



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 147  
6010.55-M  
APRIL 5, 2012**

**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:** CODING AND REIMBURSEMENT UPDATES

**CONREQ:** 15765

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** See page 3.

**EFFECTIVE DATE:** January 1, 2012: Chapter 12 changes.  
All other changes: As indicated, otherwise upon direction of the Contracting Officer.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**This change is made in conjunction with Aug 2002 TPM, Change No. 155.**

*Ann N. Fazzini*

**Ann N. Fazzini  
Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S): 138 PAGE(S)  
DISTRIBUTION: 6010.55-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 147**  
**6010.55-M**  
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**REMOVE PAGE(S)**

**CHAPTER 6**

Section 8, pages 3 through 22

**CHAPTER 7**

Addendum G (FY 2010), pages 1, 2, 5, and 6

Addendum G (FY 2011), pages 1 through 7

Addendum G (FY 2012), pages 1 through 7

**CHAPTER 12**

Table of Contents, pages i through v

Section 1, pages 7 and 8

Section 4, pages 11 through 33

Section 6, pages 21 through 47

Addendum B, pages 1 through 11

Addendum J, pages 1 through 76

Addendum L (CY 2009), pages 1 through 3

★ ★ ★ ★ ★ ★

Addendum M (CY 2009), pages 1 through 17

★ ★ ★ ★ ★ ★

**INDEX**

pages 7 through 10

**INSERT PAGE(S)**

Section 8, pages 3 through 22

Addendum G (FY 2010), pages 1, 2, 5, and 6

Addendum G (FY 2011), pages 1 through 7

Addendum G (FY 2012), pages 1 through 7

Table of Contents, pages i through vi

Section 1, pages 7 and 8

Section 4, pages 11 through 36

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Addendum B, pages 1 through 11

Addendum J, page 1

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Addendum L (CY 2012), pages 1 through 5

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Addendum M (CY 2012), pages 1 through 17

pages 7 through 10

## **SUMMARY OF CHANGES**

### **CHAPTER 6**

1. Section 8. Provides instruction on obtaining the Capital and Direct Medical Education (Cap/DME) costs from the 2011 Medicare cost reports.

### **CHAPTER 7**

2. Addendum G (FY 2010). Annual updates for RTCs.
3. Addendum G (FY 2011). Annual updates for RTCs.
4. Addendum G (FY 2012). Annual updates for RTCs.

### **CHAPTER 12**

5. Table of Contents. Deleted Addendum L (CY 2009) and Addendum M (CY 2009). Added Addendum L (CY 2012) and Addendum M (CY 2012).
6. Section 1. Provides cross-references for CY 2012.
7. Section 4. Adds case-mix adjustment variables and scores for Episodes Ending On or After January 1, 2012 and adds references to CY 2012.
8. Section 6. Revises HCPCS code descriptions.
9. Addendum B. Routine updates to the HCPCS codes.
10. Addendum J. Refers the reader to the TRICARE web site for Pricer information.
11. Addendum L (CY 2009). Deleted Annual HHA PPS Rate-CY 2009.
12. Addendum L (CY 2012). Added Annual HHA PPS Rate-CY 2012.
13. Addendum M (CY 2009). Deleted Annual HHA PPS Wage Index-CY 2009.
14. Addendum M (CY 2012). Added Annual HHA PPS Wage Index-CY 2012.

### **INDEX**

15. Deleted Addendum L (CY 2009) and Addendum M (CY 2009). Added Addendum L (CY 2012) and Addendum M (CY 2012).



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e. To obtain the total allowable capital costs from the Medicare cost reports as of October 1992, the contractor shall add the figures from Worksheet D, Part 1, Columns 3 and 6, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2, lines 37-63. The capital payment shall then be reduced by the applicable percentages and time periods outlined in [paragraph III.B.1.a.](#)

NOTE: The instructions provided in May 1996 TRICARE/CHAMPUS Policy Manual, Change 35, published on November 4, 1998, incorrectly eliminated allowable capital costs for lines 29 and 30 from Worksheet D, Part I, Column 1, and lines 60-63 from Worksheet D, Part II, Columns 1 and 2. The contractor is not required to identify those finalized reimbursement requests processed under the instructions outlined in May 1996 TRICARE/CHAMPUS Policy Manual, Change 35, however, if the hospital requests reimbursement for the above listed costs, the contractor shall reprocess the request accordingly.

f. The instructions outlined in [paragraph III.B.1.a.](#) and [e.](#), are effective for initial and amended requests received on or after October 1, 1998.

[g.](#) To obtain the total allowable capital costs from the Medicare cost reports as of November 2011, the contractor shall add the figures from Worksheet D, Part I, Column 3, lines 30-34, and 43, to the figures from Worksheet D, Part II, Column 1, lines 50-93.

[h.](#) The instructions outlined in [paragraph III.B.1.g.](#), are effective for initial and amended requests received on or after November 1, 2011.

i. Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

- (1) The capital-related equipment is leased or rented by the provider;
- (2) The capital-related equipment is located on the provider's premises; and
- (3) The capital-related portion of the charge is separately specified in the charge to the provider.

2. Direct medical education costs. TRICARE/CHAMPUS will reimburse hospitals their actual direct medical education costs as reported annually to the contractor (see below). Such direct medical education costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs will be made annually and will be calculated using the same steps required for calculating capital payments below. Allowable direct medical education costs are those specified in Medicare

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Regulation Section 413.85. See [Chapter 3, Section 2](#) for the procedures for paying direct medical education costs.

a. Direct medical education costs generally include:

(1) Formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution.

(2) Nursing schools.

(3) Medical education of paraprofessionals (e.g., radiological technicians).

b. Direct medical education costs do not include:

(1) On-the-job training or other activities which do not involve the actual operation or support, except through tuition or similar payments, of an approved education program.

(2) Patient education or general health awareness programs offered as a service to the community at large.

c. To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests, the contractor shall add the figures from Worksheet B, Part I, Columns 21-24, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, line 33, and lines 37-63. These instructions are effective for all initial and amended requests received on or after October 1, 1998.

NOTE: The instructions provided in the May 1996 TRICARE/CHAMPUS Policy Manual, Change 35, published on November 4, 1998, incorrectly eliminated allowable direct medical education costs for lines 60-63 from Worksheet B, Part I, Columns 21-24. The contractor is not required to identify those finalized reimbursement requests processed under the instructions outline in Policy Manual Change 35, however, if the hospital requests reimbursement for the above listed costs, the contractor shall reprocess the request accordingly.

d. To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests as of November 1, 2011, the contractor shall add the figures from Worksheet B, Part I, Columns 19-23, lines 30-35, 43, and 50-93. These instructions are effective for all initial and amended requests received on or after November 2011.

3. Determining amount of Capital and Direct Medical Education (CAP/DME) payment. In order to account for payments by other health insurance, TRICARE/CHAMPUS' payment amounts for CAP/DME will be determined according to the following steps. Throughout these calculations claims on which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount are not to be counted.

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- STEP 1: Determine the ratio of TRICARE/CHAMPUS inpatient days to total inpatient days using the data described below. In determining total TRICARE/CHAMPUS inpatient days the following are not to be included:
- (1) Any days determined to be not medically necessary, and
  - (2) Days included on claims for which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount.
- STEP 2: Multiply the ratio from STEP 1 by total allowable capital costs.
- STEP 3: Reduce the amount from STEP 2 by the appropriate capital reduction percentage(s). This is the total allowable TRICARE/CHAMPUS capital payment for DRG discharges.
- STEP 4: Multiply the ratio from STEP 1 by total allowable direct medical education costs. This is the total allowable TRICARE/CHAMPUS direct medical education payment for DRG discharges.
- STEP 5: Combine the amounts from STEP 3 and STEP 4. This is the amount of TRICARE/CHAMPUS payment due the hospital for CAP/DME.

4. Payment of CAP/DME costs.

a. General. All hospitals subject to the TRICARE/CHAMPUS DRG-based payment system, except for children's hospitals (see below), may be reimbursed for allowed CAP/DME costs by submitting a request and the applicable pages from the Medicare cost-report to the TRICARE/CHAMPUS contractor.

(1) Beginning October 1, 1998, initial requests for payment of CAP/DME shall be filed with the TRICARE/CHAMPUS contractor on or before the last day of the twelfth month following the close of the hospitals' cost-reporting period. The request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. Thus, for cost-reporting periods ending on or after March 1, 1998, requests for payment of CAP/DME must be filed no later than 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on June 30, 1998, the request for payment shall be filed on or before June 30, 1999. Those hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting CAP/DME costs.

(a) An extension of the due date for filing the initial request may only be granted if an extension has been granted by Centers for Medicare and Medicaid Services (CMS) due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire, as described in Section 413.24 of Title 42 CFR.

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(b) All costs reported to the TRICARE/CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. If the costs change as a result of a subsequent Medicare desk review, audit or appeal, the revised costs along with the applicable pages from the amended Medicare cost report shall be provided to the TRICARE/CHAMPUS contractor within 30 days of the date the hospital is notified of the change. The request must be signed by the hospital official responsible for verifying the amounts. The Medicare Notice of Program Reimbursement (NPR) letter should be submitted with the amended cost report.

(c) The 30 day period is a means of encouraging hospitals to report changes in its CAP/DME costs in a timely manner. If the contractor receives an amended request beyond the 30 days, it shall process the adjustment and inform the provider of the importance of submitting timely amendments.

(d) The hospital official is certifying in the initial submission of the cost report that any changes resulting from a subsequent Medicare audit will be promptly reported. Failure to promptly report the changes resulting from a Medicare audit is considered a misrepresentation of the cost report information. Such a practice can be considered fraudulent, which may result in criminal civil penalties or administrative sanctions of suspension or exclusion as an authorized provider.

(2) Prior to October 1, 1998, TRICARE/CHAMPUS had no time limit for filing initial requests for reimbursement of CAP/DME, other than the six-year statute of limitations. The time limitation for filing claims does not apply to CAP/DME payment requests. To allow TRICARE/CHAMPUS contractors to close out prior year data, all initial payment requests for CAP/DME for cost-reporting periods ending before March 1, 1998, shall be filed with the TRICARE/CHAMPUS contractor no later than five months after October 1, 1998. Requests for reimbursement for these periods must be post-marked on or before March 1, 1999. During this 5 month period, the following criteria apply:

(a) If a hospital has documentation indicating it was underpaid based on the number of inpatient days reported on the initial request, the hospital may request separate reimbursement for these costs, however, it is the hospital's responsibility to provide documentation substantiating the number of TRICARE/CHAMPUS inpatient days.

(b) The contractor shall follow the instructions for processing initial requests as outlined in [paragraph III.B.4.c.\(1\)](#).

b. Information necessary for payment of CAP/DME costs. The following information must be reported to the contractor:

- (1) The hospital's name.
- (2) The hospital's address.
- (3) The hospital's TRICARE/CHAMPUS provider number.

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- (4) The hospital's Medicare provider number.
- (5) The period covered--this must correspond to the hospital's Medicare cost-reporting period.
- (6) Total inpatient days provided to all patients in units subject to DRG-based payment.
- (7) Total TRICARE/CHAMPUS inpatient days provided in units subject to DRG-based payment. (This is to be only days which were "allowed" for payment. Therefore, days which were determined to be not medically necessary are not to be included.)
  - (a) Total inpatient days provided to active duty members in units subject to DRG-based payment.
- (8) Total allowable capital costs. This must correspond with the applicable pages from the Medicare cost-report.
- (9) Total allowable direct medical education costs. This must correspond with the applicable pages from the Medicare cost-report.
- (10) Total full-time equivalents for:
  - (a) Residents,
  - (b) Interns (see below).
- (11) Total inpatient beds (see below).
- (12) Title of official signing the report.
- (13) Reporting date.
- (14) The report must contain a certification statement that any changes to items (6), (7), (8), (9), and (10), which are a result of a review, audit, or appeal of the provider's Medicare cost-report, must be reported to the contractor within 30 days of the date the hospital is notified of the change.
- (15) All cost reports must be certified by an officer or administrator of the provider. The general concept is to notify the certifying official that misrepresentation or falsification of any of the information in the cost report is punishable by fine and/or imprisonment. The signing official must acknowledge this as well as certify that the cost report filed, together with any supporting documentation, is true, correct and complete based upon the books and records of the provider.

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c. Contractor actions.

(1) Initial requests for capital/direct medical education payment.

(a) The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an initial request being submitted.

(b) The contractor shall verify the number of TRICARE/CHAMPUS and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be made within ten working days of identification of the discrepancy and include the inpatient day verification report.

(c) The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

(d) The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

(e) The contractor must make the CAP/DME payment to the hospital within 30 days of the initial request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in [paragraph III.B.4.c.\(1\)\(b\)](#).

(f) The TRICARE/CHAMPUS contractor shall be responsible for proactively researching the Medicare web site (<http://www.cms.hhs.gov/costreports>) to identify hospitals in their region that submitted amended Medicare cost reports, obtaining copies of the amended cost reports from hospitals that failed to submit them to the TRICARE contractor as required, recalculating the CAP/DME costs based on the revised cost report data, and initiating a collection action or notifying the hospital if an underpayment was identified based on the results of recalculation. The CMS post the Hospital Cost Report files 30 days after the end of each quarter.

(g) The contractor shall submit a yearly report "Annual Capital and Direct Medical Education Report" to the Contracting Officer (CO/Contracting Officer's Representative (COR) identifying the hospitals that submitted amended Medicare cost reports directly to the TRICARE contractor and those hospitals which failed to submit amended cost reports to the TRICARE contractor identified from the CMS web site. The first report shall be for the first full (or partial) calendar year after start work. For example, if the start work date was April 1, 2011, then the first report would cover a partial year, i.e., the report period would be April 1 through December 31, 2011. The report is due no later than

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March 1 (the first day of the third month) after the end of the calendar year being reported. The report shall include the following data elements: the name(s) of the hospital(s), both those that submitted an amended cost report to the contractors and those that were identified by the contractors' review of the CMS cost report web sites; the report shall clearly distinguish the hospitals that submitted an amended cost report and the hospitals that were identified by the contractors' review of the CMS cost report web site; the amount identified as either an underpayment or overpayment, and the status of their overpayment collection efforts.

(h) For a period of one year following the report period, the "Quarterly Capital and Direct Medical Education Over and Under Payment Report" shall be updated on a calendar quarterly basis to reflect collections that are received, or underpayments refunded at the hospital's request, after the end of the previous calendar year report. The quarterly reports shall pertain only to cases initiated in the calendar year being reported. For example, the calendar year 2011 initial report will be provided to the CO/COR NLT March 1, 2012. At the end of each quarter following the calendar year 2011 initial report, quarterly reports will be due to the CO/COR by the 15th of the month following the end of the report quarter. The Quarterly reports will be due on April 15, 2012 for the January through March quarter; on July 15, 2012 for the April through June quarter; on October 15, 2012 for the July through September quarter; and on January 15, 2013 for the October through December quarter. For each hospital on the initial calendar year report, the quarterly reports shall identify the: cumulative amount collected/refunded; amount still needing to be collected/refunded for each hospital; total collections; and total underpayments and the case status. All reports submitted shall contain totals for each of the financial fields on the report. A mutually-agreeable format of the annual and quarterly reports shall be developed under separate discussions with the TRICARE Regional Offices (TROs).

