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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 134
6010.55-M
JUNE 24, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

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

**CHANGE TITLE: SKILLED NURSING FACILITY (SNF) CARE PREAUTHORIZATION
REQUIREMENT FOR DUAL ELIGIBLE BENEFICIARIES**

CONREQ: 15000

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change adds language requiring preauthorization for SNF care for TRICARE dual eligibles in the U.S. and U.S. territories beginning on day 101, when TRICARE becomes primary payer.

EFFECTIVE DATE: April 1, 2010.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 123 and Aug 2002 TPM, Change No. 142.

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**ATTACHMENT(S): 25 PAGE(S)
DISTRIBUTION: 6010.55-M**

CHANGE 134
6010.55-M
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REMOVE PAGE(S)

CHAPTER 1

Section 28, pages 1 through 5

CHAPTER 8

Section 2, pages 3 through 16

Addendum A, pages 5 through 7

Addendum E (FY 2011), pages 9 and 10

INSERT PAGE(S)

Section 28, pages 1 through 5

Section 2, pages 3 through 16

Addendum A, pages 5 through 7

Addendum E (FY 2011), pages 9 and 10

REDUCTION OF PAYMENT FOR NONCOMPLIANCE WITH UTILIZATION REVIEW REQUIREMENTS

ISSUE DATE: July 17, 1996

AUTHORITY: [32 CFR 199.15\(b\)\(4\)\(iii\)](#) and [32 CFR 199.4\(a\)\(12\)](#)

I. ISSUE

Reduction of payment for noncompliance with utilization review requirements.

II. POLICY

In the case of a provider's failure to obtain a required preauthorization, the provider's payment shall be reduced by **10%** of the amount otherwise allowable. Under the managed care contracts, a network provider's payment can be subject to a greater than **10%** reduction or a denial if the network provider has agreed to such a reduction or denial in the agreement.

A. Types of Care Subject to Payment Reduction. For a provider's failure to obtain a required preauthorization or preadmission authorization, the provider's payment will be reduced in connection with the following types of care:

1. All non-emergency mental health admissions to hospitals.
2. All admissions for residential treatment, substance use disorder rehabilitation, and psychiatric partial hospitalization. None of these can be considered emergency care.
3. Psychoanalysis. It cannot be considered as an emergency service.
4. Adjunctive dental care.
5. Organ and stem cell transplants.
6. **Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories for TRICARE dual eligible beneficiaries once TRICARE is primary payer.**
7. All non-mental health admissions requiring a Non-Availability Statement (NAS) excluding routine OB and neonatal intensive care.

NOTE: For the admissions referred to in [paragraph II.A.7.](#), the reduction of payment is not applicable when a beneficiary has "other insurance" that provides primary coverage. See the TRICARE Policy Manual (TPM), [Chapter 1, Section 7.1, paragraph I.J., Note.](#)

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 1, SECTION 28

REDUCTION OF PAYMENT FOR NONCOMPLIANCE WITH UTILIZATION REVIEW REQUIREMENTS

8. Additional procedures and services as prescribed by the **Managed Care Support Contractors (MCSCs)** except when the beneficiary has "other insurance" as provided in the **TPM, Chapter 1, Section 7.1, paragraph I.J., Note.**

B. Applicability of Payment Reduction. This **TPM** section shall apply to participating (including network providers and participating Veterans Administration (**VA**) facilities) and nonparticipating providers. For a provider's failure to obtain the required preauthorization, the payment reduction shall be subject to the policy in this section.

1. In the case of an admission to a hospital, **Substance Use Disorder Rehabilitation Facility (SUDRF)**, **Residential Treatment Center (RTC)**, or a **Partial Hospitalization Program (PHP)** (or a SNF when applicable), under TRICARE Prime, Extra, or Standard, the payment reduction shall apply to the institutional charges and any associated professional charges of the attending or admitting provider. Services of other providers shall be subject to the payment reduction as provided under the network provider agreements.

2. The amount of the reduction for TRICARE Standard providers shall be **10%** of the amount otherwise allowable (consistent with **paragraph II.C., D., and E.**) for services for which preauthorization should have been obtained, but was not obtained.

3. The amount of the reduction for TRICARE Prime and Extra providers shall be in accordance with the provider's contract with the respective contractor, but not less than **10%**.

4. The payment reduction shall apply under the Point of Service (**POS**) option.

C. DRG-Reimbursed Facilities. In the case of admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100%) of the total reimbursement equal to the number of days of care provided without preauthorization, divided by the total length of stay for the admission. See example in **Chapter 3, Section 4.**

D. Non-DRG Facilities/Units (Includes RTCs, Mental Health Per Diem Hospitals and Partial Hospitalization Programs). In the case of admissions to non-DRG facilities/units, the reduction shall be taken only against the days of care provided without preauthorization. See example in **Chapter 3, Section 4.**

E. Care Paid on Per-Service Basis. For the care for which payment is on a per-service basis, e.g., outpatient adjunctive dental care, the reduction shall be taken only against the amount that relates to the services provided without prospective authorization. See example in **Chapter 3, Section 4.**

F. Determination of Days/Services Subject to Payment Reduction. For purposes of determining the days/services which will be subject to the payment reduction, the following shall apply:

1. When the request for authorization is made prior to the admission but is not received by the contractor until after the admission occurred, the days for payment reduction shall be counted from the date of admission to the date of receipt of the request by the contractor (not counting the date of receipt).

NOTE: In the case of alleged emergency care subsequently found not to meet the emergency criteria, the days for the payment reduction shall be counted according to this [paragraph II.F.1.](#)

2. When the request for authorization is made to the contractor after the admission occurred, the days for payment reduction shall be counted from the date of admission to the date of approval of the request by the contractor (not counting the date of approval).

3. For the care paid on a per-service basis, e.g., outpatient adjunctive dental care, payment reduction shall apply to those services/sessions provided prior to receipt of the authorization request by the contractor.

G. Other Health Insurance (OHI) and Beneficiary Cost-Share.

1. When a beneficiary has OHI that provides primary coverage, certain services shall not be subject to payment reduction. See [paragraph II.A.7.](#) and [paragraph II.A.8.](#)

2. The reduction of payment is calculated based on the otherwise allowable amount (consistent with [paragraph II.C., D., and E.](#)) before the application of deductible, beneficiary cost-share, and OHI.

3. The beneficiary is still required to pay a cost-share for the days or services for which the payment is reduced. The beneficiary cost-share shall be calculated applying the normal cost-share rules before the reduction is taken.

4. The amount applied/credited toward the deductible cannot be greater than the amount for which the beneficiary remains liable after the government payment.

H. Preauthorization Process.

1. Preauthorization may be requested from a contractor in person, by telephone, FAX, or mail. The date of receipt of a request shall be the date (business day) on which a contractor receives the request to authorize the medical necessity and appropriateness of care for which it has jurisdiction.

NOTE: The date a preauthorization request is mailed to the contractor and postmarked shall determine the date the request was made (not received). If a request for preauthorization does not have a postmark, it shall be deemed made on the date received by the contractor.

2. In general, the decision regarding the preauthorization shall be issued by the contractor within one business day of the receipt of a request from the provider, and shall be followed with a written confirmation (if initial notice is verbal).

