to the full OASIS data set.

d If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case-mix for the episode with a new HIPPS code and pay the episode on the basis of the new code.

e HHAs will receive the difference between the full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code.

f The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS that was used for payment, so such cases can be clearly identified.

g If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangements which were not billed timely to the primary agency, TRICARE systems will re-price the claim and pay the full episode payment based on the original HIPPS.

h A HIPPS code may also be changed based on medical review of claims.

(i) Significant Change in Condition (SCIC). While HHA PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes a change in patient condition will occur that is significant enough to require the patient to be re-assessed during the 60-day episode period and to require new physician's orders.

1 In such cases, the HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode, even in the rare case of two different HIPPS codes applying to services on the same day.

2 Since a line-item date is required in every case, Pricer will then be able to calculate the number of days of service provided under each HIPPS code, and pay proportional amounts under each HIPPS based on the number of days of service provided under each payment group (count of days under each HIPPS from and including the first billable service, to and including the last billable service).

3 The total of these amounts will be the full payment for the episode, and such adjustments are referred to as SCIC adjustments.

4 The electronic remittance advice, including a claim for a SCIC-adjusted episode, will show the total claim reimbursement and separate segments showing the reimbursement for each HIPPS code.

5 There is no limit on the number of SCIC adjustments that can occur in a single episode. All HIPPS codes related to a single SCIC-adjusted episode should appear on the same claim at the end of that episode, with two exceptions:

a One - If the patient is re-assessed and there is no change in the HIPPS code, the same HIPPS does not have to be submitted twice, and no SCIC adjustment will apply.

b Two - If the HIPPS code weight increased but the proration of days in the SCIC adjustment would result in a financial disadvantage to the HHA, the SCIC is not required to be reported.

6 Exceptions are not expected to occur frequently, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS for an episode).

7 Payment will be made based on six HIPPS, and will be determined by contractor medical review staff, if more than six HIPPS are billed.

(6) Outlier Payments. There are cost outliers, in addition to episode payments.

(a) HHA PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in a 60-day period, TRICARE systems will provide extra, or "outlier", payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

(b) Outlier determinations will be made comparing the summed wage-adjusted imputed costs for each discipline (i.e., the summed products of each wage-adjusted per-visit rate for each discipline multiplied by the number of visits of each discipline on the claim) with the sum of: the case-mix adjusted episode payment plus a wage-adjusted fixed loss threshold amount.

(c) If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific HRG payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment, in addition to the episode payment.

(d) Outlier payment amounts are wage index adjusted to reflect the MSA in which the beneficiary was served.

(e) Outlier payment is a payment for an entire episode, and therefore only carried at the claim level in paid claim history, not allocated to specific lines of the claim.

(f) Separate outliers will not be calculated for different HIPPS codes in a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

(g) Outlier payments will be made on remittances for specific episode claims. HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total reimbursement for the episode claim on a remittance, but it will be identified separately on the claim in history with a value code 17 in CMS 1450 UB-04 FLs 39-41, with an attached amount, and in condition code 61 in CMS 1450 UB-04 FLs 18-28. Outlier payments will also appear on the electronic remittance advice in a separate segment.

v. Exclusivity and Multiplicity of Adjustments.

(1) Episode payment adjustments only apply to claims, not requests for anticipated payment (RAPs).

(2) Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold, PEP or SCIC adjustment, and also will not receive outlier payments.

(3) For other HHA PPS claims, multiple adjustments may apply on the same claim, although some combinations of adjustments are unlikely (i.e., a significant change in condition (SCIC) and therapy threshold adjustment in a shortened episode (PEP adjustment)).

(4) All claims except LUPA claims will be considered for outlier payment.

(5) Payment adjustments are calculated in Pricer software.

(6) Payments are case-mix and wage adjusted employing Pricer software (a module that will be attached to existing TRICARE claims processing systems) at the contractor processing TRICARE home health claims.

(7) The MCSC must designate the primary provider of home health services through its established authorization process. Only one HHA - the primary or the one establishing the beneficiary's plan of care - can bill for home health services other than DME under the home health benefit. If multiple agencies are providing services simultaneously, they must take payment under arrangement with the primary agency.

(8) Payment for services remains specific to the individual beneficiary who is homebound and under a physician's plan of care.

w. Chart Representation of Billing Procedures.