(2) Amended Requests for CAP/DME.

(a) The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an amended request being submitted.

(b) The contractor shall process amended payment requests based on changes in the Medicare cost-report as a result of desk reviews, audits and appeals. An adjustment will not be processed unless there are changes to items 6 through 10 on the initial CAP/DME reimbursement request. The contractor will not process amended requests for days only.

(c) The contractor shall verify the number of TRICARE/CHAMPUS and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be made within ten working days of identification of the discrepancy and include the inpatient day verification report.

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(d) The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

(e) The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the amended Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

(f) The contractor must make the CAP/DME payment to the hospital within 30 days of the amended request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in [paragraph III.B.4.c.\(2\)\(b\)](#).

(3) The contractor shall prepare a voucher in accordance with the requirements of the TRICARE Operations Manual (TOM) and send it to the TMA Contract Resource Management Directorate (CRM) for clearance before releasing the checks.

(4) Requests for reimbursement of DRG CAP/DME costs shall be paid as pass-through costs. The Managed Care Support (MCS) contractors are non-financially underwritten for these costs.

d. Negotiated Rates. If a contract between the MCS prime contractor and a subcontractor or institutional network provider does not specifically state the negotiated rate includes all costs that would otherwise be eligible for additional payment, such as CAP/DME, the MCS prime contractor is responsible for reimbursing these costs to the subcontractors and institutional network providers if a request for reimbursement is made.

e. CAP/DME costs for children's hospitals. Amounts for CAP/DME are included in both the hospital-specific and the national children's hospital differentials (see below). The amounts are based on national average costs. No separate or additional payment is allowed.

f. CAP/DME costs under TRICARE for Life (TFL). TRICARE will make no payments for CAP/DME costs for any claims on which Medicare makes payment. These costs are included in the Medicare payment. TRICARE CAP/DME cost payments will be made only on claims on which TRICARE is the primary payer (e.g., claims for stays beyond 150 days), and in those cases payment will be made following the procedures described above.

## 5. Children's Hospital Differential.

a. General. All DRG-based payments to children's hospitals for admissions occurring on or after April 1, 1989, are to be increased by adding the applicable children's hospital differential to the appropriate ASA prior to multiplying by the DRG weight.

b. Qualifying for the children's hospital differential. In order to qualify for a children's hospital differential adjustment, the hospital must be exempt from the Medicare

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PPS as a children's hospital. If the hospital is not Medicare-participating, it must meet the criteria in [32 CFR 199.6\(b\)\(4\)\(i\)](#). In addition, more than half of its inpatients must be individuals under the age of 18.

c. Calculation of the children's hospital differentials. The differentials will be equal to the difference between a specially-calculated ASA for children's hospitals (using the procedures described in [Chapter 6, Section 7](#)) and the ASA for FY 1988 which would otherwise be applicable. They will be calculated so that they are "revenue neutral" for children's hospitals; that is, for FY 1988 overall TRICARE/CHAMPUS payments to children's hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, TMA (the Office of Program Development) calculated separate ASAs for children's hospitals. Normally in calculating ASAs, TMA reduces the adjusted charges according to the Medicare Cost-To-Charge Ratio (CCR) (0.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

d. Differential amounts.

(1) Admissions prior to April 1, 1992. High volume children's hospitals (those children's hospitals with 50 or more TRICARE/CHAMPUS discharges during FY 1988) have a hospital-specific differential for a three-year transition period ending April 1, 1992. All other children's hospitals use national differentials. There are two national differentials--one for large urban areas and one for other urban areas.

(a) Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in [paragraph III.B.5.c.](#), but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990.

(b) Calculation of the hospital-specific differentials for high-volume children's hospitals. The hospital-specific differentials were calculated using the same procedures used for calculating the national differentials, except that the database used was limited to claims from the specific high-volume children's hospital.

(c) Administrative corrections. Any children's hospital that believed TMA erroneously failed to classify the hospital as a high-volume hospital or correctly calculate (in the case of a high-volume hospital) the hospital's differential could obtain administrative corrections by submitting appropriate documentation to TMA. The corrected differential was effective retroactively to April 1, 1989, so this process included adjustments, by the contractor, to any previously processed claims which were processed using an incorrect differential.

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(2) Admissions on or after April 1, 1992. These claims are reimbursed using a single set of differentials which do not distinguish high-volume and low-volume children's hospitals. The differentials are:

Large Urban Areas	
Labor portion	\$1,945.99
Non-labor portion	<u>689.42</u>
	\$2,635.41

Other Areas	
Labor portion	\$1,483.21
Non-labor portion	<u>525.47</u>
	\$2,008.68

(3) Admissions on or after October 1, 2004. Children's hospitals located in other areas shall receive the same differential payment as large urban area hospitals.

e. Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on a sufficient volume of TRICARE/CHAMPUS claims records, TMA will recalculate children's hospital differentials and appropriate retrospective and prospective adjustments will be made. To the extent possible, the recalculation will also include reestimated values of other factors (including, but not limited to, direct and Indirect Medical Education (IDME) and capital costs) for which more accurate data become available. This will probably occur about one year after implementation of the neonatal DRGs, and it will not require any actions by the contractors.

6. Outliers.

a. General. TRICARE/CHAMPUS will adjust the DRG-based payment to a hospital for atypical cases. These outliers are those cases that have either an unusually short Length-Of-Stay (LOS) or extremely long LOS or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Recognition of these outliers is particularly important, since the number of TRICARE/CHAMPUS cases in many hospitals is relatively small, and there may not be an opportunity to "average out" DRG-based payments over a number of claims. Contractors will not be required to document or verify the medical necessity of outliers prior to payment, since outlier review will be part of the admission and quality review system. However, in determining additional cost outlier payments on all claims qualifying as a cost outlier, the contractor must identify and reduce the billed charge for any non-covered items such as comfort and convenience items (line N), as well as any duplicate charges (line X) and services which can be separately billed (line 7) such as professional fees, outpatient services, and solid organ transplant acquisition costs. Comfort and convenience items are defined as those optional items which the patient may elect at an additional charge (i.e., television, guest trays, beautician services, etc.), but are not medically necessary in the treatment of a patient's condition.

b. Payment of outliers. For all admissions occurring before October 1, 1988, if the claim qualifies as both a LOS outlier and a cost outlier, payment shall be based on the LOS

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outlier. For admissions occurring on or after October 1, 1988, claims which qualify as both a LOS outlier and a cost outlier shall be paid at whichever outlier calculation results in the greater payment. For information on calculating outlier payments when a beneficiary's eligibility status changes, refer to [Chapter 6, Section 2, paragraph III.C.1.](#)

c. Provider Reporting of outliers. The provider is to identify outliers on the UB-92, form locator 24 - 30. Code 60 is to be used to report LOS outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost outlier and code 66 is not entered in the appropriate form locator (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

d. LOS outliers. The TRICARE/CHAMPUS DRG-based payment system uses both short-stay and long-stay outliers, and both are reimbursed using a per diem amount. All LOS outliers must be identified by the contractor when the claims are processed, and necessary adjustments to the payment amounts must be made automatically.

(1) Short-stay outliers.

(a) Any discharge which has a LOS less than or equal to the greater of 1 or 1.94 standard deviations below the arithmetic mean LOS for that DRG shall be classified as a short-stay outlier. In determining the actual short-stay threshold, the calculation will be rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

(b) Short-stay outliers will be reimbursed at 200% of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for IDME. Cost outlier payments shall be paid on short stay outlier cases that qualify as a cost outlier.

(c) Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

(2) Long-stay outliers.

(a) For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and childrens' hospitals.

(b) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for all neonates and childrens' hospitals.

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e. Cost outliers.

(1) Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

(a) For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the CCR and adjusting this amount for IDME costs by dividing the amount by one (1) plus the hospital's IDME adjustment factor. For admissions occurring on or after October 1, 1997, the costs for IDME are no longer standardized.

(b) Cost outliers will be reimbursed the DRG-based amount plus 80% effective October 1, 1994 of the standardized costs exceeding the threshold.

(c) For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

$$\text{Standard Cost} = (\text{Billed Charges} \times \text{CCR})$$

$$\text{Outlier Payment} = 80\% \text{ of } (\text{Standard Cost} - \text{Threshold})$$

$$\text{Total Payments} = \text{Outlier Payments} + (\text{DRG Base Rate} \times (1 + \text{IDME}))$$

NOTE: Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the CCR.

(d) The CCR for admissions occurring on or after October 1, 2009, is 0.3740. The CCR for admissions occurring on or after October 1, 2010, is 0.3664. The CCR for admissions occurring on or after October 1, 2011, is 0.3460.

(e) The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2010 is 0.923, for FY 2011 is 0.920, and for FY 2012 is 0.919.

(2) For FY 2010, a TRICARE fixed loss cost-outlier threshold is set at \$21,358. Effective October 1, 2009, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,358 (also wage-adjusted).

(3) For FY 2011, a TRICARE fixed loss cost-outlier threshold is set at \$21,229. Effective October 1, 2010, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,229 (also wage-adjusted).

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(4) For FY 2012, a TRICARE fixed loss cost-outlier threshold is set at \$21,482. Effective October 1, 2011, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,482 (also wage-adjusted).

The cost-outlier threshold shall be calculated as follows:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + (DRG Base Payment (wage-adjusted) x (1 + IDME))}

EXAMPLE: Using FY 1999 figures {[10,129 x ((0.7110 x Applicable wage index) + 0.2890) x 0.913] + (DRG Based Payment (wage-adjusted) x (1 + IDME))}

f. Burn outliers. Burn outliers generally will be subject to the same outlier policies applicable to the CHAMPUS DRG-based payment system except as indicated below. For admissions prior to October 1, 1998, there are six DRGs related to burn cases. They are:

- 456 - Burns, transferred to another acute care facility
- 457 - Extensive burns w/o O.R. procedure
- 458 - Non-extensive burns with skin graft
- 459 - Non-extensive burns with wound debridement or other O.R. procedure
- 460 - Non-extensive burns w/o O.R. procedure
- 472 - Extensive burns with O.R. procedure

Effective for admissions on or after October 1, 1998, the above listed DRGs are no longer valid.

For admissions on or after October 1, 1998, there are eight DRGs related to burn cases. They are:

- 504 - Extensive 3rd degree burn w skin graft
- 505 - Extensive 3rd degree burn w/o skin graft
- 506 - Full thick burn w sk graft or inhal inj w cc or sig tr
- 507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
- 508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
- 509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
- 510 - Non-extensive burns w cc or significant trauma
- 511 - Non-extensive burns w/o cc or significant trauma

Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.

(1) For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60%.

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(2) Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

(3) Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90%.

(4) Burn cases which qualify as long-stay outliers will be reimbursed as follows.

(a) Admissions occurring from October 1, 1988, through September 30, 1990 will be reimbursed using a marginal cost factor of 90%.

(b) Admissions occurring on or after October 1, 1990, will be reimbursed using a marginal cost factor of 60%.

(5) For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and children's hospitals.

(6) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for all neonates and children's hospitals.

(7) For a burn outlier in a children's hospital, the appropriate children's hospital outlier threshold is to be used (see below), but the marginal cost factor is to be either 60% or 90% according to the criteria above.

g. Children's hospital outliers. Children's hospitals will be subject to the same outlier policies applicable to other hospitals except that:

(1) For long-stay outliers the threshold shall be the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS. (See the addenda to this chapter for the actual outlier thresholds and their effective dates.) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated.

(2) The following special provisions apply to cost outliers.

(a) The threshold shall be the greater of two times the DRG-based amount (wage-adjusted but prior to adjustment for IDME) or \$13,500.

(b) Effective October 1, 1998, the threshold shall be the same as that applied to other hospitals.

(c) Effective October 1, 2009, the CCR was 0.4047. Effective October 1, 2010, the CCR was 0.3974. Effective October 1, 2011, the CCR was 0.3757. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

(d) The marginal cost factor shall be 80%.

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(e) For admissions occurring during FY 2010, the marginal cost factor shall be adjusted by 1.10. For admissions occurring during FY 2011, the marginal cost factor shall be adjusted by 1.00. For admissions occurring during FY 2012, the marginal cost factor shall be adjusted by 1.02.

(f) The NOSCASTC for calculating the cost-outlier threshold for FY 2010 is 0.923. The NOSCASTC for calculating the cost-outlier threshold for FY 2011 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2012 is 0.919. The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

- STEP 1: Computation of Standardized Costs:  
Billed Charges x CCR  
(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)
- STEP 2: Determination of Cost-Outlier Threshold:  
[[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]]
- STEP 3: Determination of Cost Outlier Payment  
[[(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor] x Adjustment Factor]
- STEP 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

h. Neonatal outliers. Neonatal outliers in hospitals subject to the CHAMPUS DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the CCR of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the CCR used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same CCR used for all other acute care hospitals.

7. IDME adjustment.

α. General. The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of

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discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.43 \times \left[ \left( 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{0.5795} - 1.0 \right]$$

For admissions occurring during FY 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.

b. Number of interns and residents. Initially, the number of interns and residents will be derived from the most recently available audited CMS cost-report data (1984). Subsequent updates to the adjustment factor will be based on the count of interns and residents on the annual reports submitted by hospitals to the contractors (see above). The number of interns and residents is to be as of the date the report is submitted and is to include only those interns and residents actually furnishing services in the reporting hospital and only in those units subject to DRG-based reimbursement. The percentage of time used in calculating the full-time equivalents is to be based on the amount of time the interns and residents spend in the portion of the hospital subject to DRG-based payment or in the outpatient department of the hospital on the reporting date. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of interns and residents from CMS most recently available Provider Specific File.

c. Number of beds. Initially, the number of beds will be those reported on the most recent AHA Annual Survey of Hospitals (1986). Subsequent updates to the adjustment factor will be based on the number of beds reported annually by hospitals to the contractors (see above). The number of beds in a hospital is determined by counting the number of available bed days during the period covered by the report, not including beds or bassinets assigned to healthy newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the reporting period. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of beds from CMS's most recently available Provider Specific File.

d. Updates of IDME factors. It is the contractor's responsibility to update the adjustment factors based on the data contained in the annual report. The effective date of the updated factor shall be the date payment is made to the hospital (check issued) for its CAP/DME costs, but in no case can it be later than 30 days after the hospital submits its annual report. The updated factor shall be applied to claims with a date of discharge on or after the effective date. Similarly, contractors may correct initial factors if the hospital submits information (for the same base periods) which indicates the factor provided by TMA is incorrect.

(1) Beginning in FY 1999, TRICARE/CHAMPUS will use the ratio of interns and residents to beds from CMS's most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors shall be applied to claims with a date of discharge on or after October 1 of each year.

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The contractor is no longer required to update a hospital's IDME factor based on data contained in the hospital's annual request for reimbursement for its CAP/DME costs.