3. A preauthorization is valid for the period of time, appropriate to the type of care involved. It shall state the number of days/type of care for which it is valid. In general, preauthorizations will be valid for 30 days. If the services are not obtained within the number of days specified, a new preauthorization request is required. For organ and stem cell transplants the preauthorization shall remain in effect as long as the beneficiary continues to

meet the specific transplant criteria set forth in the **TPM**, or until the approved transplant occurs.

I. Patient Not Liable. The patient (or the patient's family) may not be billed for the amount of the payment reduction due to the provider's noncompliance with the preauthorization requirements.

J. Emergency Admissions/Services.

1. Payment reductions shall not be applied in connection with bona fide emergency admissions or services. The authorization required for a continuation of services in connection with bona fide emergency admission will not be subject to payment reduction.

2. Contractor having jurisdiction for the medical review of the admission is required to review for emergency when requested by the provider. In addition to the review of alleged emergency admissions, the contractor is required to issue an initial determination providing the review decision which is appealable.

NOTE: Psychoanalysis and all admissions for residential treatment, substance use disorder rehabilitation, or psychiatric partial hospitalization are the types of services/admissions requiring preauthorization that cannot be considered as emergencies.

K. Waiver of Payment Reduction.

1. The contractor may waive the payment reduction only when a provider could not have known that the patient was a TRICARE beneficiary, e.g., when there is a retroactive eligibility determination by a Uniformed Service, or when the patient does not disclose eligibility to the provider.

2. The criteria for determining when a provider could have been expected to know of the preauthorization requirements shall be the same as applied under the Waiver of Liability provisions.

3. If at any time a payment reduction is revised after claims processing, claim processors will follow existing procedures for processing any resulting payment adjustments.

L. Appeal Rights.

1. The days/services for which the provider's payment is reduced are approved days/services and not subject to appeal.

2. The denial of a waiver request and clerical/calculation errors in connection with the payment reduction are not subject to appeal but are subject to administrative review by the contractor upon request.

3. Adverse decisions regarding alleged emergency admissions/services are appealable in cases involving payment reductions following the normal appeal procedures.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 1, SECTION 28

REDUCTION OF PAYMENT FOR NONCOMPLIANCE WITH UTILIZATION REVIEW REQUIREMENTS

M. Mental Health Day Limits. The days for which the provider payments are reduced count toward the applicable mental health day limits.

III. EFFECTIVE DATE March 1, 1997.

- END -

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002
CHAPTER 8, SECTION 2
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

1395x(h) and (i) and 42 CFR 409, Subparts C and D, except that the Medicare limitation on the number of days of coverage under section 1812(a) and (b) of the Social Security Act (42 U.S.C. 1395d(a) and (b)) and 42 CFR 409.61(b) shall not be applicable under TRICARE. This paragraph applies to SNF admissions on or after August 1, 2003. The provisions cited in this paragraph may be accessed at <http://www.gpoaccess.gov/>.

NOTE: Medicare co-insurance amounts do not apply to TRICARE when TRICARE is the primary payer. For TRICARE beneficiary cost-shares, see [Chapter 2](#).

A. Beneficiaries subject to the provisions of SNF PPS:

SNF PPS will apply to TRICARE beneficiaries who satisfy the qualifying coverage requirements of the TRICARE SNF benefit. The beneficiary must receive care from a Medicare-certified and TRICARE-certified SNF and must be assessed using the **Minimum Data Set (MDS)** assessment form. There are ten categories of beneficiaries who will be subject to the provisions of the SNF PPS if they satisfy the TRICARE SNF benefit coverage requirements.

1. Beneficiaries under age 65 who are not eligible for Medicare, but who satisfy the TRICARE SNF benefit coverage requirements, with no Other Health Insurance (OHI) [TRICARE is primary payer];
2. Beneficiaries under age 65 who are not eligible for Medicare, but who satisfy the TRICARE SNF benefit coverage requirements, with OHI (see [Chapter 4, Section 2, paragraph II.E.](#));
3. Beneficiaries under age 65 who are eligible for Medicare, with no OHI [TRICARE is secondary payer];
4. Beneficiaries under age 65 who are eligible for Medicare, with OHI [TRICARE is third payer];
5. Beneficiaries age 65 and over who are eligible for Medicare, with less than 100 day covered Medicare SNF stay, with no OHI [TRICARE is secondary payer];
6. Beneficiaries age 65 and over who are eligible for Medicare with less than a 100-day covered Medicare SNF stay, with OHI [TRICARE is third payer];
7. Beneficiaries age 65 and over who are eligible for Medicare and who have exhausted their Medicare SNF benefit by exceeding the 100 day stay maximum allowed by Medicare but who satisfy the TRICARE SNF benefit coverage requirements, with no OHI [TRICARE is primary payer];
8. Beneficiaries age 65 and over who are eligible for Medicare and who have exhausted their Medicare SNF benefit by exceeding the 100 day stay maximum allowed by Medicare but who satisfy the TRICARE SNF benefit coverage requirements, with OHI (see [Chapter 4, Section 2, paragraph II.E.](#));

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, SECTION 2

SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

9. Beneficiaries age 65 and over who are not eligible for Medicare but who satisfy the TRICARE SNF benefit coverage requirements, with no OHI [TRICARE is primary payer]; and

10. Beneficiaries age 65 and over who are not eligible for Medicare but who satisfy the TRICARE SNF benefit coverage requirements, with OHI (see [Chapter 4, Section 2, paragraph II.E.](#)).

Notes to [paragraph IV.A.](#): (1) SNF PPS will apply to Supplemental Care benefits for Active Duty Service Member (ADSM), Transitional Assistance Management Program (TAMP), and Continued Health Care Benefit Program (CHCBP). See [paragraph V.D., E., and F.](#)

(2) Beneficiaries under age 10 (on the date of SNF admission) and the Critical Access Hospital swing beds will not be subject to SNF PPS. Unless required in their Memorandum of Understanding (MOU) or Provider Agreement, Veteran Affairs (VA) facilities may not be subject to SNF PPS. However, these categories are not exempt from the SNF benefit requirements in [paragraph IV.C.3.](#)

B. For Admissions Before August 1, 2003: See [Chapter 8, Section 1.](#)

C. For Admissions on or after August 1, 2003, when TRICARE is Primary Payer:

1. TRICARE is the primary payer for SNF care for Medicare-eligible beneficiaries who have no OHI and who satisfy the TRICARE SNF qualifying coverage requirements (as discussed in [paragraph IV.C.3.](#) and [4.](#) below) after exhausting their 100 day covered Medicare SNF benefit. TRICARE is also the primary payer for non-Medicare-eligible TRICARE beneficiaries who have no OHI and who meet the TRICARE SNF coverage requirements. In both situations, TRICARE's coordination of benefit rules will determine TRICARE's status as primary payer.

2. **For TRICARE dual eligible beneficiaries,** the Medicare SNF benefit provides for 100 days of SNF care per benefit period. The Medicare benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive dates during which covered services furnished to a patient, up to certain specified maximum amounts, can be paid. This benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished SNF care. The benefit period ends with the close of a period of 60 consecutive days during which the patient did not receive hospital care or was not in a SNF. (A new benefit period starts when a beneficiary has not received hospital or SNF care for 60 days in a row). After the 100 days of Medicare-covered care, the TRICARE benefit becomes primary if the beneficiary continues to satisfy the TRICARE coverage requirements and has no OHI. After exhaustion of the Medicare 100 day benefit, a Medicare denial will be required for a SNF claim to be processed by TRICARE.

