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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 133
6010.54-M
DECEMBER 2, 2010**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: FISCAL YEAR (FY) 2011 SKILLED NURSING FACILITY PROSPECTIVE
PAYMENT SYSTEM (SNF PPS) RATES AND WAGE INDEX UPDATES

CONREQ: 15214

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): These rates include using a new Resource Utilization Group (RUG) case-mix classification system and will use information obtained from the required resident assessments using Version 3.0 of the Minimum Data Set (MDS). These rates are the same as Medicare's.

EFFECTIVE DATE: October 1, 2010.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TRM, Change No. 123.

Ann N. Fazzini

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**ATTACHMENT(S): 6 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 133
6010.54-M
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REMOVE PAGE(S)

CHAPTER 9

Section 15.1, pages 23 and 24

Addendum A, page 1

CHAPTER 12

Section 10.1, pages 1 - 3

INSERT PAGE(S)

Section 15.1, pages 23 and 24

Addendum A, page 1

Section 10.1, pages 1 - 3

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CHAPTER 9, SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

NOTE: Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHHC cap for the fiscal year beginning on that date.

(2) From the “Table 6A. RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component”, determine the highest cost RUG-IV category;

(3) Multiply the labor component obtained in paragraph VI.H.2.a.(2) by the “Table A. FY 2011 Wage Index for Urban Areas Based on CBSA Labor Market Areas” value corresponding to the beneficiary’s location;

(4) Sum the non-labor component from paragraph VI.H.2.a.(2) and the adjusted labor component from paragraph VI.H.2.a.(3); the result is the beneficiary’s EHHC per diem in that location;

(5) Multiply the per diem obtained in paragraph VI.H.2.a.(4) by 365 (366 in leap year); the result is the beneficiary’s fiscal year cap for EHHC in that location.

(6) For beneficiary’s residing in areas not listed in Table 6A, use “Table 7A. RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component” and “Table B. FY 2011 Wage Index Based on CBSA Labor Market Areas for Rural Areas” and adjust similarly to paragraph VI.H.2.a.(3) through (5) to determine the EHHC cap for beneficiaries residing in rural areas.

NOTE: See Chapter 9, Addendum A for an example of the EHHC cap based on the FY 2011 rates published in the Federal Register on July 22, 2010 (75 FR 42886).

b. Beneficiaries who seek EHHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

c. The maximum amount reimbursed in any month for EHHC services is the amount authorized in accordance with the approved plan of care and based on the actual number of hours of home health care provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHHC exceed one-twelfth (1/12) of the annual fiscal year cap established under paragraph VI.H.2.a. and as adjusted for the actual number of days in the month during which the services were provided.

d. Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHHC services will reflect the re-calculated EHHC cap.

e. The cost for EHHC services does not accrue to the maximum monthly or fiscal year Government cost-shares indicated in Chapter 9, Section 16.1.

3. The sponsor’s cost-share for EHHC services will be as indicated in Chapter 9, Section 16.1.

I. Transition to EHHC.

1. Following modification of the MCS contracts that incorporates the ECHO, the MCSCs will identify all active duty family members who are currently using, or have used any benefit of the PFPWD within the 12-month period immediately preceding the contract modification. The MCSCs will also identify those active duty family members who are in SNFs.

2. Not less than 60 days prior to the scheduled implementation of the ECHO, the MCSCs will send the government furnished notification and information brochures to all beneficiaries identified in [paragraph VI.I.1](#). The notification announces the conversion of the PFPWD to the ECHO and the brochure highlights the benefit structure, the requirements, and the primary points of contact to access the ECHO.

3. Beneficiaries in SNFs will be afforded the opportunity to relocate to a more natural setting, such as in the sponsor's home, or other primary residence as defined herein.

4. MCSCs will assist EHHC-eligible beneficiaries with initiating the ECHO registration process and developing and approving the plan of care.

5. Those homebound beneficiaries whose need for skilled services can be appropriately met by the HHA-PPS (TRM, [Chapter 12](#)) will be required to access that program for such services.

NOTE: Although it is the intent that eligible beneficiaries complete the registration process and all applicable requirements of this issuance by the date of implementation of the ECHO, it is recognized that certain requirements may not be completed at that time. Therefore, to avoid delaying necessary services, those otherwise ECHO-eligible beneficiaries will be granted provisional eligibility status for a period of not more than 90 days following the date of implementation during which EHHC benefits will be authorized and payable. Beneficiaries failing to complete the ECHO registration process and the requirements of this issuance by the end of that 90 day period will be determined ineligible, at which point authorization and Government liability for all ECHO/EHHC benefits will terminate. The Department will not recoup claims paid for ECHO benefits provided during the provisional period.

6. Following implementation of the ECHO, the MCSCs will make available the Government furnished information brochures to beneficiaries seeking information about or access to the ECHO.

VII. EXCLUSIONS

A. Basic program and the ECHO Respite Care benefit (see [Chapter 9, Section 12.1](#)).

B. EHHC services will not be provided outside the beneficiary's primary residence.

C. EHHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education.

ECHO HOME HEALTH CARE (EHHC) BENEFIT

The following example illustrates the process of calculating the maximum fiscal year benefit for ECHO Home Health Care (EHHC) as described in [Chapter 9, Section 15.1, paragraph VI.H](#).

This example is based on the Fiscal Year 2011 rates for the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year 2011; **Notice** published by the Centers for Medicare and Medicaid Services (CMS) in the **Federal Register** on **July 22, 2010** (75 FR 42886).