(1) One 60-day Episode, No Continuous Care (Patient Discharged):

RAP	CLAIM
Contains one HIPPS Code and OASIS Matching Key output from Grouper software linked to OASIS	Submitted with Patient Status Code 01 and contains same HIPPS Code as RAP
Does not give any line-item detail for TRICARE but can include line-item charges for other carrier	Gives all line-item detail for the entire HH episode
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date of Discharge or Day 60
Creates HH episode in automated authorization system (authorization screen)	Closes HH Episode automated authorization system (authorization screen)
Triggers initial percentage payment for 60-day HH Episode	Triggers final percentage payment

(2) Initial Episode in Period of Continuous Care:

FIRST EPISODE		NEXT EPISODE(S)
RAP	CLAIM	RAP(S) & CLAIM(S)
Contains one HIPPS code and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Contains same HIPPS Code as RAP with Patient Status Code 30	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPS and claims throughout the period of continuous care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. Claims submitted at the end of each 60 day period
Does not give any other line-item detail for TRICARE use	Gives all line item detail for entire HH Episode	
From and Through Dates match first service delivered	From Date same as RAP, Through Date, Day 60 of HH Episode	The RAP and claim From and Through Dates in a period of continuous care are first day of HH Episode, w/ or w/o service (i.e., Day 61, 121, 181, etc.)

FIRST EPISODE		NEXT EPISODE(S)
RAP	CLAIM	RAP(S) & CLAIM(S)
Creates HH Episode in authorization system	Closes HH Episode in authorization system	
Triggers initial percentage payment	Triggers final percentage payment for 60-day HH Episode	Creates or closes HH Episode

(a) The above scenarios are expected to encompass most episode billings.

(b) For RAPs, Source of Admission Code "B" is used to receive transfers from other agencies; "C", if readmission to same agency after discharge.

(c) There is no number limit on medically necessary episodes in continuous care periods.

(3) A Single LUPA Episode:

RAP	CLAIM
Contains one HIPPS Code and Claims-OASIS Matching Key output from Grouper software linked to OASIS. Does not give any other line-item detail for TRICARE use	Submitted after discharge or 60 days with Patient Status Code 01. Contains same HIPPS Code as RAP, gives all line-item detail for the entire HH Episode - line item detail will not show more than 4 visits for entire episode.
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60
Creates HH Episode in authorization system	Closes HH Episode in authorization system
Triggers initial percentage payment	Triggers final percentage payment for 60-day HH Episode

(a) Though less likely, a LUPA can also occur in a period of continuous care.

(b) While also less likely, a LUPA, though never prorated, can also be part of a shortened episode or an episode in which the patient condition changes.

(4) "No-RAP" LUPA Episode. When a home health agency (HHA) knows from the outset that an episode will be 4 visits or less, the agency may choose to bill only a

claim for the episode. Claims characteristics are the same as the LUPA final claim on the previous page.

PROS:	CONS:
Will not get large episode percentage payment up-front for LUPA that will be reimbursed on a visit basis (overpayment concern, but new payment system will recoup such "overpayments" automatically against future payments) and less paperwork.	No payment until claim is processed

(5) Episode with a PEP Adjustment - Transfer to Another Agency or Discharge-Known Readmission to Same Agency:

RAP	CLAIM
Contains one HIPPS Code and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Submitted after discharge with Patient Status Code of 06
Does not contain other line-item detail for TRICARE use	Contains same HIPPS Code as RAP, and gives all line-item detail for entire HH Episode
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date is discharge
Creates HH Episode in authorization system	Closes HH Episode in authorization system at date of discharge, not 60 days
Triggers initial percentage payment	Triggers final percentage payment, and total payment for the episode will be cut back proportionately (x/60), "x" being the number of days of the shortened HH Episode.

(a) Known Readmission: agency has found after discharge the patient will be re-admitted in the same 60-day episode ("transfer to self" - new episode) before final claim submitted.

(b) A PEP can also occur in a period of otherwise continuous care.

(c) A PEP episode can contain a change in patient condition.