(2) This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

e. Adjustment for children's hospitals. An IDME adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

(1) Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated information on its number of interns, residents and beds since the previous October 1 and advise them to provide the updated information by October 1 of that same year.

(2) The contractors shall send the updated ratios for children's hospitals to TMA, MB&RS, or designee, by April 1 of each year to be used in TMA's annual DRG update calculations.

f. TFL. No adjustment for IDME costs is to be made on any TFL claim on which Medicare has made any payment. If TRICARE is the primary payer (e.g., claims for stays beyond 150 days) payments are to be adjusted for IDME in accordance with the provisions of this section.

8. Present On Admission (POA) Indicators and Hospital Acquired Conditions (HACs).

a. Effective for admissions on or after October 1, 2009, those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and ICD-9-CM Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

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b. There are five POA indicator reporting options, as defined by the ICD-9-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was POA.
- W = Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not POA.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.
- 1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting.  
(This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.

c. HACs. TRICARE shall adopt those HACs adopted by CMS. The HACs, and their respective diagnosis codes, are posted at <http://www.tricare.mil/drgates/>.

d. Provider responsibilities and reporting requirements. For non-exempt providers, issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA.

e. The TRICARE/CHAMPUS contractor shall accept, validate, retain, pass, and store the POA indicator.

f. Exempt Providers.

(1) The following hospitals are exempt from POA reporting for TRICARE:

- (a) Critical Access Hospitals (CAHs)
- (b) Long Term Care (LTC) Hospitals
- (c) Maryland Waiver Hospitals
- (d) Cancer Hospitals
- (e) Children's Inpatient Hospitals

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- (f) Inpatient Rehabilitation Hospitals
- (g) Psychiatric Hospitals and Psychiatric Units
- (h) Sole Community Hospitals (SCHs)
- (i) Department of Veterans Affairs (DVA) Hospitals

(2) Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

g. The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complication or charges because the DRG was demoted to a lesser-severity level.

h. Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

i. Reports. Contractors shall create a monthly report listing all TRICARE Encounter Data (TED) records that had HACs. The report shall include, at a minimum, the TED Record Indicator, each HAC reported, the POA indicator for each HAC, the dates of service/admission, the DRG that was paid, the total amount paid by TRICARE, and the following provider data: Taxpayer Identification Number (TIN), Sub-Identifier (SUBID), Zip Code, Type of Institution, and National Provider Identifier (NPI). The report shall be provided to TMA by the 10th of each month in an Excel file and submitted via the E-Commerce Extranet. The first monthly report shall be due no later than November 10, 2009.

9. Replacement Devices.

a. TRICARE is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Reimbursement in cases in which an implanted device is replaced shall be made:

- (1) At reduced or no cost to the hospital; or
- (2) With partial or full credit for the removed device.

b. The following condition codes 49 and 50 allow TRICARE to identify and track claims billed for replacement devices:

(1) Condition Code 49. Product replacement within product lifecycle. Condition code 49 is used to describe replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly - warranty.

(2) Condition Code 50. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

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Condition code 50 is used to describe that the manufacturer or the U.S. Food and Drug Administration (FDA) has identified the product for recall and, therefore, replacement.

c. When a hospital receives a credit for a replaced device that is 50% or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code **FD**.

d. Beginning with admissions on or after October 1, 2009, the contractor shall reduce hospital reimbursement for those DRGs subject to the replacement device policy, by the full or partial credit a provider received for a replaced device. The specific DRGs subject to the replacement device policy will be posted on TRICARE's DRG web page at <http://www.tricare.mil/drgrates/>. As necessary, the DRGs subject to the replacement device policy will be updated as part of the annual DRG update.

e. Hospitals must use the combination of condition code 49 or 50, along with value code **FD** to correctly bill for a replacement device that was provided with a credit or no cost. The condition code 49 or 50 will identify a replacement device while value code **FD** will communicate to TRICARE the amount of the credit, or cost reduction, received by the hospital for the replaced device.

f. The contractor shall deduct the partial/full credit amount, reported in the amount for value code **FD** from the final DRG reimbursement when the assigned DRG is one of the DRGs subject to the replacement device policy.

g. Once a DRG rate is determined, any full/partial credit amount is deducted from the DRG reimbursement rate. The beneficiary copayment/cost-share is then determined based on the reduced rate.

- END -

CHAPTER 7  
 ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR  
 PAYMENT OF SERVICES PROVIDED ON OR AFTER 10/01/2009

The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2009. The rates were adjusted by the lesser of the FY 2009 Medicare update factor (2.1%) or the amount that brought the rate up to the new cap amount of \$758.

NOTE: This listing is for residential treatment center per diem rates only. It does not reflect a facility's status as a TRICARE-authorized residential treatment center. Information regarding a facility's current status as an authorized provider can be obtained from the appropriate contractor.

FACILITY	TRICARE/CHAMPUS RATE
<b>ALASKA</b>	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	758.00
<b>ARKANSAS</b>	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	753.00
<b>COLORADO</b>	
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc. 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	758.00
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	697.00
<b>FLORIDA</b>	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	719.00

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FACILITY	TRICARE/CHAMPUS RATE
Ten Broeck Ocala Behavioral 3130 SW 27th Ave Ocala, FL 34474 EIN: 32-0235544	387.00
River Point Behavioral Health TBJ Behavioral, LLC 6300 Beach Blvd Jacksonville, FL 32216 EIN: 20-4865566	584.00
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	675.00
<b>GEORGIA</b>	
Costal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	419.00
UHS of Laurel Heights, LP Laurel Heights Hospital 934 Briarcliff Road NE Atlanta, GA 30306 EIN: 23-3045288	723.00
Youth Villages, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-1716970	758.00
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	758.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	731.00

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FACILITY	TRICARE/CHAMPUS RATE
<b>SOUTH CAROLINA</b>	
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	435.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	727.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	451.00
Dickson Recovery Center 222 Church Street Dickson, TN 37055 EIN: 20-4990101	413.00
Youth Villages, Inc 3320 Brother Blvd Memphis, TN 38133 EIN: 58-1716970	758.00
<b>TEXAS</b>	
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	758.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	632.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	711.00

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TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES PROVIDED ON  
OR AFTER 10/01/2009

FACILITY	TRICARE/CHAMPUS RATE
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	653.00
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	696.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc/ <b>Provo Canyon School</b> <b>4501 North University Avenue</b> <b>Provo, UT 84604</b> EIN: 23-3044423	449.00
<b>VIRGINIA</b>	
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	445.00
Poplar West HHC Poplar Springs, Inc. 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	730.00
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	632.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	495.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	628.00

- END -

CHAPTER 7  
 ADDENDUM G (FY 2011)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR  
 PAYMENT OF SERVICES PROVIDED ON OR AFTER 10/01/2010

The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2010. The rates were adjusted by the lesser of the FY 2010 Medicare update factor (2.6%) or the amount that brought the rate up to the new cap amount of \$777.

NOTE: This listing is for residential treatment center per diem rates only. It does not reflect a facility's status as a TRICARE-authorized residential treatment center. Information regarding a facility's current status as an authorized provider can be obtained from the appropriate contractor.

FACILITY	TRICARE/CHAMPUS RATE
<b>ALASKA</b>	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	777.00
<b>ARKANSAS</b>	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	772.00
<b>COLORADO</b>	
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc. 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	777.00
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	715.00
<b>FLORIDA</b>	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	737.00

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CHAPTER 7, ADDENDUM G (FY 2011)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES  
PROVIDED ON OR AFTER 10/01/2010

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	692.00
The National Deaf Academy, LLC RTC 19650 Hwy 441 Mt. Dora, FL 32757 EIN 59-3653865	777.00
River Point Behavioral Health TBJ Behavioral, LLC 6300 Beach Blvd Jacksonville, FL 32216 EIN: 20-4865566	599.00
Ten Broeck Ocala Behavioral 3130 SW 27th Ave Ocala, FL 34474 EIN: 32-0235544	397.00
<b>GEORGIA</b>	
Costal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	429.00
UHS of Laurel Heights, LP Laurel Heights Hospital 934 Briarcliff Road NE Atlanta, GA 30306 EIN: 23-3045288	741.00
Youth Villages, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-1716970	777.00
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	777.00

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<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	750.00
<b>IDAHO</b>	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	352.00
Kootenai Medical Center 2003 Lincoln Way Coeur d'Alene, ID 83814 EIN: 82-0231746	447.00
<b>INDIANA</b>	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	438.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	464.00
<b>KENTUCKY</b>	
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	699.00
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	657.00

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PROVIDED ON OR AFTER 10/01/2010

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>MARYLAND</b>	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	403.00
<b>MISSOURI</b>	
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	409.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	418.00
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	\$334.00
<b>MONTANA</b>	
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	447.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	777.00
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	328.00

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PROVIDED ON OR AFTER 10/01/2010

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 561317433	476.00
<b>OHIO</b>	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	410.00
<b>SOUTH CAROLINA</b>	
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	446.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	745.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	462.00
Youth Villages, Inc 3320 Brother Blvd Memphis, TN 38133 EIN: 58-1716970	777.00
<b>TEXAS</b>	
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	777.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	648.00

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TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES  
PROVIDED ON OR AFTER 10/01/2010

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	729.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	669.00
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	714.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	460.00
UHS of Provo Canyon, Inc/Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	460.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	577.00
<b>VIRGINIA</b>	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN: 02-0567575	762.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	772.00

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PROVIDED ON OR AFTER 10/01/2010

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	456.00
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	648.00
Poplar West HHC Poplar Springs, Inc. 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	748.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	507.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	644.00

- END -



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TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR  
 PAYMENT OF SERVICES PROVIDED ON OR AFTER 10/01/2011

The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2011. The rates were adjusted by the lesser of the FY 2012 Medicare update factor (3.0%) or the amount that brought the rate up to the new cap amount of \$801.

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FACILITY	TRICARE/CHAMPUS RATE
<b>ALASKA</b>	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	801.00
<b>ARKANSAS</b>	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	796.00
<b>COLORADO</b>	
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc. 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	801.00
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	737.00
<b>FLORIDA</b>	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	760.00

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FACILITY	TRICARE/CHAMPUS RATE
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	713.00
The National Deaf Academy, LLC RTC 19650 Hwy 441 Mt. Dora, FL 32757 EIN 59-3653865	801.00
River Point Behavioral Health TBJ Behavioral, LLC 6300 Beach Blvd Jacksonville, FL 32216 EIN: 20-4865566	617.00
<b>GEORGIA</b>	
Costal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	442.00
UHS of Laurel Heights, LP Laurel Heights Hospital 934 Briarcliff Road NE Atlanta, GA 30306 EIN: 23-3045288	764.00
Youth Villages, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-1716970	801.00
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	801.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	773.00

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<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>IDAHO</b>	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	363.00
Kootenai Medical Center 2003 Lincoln Way Coeur d'Alene, ID 83814 EIN: 82-0231746	461.00
<b>INDIANA</b>	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	452.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	478.00
<b>KENTUCKY</b>	
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	720.00
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	677.00
<b>MARYLAND</b>	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	416.00

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<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>MISSOURI</b>	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	345.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	422.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	431.00
<b>MONTANA</b>	
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	461.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	801.00
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	338.00
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 561317433	491.00

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<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>OHIO</b>	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	423.00
<b>SOUTH CAROLINA</b>	
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	460.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	768.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	476.00
Youth Villages, Inc 3320 Brother Blvd Memphis, TN 38133 EIN: 58-1716970	801.00
<b>TEXAS</b>	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	736.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	801.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	668.00

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PROVIDED ON OR AFTER 10/01/2011

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	751.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	690.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	474.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	474.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	595.00
<b>VIRGINIA</b>	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	785.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	796.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	470.00
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	668.00

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 7, ADDENDUM G (FY 2012)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES  
PROVIDED ON OR AFTER 10/01/2011

FACILITY	TRICARE/CHAMPUS RATE
Poplar West HHC Poplar Springs, Inc. 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	771.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	523.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	644.00

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## HOME HEALTH CARE

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1	Home Health Benefit Coverage And Reimbursement - General Overview
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3	Home Health Benefit Coverage And Reimbursement - Assessment Process
4	Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology
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	FIGURE 12-4-2 Clinical Severity Domain
	FIGURE 12-4-3 Functional Status Domain
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	FIGURE 12-4-5 HHRG To HIPPS Code Crosswalk
	FIGURE 12-4-6 New HIPPS Code Structure Under HH PPS Case-Mix Refinement
	FIGURE 12-4-7 Scoring Matrix For Constructing HIPPS Code
	FIGURE 12-4-8 Case-Mix Adjustment Variables And Scores For Episodes Ending Before January 1, 2012
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	FIGURE 12-4-16 Standardization For Case-Mix And Wage Index
	FIGURE 12-4-17 Per Visit Payment Amounts For LUPAs

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CHAPTER 12 - HOME HEALTH CARE

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SECTION	SUBJECT
5	Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care
6	Home Health Benefit Coverage And Reimbursement - Claims And Billing Submission Under HHA PPS
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FIGURE 12-L-2010-2	National Per-visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2010 Home Health Market Basket Update, Before Wage Index Adjustment
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FIGURE 12-L-2010-4	Non-Routine Medical Supply (NRS) Conversion Factor For CY 2010
FIGURE 12-L-2010-5	Relative Weights For The Six-Severity NRS System
FIGURE 12-L-2010-6	National 60-Day Episode Payment Amounts For Beneficiaries Residing In Rural Areas, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
FIGURE 12-L-2010-7	National Per-Visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The 3% Rural Add-On
FIGURE 12-L-2010-8	LUPA Add-On Payment Amount For Beneficiaries Who Reside In A Rural Area
FIGURE 12-L-2010-9	NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
FIGURE 12-L-2010-10	Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
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FIGURE 12-L-2011-1	National 60-Day Episode Payment Rate Updated By The Home Health Market Basket Update For CY 2011, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
FIGURE 12-L-2011-2	National Per-visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2011 Home Health Market Basket Update, Before Wage Index Adjustment
FIGURE 12-L-2011-3	CY 2011 LUPA Add-On Payment Amounts

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FIGURE 12-L-2011-5	Relative Weights For The Six-Severity NRS System For CY 2011
FIGURE 12-L-2011-6	National 60-Day Episode Payment Amounts For Beneficiaries Residing In Rural Areas, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
FIGURE 12-L-2011-7	National Per-Visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The 3% Rural Add-On
FIGURE 12-L-2011-8	LUPA Add-On Payment Amount For Beneficiaries Who Reside In A Rural Area
FIGURE 12-L-2011-9	NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
FIGURE 12-L-2011-10	Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
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FIGURE 12-L-2012-1	National 60-Day Episode Payment Rate Updated By The Home Health Market Basket Update For CY 2012, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
FIGURE 12-L-2012-2	National Per-visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2012 HH PPS Payment Update Percentage, Before Wage Index Adjustment
FIGURE 12-L-2012-3	CY 2012 LUPA Add-On Payment Amounts
FIGURE 12-L-2012-4	Non-Routine Medical Supply (NRS) Conversion Factor For CY 2012
FIGURE 12-L-2012-5	Relative Weights For The Six-Severity NRS System For CY 2012
FIGURE 12-L-2012-6	CY 2012 Payment Amounts For Services Provided In A Rural Area, Before Case-Mix Adjustment And Wage Index Adjustment

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SECTION	SUBJECT
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	FIGURE 12-L-2012-8 CY 2012 LUPA Add-On Payment Amount For Services Provided In A Rural Area
	FIGURE 12-L-2012-9 CY 2012 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
	FIGURE 12-L-2012-10 CY 2012 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
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ADDENDUM M	(CY 2011) - Annual HHA PPS Wage Index Updates - Calendar Year 2011
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	FIGURE 12-Q-2 RAP - Non-Transfer Situation With Line Item Service Added
	FIGURE 12-Q-3 RAP - Transfer Situation
	FIGURE 12-Q-4 RAP - Discharge/Re-Admit
	FIGURE 12-Q-5 RAP - Cancellation
	FIGURE 12-Q-6 Claim - Non-Transfer Situation
	FIGURE 12-Q-7 Claim - Transfer Situation - Beneficiary Transfers To Your HHA
	FIGURE 12-Q-8 Claim - Significant Change in Condition (SCIC) Situation
	FIGURE 12-Q-9 Claim - No-RAP-Low Utilization Payment Adjustment (LUPA) Claim
	FIGURE 12-Q-10 Claim Adjustment

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SECTION	SUBJECT
	FIGURE 12-Q-11 Claim - Cancellation
ADDENDUM R	Input/Output Record Layout
ADDENDUM S	Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

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3. The HHA PPS will apply in all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and Guam.