3. For a SNF admission to be covered under TRICARE, the beneficiary must both have a qualifying hospital stay of **three** consecutive days or more, not including the hospital discharge day, and the beneficiary must enter the SNF within 30 days of discharge from the hospital. **For TRICARE dual eligible beneficiaries, this requirement is already met before TRICARE becomes primary.** TRICARE and Medicare do make exceptions to this "within 30

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002
CHAPTER 8, SECTION 2
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

days” rule for those cases that require future therapy after 30 days (e.g., a hip fracture patient who can’t do weight-bearing exercises until after 30 days). TRICARE will follow Centers for Medicare and Medicaid Services (CMS) policy as provided in the Medicare Benefit Policy Manual, Chapter 8. Any application of the Medicare Benefit Policy Manual to TRICARE shall be subject to TRICARE requirements in the law, 32 CFR Part 199, and TRICARE manuals. The Medicare Benefit Policy Manual (Publication # 100-02) is an Internet Only Manual (IOM) and can be accessed at <http://www.cms.hhs.gov/manuals>. When TRICARE is the primary payer, it will be the responsibility of the contractor to determine whether the beneficiary has had a qualifying **three**-day inpatient stay and has met the **30**-day discharge standard. The contractor will use the information in blocks 35 **and** 36 of CMS 1450 UB-04 to make this determination. If blocks 35 **and** 36 of CMS 1450 UB-04 is blank, the SNF claim will be denied unless the patient was involuntarily disenrolled from Medicare+Choice plan (see [paragraph IV.C.4.](#)). The contractor will calculate the **Length-Of-Stay (LOS)** based on the SNF actual admission date provided on the CMS 1450 UB-04 claim form. Any adverse TRICARE determinations involving medical necessity issues will be appealable to TRICARE whenever TRICARE is the primary payer. However, a denial based on the factual dispute (not the medical necessity) of SNF benefit for failure to meet the **three**-day prior hospitalization of “within 30 days” requirement is not appealable. Any factual disputes surrounding the **three**-day prior hospitalization or “within 30 days” requirement can be submitted to the TRICARE contractor for an administrative review.

Notes to [paragraph IV.C.3.](#): (1) If the qualifying hospital stay is denied as not being medically necessary **and appropriate care**, the SNF admission will be denied. (2) If a beneficiary receives custodial, non-covered services, **or care at an inappropriate level** in a SNF for greater than 30 consecutive days, a new qualifying hospital stay requirement is to be met for a medically necessary SNF stay in order to be covered under TRICARE with the exception for medical appropriateness reasons as provided in the Medicare Benefit Policy Manual, Chapter 8.

4. Covered SNF services must meet the requirements in [32 CFR 199.4\(b\)\(3\)\(xiv\)](#) and are to be skilled services as provided in the Medicare Benefit Policy Manual, Chapter 8. Such skilled services must be for a medical condition that was either treated during the qualifying **three**-day hospital stay, or started while the beneficiary was already receiving covered SNF care. These coverage requirements are the same as applied under Medicare. TRICARE will follow CMS policy and waive the **three**-day prior hospitalization requirement for those **TRICARE dual eligible** beneficiaries involuntarily disenrolling from Medicare+Choice plans. Code 58 in the Condition Codes block in CMS 1450 UB-04 will be the indication that patient is a terminated enrollee in a Medicare+Choice Organization plan whose **three**-day inpatient hospital stay was waived.

Note to [paragraph IV.C.4.](#): With regard to the requirement that the skilled services must be for a medical condition that was treated during the qualifying **three**-day hospital stay, it will generally be presumed that this requirement is met if the qualifying **three**-day hospital requirement is met. When the facts which come to the attention of the contractor/claims processor in their normal review process indicate that the skilled services are not related to any of the diagnoses treated during the qualifying hospital stay, the SNF claim may be denied.

5. TRICARE reimbursement will follow Medicare's SNF prospective payment system (PPS) methodology and assessment schedule. However, if the SNF admission precedes the TRICARE implementation date of SNF PPS (regardless of the discharge date), all claims for that admission will be processed using the payment methodology as provided in [Chapter 8, Section 1, paragraph III.A.](#)

6. Under the SNF PPS methodology and assessment schedule system, the patient will be assessed upon admission to the SNF using the MDS assessment tool. The Nursing Home Reform Act of the Omnibus Budget Reconciliation Act (OBRA 1987) mandates that all certified long term care facilities must use the MDS as a condition of participating in Medicare or Medicaid which TRICARE is also adopting.

7. The MDS is a set of clinical and functional status measures that provides the basis for the Resource Utilization Group (RUG) classification system and the PPS. Nursing facilities must collect these data on each of their residents at prescribed intervals and upon any significant change in physical or mental condition. The MDS data are then used to classify residents into one of the SNF case-mix RUGs based on their clinical characteristics, functional status and expected resource needs. Until December 31, 2005, there were 44 RUGs (see [Addendum A, Figure 8-A-1](#)). Effective January 1, 2006, **nine** additional RUGs were added for a total of 53 RUGs (see [Addendum A, Figure 8-A-2](#)). Effective October 1, 2010, 13 additional RUGs were added for a total of 66 RUGs (see [Addendum A, Figure 8-A-3](#)).

8. SNF residents will be assessed by SNFs on days 5, 14, 30, 60, and 90. Thereafter, under TRICARE, the residents will be assessed every 30 days using the same MDS assessment form. For untimely assessments, there will be penalties similar to those used by CMS. In a case of untimely assessment, the SNF will submit the claim with a default rate code and the SNF will be reimbursed at the lowest RUG pricing. If a SNF resident returns to the SNF following a temporary absence for hospitalization or therapeutic leave, it will be considered a readmission.

9. SNFs are not required to assess a resident upon readmission, unless there has been a significant change in the resident's condition. If the resident experiences a significant change in condition (i.e. either an improvement or decline in the physical, mental or psychosocial level of well-being), the facility must complete a full comprehensive assessment by the end of the 14th calendar day following determination that a significant change has occurred. A "significant change" is defined as a major change in the resident's status that:

- a. Is not self-limiting (i.e. the condition will not normally resolve itself without further clinical intervention);
- b. Impacts on more than one area of the resident's health status; and
- c. Requires interdisciplinary review or revision of the care plan.