(6) Episode with a PEP Adjustment - Discharge and "Unknown" Re-Admit, Continuous Care:

FIRST EPISODE (RAP)	CLAIM	START OF NEXT EPISODE (RAP)
Contains one HIPPS and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Submitted after discharge or 60 days with Patient Status 01 - agency submitted claim before the patient was re-admitted in the same 60-day episode	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPS and claims throughout the period of continuous care
Does not contain other line-item detail for TRICARE use	Contains same HIPPS Code as RAP, and gives all line-item detail for the entire Episode	Contains Source of Admission Code "C" to indicate patient re-admitted in same 60 days that would have been in previous episode, but now new Episode will begin and previous episode automatically shortened
Creates HH Episode in authorization system	Closes HH Episode in authorization system 60 days initially, and then revised to less than 60 days after next RAP received	
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60 of HH Episode	From and Through Dates, equal first episode day with service or Day 60 of HH Episode without service (i.e., Day 61, 121, 181)
Triggers initial percentage payment	Triggers final payment, may be total payment for HH Episode at first, will be cut back proportionately (x/60) to the number of the shortened episode when next billing received	Opens next Episode in authorization system Triggers initial payment for new HH Episode

(7) Episode with a SCIC Adjustment:

RAP	CLAIM
Contains one HIPPS Code and Claim-OASIS Matching Key output from Grouper	Submitted after discharge with Patient Status Code software linked to OASIS as appropriate (01, 30, etc.). Carries Matching Key and diagnoses consistent with last OASIS assessment
Does not contain other line-item for TRICARE use	Contains same HIPPS Code as RAP, additional HIPPS output every time patient reassessed because of change in condition, and gives all line-item detail for the entire HH Episode
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60
Creates HH Episode in authorization system	Closes HH Episode in authorization system
Triggers initial percentage payment	Triggers final percentage payment

(8) General Guidance on Line Item Billing Under HHA PPS - Quick Reference on Billing Most Line-Items on HHA PPS Requests for Anticipated Payment (RAPs) and Claims:

TYPE OF LINE ITEM	EPISODE	SERVICES/VISITS	OUTLIER
Claim Coding	New 023 revenue code with new HIPPS on HCPCS of same line	Current revenue codes 42X, 43X,44X, 55X, 56X, 57X w/Gxxxx HCPCs for increment reporting (Note: Revenue codes 58X and 59X not permitted for HHA PPS)	Determined by Pricer - Not billed by HHAs
Type of Bill (TOB)	Billed on 32X only (have 485, patient homebound)	Billed on 32X only if POC; 34X* if no 485	Appears on remittance only for HHA PPS (via Pricer)
Payment Bases	PPS episode rate: (1) full episode w/ or w/out SCIC adjustment, (2) less than full episode w/PEP adjustment, (3) LUPA paid on visit basis, (4) therapy threshold adjustment	When LUPA on 32X, visits paid on adjusted national standardized per visit rates; paid as part of Outpatient PPS for 34X*	Addition to PPS episode rate payment only, not LUPA, paid on claim basis, not line item
PPS Claim?	Yes, RAPs and Claims	Yes, Claims only [34X*; no 485/non-PPS]	Yes, Claims only

NOTE: For HHA PPS, HHA submitted IC TOB must be 322 - may be adjusted by 328; Claim TOB must be 329- may be adjusted by 327, or 328.
*** - 34X claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on the system (exceptions noted on chart below).**

TYPE OF LINE ITEM	DME** (NON-IMPLANTABLE, OTHER THAN OXYGEN & P/O)	OXYGEN & P/O (NON-IMPLANTABLE P/O)	NON-ROUTINE*** MEDICAL SUPPLIES	OSTEOPOROSIS DRUGS	VACCINE	OTHER OUTPUT ITEMS (ANTIGENS, SPLINTS & CASTS)
Claim Coding	Current revenue codes 29X, 294 for drugs/supplies for effective DME use w/HCPCs	Current revenue codes 60X (Oxygen) and 274 (P/O) w/HCPCs	Current revenue code 27X, and voluntary use of 623 for wound care supplies	Current revenue code 636 & HCPCs	Current revenue codes 636 (drug) and HCPCs, 771 (administration)	Current revenue code 550 & HCPCs
Type of Bill (TOB)	Billed to Contractor on 32X if 485; 34X*, if no 485	Billed to Contractor on 32X if 485; 34X*, if no 485	Billed on 32X if 485; or 34X*, if no 485	Billed on 34X* only	Billed on 34X* only	Billed on 34X* only