G. Implementing Instructions. Since this issuance only deals with a general overview of the HHC benefit and reimbursement methodology, the following cross-reference is provided to facilitate access to specific implementing instructions within Chapter 12:

<b>IMPLEMENTING INSTRUCTIONS</b>	
<b>POLICIES</b>	
General Overview	<a href="#">Section 1</a>
Benefits and Conditions for Coverage	<a href="#">Section 2</a>
Assessment Process	<a href="#">Section 3</a>
Reimbursement Methodology	<a href="#">Section 4</a>
Primary Provider Status and Episodes of Care	<a href="#">Section 5</a>
Claims and Billing Submission Under HHA PPS	<a href="#">Section 6</a>
Pricer Requirements and Logic	<a href="#">Section 7</a>
Medical Review Requirements	<a href="#">Section 8</a>
<b>ADDENDA</b>	
Acronym Table	<a href="#">Addendum A</a>
Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes	<a href="#">Addendum B</a>
Home Health Consolidated Billing Code List - Therapy Codes	<a href="#">Addendum C</a>
CMS Form 485 - Home Health Certification And Plan Of Care Data Elements	<a href="#">Addendum D</a>
Primary Components of Home Health Assessment	<a href="#">Addendum E</a>
Outcome and Assessment Information Set (OASIS-B1)	<a href="#">Addendum F</a>
OASIS Items Used for Assessments Of 60-Day Episodes	<a href="#">Addendum G</a>
ICD-9-CM Diagnosis Codes for HHRG Assignment	<a href="#">Addendum H</a>
Home Health Resource Group (HHRG) Worksheet	<a href="#">Addendum I</a>
HIPPS Tables for Pricer	<a href="#">Addendum J</a>
HAVEN Reference Manual	<a href="#">Addendum K</a>
Annual HHA PPS Rate Updates	
Calendar Year 2010	<a href="#">Addendum L (CY 2010)</a>
Calendar Year 2011	<a href="#">Addendum L (CY 2011)</a>
Calendar Year 2012	<a href="#">Addendum L (CY 2012)</a>

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IMPLEMENTING INSTRUCTIONS (CONTINUED)

Annual HHA PPS Wage Index Updates	
Calendar Year 2010	<a href="#">Addendum M (CY 2010)</a>
Calendar Year 2011	<a href="#">Addendum M (CY 2011)</a>
<b>Calendar Year 2012</b>	<a href="#">Addendum M (CY 2012)</a>
Diagnoses Associated with Diagnostic Categories Used In Case-Mix Scoring (CY 2008)	<a href="#">Addendum N</a>
Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model	<a href="#">Addendum O</a>
Code Table for Converting Julian Dates to Two Position Alphabetic Values	<a href="#">Addendum P</a>
Examples of Claims Submissions Under Home Health Agency Prospective Payment System (HHA PPS)	<a href="#">Addendum Q</a>
Input/Output Record Layout	<a href="#">Addendum R</a>
Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008	<a href="#">Addendum S</a>

- END -

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are), there are actually 1836 new HIPPS codes. Refer to [the TMA web site \(http://www.tricare.osd.mil/tma/rates.aspx\)](http://www.tricare.osd.mil/tma/rates.aspx) for a complete listing of HH PPS case-mix refined HIPPS codes (all five positions) with associated weights.

2. Constructing of HIPPS Codes from Grouping Step and Point Scores.

The following scoring matrix (Figure 12-4-7) will be used in construction of the HIPPS code for payment under HH PPS:

**FIGURE 12-4-7 SCORING MATRIX FOR CONSTRUCTING HIPPS CODE**

	LEVEL	FIRST & SECOND EPISODES		THIRD + EPISODES		ALL EPISODES	HIPPS CODE		
		0-13 THERAPY VISITS	14-19 THERAPY VISITS	0-13 THERAPY VISITS	14-19 THERAPY VISITS	20 + THERAPY VISITS	LEVEL	HIPPS VALUES	HIPPS POSITION
<b>Grouping Step:</b>		1	2	3	4	5	<b>Step:</b>	1-5	1
<b>Clinical Severity Level:</b> (by point scores- <a href="#">Figure 12-4-8</a> )	C1	0 to 4	0 to 6	0 to 2	0 to 8	0 to 7	C1	A	2
	C2	5 to 8	7 to 14	3 to 5	9 to 16	8 to 14	C2	B	
	C3	9+	15+	6+	17+	15+	C3	C	
<b>Functional Severity Level:</b> (by point scores- <a href="#">Figure 12-4-8</a> )	F1	0 to 5	0 to 6	0 to 8	0 to 7	0 to 6	F1	F	3
	F2	6	7	9	8	7	F2	G	
	F3	7+	8+	10+	9+	8+	F3	H	
<b>Services Utilization Level:</b> (by number of therapy visits)	S1	0 to 5	14 to 15	0 to 5	14 to 15	20+ (1 Group)	S1	K	4
	S2	6	16 to 17	6	16 to 17		S2	L	
	S3	7 to 9	18 to 19	7 to 9	18 to 19		S3	M	
	S4	10		10			S4	N	
	S5	11 to 13		11 to 13			S5	P	
<b>NRS - Supplies Severity Level:</b> (by NRS point scores- <a href="#">Figure 12-4-10</a> )	NRS-1	0					NRS-1	S	5
	NRS-2	1 to 14					NRS-2	T	
	NRS-3	15 to 27					NRS-3	U	
	NRS-4	28 to 48					NRS-4	V	
	NRS-5	49 to 98					NRS-5	W	
	NRS-6	99+					NRS-6	X	

**Note:** If an episode has 20 or more visits, the case mix points could come from the second leg if it is an early episode, and from the fourth leg if it is a later episode. The table column headers indicate that these two legs are for 14 or more therapy visits.

a. Case-mix adjustment variables and scores used in constructing HIPPS codes (i.e., point scoring used in [Figure 12-4-6](#) for determining the appropriate HIPPS code for payment).

(1) The point scores for clinical and functional severity levels (second and third positions of HIPPS code) are derived from [Figure 12-4-8](#) which gives a description of each diagnosis group followed by four columns representing the four legs of the four-equation model. The diagnoses associated with each of the diagnostic categories in [Figure 12-4-8](#) can be found in [Addendum N](#).

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**FIGURE 12-4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012**

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
CLINICAL DIMENSION					
1	Primary or Other Diagnosis = Blindness/Low Vision	3	3	3	3
2	Primary or Other Diagnosis = Blood disorders	2	5		
3	Primary or Other Diagnosis = Cancer, selected benign neoplasms	4	7	3	10
4	Primary Diagnosis = Diabetes	5	12	1	8
5	Other Diagnosis = Diabetes	2	4	1	4
6	Primary or Other Diagnosis = Dysphagia AND Primary or Other Diagnosis = Neuro 3 - Stroke	2	6		6
7	Primary or Other Diagnosis = Dysphagia AND M0250 (Therapy at home) = 3 (Enteral)		6		
8	Primary or Other Diagnosis = Gastrointestinal disorders	2	6	1	4
9	Primary or Other Diagnosis = Gastrointestinal disorders AND M0550 (ostomy) = 1 or 2	3			
10	Primary or Other Diagnosis = Gastrointestinal disorders AND Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis, OR Neuro 2 - Peripheral neurological disorders, OR Neuro 3 - Stroke, OR Neuro 4 - Multiple Sclerosis			2	
11	Primary or Other Diagnosis = Heart Disease OR Hypertension	3	7	1	8
12	Primary Diagnosis = Neuro 1 - Brain disorders and paralysis	3	8	5	8
13	Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis AND M0680 (Toileting) = 2 or more	3	10	3	10
14	Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis OR Neuro 2 - Peripheral neurological disorders AND M0650 or M0660 (Dressing upper or lower body) = 1, 2, or 3	2	4	2	2
15	Primary or Other Diagnosis = Neuro 3 - Stroke		1		
16	Primary or Other Diagnosis = Neuro 3 - Stroke AND M0650 or M0660 (Dressing upper or lower body) = 1, 2, or 3	1	3	2	8
17	Primary or Other Diagnosis = Neuro 3 - Stroke AND M0700 (Ambulation) = 3 or more	1	5		

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**FIGURE 12-4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012 (CONTINUED)**

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
18	Primary or Other Diagnosis = Neuro 4 - Multiple Sclerosis <b>AND AT LEAST ONE OF THE FOLLOWING:</b> M0670 (bathing) = 2 or more <b>OR</b> M0680 (Toileting) = 2 or more <b>OR</b> M0690 (Transferring) = 2 or more <b>OR</b> M0700 (Ambulation) = 3 or more	3	3	12	18
19	Primary or Other Diagnosis = Ortho 1 - Leg Disorders or Gait Disorders <b>AND</b> M0460 (most problematic pressure ulcer stage) = 1, 2, 3 or 4	2			
20	Primary or Other Diagnosis = Ortho 1 - Leg OR Ortho 2 - Other orthopedic disorders <b>AND</b> M0250 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	5	5		
21	Primary or Other Diagnosis = Psych 1 - Affective and other psychoses, depression	3	5	2	5
22	Primary or Other Diagnosis = Psych 2 - Degenerative and other organic psychiatric disorders	1	2		2
23	Primary or Other Diagnosis = Pulmonary disorders	1	5	1	5
24	Primary or Other Diagnosis = Pulmonary disorders <b>AND</b> M0700 (Ambulation) = 1 or more	1			
25	Primary Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications	10	20	8	20
26	Other Diagnosis = Skin 1 - Traumatic wounds, burns, post-operative complications	6	6	4	4
27	Primary or Other Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications <b>OR</b> Skin 2 - Ulcers and other skin conditions <b>AND</b> M0250 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	2		2	
28	Primary or Other Diagnosis = Skin 2 - Ulcers and other skin conditions	6	12	5	12
29	Primary or Other Diagnosis = Tracheostomy	4	4	4	
30	Primary or Other Diagnosis = Urostomy/Cystostomy	6	23	4	23
31	M0250 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	8	15	5	12
32	M0250 (Therapy at home) = 3 (Enteral)	4	12		12
33	M0390 (Vision) = 1 or more	1			1
34	M0420 (Pain) = 2 or 3	1			
35	M0450 = Two or more pressure ulcers at stage 3 or 4	3	3	5	5
36	M0460 (Most problematic pressure ulcer stage) = 1 or 2	5	11	5	11

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**FIGURE 12-4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012 (CONTINUED)**

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
37	M0460 (Most problematic pressure ulcer stage) = 3 or 4	16	26	12	23
38	M0476 (Stasis ulcer status) = 2	8	8	8	8
39	M0476 (Stasis ulcer status) = 3	11	11	11	11
40	M0488 (Surgical wound status) = 2		2	3	
41	M0488 (Surgical wound status) = 3	4	4	4	4
42	M0490 (Dyspnea) = 2, 3, or 4	2	2		
43	M0540 (Bowel Incontinence) = 2 to 5	1	2	1	
44	M0550 (Ostomy) = 1 or 2	5	9	3	9
45	M0800 (Injectable Drug Use) = 0, 1, or 2	1	1	2	4
<b>FUNCTIONAL DIMENSION</b>					
46	M0650 or M0660 (Dressing upper or lower body) = 1, 2, or 3	2	4	2	2
47	M0670 (Bathing) = 2 or more	3	3	6	6
48	M0680 (Toileting) = 2 or more	2	3	2	
49	M0690 (Transferring) = 2 or more		2		
50	M0700 (Ambulation) = 1 or 2	1		1	
51	M0700 (Ambulation) = 3 or more	3	4	4	5

**Notes:** The data for the regression equations come from a 20% random sample of episodes from CY 2005. The sample excludes LUPA episodes, outlier episodes, and episodes with SCIC or PEP adjustments.

Points are additive; however, points may not be given for the same line item in the table more than once.

Please see Medicare Home Health Diagnosis Coding guidance at [http://www.cms.hhs.gov/HomeHealthPPS/03\\_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp) for definitions of primary and secondary diagnoses.