If a SNF has discharged a resident without the expectation that the resident would return, then the returning resident is considered a new admission (return stay) and would require an initial admission comprehensive assessment including Sections AB (Demographic Information) and AC (Customary Routine) of the assessment form within 14 days of admission.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002
CHAPTER 8, SECTION 2
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

10. SNFs are not required to automatically transmit MDS assessment data to the TRICARE contractors. However, the TRICARE contractor, at its discretion, may collect the MDS assessment data **and documentation for claim adjudication or audit and tracking purposes at any time** from SNFs when TRICARE is the primary payer. MDS forms and relevant background information may be found **on the following web sites:** http://www.cms.gov/NursingHomeQualityInits/25_NHOIMDS30.asp#TopOfPage, <http://www.cms.gov/medicaid/mds20/man-form.asp>, and <http://www.cms.hhs.gov/MinimumDataSets20/>. For **TRICARE dual eligible beneficiaries, during the first 100 days of an inpatient SNF stay**, TRICARE will function as a secondary payer to Medicare under SNF PPS in which case there is no need to collect the MDS assessment data. **At any time** TRICARE is primary payer, the MDS assessment data **may be collected** for audit and tracking purposes. **Effective for dates of service June 1, 2010, SNF care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Intermediary Contract (TDEFIC) contractor shall preauthorize SNF care beginning on day 101, when TRICARE is primary payer (see the TRICARE Policy Manual (TPM), Chapter 1, Section 7.1 and TRICARE Operations Manual (TOM), Chapter 7, Section 2).**

11. SNF staff will input the MDS assessment data into the MDS RUG-III/IV grouper, depending on the date of service. The Grouper will then generate an appropriate three-digit RUG-III/IV code. A complete listing of three-digit RUG-III/IV codes with corresponding definitions is included in **Addendum A**. To supplement the three-digit RUG-III/IV codes, the SNF will add the appropriate two-digit modifier to indicate the reason for the MDS assessment before submitting the claim for payment. The three-digit RUG-III/IV code and the two-digit modifier make up the five-digit Health Insurance Prospective Payment System (HIPPS) code. The assessment indicators and the HIPPS code information related to SNF are available at http://www.cms.hhs.gov/prospmedicarefeesvcpmgtgen/02_hippscodes.asp. The SNF will enter the HIPPS code on the CMS 1450 UB-04 claim form in the HCPCS code field that corresponds with the Revenue Code 022. After the 100th day, for TRICARE patients, SNFs will use an appropriate three-digit RUG-III/IV code with a TRICARE-specific two-digit modifier that makes up the HIPPS code. The TRICARE-specific two-digit modifiers will be as follows:

120-day assessment	8A
150-day assessment	8B
180-day assessment	8C
210-day assessment	8D
240-day assessment	8E
270-day assessment	8F
300-day assessment	8G
330-day assessment	8H
360-day assessment	8I
Post 360-day assessments with 30-day interval	8X

12. Upon completion of the requisite HIPPS coding, when TRICARE is the primary payer, the SNF will submit the claim to the TRICARE claims processor for payment only after the beneficiary has been admitted, has satisfactorily met the qualifying coverage criteria and

has had an appropriate MDS assessment completed. When TRICARE is the secondary payer, the claim will be submitted in accordance with standard billing procedures.

13. Consistent with Medicare's SNF PPS methodology, under the TRICARE SNF PPS:

a. The PPS payment rates will cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).

b. The PPS per diem payment rate is the sum of three parts - - the nursing component, the therapy component and the non-case-mix component. The nursing component includes nursing, social service and non-therapy ancillary costs (such as medications, laboratory tests, radiology procedures, respiratory therapy, medical supplies, and intravenous therapy). The therapy component includes physical, occupational and speech-language therapy costs. The non-case-mix component includes administrative, overhead and other generally fixed patient care costs (such as dietary services).

c. The MDS data are used to classify residents into one of the case-mix RUGs. (RUG-III was in place and effective prior to October 1, 2010. RUG-IV is effective on/after October 1, 2010). Each of these RUG subgroups is assigned a relative weight factor (when applicable) to determine the nursing component and the therapy component of the total PPS rate. The relative weight factor reflects the costliness of providing services to residents in that group relative to the average costliness of residents across all groups. The relative weight factor is multiplied by the applicable nursing or therapy base rate (urban or rural) which results in the nursing component and the therapy component of the total rate. Patients who are expected to be more resource-intensive (based on the MDS assessment), are assigned to a RUG-III/IV category that carries a higher relative weight factor. The non-case-mix component is not adjusted. The total PPS payment rate is the sum of the nursing component, the therapy component and the non-case-mix component. The labor portion of the total PPS payment rate is then adjusted for geographic variation in wages using the wage index. Contractors are not required to do these calculations as all of these calculations are automated in using the RUG-III/IV pricer software.

d. Section 4432(b) of the Balance Budget Act (BBA) of 1997 sets forth a consolidated billing requirement applicable to all SNFs providing Medicare services. Under this requirement, SNFs must submit to Medicare all bills for Medicare-covered services furnished to their residents, regardless of who provides the services. This requirement is similar to the requirement that has been in effect for inpatient hospital services. TRICARE is adopting the Medicare's consolidated billing requirements applicable to SNFs. Services excluded from consolidated billing have been mandated by the provisions of two separate pieces of legislation. First, there are several services that are beyond the general scope of SNF comprehensive care plans (excluded under 42 CFR 411.15 (p)(3)(iii)). Second, there are several other services excluded from consolidated billing per the provisions of Section 1882(c)(2)(A)(iii) of the Social Security Act, as amended by Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA). A comprehensive listing of these services excluded from consolidated billing is provided in [paragraph IV.C.13.e](#). The contractor will not issue benefit modifications for non-Medicare covered, medically necessary services for TRICARE beneficiaries receiving SNF care. There will be no benefit exceptions permitted. Services excluded from the consolidated billing provisions of the SNF PPS (e.g., cardiac catheterizations and emergency services, etc.) will be paid at the TRICARE rates.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002
CHAPTER 8, SECTION 2
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

e. The cost of the services listed below will be excluded from the SNF PPS rate. These services may be billed directly and paid separately using TRICARE rates. The “technical” component of a covered SNF service is included in the PPS rate **but** the “professional” component **shall** be billed separately. The identifying codes for contractor implementation of the Consolidated Billing (CB) provisions of the SNF PPS are provided at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>. This website provides the SNF CB annual updates in Excel and PDF formats. Annual update files, as well as subsequent quarterly updates (if any), for SNF CB can be found at the above website. This file lists services by HCPCS Code, Short Descriptors, and the Major Category under which the HCPCS falls. HCPCS added or removed by subsequent quarterly updates will be listed under the respective year’s annual update section at the above website. The respective year’s annual update file will be updated to add or remove the HCPCS listed in the quarterly updates. A separate file containing the explanation of the five Major Categories for SNF CB can also be found at the above website and it includes additional exclusions that are not driven by HCPCS codes (as some Major Categories exclude services by revenue code as well as bill types). These additional exclusions shall be included in SNF CB implementation. The effective dates for CB updates for TRICARE shall be the same as under Medicare and those will be provided with the CB updates at the above web site. With regard to the identifying codes for CB, contractors should program to call a table, so as changes occur the contractor can simply update or replace the table. No additional services will be added by the annual or quarterly updates related to CB; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Contractors will implement these updates within 30 days of release on the above website (unless the implementation date provided in the update allows for greater time for implementation) at no additional cost to the government. To implement this requirement, contractors shall check the above web site for annual SNF CB updates no later than the fifth business day in December for implementation in the following January each year. If the annual CB update is delayed by CMS (due to delay in the Medicare Physician Fee Schedule), contractors shall check the above CMS web site for annual CB updates by no later than the annual CHAMPUS Maximum Allowable Charge (CMAC) update for implementation within 30 days of the annual CMAC update. For quarterly SNF CB updates, contractors shall check the above CMS website no later than the fifth business day in March, June, and September of each year for implementation of any updates in April, July, and October of each year respectively. Contractors will closely monitor billings and claims to prevent any duplicate billings. Following is a list of services excluded from the SNF PPS and CB:

- (1) Services provided to individual SNF residents by authorized practitioners, such as, physicians, certified nurse-midwives, clinical psychologists, certified clinical social workers, nurse anesthetists;
- (2) Home dialysis supplies and equipment;
- (3) Erythropoietin (EPO) for dialysis patients as under Medicare;
- (4) Hospice care related to a beneficiary’s terminal condition. Such hospice care will be excluded from the consolidated billing provisions of the SNF PPS and will be reimbursed in accordance with the TRICARE hospice benefit.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, SECTION 2

SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

(5) An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge. If the beneficiary is a resident of the SNF, then ambulance services are covered under consolidated billing and are included in the bundled rate. The initial admission ambulance ride and the final discharge ambulance ride are not covered under consolidated billing because the patient is not considered a SNF resident. (42 CFR 411.15 (p)(3)(I)-(iv)). TRICARE will follow CMS policy for medical necessity for ambulance transportation (42 CFR 410.40(d)(1)) which is consistent with the TMA policy;

Note to [paragraph IV.C.13.e.\(5\)](#): If the beneficiary meets the criteria of a SNF resident, then ambulance transportation for “medically necessary” services are covered under consolidated billing and are included in the bundled SNF PPS rate. However, when a SNF resident leaves the SNF to receive any outpatient hospital services that are specifically excluded from consolidated billing (e.g., cardiac catheterization, CT scans, Magnetic Resonance Imagings (MRIs), emergency room services, etc.), then that beneficiary is no longer considered to be a SNF resident for consolidated billing purposes. As such, any associated ambulance trips themselves would be excluded from consolidated billing. Such ambulance trips associated with the receipt of excluded services are not included in the bundled SNF PPS rate and may be billed separately to Part B (Medicare) and TRICARE. If the beneficiary leaves the SNF to receive outpatient hospital services that are excluded from consolidated billing, then by definition that beneficiary no longer retains the status of a SNF “resident”. See Medicare fact sheet regarding consolidated billing and ambulance services at [Addendum C](#) which is being adopted for TRICARE.

(6) Chemotherapy items and administration services;

(7) Radioisotope services;

(8) Customized prosthetic devices;

(9) Ambulance transportation for dialysis;

(10) Certain outpatient services when provided in a hospital (including associated medically indicated ambulance transport) as these services are considered beyond the scope of the SNF care. Pre-authorization of MRIs for SNF residents would be subject to MCSC discretion:

- Cardiac catheterization
- CT scans
- MRIs
- Ambulatory surgery performed in operating rooms
- Emergency services
- Radiation therapy
- Angiography
- Venous and lymphatic procedures.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002
CHAPTER 8, SECTION 2
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

Note to [paragraph IV.C.13.e.\(10\)](#): If the listed service is delivered in another setting (such as an ambulatory surgery center or imaging center) or if another (not excluded) service is provided in a hospital outpatient department (such as an x-ray), the beneficiary is still considered a SNF resident, and the service, and payment for it, is included in the SNF PPS rate.

(11) Additional services as identified in SNF CB updates at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>.

f. If the SNF submits a PPS claim that also includes an excluded service (see [paragraph IV.C.13.e.](#)), the service that is excluded will be ignored and the claim will process and pay as it would without the excluded service. The SNF PPS claims are priced strictly on the RUG-III groups, and none of the ancillaries are themselves paid. If the SNF claim is just for the excluded service that SNFs may not bill, the claim will be rejected, and an explanation should appear on the explanation of benefits. This is similar to a denial, but does not carry appeal rights.

14. SNF Pricer.

a. TMA will provide the annual SNF PPS pricer cartridge to the claims processors with the issuance of this instruction. Any updated pricer cartridge will be provided to the claims processors upon receipt from CMS (annually and/or about each quarter) and the claims processors are required to replace the existing pricer with the updated pricer within 10 calendar days of receipt. As the annual or quarterly pricer cartridge totally replaces the previous pricer, claims processors are not required to maintain quarterly iterations. Claims processors must maintain the last version of the pricer software for each prior fiscal year and the most recent quarterly release of the current fiscal year.

b. Claims processors will use the 100% of the PPS rate and override any rate that is less than 100% of the PPS rate. For the call to the SNF pricer the claims processors should use the following:

- (1) HIPPS = HIPPS code from claim
- (2) EFFECTIVE DATE = end date of service or through date from claim
- (3) FEDERAL BLEND = 4
- (4) FACILITY RATE = 0

The federal blend and facility rate fields were used to provide a percentage mixture between straight PPS and facility rate payments. During Medicare's phase in period Federal blend went from 0 - 4 and this caused a percentage of the facility rate to be part of the PPS calculations. Now that the PPS is fully phased in TRICARE will use Federal Blend of 4 and no percentage of the old facility rate.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, SECTION 2

SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

c. The pricer will automatically give the contractor the calculated rate for a one day stay for the claim's dates of service. Contractors will need to multiply the PPS rate given to the revenue 022 line units on the claim to come up with the complete rate for that HIPPS claim line.

d. Claims processors will not need to split claims when an SNF admission cross fiscal year dates. Providers are to prepare separate bills for services prior to and on or after October 1 as the SNF PPS rate is updated for each fiscal year. This split billing by providers ensures that the claim is paid using the correct rate.

Note to [paragraph IV.C.14.d.](#): The provider shall bill the appropriate RUG category based on the calendar date of service. For days of service before January 1, 2006, the provider shall record the 44-group RUG on the claim. For days of services beginning on or after January 1, 2006, the provider shall record the 53-group RUG on the claim. For days of services beginning on or after October 1, 2010, the provider shall record the 66-group RUG on the claim.

e. For information purposes, the Policy and Statistical Analysis Services contractor will electronically transmit the current Wage Index file, the SNF PPS rates, and other related updates annually to TMA. These will be issued as routine changes to [Addendums A, B, D, E, and F](#), as applicable. Contractors do not need to wait for issuance of these routine changes for implementation, as the SNF rate, wage index, and these updates are built into the SNF Pricer. See [paragraph IV.C.14.a.](#) regarding implementation of the SNF Pricer.

15. If the SNF does an off-schedule assessment, a late patient assessment or, in some cases, no patient assessment at all, the SNF will submit the claim using the default HIPPS rate code of AAA and the two-digit default assessment indicator modifier code of 00 which will result in payment of the Default rate.

16. With regard to payment for the lower 18 RUGs (i.e., IB2, IB1, IA2, IA1, BB2, BB1, BA2, BA1, PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1), for services prior to October 1, 2010, and the lower 14 RUGs (i.e., BB2, BA2, BB1, BA1, PE2, PD2, PC2, PB2, PA2, PE1, PD1, PC1, PB1, PA1) for services on/after October 1, 2010, TRICARE will follow the SNF level of care criteria as provided in the Medicare Benefit Policy Manual, Chapter 8 (Publication # 100-02), which can be accessed at <http://www.hhs.gov/manuals>. Beneficiaries in the lower 14 RUGs do not automatically qualify for SNF coverage. Instead, these beneficiaries will be individually reviewed to determine whether they meet criteria for skilled services and the need for skilled services as defined in 42 CFR 409.32, Subpart D, which can be accessed at <http://www.gpoaccess.gov/>. In determining "medical necessity", the contractor will use generally acceptable criteria such as InterQual. If SNF services are determined not to be medically necessary under Medicare, they will not be covered under TRICARE.