NOTES: For HHA PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).
*** - 34X claims for HH services, except as noted for specific items above, will not be paid separately if a HH episode for the same beneficiary is open on the system.**
**** - Other than DME treated as routine supplies according to TRICARE.**
***** - Routine supplies are not separately billable or payable under TRICARE home health care. When billing on type of bill 32X, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270.**

TYPE OF LINE ITEM	DME** (NON-IMPLANTABLE, OTHER THAN OXYGEN & P/O)	OXYGEN & P/O (NON-IMPLANTABLE P/O)	NON-ROUTINE*** MEDICAL SUPPLIES	OSTEOPOROSIS DRUGS	VACCINE	OTHER OUTPUT ITEMS (ANTIGENS, SPLINTS & CASTS)
Payment Basis	Lower of total rental cost or reasonable purchase cost	Allowable charge methodology Oxygen concentrator - rental or purchase	Bundled into PPS payment if 32X (even LUPA); paid in cost report settlement for 34X*	Average wholesale cost, and paid separately with or without open HHA PPS episode	Average wholesale cost, and paid separately with or without open HHA PPS episode	
PPS Claims?	**Yes,** Claim only [34X*, no 485/non-PPS]	**Yes**, Claim only [34X*; if no 485/non-PPS]	**Yes,** Claim only [34X*, if no POC/non-PPS]	**No** (34X*; claims only)	**No** (34X*; claims only)	**No** (34X*; claims only)

NOTES: For HHA PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).
*** - 34X claims for HH services, except as noted for specific items above, will not be paid separately if a HH episode for the same beneficiary is open on the system.**
**** - Other than DME treated as routine supplies according to TRICARE.**
***** - Routine supplies are not separately billable or payable under TRICARE home health care. When billing on type of bill 32X, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270.**

x. Other Billing Considerations.

(1) Billing for Nonvisit Charges. Under HHA PPS, all services under a plan of care must be billed as a HHA PPS episode. All services within an episode of care must be billed on one claim for the entire episode.

(a) Type of bill 329 and 339 are not accepted without any visit charges.

(b) Nonvisit charges incurred after termination of the plan of care are payable under medical and other health services on type of bill 34X.

(2) Billing for Use of Multiple Providers. When a physician deems it necessary to use two participating HHAs, the physician designates the agency which furnishes the major services and assumes the major responsibility for the patient's care.

(a) The primary agency bills for all services furnished by both agencies and keeps all records pertaining to the care. The primary agency's status as primary is established through the submission of a Request for Anticipated Payment.

(b) The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies.

(c) Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the system indicates an episode of care is open for a

beneficiary, deny the RAP on any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

(3) Home Health Services Are Suspended or Terminated and Then Reinstated. A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health service. When the suspension is temporary (does not extend beyond the end of the 60-day episode) and the physician later determines that the services must be resumed, the resumed services are paid as part of the same episode and under the same plan of care as before. The episode from date and the admission date remain the same as on the RAP. No special indication need be made on the episode claim for the period of suspended services. Explanation of the suspension need only be indicated in the medical record.

(a) If, when services are resumed after a temporary suspension (one that does not extend beyond the end date of the 60-day episode), the HHA believes the beneficiary's condition is changed sufficiently to merit a SCIC adjustment, a new OASIS assessment may be performed, and change orders acquired from the physician. The episode may then be billed as a SCIC adjustment, with an additional 023 revenue code line reflecting the HIPPS code generated by the new OASIS assessment.

(b) If the suspension extends beyond the end of the current 60-day episode, HHAs must submit a discharge claim for the episode. Full payment will be due for the episode. If the beneficiary resumes care, the HHA must establish a new plan of care and submit a RAP for a new episode. The admission date would match the episode from date, as the admission is under a new plan of care and care was not continuous.

(4) Preparation of a Home Health Billing Form in No-Payment Situations. HHAs must report all non-covered charges on the CMS 1450 UB-04, including no-payment claims as described below. HHAs must report these non-covered charges for all home health services, including both Part A (0339 type bill) and Part B (0329 or 034X type bill) service. Non-covered charges must be reported only on HHA PPS claims. RAPs do not require the reporting of non-covered charges. HHA no-payment bills submitted with types of bill 0329 or 0339 will update any current home health benefit period on the system.