**FIGURE 12-4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012**

**NOTE:** 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
<b>CLINICAL DIMENSION</b>					
1	Primary or Other Diagnosis = Blindness/Low Vision	3	3	3	3
2	Primary or Other Diagnosis = Blood disorders	2	5		
3	Primary or Other Diagnosis = Cancer, selected benign neoplasms	3	8	3	10
4	Primary Diagnosis = Diabetes	5	13	1	8
5	Other Diagnosis = Diabetes	3	5	1	5
6	Primary or Other Diagnosis = Dysphagia AND Primary or Other Diagnosis = Neuro 3 - Stroke	2	6		6

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**FIGURE 12-4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012 (CONTINUED)**

**NOTE:** 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
7	Primary or Other Diagnosis = Dysphagia AND M1030 (Therapy at home) = 3 (Enteral)		6		
8	Primary or Other Diagnosis = Gastrointestinal disorders	2	6	1	5
9	Primary or Other Diagnosis = Gastrointestinal disorders AND M1630 (ostomy) = 1 or 2	2			
10	Primary or Other Diagnosis = Gastrointestinal disorders AND Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis, OR Neuro 2 - Peripheral neurological disorders, OR Neuro 3 - Stroke, OR Neuro 4 - Multiple Sclerosis			2	
11	Primary or Other Diagnosis = Heart Disease OR Hypertension	3	6	1	7
12	Primary Diagnosis = Neuro 1 - Brain disorders and paralysis	3	8	5	8
13	Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis AND M1840 (Toileting) = 2 or more	3	10	3	10
14	Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis OR Neuro 2 - Peripheral neurological disorders AND M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	1	4	1	2
15	Primary or Other Diagnosis = Neuro 3 - Stroke		2		
16	Primary or Other Diagnosis = Neuro 3 - Stroke AND M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	1	3	2	8
17	Primary or Other Diagnosis = Neuro 3 - Stroke AND M1860 (Ambulation) = 4 or more	1	5		
18	Primary or Other Diagnosis = Neuro 4 - Multiple Sclerosis <b>AND AT LEAST ONE OF THE FOLLOWING:</b> M1830 (bathing) = 2 or more <b>OR</b> M1840 (Toileting) = 2 or more <b>OR</b> M1850 (Transferring) = 2 or more <b>OR</b> M1860 (Ambulation) = 4 or more	3	3	12	18
19	Primary or Other Diagnosis = Ortho 1 - Leg Disorders or Gait Disorders AND M1324 (most problematic pressure ulcer stage) = 1, 2, 3, or 4	2			

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**FIGURE 12-4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012 (CONTINUED)**

**NOTE:** 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	<b>Episode number within sequence of adjacent episodes</b>	<b>1 or 2</b>	<b>1 or 2</b>	<b>3+</b>	<b>3+</b>
	<b>Therapy visits</b>	<b>0-13</b>	<b>14+</b>	<b>0-13</b>	<b>14+</b>
	<b>EQUATION:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
20	Primary or Other Diagnosis = Ortho 1 - Leg OR Ortho 2 - Other orthopedic disorders <b>AND</b> M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	5	5		
21	Primary or Other Diagnosis = Psych 1 - Affective and other psychoses, depression	4	6	2	6
22	Primary or Other Diagnosis = Psych 2 - Degenerative and other organic psychiatric disorders	1	3		3
23	Primary or Other Diagnosis = Pulmonary disorders	1	5	1	5
24	Primary or Other Diagnosis = Pulmonary disorders <b>AND</b> M1860 (Ambulation) = 1 or more	1			
25	Primary Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications	10	20	8	20
26	Other Diagnosis = Skin 1 - Traumatic wounds, burns, post-operative complications	6	6	4	4
27	Primary or Other Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications OR Skin 2 - Ulcers and other skin conditions <b>AND</b> M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	2		2	
28	Primary or Other Diagnosis = Skin 2 - Ulcers and other skin conditions	6	12	5	12
29	Primary or Other Diagnosis = Tracheostomy	4	4	4	
30	Primary or Other Diagnosis = Urostomy/Cystostomy	6	22	4	22
31	M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	8	15	5	11
32	M1030 (Therapy at home) = 3 (Enteral)	4	11		11
33	M1200 (Vision) = 1 or more	1			2
34	M1242 (Pain) = 3 or 4	1			
35	M1308 = Two or more pressure ulcers at stage 3 or 4	3	3	5	5
36	M1324 (Most problematic pressure ulcer stage) = 1 or 2	5	11	5	11
37	M1324 (Most problematic pressure ulcer stage) = 3 or 4	16	26	12	22
38	M1334 (Stasis ulcer status) = 2	7	7	7	7
39	M1334 (Stasis ulcer status) = 3	11	11	11	11
40	M1342 (Surgical wound status) = 2		2	3	
41	M1342 (Surgical wound status) = 3	4	4	4	4
42	M1400 (Dyspnea) = 2, 3, or 4	2	2		
43	M1620 (Bowel Incontinence) = 2 to 5	1	2	1	
44	M1630 (Ostomy) = 1 or 2	5	9	3	9

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**FIGURE 12-4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012 (CONTINUED)**

**NOTE:** 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
45	M2030 (Injectable Drug Use) = 0, 1, 2, or 3	0	1	2	3
<b>FUNCTIONAL DIMENSION</b>					
46	M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	2	4	2	2
47	M1830 (Bathing) = 2 or more	3	3	6	6
48	M1840 (Toileting) = 2 or more	2	3	2	
49	M1850 (Transferring) = 2 or more		1		
50	M1860 (Ambulation) = 1, 2, or 3	1		1	
51	M1860 (Ambulation) = 4 or more	3	3	4	5

**Notes:** The data for the regression equations come from a 20% random sample of episodes from CY 2005. The sample excludes LUPA episodes, outlier episodes, and episodes with SCIC or PEP adjustments. Points are additive; however, points may not be given for the same line item in the table more than once. Please see Medicare Home Health Diagnosis Coding guidance at [http://www.cms.hhs.gov/HomeHealthPPS/03\\_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp) for definitions of primary and secondary diagnoses.

(2) The point scores for service utilization levels (fourth position of the HIPPS code) are determined by the number of therapy visits (see Figure 12-4-7 for range of visits within each service utilization level and associated episode).

(3) The point scores for NRS levels (fifth position of the HIPPS code) are derived from the six severity groups in Figure 12-4-10. These severity levels more accurately reflect the large variation in NRS used across all patient types.

**FIGURE 12-4-10 RELATIVE WEIGHTS FOR NRS - SIX-GROUP APPROACH**

SEVERITY LEVEL	POINTS (SCORING)	RELATIVE WEIGHT	PAYMENT AMOUNT
1	0	0.2698	\$ 14.12
2	1 to 14	0.9742	51.00
3	15 to 27	2.6712	139.84
4	28 to 48	3.9686	207.76
5	49 to 98	6.1198	320.37
6	99+	10.5254	551.00

**Note:** NRS conversion factor = \$52.35.

(c) Figure 12-4-11 provides the case-mix variables (i.e., selected skin conditions and other clinical factors) and scores used in assigning a NRS to one of the six severity levels in Figure 12-4-10.

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**FIGURE 12-4-11 NRS CASE-MIX ADJUSTMENT VARIABLES AND SCORES**

ITEM	DESCRIPTION	SCORE
<b>SELECTED SKIN CONDITIONS:</b>		
1	Primary diagnosis = Anal fissure, fistula and abscess	15
2	Other diagnosis = Anal fissure, fistula and abscess	13
3	Primary diagnosis = Cellulitis and abscess	14
4	Other diagnosis = Cellulitis and abscess	8
5	Primary diagnosis = Diabetic ulcers	20
6	Primary diagnosis = Gangrene	11
7	Other diagnosis = Gangrene	8
8	Primary diagnosis = Malignant neoplasms of skin	15
9	Other diagnosis = Malignant neoplasms of skin	4
10	Primary or Other diagnosis = Non-pressure and non-stasis ulcers	13
11	Primary diagnosis = Other infections of skin and subcutaneous tissue	16
12	Other diagnosis = Other infections of skin and subcutaneous tissue	7
13	Primary diagnosis = Post-operative Complications	23
14	Other diagnosis = Post-operative Complications	15
15	Primary diagnosis = Traumatic Wounds and Burns	19
16	Other diagnosis = Traumatic Wounds and Burns	8
17	Primary or other diagnosis = V code, Cystostomy care	16
18	Primary or other diagnosis = V code, Tracheostomy care	23
19	Primary or other diagnosis = V code, Urostomy care	24
20	OASIS M0450 = 1 or 2 pressure ulcers, stage 1	4
21	OASIS M0450 = 3+ pressure ulcers, stage 1	6
22	OASIS M0450 = 1 pressure ulcer, stage 2	14
23	OASIS M0450 = 2 pressure ulcers, stage 2	22
24	OASIS M0450 = 3 pressure ulcers, stage 2	29
25	OASIS M0450 = 4+ pressure ulcers, stage 2	35
26	OASIS M0450 = 1 pressure ulcer, stage 3	29
27	OASIS M0450 = 2 pressure ulcers, stage 3	41
28	OASIS M0450 = 3 pressure ulcers, stage 3	46
29	OASIS M0450 = 4+ pressure ulcers, stage 3	58
30	OASIS M0450 = 1 pressure ulcer, stage 4	48
31	OASIS M0450 = 2 pressure ulcers, stage 4	67
32	OASIS M0450 = 3+ pressure ulcers, stage 4	75
33	OASIS M0450e = 1(unobserved pressure ulcer(s))	17
34	OASIS M0470 = 2 (2 stasis ulcers)	6
35	OASIS M0470 = 3 (3 stasis ulcers)	12
36	OASIS M0470 = 4 (4+ stasis ulcers)	21
37	OASIS M0474 = 1 (unobservable stasis ulcers)	9
38	OASIS M0476 = 1 (status of most problematic stasis ulcer: fully granulating)	6
39	OASIS M0476 = 2 (status of most problematic stasis ulcer: early/partial granulation)	25

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**FIGURE 12-4-11 NRS CASE-MIX ADJUSTMENT VARIABLES AND SCORES (CONTINUED)**

ITEM	DESCRIPTION	SCORE
40	OASIS M0476 = 3 (status of most problematic stasis ulcer: not healing)	36
41	OASIS M0488 = 2 (status of most problematic surgical wound: early/partial granulation)	4
42	OASIS M0488 = 3 (status of most problematic surgical wound: not healing)	14
<b>OTHER CLINICAL FACTORS:</b>		
43	OASIS M0550 = 1 (ostomy not related to inpt stay/no regimen change)	27
44	OASIS M0550 = 2 (ostomy related to inpt stay/regimen change)	45
45	Any "Selected Skin Conditions" (rows 1-42 above) AND M0550 = 1 (ostomy not related to inpt stay/no regimen change)	14
46	Any "Selected Skin Conditions" (rows 1-42 above) AND M0550 = 2 (ostomy related to inpt stay/ regimen change)	11
47	OASIS M0250 (Therapy at home) = 1 (IV/Infusion)	5
48	OASIS M0520 = 2 (patient requires urinary catheter)	9
49	OASIS M0540 = 4 or 5 (bowel incontinence, daily or > daily)	10

**Note:** Points are additive; however, points may not be given for the same line item in the table more than once. Points are not assigned for a secondary diagnosis if points are already assigned for a primary diagnosis from the same diagnosis/condition group.

Please see Medicare Home Health Diagnosis Coding guidance at [http://www.cms.hhs.gov/HomeHealthPPS/03\\_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp) for definitions of primary and secondary diagnoses.

(b) The supply payment amounts derived from the above severity level matrix (Figure 12-4-10) will be included in the total payment returned by the HH Pricer. It will not be reflected separately on the claim. Supply amounts will not be calculated on LUPA claims.

(c) Refer to **Addendum O** for the ICD-9-CM diagnoses included in the diagnostic categories for the NRS case-mix adjustment model (Figure 12-4-11).

(d) NRS provided during an EOC are subject to consolidated billing. If the date of service for NRS falls within the dates of an EOC, payment for the NRS is denied. However, NRS claims may be submitted by suppliers on the professional claim format, which has both "from" and "to" dates on each item. Medicare has instructed suppliers to report the delivery date as the "from" date, and the date by which the supplies will be used in the "to" date. When this causes the "to" date on a supply line item subject to consolidated billing to overlap on EOC, the service may be denied incorrectly. Contractors shall ensure proper payment of NRS provided prior to the beginning of an EOC ("from" date prior to the beginning of an EOC), even if the "to" date overlaps the EOC.

3. Adjustment of HIPPS Code for Incorrect Episode Designation. The contractors' claims processing systems will perform re-coding of claims where the HIPPS code does not reflect the correct episode using the 18-position treatment authorization code (formally known as the claim-OASIS matching key code) reported in Form Locator (FL) 63 of the UB-04 (CMS Form 1450).

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a. Following is the new format of the treatment authorization code for episodes beginning on or after January 1, 2008:

**FIGURE 12-4-12 FORMAT FOR TREATMENT AUTHORIZATION CODE**

POSITION	DEFINITION	FORMAT
1-2	M0030 (Start-of-care date) - 2 digit year	99
3-4	M0030 (Start-of-care date) - alpha code for Julian date	XX
5-6	M0090 (Date assessment completed) - 2 digit year	99
7-8	M0090 (Date assessment completed) - alpha code for Julian Date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) - Early=1, Late=2	9
11	Alpha code for Clinical severity points - under Equation 1	X
12	Alpha code for Functional severity points - under Equation 1	X
13	Alpha code for Clinical severity points - under Equation 2	X
14	Alpha code for Functional severity points - under Equation 2	X
15	Alpha code for Clinical severity points - under Equation 3	X
16	Alpha code for Functional severity points - under Equation 3	X
17	Alpha code for Clinical severity points - under Equation 4	X
18	Alpha code for Functional severity points - under Equation 4	X

(1) The Julian dates in positions 3-4 and 7-8 are converted from three position numeric values to two position alphabetic values using the code system in [Addendum P](#).

(2) The two position numeric scores in positions 11-18 are converted to a single alphabetic code using values in [Figure 12-4-13](#).

**FIGURE 12-4-13 CONVERTING POINT VALUES TO LETTER CODES**

POINTS	LETTER CODE						
0 or 1	A	8	H	15	O	22	V
2	B	9	I	16	P	23	W
3	C	10	J	17	Q	24	X
4	D	11	K	18	R	25	Y
5	E	12	L	19	S	26	Z
6	F	13	M	20	T		
7	G	14	N	21	U		

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b. Figure 12-4-14 provides an example of a treatment authorization code that is created by the grouper software using the format outlined in Figure 12-4-13.

**FIGURE 12-4-14 EXAMPLE OF A TREATMENT AUTHORIZATION CODE**

POSITION	DEFINITION	ACTUAL VALUE	RESULTING CODE
1-2	M0030 (Start-of-care date) - two digit year	2007	07
3-4	M0030 (Start-of-care date) - alpha code for Julian date	Julian date 245	JK
5-6	M0090 (Date assessment completed) - two digit year	2008	08
7-8	M0090 (Date assessment completed) - alpha code for Julian date	Julian date 001	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing) - Early = 1, Late = 2	01	1
11	Clinical severity points - under Equation 1	7	G
12	Functional severity points - under Equation 1	2	B
13	Clinical severity points - under Equation 2	13	M
14	Functional severity points - under Equation 2	4	D
15	Clinical severity points - under Equation 3	3	C
16	Functional severity points - under Equation 3	4	D
17	Clinical severity points - under Equation 4	12	L
18	Functional severity points - under Equation 4	7	G

The treatment authorization code that would appear on the claim would be, in this example: **07JK08AA41GBMDCDLG**

c. Episode adjustment process using authorization code.

(1) Contractor claims processing systems will validate the treatment authorization code except where condition code 21 is present on the claim. If the code is validated, the contractors will return claims to the provider if the treatment authorization code fails any of the following validation edits:

(a) The first, second, fifth, sixth, and ninth positions of the treatment authorization codes must be numeric;

(b) The third, fourth, seventh, and eighth positions of the code must be alphabetic;

(c) The tenth position of the code must contain a value of one or two; and

(d) The eleventh through 18th positions of the code must be alphabetic.

(2) The system shall read the home health episode history when a new episode is received and identify any HIPPS codes that represent an incorrect position in the sequence. The sequence of episodes are determined without regard to changes in the HHA.

The calculated 60-day episode end date will be used to measure breaks between episodes in all cases except for episodes subject to PEP adjustments. In the case of PEP episodes, the date of latest billing will be used.