Note to [paragraph IV.C.16.](#): Prior to January 1, 2006, the upper 26 RUGs (i.e., the first 26 RUGs listed in [Addendum A, Figure 8-A-1](#)) represent the required SNF level of care during the immediate post-hospital period. With the addition of nine new RUGs, effective January 1, 2006, the upper 35 RUGs (i.e., the first 35 RUGs listed in [Addendum A, Figure 8-A-2](#)) represent the required SNF level of care during the immediate post-hospital period. With the addition of 13 new RUGs, effective October 1, 2010, the upper 52 RUGs (i.e., the first 52

RUGs listed in [Addendum A, Figure 8-A-3](#)) represent the required SNF level of care during the immediate post-hospital period. A beneficiary who is correctly assigned to one of the upper RUGs under the initial five-day assessment is automatically classified as meeting the SNF level of care definition and does not require a medical review unless there is a reason to do so (e.g., data analysis suggests an unusual pattern of claims submission). When a beneficiary is correctly assigned to one of the upper RUG-III/IV groups, depending on the date of service, under the initial five-day assessment, the SNF level of care requirement is met for the period from SNF admission up to and including the assessment reference date for that assessment. This presumption of coverage only applies if the beneficiary is admitted to the SNF immediately following a three-day qualifying hospital stay, and lasts through the assessment reference date of the five-day assessment, which must occur no later than the **eighth** day of the stay due to the three-day grace period for SNF assessments.

NOTE: For TRICARE dual eligible beneficiaries: Medicare is primary payer during the presumption of coverage period; therefore, TRICARE will follow Medicare's determination. If the services are determined not to be medically necessary under Medicare, they will not be covered under TRICARE. Effective for dates of service June 1, 2010, SNF care received in the U.S. and U.S. territories will require preauthorization. The TDEFIC will preauthorize care beginning on day 101, when TRICARE becomes primary payer.

17. If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE. The cover letter to SNFs and the Participation Agreement are provided at [Addendum G](#) which the contractor will send to SNFs. SNFs must provide evidence that they are certified by Medicare (or Medicaid). The contractor will be responsible for verification that the SNF is Medicare-certified (or Medicaid-certified), and has entered into a Participation Agreement with TRICARE. TRICARE will not permit a waiver to allow non-Medicare (or non-Medicaid) certified SNFs to be authorized SNFs under TRICARE. Non-participating SNFs will not be eligible for reimbursement under TRICARE. If a PPS claim is received from a SNF that has not signed a TRICARE Participation Agreement, the contractor will deny the claim and send a Participation Agreement to the SNF for signature. Once the SNF has signed the Participation Agreement, the claim will be processed provided the SNF was Medicare (or Medicaid) certified and met all other TRICARE SNF criteria at the time when the services were furnished to the TRICARE beneficiary.

Note to [paragraph IV.C.17.](#): VA facilities are required to be Medicare approved or they are required to be Joint Commission accredited in order to have deemed status under Medicare or TRICARE. The VA facilities that enter into an MOU with the Department of Defense (DoD) are not required to enter into the Participation Agreement provided at [Addendum G](#).

18. At their own discretion, the contractors may conduct any data analysis to identify aberrant PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG.

19. Refer to the TRICARE Systems Manual ([TSM](#)), [Chapters 2](#) and [4](#) for the SNF PPS related revenue and edit codes.

D. For Admissions on or after August 1, 2003, when TRICARE is Secondary Payer to Medicare:

1. TRICARE is the secondary payer to Medicare for SNF care for beneficiaries under age 65 who are eligible for Medicare, with no OHI and for beneficiaries age 65 and over who are eligible for Medicare with less than a 100-day covered Medicare SNF stay with no OHI.

2. The beneficiary has no liability under Medicare for days 1 through 20; therefore, there will not be any unpaid amount for TRICARE to reimburse until day 21. For days 21 to 100, the beneficiary does have a cost-share for which TRICARE will pay the remaining liability as secondary payer.

3. The Medicare-eligible patient will be assessed by the SNF using the MDS.

4. The MDS data will be run through the MDS RUG-III/IV grouper to generate a three-digit RUG-III/IV code. (RUG-III was in place and effective prior to October 1, 2010. RUG-IV is effective on/after October 1, 2010). The RUG grouper software assigns a RUG code for billing and payment purposes. Each Medicare-certified SNF must process the MDS assessment data by using the appropriate RUG grouper, depending on the date of service. A two-digit modifier will be added to this to get the five-digit HIPPS code which the SNF will put on the claim and send that to the Medicare claims processor for payment.

5. For TRICARE **dual eligible** beneficiaries, the Medicare claims processor will pay the SNF claim as the primary payer and then electronically submit the claim to the TRICARE contractor for secondary payer purposes.

6. For a beneficiary who is both Medicare and TRICARE eligible, TRICARE can pay secondary for a SNF that participates in Medicare and has entered into a Participation Agreement with TRICARE. Upon exhaustion of Medicare benefits, TRICARE may pay primary to such SNFs.

7. As secondary payer, TRICARE will use Medicare's determination of coverage rather than performing an additional review. If Medicare denies the services as not medically necessary, TRICARE will also deny the care and the beneficiary will have appeal rights through Medicare.

V. MISCELLANEOUS POLICY

A. TMA will follow CMS policy regarding use of the default payment rate whenever the SNF does an off-schedule assessment, a late patient assessment, or in some cases, no patient assessment at all (but can prove patient eligibility). The default payment will always be equal to the lowest RUG group rate (currently, this is the payment rate for PA1).

B. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard **and** Extra patients when TRICARE is the primary payer. The review required for the lower 18 RUGs (services prior to October 1, 2010) and lower 14 RUGs (services effective October 1, 2010) is a requirement for all TRICARE patients when TRICARE is primary (see [paragraph IV.C.16](#)). There will be no review for Standard **and** Extra patients

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002
CHAPTER 8, SECTION 2
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

C. Effective for dates of service **June 1, 2010**, SNF care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TDEFIC contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. In the event that TRICARE is the primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review. The payment reduction may be applied in these cases. There will be no review when TRICARE is the secondary payer.

D. Supplemental care benefits for ADSM will be paid according to the TRICARE SNF PPS. If the ADSM is enrolled to a Military Treatment Facility (MTF), this care must be approved by the MTF. Otherwise the care will be approved by the Service Point of Contact/Military Medical Support Office (SPOC/MMSO). TRICARE will pay the claim and the ADSM will not have any out-of-pocket expense.

E. SNF PPS will apply to TAMP beneficiaries.

F. SNF PPS will apply to CHCBP beneficiaries.

G. SNF PPS claims are required to be filed sequentially at least every 30 days. Current timeliness standards will continue to apply which require claims to be filed within one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. If a claim is not filed sequentially, the contractor may return that to the submitting SNF.