(5) HHA Claims With Both Covered and Non-Covered Charges. HHAs must report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. (Provider should not report the non-payment codes outlined below). On the CMS 1450 UB-04 flat file, HHAs must use record type 61, Field No. 10 (outpatient total charges) and Field No. 11 (outpatient non-covered charges) to report these charges. Providers utilizing the hard copy CMS 1450 UB-04 report these charges in FL 47. "Total Charges," and in FL 48 "Non-Covered Charges." You must be able to accept these charges in your system and pass them on to other payers.

(6) HHA Claims With All Non-Covered Charges. HHAs must submit claims when all of the charges on the claim are non-covered (no-payment claim). HHAs must complete all items on a no-payment claim in accordance with instructions for completing payment bills, with the exception that all charges are reported as non-covered. You must

provide a complete system record for these claims. Total the charges on the system under revenue code 0001 (total and non-covered). Non-payment codes are required in the system records where no payment is made for the entire claim. Utilize non-payment codes in §3624. These codes alert TRICARE to bypass edits in the systems processing that are not appropriate in non-payment cases. Enter the appropriate code in the "Non-Payment Code" field of the system record if the nonpayment situation applies to all services covered by the bill. When payment is made in full by an insurer primary to TRICARE, enter the appropriate "Cost Avoidance" codes for MSP cost avoided claims. When you identify such situations in your development or processing of the claim, adjust the claim data the provider submitted, and prepare an appropriate system record.

(7) No-Payment Billing and Receipt of Denial Notices Under HHA PPS. HHAs may seek denials for entire claims from TRICARE in cases where a provider knows all services will not be covered by TRICARE. Such denials are usually sought because of the requirements of other payers (e.g., Medicaid) for providers to obtain TRICARE denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

(a) Submission and Processing. In order to submit a no-payment bill to TRICARE under HHA PPS, providers must:

(b) Use TOB 03x0 in FL 4 and condition code 21 in FL 18-28 of the CMS 1450 UB-04 claim form.

(c) The statement dates on the claim, FL 6, should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported.

(d) Providers must also key in the charge for each line item on the claim as a non-covered charge in FL 48 of each line.

(e) In order for these claims to process through the subsequent HHA PPS edits in the system, providers are instructed to submit a 023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (HAEJ1) as a proxy, an 18-digit string of the number 1, "111111111111111111", for the OASIS Claim-Matching Key in FL 63, and meet other minimum TRICARE requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching Key output should be used.

(f) TRICARE standard systems will bypass the edit that required a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems must also ensure that a matching RAP has not been paid for that billing period.

(g) FL 15, source of admission, and treatment authorization code, FL 63, should be unprotected for no-pay bills.

(8) Simultaneous Covered and Non-Covered Services. In some cases, providers may need to obtain a TRICARE denial notice for non-covered services delivered in the same period as covered services that are a part of an HHA PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, and submit the appropriate HHA PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. TRICARE claims processing systems and automated authorization files will allow such duplicate claims to process when all services on the claim are non-covered.

B. Reporting Requirements. Effective for home health services rendered on or after the first day of health care delivery of the new contract, reimbursement will follow Medicare's HHA PPS methodology. With the implementation of HHA PPS, revenue code 023 must be present on all HHA PPS TEDs in addition to all other revenue code information pertinent to the treatment. See the TRICARE Systems Manual, Chapter 2, Addendum I for a list of valid revenue codes. In addition, under HHA PPS all HHA TEDs must be coded with special rate code "V" Medicare Reimbursement Rate or Special Rate Code "D" for a Discount Rate Agreement.

1. With the implementation of HHA PPS, for each calendar quarter, contractors shall deliver a file (on a computer-readable standard IBM cartridge tape or CD-ROM or diskette) in simple EBCDIC or ASCII data format to the Office of Medical Benefits and Reimbursement Systems, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, CO 80011-9066. This file must contain the full TED number (21 characters) and the 5-digit Health Insurance Prospective Payment System (HIPPS) code for each HHA PPS claim.

2. The quarterly report file must reflect all HHA PPS claims which have cleared all TMA edits and have been accepted on the TED database in the quarter (whether denied or allowed and regardless of government liability) and shall be delivered within 30 days after the end of each quarter. This HHA PPS report file shall have a record length of 26 and contain the two data elements according to the following file layout.

DATA ELEMENT	START BYTE	END BYTE
TED-NBR	1	21
HIPPS Code	22	26

- END -