(3) If the contractors' system identifies a HIPPS code that represents an incorrect position in the sequence of episodes it will be re-coded and adjusted using the last 9 positions of the treatment authorization code and the following re-coding logic:

(a) The last eight positions of the treatment authorization will contain codes representing the points for the clinical domain and the functional domain as calculated under each of the four equations of the refined HH PPS case mix system. The treatment authorization code, including these domain codes, will be calculated by the HH PPS Grouper software, so that providers can transfer this 18 position code to their claims.

(b) The input/output record for the HH Pricer will be modified to convert existing filler fields into new fields to facilitate recording. A new nine position field will be created to carry the clinical and functional severity point information. The last nine positions of the treatment authorization code will be extracted and placed into this new field in the input/output record. This will enable the HH Pricer to record claims using the point information.

(c) On incoming original RAPs and claims, the HH Pricer will disregard the code in this nine position field, since the submitted HIPPS code is being priced at face value. The code in this nine position field will be used in recording claims identified as misrepresenting the episode sequence. To enable the Pricer to distinguish these two cases, an additional one position numeric field will be added to the input/output record.

(d) On the original RAPs and claims, the system will populate the new one position field with a zero.

1 If a claim is submitted by the provider as a first or second episode and the claim is actually a third or later episode, the system will populate the new field with a 3 to indicate this.

2 If a claim is submitted by the provider as a third or later episode and the claim is actually a first or second episode, the system will populate the new field with a 1 to indicate this.

(e) When the new one position field is populated with a 1 or a 3, the HH Pricer will record the claim using the following steps:

STEP 1: The HH Pricer will determine, from the new episode sequence and the number of therapy visits on the claim, which equation of the HH PPS case-mix model applies to the claim.

STEP 2: The HH Pricer will find the two positions in the new nine position field that correspond to the equation identified in Step 1.

- STEP 3: The HH Pricer will convert the alphabetic codes in these positions to numeric point values.
- STEP 4: The HH Pricer will read the appropriate column on the case-mix scoring table to find the new clinical and functional severity levels that correspond to that point value (Figure 12-4-8).
- STEP 5: Using the severity levels identified in Step 4 and the HIPPS code structure shown in the above table, the HH Pricer will determine the new HIPPS code that applies to the claim.

(f) The HH Pricer will use the new HIPPS code resulting from these steps to re-price the claim and will return the new code to the existing output HIPPS code field in the input/output record.

(g) When the first position of the HIPPS code is a five and the number of therapy services on the claim are less than 20, the HH Pricer will use the first position of the new nine position field to record the first position of the HIPPS code and complete the steps described above.

d. Adjustment of previously paid episodes.

(1) The contractor claims processing systems will initiate automatic adjustments for previously paid episodes when the receipt of earlier dated episodes change their position in a sequence of episodes. The system will re-code and re-price the automatic adjustments.

(2) The system will calculate a supply adjustment amount and add it to the otherwise re-priced episode amount.

e. Determining the gap between episodes (i.e., if the episodes are adjacent/contiguous.

(1) The 60-day period to determine a gap that will begin a new sequence of episodes will be counted in most instances from the calculated 60-day end date of the episode. The exception to this is for episodes that were subject to PEP adjustment.

(2) In PEP cases, the system will count 60 days from the date of the last billable home health visit provided in the PEP episode.

(3) Intervening stays in inpatient facilities will not create any special consideration in counting the 60-day gap.

(c) If an inpatient stay occurred within an episode, it would not be a part of the gap, as counting would not begin at Day 60, which in this case could be later than the inpatient discharge date.

(b) If an inpatient stay occurred within the period after the end of all HH episode and before the beginning of the next one, those days would be counted as part of the gap just as any other days would.

(4) If episodes are received after a particular claim is paid that change the sequence initially assigned to the paid episode (for example, by service dates falling earlier than those of the paid episode, or by falling within a gap between paid episodes), the system will initiate automatic adjustments to correct the payment of any necessary episodes as described above.

f. Refer to [Addendums R and S](#) for changes in input/output record layout and Pricer logic for 60-day episodes beginning on or after January 1, 2008.

F. Abbreviated Assessments for Establishment of Payments Under HHA PPS.

1. Medicare-certified HHAs will be required to conduct abbreviated assessments for TRICARE beneficiaries who are under the age of 18 or receiving maternity care for payment under the HHA PPS. This will require the manual completion and scoring of a HHRG Worksheet (refer to [Chapter 12, Addendum I](#) for copy of worksheet). The HIPPS code generated from this scoring process will be submitted on the CMS 1450 UB-04 for pricing and payment. This abbreviated 23 item assessment (as opposed to the full 79 item comprehensive assessment) will provide the minimal amount of data necessary for reimbursement under the HHA PPS. This is preferable, from an integrity standpoint, to dummied up the missing data elements on the comprehensive assessment. HHAs will also be responsible for collecting the OASIS data element links necessary in reporting the claims-OASIS matching key (i.e., the 18 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). The claims-OASIS matching key is reported in FL 44 of the CMS 1450 UB-04.

2. Use of Abbreviated Assessments for Episodes Beginning On or After January 1, 2008. Abbreviated assessments will continue to be used for TRICARE beneficiaries who are under the age of 18 or receiving maternity care for payment under the HHA PPS with the following modifications:

a. The first position of the HIPPS code - which assigns differing scores in the clinical, functional and services domains based on whether an episode is an early or later episode in a sequence of adjacent episodes and the number of visits incurred during that episode - will be reported by the HHA in accordance with the HIPPS coding structure outlined in [Figure 12-4-6](#) (i.e., numerical values 1 through 5 based on the EOC and number of visits).

b. The second, third, and fourth positions of the HIPPS code (alphabetical characters) will be assigned based on the scoring of the 23 OASIS items reflected in the HHRG Worksheet for episodes beginning on or after January 1, 2008 in [Addendum I](#). The OASIS items for use in this abbreviated assessment scoring will be available on the CMS web site (<http://www.cms.hhs.gov/HomeHealthQualityInits/>) as indicated in [Addendum G](#). However, since Clinical Severity Domain category "C0", Function Status Domain category "F0", and Service Utilization Domain category "S0" are no longer recognized as part of the

refined HIPPS coding structure they will default to “C1”, “F1”, and “S1”, respectively, in establishing reimbursement under the abbreviated assessment for TRICARE beneficiaries who are under the age of 18 or receiving maternity care.

c. The fifth position of the HIPPS code will be reported by the HHA using the HIPPS coding structure outlined in [Figure 12-4-6](#) based on the EOC and number of visits, along with whether or not supplies were actually provided during the episode of HHC; i.e., 1-6 in cases where NRSs are not associated with the first four positions of the HIPPS code and S-X where they are.

d. A treatment authorization code will not be required for the processing and payment of home health episodes under the abbreviated assessment process. As a result, the contractors will not have the responsibility of recoding claims and/or validating the 18-position treatment authorization code that is normally required for the processing and payment of home health claims subject to the full-blown OASIS assessment.

3. The following hierarchy will be adhered to in the placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of 18 or receiving maternity care. The MCSCs will adhere to this hierarchical placement through their role in establishing primary provider status under the HHA PPS (i.e., designating that HHA which may receive payment under the consolidated billing provisions for home health services provided under a POC.)

a. Authorization for care in and primary provider status designation for a Medicare certified HHA (i.e., in a HHA meeting all Medicare conditions of participation [Sections 1861(o) and 1891 of the Social Security Act and part 484 of the Medicare regulation (42 CFR 484)] will result in payment of home health services under the PPS. The HHA will be reimbursed a fixed case-mix and wage-adjusted 60-day episode payment amount based on the HIPPS code generated from the required abbreviated assessment. For example, if there are two HHAs within a given treatment area that can provide care for a TRICARE beneficiary under the age of 18, and one is Medicare certified and the other is not due to its targeted patient population (HHA specializing solely in the home health needs of patients under the age of 18), the contractor will authorize care in, and designate primary provider status to, the Medicare HHA.

b. If a Medicare-certified HHA is not available within the service area, the MCSC may authorize care in a non-Medicare certified HHA (e.g., a HHA which has not sought Medicare certification/approval due to the specialized beneficiary categories it services - patients receiving maternity care and/or patients under the age 18) that qualifies for corporate services provider status under TRICARE (refer to the TRICARE Policy Manual (TPM), [Chapter 11, Section 12.1](#), for the specific qualifying criteria for granting corporate services provider status under TRICARE.) The following payment provisions will apply to HHAs qualifying for coverage under the corporate services provider class:

(1) Otherwise covered professional services provided by TRICARE authorized individual providers employed by or under contract with a freestanding corporate entity will be paid under the TRICARE Maximum Allowable Charge (TMAC) reimbursement system, subject to any restrictions and limitations as may be prescribed under existing TRICARE policy.

(2) Payment will also be allowed for supplies used by a TRICARE authorized individual provider employed by or contracted with a corporate services provider in the direct treatment of a TRICARE eligible beneficiary. Allowable supplies will be reimbursed in accordance with TRICARE allowable charge methodology as described in [Chapter 5](#).

(3) Reimbursement of covered professional services and supplies will be made directly to the TRICARE authorized corporate services provider under its own tax identification number.

(4) There are also regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems as long as they do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies.

G. Split Payments (Initial and Final Payments).

1. A split percentage approach has been taken in the payment of HHAs in order to minimize potential cash-flow problems.

a. A split percentage payment will be made for most episode periods. There will be two payments (initial and final) - the initial paid in response to a Request for Anticipated Payment (RAP), and the final in response to a claim. Added together, the initial and final payments equal 100% of the permissible reimbursement for the episode.

b. There will be a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments will be 60% in response to the RAP, and 40% in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments will equal 50% of the estimated case-mix adjusted episode payment. There is no set length required for a gap in services between episodes for a following episode to be considered initial rather than subsequent. If any gap occurs, the next episode will be considered initial for payment purposes.

c. The HHA may request and receive accelerated payment if the contractor fails to make timely payments. While a physician's signature is not required on the POC for initial payment, it is required prior to claim submission for final payment.

H. Calculation of Prospective Payment Amounts.

1. National 60-Day Episode Payment Amounts.

a. Medicare, in establishment of its prospective payment amount, included all costs of home health services derived from audited Medicare cost reports for a nationally representative sample of HHAs for Fiscal Year (FY) 1997. Base-year costs were adjusted using the latest available market basket increases between the cost reporting periods contained in the database and September 30, 2001. Total costs were divided by total visits in establishing an average cost per visit per discipline. The discipline specific cost per visit was then multiplied by the average number of visits per discipline provided within a 60-day EOC in

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the establishment of a home health prospective payment rate per discipline. The 60-day utilization rates were derived from Medicare home health claims data for FY 1997 and 1998. The prospective payment rates for all six disciplines were summed to arrive at a total non-standardized prospective payment amount per 60-day EOC.

b. [Figure 12-4-15](#) provides the calculations involved in the establishment of the non-standardized prospective payment amount per 60-day episode in FY 2001, along with adjustments for NRS, Part B therapies and OASIS implementation and ongoing costs.

**FIGURE 12-4-15 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS**

DISCIPLINES	TOTAL COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	AVER. # VISITS PER 60-DAYS	HOME HEALTH PROSPECTIVE PAYMENT RATE
Home Health Aide Services	\$5,915,395,602	141,682,907	\$ 41.75	13.40	\$559.45
Medical Social Services	458,571,353	2,985,588	153.59	0.32	49.15
Occupational Therapy	444,691,130	4,244,901	104.76	0.53	55.52
Physical Therapy	2,456,109,303	23,605,011	104.05	3.05	317.35
Skilled Nursing Services	12,108,884,714	127,515,950	94.96	14.08	1,337.04
Speech Pathology Service	223,173,331	1,970,399	113.26	0.18	20.39
Total Non-Standardized Prospective Payment Amount Per 60-Day Episode for FY 2001: <b>\$2,338.90</b>					
<b>ADJUSTMENTS:</b>					
1) Average cost per episode for NRS included in the home health benefit and reported as costs on the cost report . . . . .					<b>\$43.54</b>
2) Average payment per episode for NRS possibly unbundled and billed separately for Part B . . . . .					<b>\$6.08</b>
3) Average payment per episode for Part B therapies . . . . .					<b>\$17.76</b>
4) Average payment per episode for OASIS one time adjustment for form changes . . . . .					<b>\$5.50</b>
5) Average payment per episode for ongoing OASIS adjustment costs . . . . .					<b>\$4.32</b>
Total Non-Standardized Prospective Payment Amount for 60-Day Episode for FY 2001 Plus Medical Supplies, Part B Therapies and OASIS					<b>\$2,416.01</b>

c. The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in [Figure 12-4-16](#) for case-mix, budget neutrality and outliers in the establishment of a final standardized and budget neutral payment amount per 60-day episode for FY 2001.

**FIGURE 12-4-16 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX**

NON-STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS	STANDARDIZATION FACTOR FOR WAGE INDEX AND CASE-MIX	BUDGET NEUTRALITY FACTOR	OUTLIER ADJUSTMENT FACTOR	STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS
\$2,416.01	0.96184	0.88423	1.05	<b>\$2,115.30</b>

(1) The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in [Addendums L \(CY 2010\)](#), [L \(CY 2011\)](#), and [L \(CY 2012\)](#).

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(2) The standardized prospective payment amount per 60-day EOC is case-mix and wage-adjusted in determining payment to a specific HHA for a specific beneficiary. The wage adjustment is made to the labor portion (0.77668) of the standardized prospective payment amount after being multiplied by the beneficiary's designated HHRG case-mix weight. For example, a HHA serves a TRICARE beneficiary in Denver, CO. The HHA determines the patient is in HHRG C2F1S2 with a case-mix weight of 1.8496. The following steps are used in calculating the case-mix and wage-adjusted 60-day episode payment amount:

STEP 1: Multiply the standard 60-day prospective payment amount by the applicable case-mix weight.

$$(1.8496 \times \$2,115.30) = \$3,912.46$$

STEP 2: Divide the case-mix adjustment episode payment into its labor and non-labor portions.

$$\text{Labor Portion} = (0.77668 \times \$3,912.46) = \$3,038.73$$

$$\text{Non-Labor Portion} = (0.22332 \times \$3,912.46) = \$873.73$$

STEP 3: Adjust the labor portion by multiplying by the wage index factor for Denver, CO.

$$(1.0190 \times \$3,038.73) = \$3,096.47$$

STEP 4: Add the wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted episode payment.

$$(\$873.73 + \$3,096.47) = \boxed{\$3,970.20}$$

d. Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts has not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in [Addendums L \(CY 2010\)](#), [L \(CY 2011\)](#), [L \(CY 2012\)](#), [M \(CY 2010\)](#), [M \(CY 2011\)](#), and [M \(CY 2012\)](#).

e. Annual Updating of HHA PPS Rates and Wage Indexes.

(1) In subsequent fiscal years, HHA PPS rates (i.e., both the national 60-day episode amount and per-visit rates) will be increased by the applicable home health market basket index change.