H. TRICARE will allow those hospital-based SNFs with medical education costs to request reimbursement for those expenses. Only medical education costs that are allowed under the Medicare SNF PPS will be considered for reimbursement. These education costs will be separately invoiced by hospital-based SNFs on an annual basis as part of the reimbursement process for hospitals (see [Chapter 6, Section 8](#)). Hospitals with SNF medical education costs will include appropriate lines from the cost report and the ratio of TRICARE days/total facility days. The product will equal the portion that TRICARE will pay. TRICARE days do not include any days determined to be not medically necessary, and days included on claims for which TRICARE made no payment because other health insurance or Medicare paid the full TRICARE allowable amount. The hospital's reimbursement requests will be sent on a voucher to the TMA Finance Office for reimbursement as a pass through cost.

I. Swing Bed Providers.

1. TRICARE will follow CMS policy regarding swing bed providers. To be reimbursed under SNF PPS, a hospital must be certified as a swing bed provider by CMS.

2. TRICARE will exempt Critical Access Hospital (CAH) swing beds from the SNF PPS. Section 203 of the Medicare, Medicaid, and **State Children's Health Insurance Program (SCHIP)** Benefits Improvement and Protection Act of 2000 [Public Law 106-554], exempted

CAH swing beds from the SNF PPS. Accordingly, it will not be necessary to complete an MDS assessment for CAH swing bed SNF resident. The CAH will directly bill the claims processor for the services received. Under the TRICARE benefit, CAHs will be reimbursed for their swing bed SNF services based on the reasonable cost method, reference [Chapter 15, Section 1](#). Currently, the list of current CAHs can be accessed at <http://www.flexmonitoring.org>.

3. The CAH swing bed claims can be identified by the Medicare provider number (CMS 1450 UB-04). There are two provider numbers issued to each CAH with swing beds. One number is all numeric and the second number is an alpha "z" in the third-digit. For example, the acute beds would use 131300 and the swing beds 13z300. Other than the "z" the numbers are identical. The first two-digits identifies the State code, and the 1300-1399 series identifies the CAH category.

J. Children under age 10 at the time of admission to a SNF will not be assessed using the MDS. TRICARE contractors will determine whether SNF services for these pediatric residents are covered based on the criteria of skilled services defined in 42 CFR 409.32, Subpart D and the Medicare Benefit Policy Manual, Chapter 8. The criteria used to determine SNF coverage for a child under the age of 10 will be the same whether that child is or is not Medicare-eligible. SNF benefit requirements will apply to these pediatric patients. SNF care for children under age 10 will be paid as provided in [Chapter 8, Section 1, paragraph III.A](#). The TRICARE contractor will have the ability to negotiate these reimbursement rates.

K. The Waiver of Liability provisions in the TPM, [Chapter 1, Section 4.1](#) apply to SNF cases.

- END -

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, ADDENDUM A

RUG-III/IV

FIGURE 8-A-3 RUG-66 CATEGORY (RUG-IV EFFECTIVE OCTOBER 1, 2010)

RUG-66 CODE	CATEGORY AND DEFINITION	ADL INDEX
REHABILITATION PLUS EXTENSIVE SERVICES GROUPS		
RUX	Rehabilitation, Ultra High, Plus Extensive Services, High	11-16
RUL	Rehabilitation, Ultra High, Plus Extensive Services, Low	2-10
RVX	Rehabilitation, Very High, Plus Extensive Services, High	11-16
RVL	Rehabilitation, Very High, Plus Extensive Services, Low	2-10
RHX	Rehabilitation, High, Plus Extensive Services, High	11-16
RHL	Rehabilitation, High, Plus Extensive Services, Low	2-10
RMX	Rehabilitation, Medium, Plus Extensive Services, High	11-16
RML	Rehabilitation, Medium, Plus Extensive Services, Low	2-10
RLX	Rehabilitation, Low, Plus Extensive Services	2-16
REHABILITATION GROUPS		
RUC	Rehabilitation, Ultra High	11-16
RUB	Rehabilitation, Ultra High	6-10
RUA	Rehabilitation, Ultra High	0-5
RVC	Rehabilitation, Very High	11-16
RVB	Rehabilitation, Very High	6-10
RVA	Rehabilitation, Very High	0-5
RHC	Rehabilitation, High	11-16
RHB	Rehabilitation, High	6-10
RHA	Rehabilitation, High	0-5
RMC	Rehabilitation, Medium	11-16
RMB	Rehabilitation, Medium	6-10
RMA	Rehabilitation, Medium	0-5
RLB	Rehabilitation, Low	11-16
RLA	Rehabilitation, Low	0-10
EXTENSIVE SERVICES		
ES3	Tracheostomy & Ventilator/Respirator	2-16
ES2	Tracheostomy & Ventilator/Respirator	2-16
ES1	Isolation for Active Infectious Disease	2-16
SPECIAL CARE HIGH		
HE2	Clinically High with Depression	15-16
HD2	Clinically High with Depression	11-14
HC2	Clinically High with Depression	6-10
HB2	Clinically High with Depression	2-5
HE1	Clinically High	15-16

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, ADDENDUM A

RUG-III/IV

FIGURE 8-A-3 RUG-66 CATEGORY (RUG-IV EFFECTIVE OCTOBER 1, 2010) (CONTINUED)

RUG-66 CODE	CATEGORY AND DEFINITION	ADL INDEX
HD1	Clinically High	11-14
HC1	Clinically High	6-10
HB1	Clinically High	2-5
SPECIAL CARE LOW		
LE2	Clinically Low with Depression	15-16
LD2	Clinically Low with Depression	11-14
LC2	Clinically Low with Depression	6-10
LB2	Clinically Low with Depression	2-5
LE1	Clinically Low	15-16
LD1	Clinically Low	11-14
LC1	Clinically Low	6-10
LB1	Clinically Low	2-5
CLINICALLY COMPLEX		
CE2	Clinically Complex with Depression	15-16
CD2	Clinically Complex with Depression	11-14
CC2	Clinically Complex with Depression	6-10
CB2	Clinically Complex with Depression	2-5
CA2	Clinically Complex with Depression	0-1
CE1	Clinically Complex	15-16
CD1	Clinically Complex	11-14
CC1	Clinically Complex	6-10
CB1	Clinically Complex	2-5
CA1	Clinically Complex	0-1
BEHAVIOR SYMPTOMS AND COGNITIVE PERFORMANCE		
BB2	Nursing Rehab 2+	2-5
BA2	Nursing Rehab 2+	0-1
BB1	Nursing Rehab 0 to 1	2-5
BA1	Nursing Rehab 0 to 1	0-1
PHYSICAL FUNCTION REDUCED		
PE2	Physical Function Reduced, with Nursing Rehab 2+	15-16
PD2	Physical Function Reduced, with Nursing Rehab 2+	11-14
PC2	Physical Function Reduced, with Nursing Rehab 2+	6-10
PB2	Physical Function Reduced, with Nursing Rehab 2+	2-5
PA2	Physical Function Reduced, with Nursing Rehab 2+	0-1
PE1	Physical Function Reduced, with Nursing Rehab 0 to 1	15-16