STEP	DESCRIPTION	URBAN ¹	RURAL ²
1	Tables 6A and 7A Highest RUG-III Category	RUX	RUX
2	Tables 6A and 7A Labor Component of RUX	602.60	609.74
3	Tables A and B Wage Index	1.6703	1.2626
4	Adjusted Labor Component (Step 2 x Step 3)	1,006.52	769.86
5	Tables 6A and 7A Non-Labor Component	266.82	269.98
6	Total RUX Daily Rate (Step 4 + Step 5)	1,273.34	1,039.84
7	Total Fiscal Year EHHC Benefit (Step 6 x 365) ³	464,769.10	379,541.60
¹ Beneficiary resides in Santa Cruz, CA. ² Beneficiary resides in rural Massachusetts. ³ 366 in Leap Year.			

- END -

PAYMENT POLICY

ISSUE DATE:

AUTHORITY: 32 CFR 199.17

I. POLICY

A. With the exception of all hospital inpatient and professional charges in Philippines and Panama subject to the foreign fee schedule, Puerto Rico, and prescription drugs, reimbursement of all other TOP beneficiary claims for overseas health care shall be based upon the billed charges. (See [Chapter 12, Section 11.1](#), TRICARE Reimbursement Manual (TRM), Chapter 1, [Sections 34](#) and [35](#), for additional guidelines). Puerto Rico claims shall be reimbursed following continental United States (CONUS) reimbursement guidelines.

B. Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. Territories (Guam, the U.S. Virgin Islands, and American Samoa) shall be processed as routine foreign claims and shall be subject to the Prospective Payment System (PPS), as required under Medicare in accordance with the Social Security Act. These SNFs will be subject to the same rules as applied to SNFs in the U.S. (see the TRM, [Chapter 8](#)):

1. Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and TRICARE for Life (TFL) patients when TRICARE is the primary payer. The review required for the lower 18 Resource Utilization Groups (RUGs) **for services prior to October 1, 2010, and the lower 14 RUGs for services on/after October 1, 2010, are** a requirement for all TRICARE patients when TRICARE is primary (see TRM, [Chapter 8, Section 2, paragraph IV.C.16.](#)). There will be no review for Standard or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

2. Beneficiaries in the lower 18 **or 14 RUGs depending on date of service** do not automatically qualify for SNF coverage. These beneficiaries will be individually reviewed to determine whether they meet the criteria for skilled services and the need for skilled services (see the TRM, [Chapter 8, Section 2](#)). If these beneficiaries do not meet these criteria, the SNF PPS claim shall be denied.

3. The TRICARE Managed Care Support Contractor (MCSC), South Region (hereinafter known as “overseas claims processing contractor”), at their own discretion, may collect MDS assessment data per the TRM, [Chapter 8, Section 2](#).

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4. The overseas claims processing contractor shall be responsible to enter into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, and American Samoa.

5. The overseas claims processing contractor, at their own discretion, may conduct any data analysis to identify aberrant SNF PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG. The contractor shall also assist the TRICARE Area Office (TAO) Directors in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

C. Balance billing provisions do not apply to TOP beneficiary claims for TOP overseas health care paid as billed.

D. For health care rendered in Puerto Rico and in the U.S., reimbursement for all TOP beneficiary care shall follow the TRICARE payment policies except as outlined in [paragraph I.E.](#)

E. Non-assigned provider claims for active duty service member (ADSM) CONUS health care shall be paid following normal TRICARE CONUS reimbursement rules for institutional and non-institutional care. The contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, first a rate within the 100% CHAMPUS Maximum Allowable Charge (CMAC) limitation and then second, a rate between 100 and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the TAO Director, as the designee of the Chief Operating Office (COO), TRICARE Management Activity (TMA), to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the TAO Director before the negotiation can be concluded. The contractors shall ensure that the approval payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

1. TOP ADSM who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. After processing the claim, the contractor shall initiate recoupment action from the non-participating provider for any amount above the maximum allowed by law.

2. In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve, they shall pend the file and forward the issue to the appropriate TAO Director. The appropriate TAO Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the TAO Director has requested and has been granted a waiver from the COO, TMA, or designee.

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F. TRICARE Global Remote Overseas (TGRO)/TRICARE Puerto Rico Contract (TPRC) healthcare contractor claims submitted for Active Duty Family Members (ADFMs) not enrolled in TOP Prime shall be paid following TOP Standard cost-sharing provisions. The overseas claims processing contractor's EOB shall advise the TGRO contractor/TPRC that the beneficiary was not enrolled in TOP Prime. Upon receipt of the EOB, the TGRO contractor/TPRC shall contact the appropriate overseas TAO Director for review of the enrollment problem. The beneficiary's enrollment will be corrected if the case warrants a retroactive enrollment per [Chapter 12, Section 3.2](#).

G. Overseas drug claims shall be paid following the guidelines outlined in the TRM, [Chapter 1, Section 15](#), and [Chapter 12, Section 11.1](#), TOP Prime and Standard cost share for pharmacy services are as outlined in [Chapter 12, Section 2.1](#).

H. Prior to payment, overseas ambulance service shall follow the CONUS medical necessity guidelines outlined in [Chapter 8, Section 1.1](#).

I. Payment may be made for TGRO contractor ambulance services provided by commercial transport (see [Chapter 12, Section 11.1, paragraph IV.A.5.b.\(2\)](#) for additional guidance on processing these claims).

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