(2) Three iterations of these rates will be maintained in [Addendums L \(CY 2010\)](#), [L \(CY 2011\)](#), and [L \(CY 2012\)](#). These rate adjustments are also integral data elements used in updating the Pricer.

(3) Three iterations of wage indexes will also be maintained in [Addendums L \(CY 2010\)](#), [L \(CY 2011\)](#), [L \(CY 2012\)](#), [M \(CY 2010\)](#), [M \(CY 2011\)](#), and [M \(CY 2012\)](#) for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

2. Calculation of Reduced Payments.

a. Under certain circumstances, payment will be less than the full 60-day episode rate to accommodate changes of events during the beneficiary's care. The start and end dates of each event will be used in the apportionment of the full-episode rate. These reduced payment amounts are referred to as: 1) PEP adjustments; 2) SCIC adjustments; 3) LUPAs; and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

NOTE: Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) has not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in [Addendums L \(CY 2010\)](#), [L \(CY 2011\)](#), [L \(CY 2012\)](#), [M \(CY 2010\)](#), [M \(CY 2011\)](#), and [M \(CY 2012\)](#).

(1) PEP Adjustment. The PEP adjustment is used to accommodate payment for EOCs less than 60 days resulting from one of the following intervening events: 1) beneficiary elected a transfer prior to the end of the 60-day EOC; or 2) beneficiary discharged after meeting all treatment goals in the original POC and subsequently readmitted to the same HHA before the end of the 60-day EOC. The PEP adjustment is based on the span of days over which the beneficiary received treatment prior to the intervening event; i.e., the days, including the start-of-care date/first billable service date through and including the last billable service date, before the intervening event. The original POC must be terminated with no anticipated need for additional home health services. A new 60-day EOC would have to be initiated upon return to a HHA, requiring a physician's recertification of the POC, a new OASIS assessment, and authorization by the contractor. The PEP adjustment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary was receiving care prior to the intervening event by the beneficiary's assigned 60-day episode payment. The PEP adjustment is only applicable for beneficiaries having more than four billable home health visits. Transfers of beneficiaries between HHAs of common ownership are only applicable when the agencies are located in different metropolitan statistical areas. Also, PEP adjustments do not apply in situations where a patient dies during a 60-day EOC. Full episode payments are made in these particular cases. For example, a beneficiary assigned to HHRG C2F1S2 and receiving care in Denver, CO was discharged from a HHA on Day 28 of a 60-day EOC and subsequently returned to the same HHA on Day 40. However, the first billable visit (i.e., a physician ordered visit under a new POC) did not occur until Day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original POC were accomplished and there was no anticipated need for home care during the balance of the 60-day episode. Since the last visit was furnished on Day 28 of the initial 60-day episode, the PEP adjustment would be equal to the assigned 60-day episode payment times 28/60, representing the proportion of the 60 days that the patient

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was in treatment. Day 42 of the original episode becomes Day 1 of the new certified 60-day episode. The following steps are used in calculating the PEP adjustment:

STEP 1: Calculate the proportion of the 60 days that the beneficiary was under treatment.

$$(28/60) = 0.4667$$

STEP 2: Multiply the beneficiary assigned 60-day episode payment amount by the proportion of days that the beneficiary was under treatment.

$$(\$3,970.20 \times 0.4667) = \boxed{\$1,852.90}$$

(2) SCIC Payment Adjustment.

For Episodes Beginning On Or After January 1, 2008. The refined HH PPS no longer contains a policy to allow for adjustments reflecting SCICs. Episodes paid under the refined HH PPS will be paid based on a single HIPPS code. Claims submitted with additional HIPPS codes reflecting SCICs will be returned to the provider; i.e., claims for episodes beginning on or after January 1, 2008, that contain more than one revenue code 0023 line.

(3) LUPA.

(a) For Episodes Beginning Prior To January 1, 2008.

1 The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in [Figure 12-4-1](#) plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in [Figure 12-4-17](#).

**FIGURE 12-4-17 PER VISIT PAYMENT AMOUNTS FOR LUPAS**

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for NRS*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjustment factor	Per-visit payment amounts per 60-day episode for FY 2001
Home Health Aide	\$41.75	\$1.94	\$0.12	\$0.21	0.96674	1.05	\$43.37
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74

\* Combined average cost per-visit amounts for NRS reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.

**FIGURE 12-4-17 PER VISIT PAYMENT AMOUNTS FOR LUPAS**

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for NRS*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjustment factor	Per-visit payment amounts per 60-day episode for FY 2001
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

\* Combined average cost per-visit amounts for NRS reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.

2 The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from Figure 12-4-17) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

NOTE: Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and Fixed Dollar Loss (FDL) amounts in Addendums L (CY 2010), L (CY 2011), L (CY 2012), M (CY 2010), M (CY 2011), and M (CY 2012).

STEP 1: Multiple the per-visit rate per discipline by the number of visits and add them together to get the total unadjusted low-utilization payment amount.

Skilled nursing visits (1 x \$95.79)	=	\$ 95.79
Physical therapy visits (1 x \$104.74)	=	\$104.74
Home health aide visits (2 x \$43.37)	=	\$ 86.74
<u>Total unadjusted payment amount</u>		<u>\$287.27</u>

STEP 2: Multiply the unadjusted payment amount by its labor and non-labor related percentages to get the labor and non-labor portion of the payment amount.

Labor Portion	=	(\$287.27 x 0.77668)	=	\$223.12
Non-labor Portion	=	(\$287.27 x 0.22332)	=	\$64.15

STEP 3: Multiply the labor portion of the payment amount by the wage index for Denver, CO.

$$(\$223.12 \times 1.0190) = \$227.36$$

STEP 4: Add the labor and non-labor portions together to arrive at the LUPA.

$$(\$227.36 + \$64.15) = \boxed{\$291.51}$$

(b) For Episodes Beginning On Or After January 1, 2008. LUPA may be subject to an additional payment adjustment. If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only EOC the beneficiary received and the Source of Referral and Admission or Visit Code is not "B" (Transfer From Another HHA) or "C" (Readmission to Same HHA), an additional add-on payment will be made. A lump-sum established in regulation and updated annually will be added to these claims. The additional amount for CY 2008 is \$87.93.

(4) Therapy Threshold Adjustment.

(a) For Episodes Beginning Prior To January 1, 2008. There is a downward adjustment in the 60-day episode payment amount if the number of therapy services delivered during an episode does not meet the threshold. The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode. The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, is confirmed by the visit information submitted in line-item detail on the claim for the episode. If therapy use is below the utilization threshold (i.e., the projected range of hours for physical, occupational or speech therapy combined), there is an automatic downward adjustment in the 60-day episode payment amount.

(b) For Episodes Beginning On Or After January 1, 2008.

1 The refined HH PPS adjusts Medicare payment based on whether one of three therapy thresholds (6, 14, or 20 visits) is met. As a result of these multiple thresholds, and since meeting a threshold can change the payment equation that applies to a particular episode, a simple "fallback" coding structure is no longer possible. Also, additional therapy visits may change the score in the services domain of the HIPPS code.

2 Due to this increased complexity of the payment system regarding therapies, the Pricer software in the claims processing system will re-code all claims based on the actual number of therapy services provided. The re-coding will be performed without regard to whether the number of therapies delivered increased or decreased compared to the number of expected therapies reported on the OASIS assessment and used to base RAP payment. As in the original HH PPS, the remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

3. Calculation of Outlier Payments.

a. A methodology has been established under the HHA PPS to allow for outlier payments in addition to regular 60-day episode payments for beneficiaries generating excessively large treatment costs. The outlier payments under this methodology are made for

those episodes whose estimated imputed costs exceed the predetermined outlier thresholds established for each HHRG. Outlier payments are not restricted solely to standard 60-day EOCs. They may also be extended for atypically costly beneficiaries who qualify for SCIC or PEP payment adjustments under the HHA PPS. The outlier threshold amount for each HHRG is calculated by adding a FDL amount, which is the same for all case-mix groups (HHRGs), to the HHRG's 60-day episode payment amount. A FDL amount is also added to the PEP and SCIC adjustment payments in the establishment of PEP and SCIC outlier thresholds.

b. The outlier payment amount is a proportion of the wage-adjusted estimated imputed costs beyond the wage-adjusted threshold. The loss-sharing ratio is the proportion of additional costs paid as an outlier payment. The loss-sharing ratio, along with the FDL amount, is used to constrain outlier costs to five percent of total episode payments. The estimated imputed costs are derived from those home health visits actually ordered and received during the 60-day episode. The total visits per discipline are multiplied by their national average per-visit amounts (refer to [Figure 12-4-4](#) for the calculation of national average per-visit amounts) and are wage-adjusted. The wage-adjusted imputed costs for each discipline are summed to get the total estimated wage-adjusted imputed costs for the 60-day EOC. The outlier threshold is then subtracted from the total wage-adjusted imputed per visit costs for the 60-day episode to come up with the imputed costs in excess of the outlier threshold. The amount in excess of the outlier threshold is multiplied by 80% (i.e., the loss share ratio) to obtain the outlier payment. The HHA receives both the 60-day episode and outlier payment. For example, a beneficiary assigned to HHRG C2L2S2 [case-mix weight of 1.9532 and receiving HHA care in Missoula, MT (wage index of 0.9086)], has physician orders for and received 54 skilled nursing visits, 48 home health aide visits, and six physical therapy visits. The following steps are used in calculating the outlier payment:

(1) Calculation of Case-Mix and Wage-Adjusted Episode Payment.

STEP 1: Multiply the case-mix weight for HHRG C2L2S2 by the standard 60-day prospective episode payment amount.

$$(1.9532 \times \$2,115.30) = \$4,131.60$$

STEP 2: Divide the case-mix-adjusted episode payment amount into its labor and non-labor portions.

Labor Portion	=	$(0.77668 \times \$4,131.60)$	=	\$3,208.93
Non-labor Portion	=	$(0.22332 \times \$4,131.60)$	=	\$922.67

STEP 3: Multiply the labor portion of the case-mix adjusted episode payment by the wage index factor for Missoula, MT.

$$(0.9086 \times \$3,208.93) = \$2,915.63$$

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STEP 4: Add the wage-adjusted labor portion to the non-labor portion to get the total case-mix and wage-adjusted 60-day episode payment amount.

$$(\$2,915.63 + \$922.67) = \boxed{\$3,838.30}$$

(2) Calculation of the Wage-Adjusted Outlier Threshold.

STEP 1: Multiply the 60-day episode payment amount by the FDL ratio (1.13) to come up with the FDL amount.

$$(\$2,115.30 \times 1.13) = \$2,390.29$$

STEP 2: Divide the FDL amount into its labor and non-labor portions.

$$\begin{aligned} \text{Labor Portion} &= (0.77668 \times \$2,390.29) = \$1,856.49 \\ \text{Non-labor Portion} &= (0.22332 \times \$2,390.29) = \$533.80 \end{aligned}$$

STEP 3: Multiply the labor portion of the FDL amount by the wage index for Missoula, MT (0.9086).

$$(0.9086 \times \$1,856.49) = \$1,686.81$$

STEP 4: Add back the non-labor portion to the wage-adjusted labor portion to get the total wage-adjusted FDL amount.

$$(\$1,686.81 + \$533.80) = \$2,220.61$$

STEP 5: Add the case-mix and wage-adjusted 60-day episode payment amount to the wage-adjusted fixed dollar amount to obtain the wage-adjusted outlier threshold.

$$(\$3,838.32 + \$2,220.60) = \boxed{\$6,058.92}$$

(3) Calculation of Wage-Adjusted Imputed Cost of 60-Day Episode.

STEP 1: Multiply the total number of visits by the national average cost per visit for each discipline to arrive at the imputed costs per discipline over the 60-day episode.

$$\begin{aligned} \text{Skilled Nursing Visits} & (54 \times \$95.79) = \$5,172.66 \\ \text{Home Health Aide Visits} & (48 \times \$43.37) = \$2,081.76 \\ \text{Physical Therapy Visits} & (6 \times \$104.74) = \$628.44 \end{aligned}$$

STEP 2: Calculate the wage-adjusted imputed costs by dividing the total imputed cost per discipline into their labor and non-labor portions and multiplying the labor portions by the wage index for Missoula, MT (0.9086) and adding back the non-labor portions to arrive at the total wage-adjusted imputed costs per discipline.

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1 Skilled Nursing Visits

portions.

a Divide total imputed costs into their labor and non-labor

$$\begin{aligned} \text{Labor Portion} &= (0.77668 \times \$5,172.66) = \$4,017.50 \\ \text{Non-labor Portion} &= (0.22332 \times \$5,172.66) = \$1,155.16 \end{aligned}$$

b Wage-adjusted labor portion of imputed costs.

$$(\$4,017.50 \times 0.9086) = \$3,650.30$$

c Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for skilled nursing visits.

$$(\$3,650.30 + \$1,155.16) = \$4,805.46$$

2 Home Health Aide Visits

portions.

a Divide total imputed costs into their labor and non-labor

$$\begin{aligned} \text{Labor Portion} &= (0.77668 \times \$2,081.76) = \$1,616.86 \\ \text{Non-labor Portion} &= (0.22332 \times \$2,081.76) = \$464.90 \end{aligned}$$

b Wage-adjusted labor portion of imputed costs.

$$(\$1,616.86 \times 0.9086) = \$1,469.08$$

c Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

$$(\$1,469.08 + \$464.90) = \$1,933.98$$

3 Physical Therapy Visits

portions.

a Divide total imputed costs into their labor and non-labor

$$\begin{aligned} \text{Labor Portion} &= (0.77668 \times \$628.44) = \$488.10 \\ \text{Non-labor Portion} &= (0.22332 \times \$628.44) = \$140.34 \end{aligned}$$

b Wage-adjusted labor portion of imputed costs.

$$(\$488.10 \times 0.9086) = \$443.49$$

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c Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

$$(\$443.49 + \$140.34) = \boxed{\$583.83}$$

STEP 3: Add together the wage-adjusted imputed costs for the skilled nursing, home health aide and physical therapy visits to obtain the total wage-adjusted imputed costs of the 60-day episode.

$$(\$4,805.46 + \$1,933.98 + \$583.83) = \boxed{\$7,323.27}$$

(4) Calculation of Outlier Payment.

STEP 1: Subtract the outlier threshold amount from the total wage-adjusted imputed costs to arrive at the costs in excess of the outlier threshold.

$$(\$7,323.27 - \$6,058.92) = \$1,264.35$$

STEP 2: Multiply the imputed cost amount in excess of the HHRG threshold amount by the loss sharing ratio (80%) to arrive at the outlier payment.

$$(\$1,264.35 \times 0.80) = \boxed{\$1,011.48}$$

(5) Calculation of Total Payment to HHA.

(c) Add the outlier payment amount to the case-mix and wage-adjusted 60-day episode payment amount to obtain the total payment to the HHA.

$$(\$3,838.30 + \$1,011.48) = \boxed{\$4,849.78}$$

l. Other Health Insurance (OHI) Under HHA PPS.