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, ADDENDUM A

RUG-III/IV

FIGURE 8-A-3 RUG-66 CATEGORY (RUG-IV EFFECTIVE OCTOBER 1, 2010) (CONTINUED)

RUG-66 CODE	CATEGORY AND DEFINITION	ADL INDEX
PD1	Physical Function Reduced, with Nursing Rehab 0 to 1	11-14
PC1	Physical Function Reduced, with Nursing Rehab 0 to 1	6-10
PB1	Physical Function Reduced, with Nursing Rehab 0 to 1	2-5
PA1	Physical Function Reduced, with Nursing Rehab 0 to 1	0-1

- END -

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, ADDENDUM E (FY 2011)

WAGE INDEXES FOR URBAN AREAS FOR SNFS BASED ON CBSA LABOR MARKET
AREAS - FISCAL YEAR 2011

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
35840	Berrien, MI North Port-Bradenton-Sarasota-Venice, FL Manatee, FL Sarasota, FL	0.9481	36780	Osceola, FL Seminole, FL Oshkosh-Neenah, WI Winnebago, WI	0.9566	38060	Phoenix-Mesa-Scottsdale, AZ Maricopa, AZ Pinal, AZ	1.0642
35980	Norwich-New London, CT New London, CT	1.1215	36980	Owensboro, KY Davies, KY Hancock, KY McLean, KY	0.8370	38220	Pine Bluff, AR Cleveland, AR Jefferson, AR Lincoln, AR	0.8012
36084	Oakland-Fremont-Hayward, CA Alameda, CA Contra Costa, CA	1.6354	37100	Oxnard-Thousand Oaks-Ventura, CA Ventura, CA	1.2377	38300	Pittsburgh, PA Allegheny, PA Armstrong, PA	0.8605
36100	Ocala, FL Marion, FL	0.8468	37340	Palm Bay-Melbourne-Titusville, FL Brevard, FL	0.9211		Beaver, PA Butler, PA Fayette, PA	
36140	Ocean City, NJ Cape May, NJ	1.0879	37380	Palm Coast, FL Flagler, FL	0.8405		Washington, PA Westmoreland, PA	
36220	Odessa, TX Ector, TX	0.9436	37460	Panama City-Lynn Haven, FL Bay, FL	0.7954	38340	Pittsfield, MA Berkshire, MA	1.0371
36260	Ogden-Clearfield, UT Davis, UT Morgan, UT Weber, UT	0.9267	37620	Parkersburg-Marietta-Vienna, WV-OH Washington, OH Pleasants, WV	0.7455	38540	Pocatello, ID Bannock, ID Power, ID	0.9507
36420	Oklahoma City, OK Canadian, OK Cleveland, OK Grady, OK Lincoln, OK Logan, OK McClain, OK Oklahoma, OK	0.8877		Wirt, WV Wood, WV		38660	Ponce, PR Juana Diaz, PR Ponce, PR Villalba, PR	0.4326
36500	Olympia, WA Thurston, WA	1.1269	37700	Pascagoula, MS George, MS Jackson, MS	0.8299	38860	Portland-South Portland-Biddeford, ME Cumberland, ME Sagadahoc, ME York, ME	0.9899
36540	Omaha-Council Bluffs, NE-IA Harrison, IA Mills, IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Saunders, NE Washington, NE	0.9583	37764	Peabody, MA Essex, MA	1.0979			
			37860	Pensacola-Ferry Pass-Brent, FL Escambia, FL	0.8254	38900	Portland-Vancouver-Beaverton, OR-WA Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA Skamania, WA	1.1476
			37900	Santa Rosa, FL Peoria, IL Marshall, IL Peoria, IL Stark, IL Tazewell, IL Woodford, IL	0.9149			
			37964	Philadelphia, PA Bucks, PA Chester, PA	1.0803	38940	Port St. Lucie, FL Martin, FL St. Lucie, FL	1.0723
36740	Orlando-Kissimmee, FL Lake, FL Orange, FL	0.9163		Delaware, PA Montgomery, PA Philadelphia, PA		39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess, NY	1.1354

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 8, ADDENDUM E (FY 2011)

WAGE INDEXES FOR URBAN AREAS FOR SNFs BASED ON CBSA LABOR MARKET AREAS - FISCAL YEAR 2011

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
39140	Orange, NY Prescott, AZ Yavapai, AZ	1.2234		King William, VA Louisa, VA New Kent, VA			Placer, CA Sacramento, CA Yolo, CA	
39300	Providence-New Bedford-Fall River, RI-MA Bristol, MA Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.0714		Powhatan, VA Prince George, VA Sussex, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA		40980	Saginaw-Saginaw Township North, MI Saginaw, MI	0.8728
39340	Provo-Orem, UT Juab, UT Utah, UT	0.9321	40140	Riverside-San Bernardino-Ontario, CA Riverside, CA San Bernardino, CA	1.1570	41060	St. Cloud, MN Benton, MN Stearns, MN	1.1042
39380	Pueblo, CO Pueblo, CO	0.8721		Roanoke, VA	0.8827	41100	St. George, UT Washington, UT	0.9133
39460	Punta Gorda, FL Charlotte, FL	0.8759		Botetourt, VA Craig, VA Franklin, VA Roanoke, VA		41140	St. Joseph, MO-KS Doniphan, KS Andrew, MO Buchanan, MO DeKalb, MO	1.0302
39540	Racine, WI Racine, WI	1.0580	40220	Roanoke, VA	0.8827	41180	St. Louis, MO-IL Bond, IL Calhoun, IL Clinton, IL Jersey, IL Macoupin, IL Madison, IL Monroe, IL St. Clair, IL Crawford, MO Franklin, MO Jefferson, MO Lincoln, MO St. Charles, MO St. Louis, MO Warren, MO Washington, MO St. Louis City, MO	0.9090
39580	Raleigh-Cary, NC Franklin, NC Johnston, NC Wake, NC	0.9811		Roanoke City, VA Salem City, VA				
39660	Rapid City, SD Meade, SD Pennington, SD	1.0442	40340	Rochester, MN Dodge, MN Olmsted, MN Wabasha, MN	1.0942			
39740	Reading, PA Berks, PA	0.8904	40380	Rochester, NY Livingston, NY Monroe, NY	0.8595			
39820	Redding, CA Shasta, CA	1.4134		Ontario, NY Orleans, NY Wayne, NY				
39900	Reno-Sparks, NV Storey, NV Washoe, NV	1.0419	40420	Rockford, IL Boone, IL	1.0033	41420	Salem, OR	1.1133
40060	Richmond, VA Amelia, VA Caroline, VA Charles City, VA Chesterfield, VA Cumberland, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA King and Queen, VA	0.9661	40484	Winnebago, IL Rockingham, NH Strafford, NH	1.0026	41500	Salinas, CA Monterey, CA	1.5686
			40580	Rocky Mount, NC Edgecombe, NC Nash, NC	0.9034	41540	Salisbury, MD Somerset, MD Wicomico, MD	0.9005
			40660	Rome, GA Floyd, GA	0.8635	41620	Salt Lake City, UT Salt Lake, UT Summit, UT Tooele, UT	0.9266
			40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado, CA	1.4053			