Payment under the HHA PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see [Chapter 12, Section 6](#)). However, if the beneficiary has OHI which has processed the claim as primary payer, it is likely that the information necessary to determine the TRICARE PPS payment amount will not be available. Therefore, special procedures have been established for processing HHA claims involving OHI. These claims will not be processed as PPS claims. Such claims will be allowed as billed unless there is a provider discount agreement. The only exception to this is cases when there is evidence on the face of the claim that the beneficiary's liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

- END -

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□ 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

□ 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.

□ 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

□ Required detail: HCPCS code G0151 (services performed by a qualified physical therapist in the home health or hospice setting, 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

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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 performed by a qualified occupational therapist in the home health or hospice setting, 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 performed by a qualified speech-language pathologist in the home health or hospice setting, 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

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

Required detail: HCPCS code G0154 (**direct skilled nursing services of a licensed nurse Licensed Practical Nurse (LPN) or Registered Nurse (RN) in the home health or hospice setting**, 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.

Q 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 (services of a clinical social worker **in home health or hospice setting**, 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.

Q 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/**hospice aide in home health or hospice setting**, 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

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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.

□ 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.

□ 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

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(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:

q 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 charge 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.

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

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(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.

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(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.

<b>Report the multiple 023 lines in a SCIC situation as follows:</b>					
<b>FL 42</b>	<b>FL 44</b>	<b>FL 45</b>	<b>FL 46</b>	<b>FL 47</b>	<b>FL 48</b>
023	HAEJ1	100101		0.00	
023	HAFM1	100101		0.00	
<b>Report additional revenue code lines as follows:</b>					
<b>FL 42</b>	<b>FL 44</b>	<b>FL 45</b>	<b>FL 46</b>	<b>FL 47</b>	<b>FL 48</b>
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

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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

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<b>CODE STRUCTURE (CONTINUED):</b>		
<b>CODE</b>	<b>TITLE</b>	<b>DEFINITION</b>
03	Natural Child/Insured Financial Responsibility	Self-explanatory
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.

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(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.

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(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.

(c) 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.

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(63) FL 80. Remarks Not Required

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

†. 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.

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(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”).

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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).

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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).

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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

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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

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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.

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(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):

<b>RAP</b>	<b>CLAIM</b>
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:

<b>FIRST EPISODE</b>		<b>NEXT EPISODE(S)</b>
<b>RAP</b>	<b>CLAIM</b>	<b>RAP(S) &amp; CLAIM(S)</b>
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	

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FIRST EPISODE		NEXT EPISODE(S)
RAP	CLAIM	RAP(s) & CLAIM(s)
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.)
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

(c) 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

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

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(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.

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(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

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RAP	CLAIM
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
<b>Claim Coding</b>	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
<b>Type of Bill (TOB)</b>	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)
<b>Payment Bases</b>	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
<b>PPS Claim?</b>	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)
<b>Claim Coding</b>	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

**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.

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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)
<b>Type of Bill (TOB)</b>	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
<b>Payment Basis</b>	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	
<b>PPS Claims?</b>	<b>Yes</b> , Claim only [34X*, no 485/non-PPS]	<b>Yes</b> , Claim only [34X*; if no 485/non-PPS]	<b>Yes</b> , Claim only [34X*, if no POC/non-PPS]	<b>No</b> (34X*; claims only)	<b>No</b> (34X*; claims only)	<b>No</b> (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.

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(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.

(c) 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.

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(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.

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(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 Centretch 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 -



CHAPTER 12  
ADDENDUM B

HOME HEALTH (HH) CONSOLIDATED BILLING CODE LIST -  
NON-ROUTINE SUPPLY (NRS) CODES

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4212	Non coring needle or stylet	10/01/2000	B-00-50			NRS
A4213	20+ cc syringe only	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4213 (5)	Syringe, Sterile, 20 cc or greater	01/01/2007	Tr.1082			NRS
A4215	sterile needle	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4215 (5)	Needle, sterile, any size, each	01/01/2007	Tr.1082			NRS
A4216	Sterile water/saline up to 10ml	01/01/2004	Tr.8			NRS
A4217	Sterile water/saline 500ml	01/01/2004	Tr.8			NRS
A4244	Alcohol or peroxide, per pint	01/01/2007	Tr.1082			NRS
A4245	Alcohol wipes, per box	01/01/2007	Tr.1082			NRS
A4246	Betadine or phiso hex solution, per pint	01/01/2007	Tr.1082			NRS
A4247	Betadine or iodine swabs/wipes, per box	01/01/2007	Tr.1082			NRS
A4248	Chlorhexidine, containing antiseptic, 1ml	01/01/2004	Tr.8			NRS
A4310	Insert tray w/o bag/cath	10/01/2000	B-00-50			NRS
A4311	Catheter w/o bag 2-way latex	10/01/2000	B-00-50			NRS
A4312	Cath w/o bag 2-way silicone	10/01/2000	B-00-50			NRS
A4313	Catheter w/bag 3-way	10/01/2000	B-00-50			NRS
A4314	Cath w/drainage 2-way latex	10/01/2000	B-00-50			NRS
A4315	Cath w/drainage 2-way silcne	10/01/2000	B-00-50			NRS
A4316	Cath w/drainage 3-way	10/01/2000	B-00-50			NRS
A4319	Sterile H2O irrigation solut	01/01/2001	AB-01-65	01/01/2004	A4216, A4217	NRS
A4320	Irrigation tray	10/01/2000	B-00-50			NRS
A4321	Cath therapeutic irrig agent	10/01/2000	B-00-50			NRS
A4322	Irrigation syringe	10/01/2000	B-00-50			NRS
A4323	Saline irrigation solution	10/01/2000	B-00-50	01/01/2004	A4216, A4217	NRS
A4324	Male ext cath w/adh coating	01/01/2001	AB-01-65	01/01/2005	A4349	NRS
A4325	Male ext cath w/adh strip	01/01/2001	AB-01-65	01/01/2005	A4349	NRS
A4326	Male external catheter	10/01/2000	B-00-50			NRS
A4327	Fem urinary collect dev cup	10/01/2000	B-00-50			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4328	Fem urinary collect pouch	10/01/2000	B-00-50			NRS
A4329	external catheter start set	10/01/2000	B-00-50	01/01/2002	N/A	NRS
A4330	Stool collection pouch	10/01/2000	B-00-50			NRS
A4331	Extension drainage tubing	01/01/2001	AB-01-65			NRS
A4332	Lubricant for cath insertion	01/01/2001	AB-01-65			NRS
A4333	Urinary cath anchor device	01/01/2001	AB-01-65			NRS
A4334	Urinary cath leg strap	01/01/2001	AB-01-65			NRS
A4335	Incontinence supply	10/01/2000	B-00-50			NRS
A4338	Indwelling catheter latex	10/01/2000	B-00-50			NRS
A4340	Indwelling catheter special	10/01/2000	B-00-50			NRS
A4344	Cath index foley 2 way	10/01/2000	B-00-50			NRS
A4346	Cath indw foley 3 way	10/01/2000	B-00-50			NRS
A4347	Male external catheter	10/01/2000	B-00-50	01/01/2005	A4349	NRS
A4348	Male ext cath extended wear	01/01/2001	AB-01-65	01/01/2007		NRS
A4349	Male ext catheter, with or without adhesive, disposable, each	01/01/2005	Tr. 340	01/01/2007		NRS
A4351	Straight tip urine catheter	10/01/2000	B-00-50			NRS
A4352	Coude tip urinary catheter	10/01/2000	B-00-50			NRS
A4353	Intermittent urinary cath	10/01/2000	B-00-50			NRS
A4354	Cath insertion tray w/bag	10/01/2000	B-00-50			NRS
A4355	Bladder irrigation tubing	10/01/2000	B-00-50			NRS
A4356	Ext ureth clmp or compr	10/01/2000	B-00-50			NRS
A4357	Bedside drainage bag	10/01/2000	B-00-50			NRS
A4358	Urinary leg bag	10/01/2000	B-00-50			NRS
A4359	Urinary suspensory w/o leg bag	10/01/2000	B-00-50			NRS
A4360	Disposable external urethral clamp or compression device with pad and/or pouch	01/01/2010	1827			NRS
A4361	Ostomy face plate	10/01/2000	B-00-50			NRS
A4362	Solid skin barrier	10/01/2000	B-00-50			NRS
A4363	Ostomy clamp, any type, replacement only, each	01/01/2006	Tr. 710			NRS
A4364	Ostomy/cath adhesive	10/01/2000	B-00-50			NRS
A4365	Ostomy adhesive remover wipe	10/01/2000	B-00-50	01/01/2010	A4456	NRS
A4366	Ostomy vent, any type, each	01/01/2004	Tr.8			NRS
A4367	Ostomy belt	10/01/2000	B-00-50			NRS
A4368	Ostomy filter	10/01/2000	B-00-50			NRS
A4369	Skin barrier liquid per oz	10/01/2000	B-00-50			NRS
A4370	Skin barrier paste per oz	10/01/2000	B-00-50	10/01/2002	K0561, K0562	NRS
A4371	Skin barrier powder per oz	10/01/2000	B-00-50			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4372	Skin barrier solid 4x4 equiv	10/01/2000	B-00-50			NRS
A4373	Skin barrier with flange	10/01/2000	B-00-50			NRS
A4374	Skin barrier extended wear	10/01/2000	B-00-50	10/01/2002	K0563, K0564	NRS
A4375	Drainable plastic pch w fcpl	10/01/2000	B-00-50			NRS
A4376	Drainable rubber pch w fcplt	10/01/2000	B-00-50			NRS
A4377	Drainable plstic pch w/o fp	10/01/2000	B-00-50			NRS
A4378	Drainable rubber pch w/o fp	10/01/2000	B-00-50			NRS
A4379	Urinary plastic pouch w fcpl	10/01/2000	B-00-50			NRS
A4380	Urinary rubber pouch w fcplt	10/01/2000	B-00-50			NRS
A4381	Urinary plastic pouch w/o fp	10/01/2000	B-00-50			NRS
A4382	Urinary hvy plstc pch w/ofp	10/01/2000	B-00-50			NRS
A4383	Urinary rubber pouch w/o fp	10/01/2000	B-00-50			NRS
A4384	Ostomy faceplt/silicone ring	10/01/2000	B-00-50			NRS
A4385	Ost skn barrier sld extwear	10/01/2000	B-00-50			NRS
A4386	Ost skn barrier w flngex wr	10/01/2000	B-00-50	10/01/2002	K0565, K0566	NRS
A4387	Ost clsd pouch w attst barr	10/01/2000	B-00-50			NRS
A4388	Drainable pch w ex wearbarr	10/01/2000	B-00-50			NRS
A4389	Drainable pch w st wearbarr	10/01/2000	B-00-50			NRS
A4390	Drainable pch ex wear convex	10/01/2000	B-00-50			NRS
A4391	Urinary pouch w ex wearbarr	10/01/2000	B-00-50			NRS
A4392	Urinary pouch w st wearbarr	10/01/2000	B-00-50			NRS
A4393	Urine pch w ex wearbar conv	10/01/2000	B-00-50			NRS
A4394	Ostomy pouch liq deodorant	10/01/2000	B-00-50			NRS
A4395	Ostomy pouch solid deodorant	10/01/2000	B-00-50			NRS
A4396	Peristomal hernia supprt blt	10/01/2000	B-00-50			NRS
A4397	Irrigation supply sleeve	10/01/2000	B-00-50			NRS
A4398	Ostomy irrigation bag	10/01/2000	B-00-50			NRS
A4399	Ostomy irrig cone/cath w brs	10/01/2000	B-00-50			NRS
A4400	Ostomy irrigation set	10/01/2000	B-00-50			NRS
A4402	Lubricant per ounce	10/01/2000	B-00-50			NRS
A4404	Ostomy ring each	10/01/2000	B-00-50			NRS
A4405	Nonpectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4406	Pectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4407	Ext wear ost skn barr <=4sq"	01/01/2003	AB-02-137			NRS
A4408	Ext wear ost skn barr > 4sq"	01/01/2003	AB-02-137			NRS
A4409	Ost skn barr w flng <= 4 sq"	01/01/2003	AB-02-137			NRS
A4410	Ost skn barr w flng > 4sq"	01/01/2003	AB-02-137			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4411	Ostomy skin barrier, solid 4x4 or equiv., extended wear, w/ built-in convexity, each	01/01/2006	Tr. 710			NRS
A4412	Ostomy pouch, drainable, high output, for use on a barrier w/ flange (2 piece system) without filter, each	01/01/2006	Tr. 710			NRS
A4413	2 pc drainable ost pouch w/ filter	01/01/2003	AB-02-137			NRS
A4414	Ostomy skn barr w/ flng < 4sq	01/01/2003	AB-02-137			NRS
A4415	Ostomy skn barr w/ flng > 4sq	01/01/2003	AB-02-137			NRS
A4416	Ost pch clsd w barrier/filtr	01/01/2004	Tr. 8			NRS
A4417	Ost pch w bar/bltinconv/fltr	01/01/2004	Tr. 8			NRS
A4418	Ost pch clsd w/o bar w filtr	01/01/2004	Tr. 8			NRS
A4419	Ost pch for bar w flange/flt	01/01/2004	Tr. 8			NRS
A4420	Ost pch clsd for bar w lk fl	01/01/2004	Tr. 8			NRS
A4421 (6)	Ostomy supply misc	10/01/2000	B-00-50		N/A	NRS
A4422	Ost pouch absorbent material	01/01/2003	AB-02-137			NRS
A4423	Ost pch for bar w lk fl/fltr	01/01/2004	Tr. 8			NRS
A4424	Ost pch drain w bar & filter	01/01/2004	Tr. 8			NRS
A4425	Ost pch drain for barrier fl	01/01/2004	Tr. 8			NRS
A4426	Ost pch drain 2 piece system	01/01/2004	Tr. 8			NRS
A4427	Ost pch drain/barr lk flng/f	01/01/2004	Tr. 8			NRS
A4428	Urine ost pouch w faucet/tap	01/01/2004	Tr. 8			NRS
A4429	Urine ost pouch w bltinconv	01/01/2004	Tr. 8			NRS
A4430	Ost urine pch w b/bltin conv	01/01/2004	Tr. 8			NRS
A4431	Ost pch urine w barrier/tapv	01/01/2004	Tr. 8			NRS
A4432	Os pch urine w bar/fange/tap	01/01/2004	Tr. 8			NRS
A4433	Urine ost pch bar w lock fln	01/01/2004	Tr. 8			NRS
A4434	Ost pch urine w lock flng/ft	01/01/2004	Tr. 8			NRS
A4455	Adhesive remover per ounce	10/01/2000	B-00-50			NRS
A4456	Adhesive remover, wipes, any type, each	01/01/2010	1827			NRS
A4458	Reusable enema bag	01/01/2003	AB-02-137			NRS
A4460	Elastic compression bandage	10/01/2000	B-00-50			NRS
A4461	Surgical dressing holder, non-reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4462	Abdmnl drssng holder/binder	10/01/2000	B-00-50	01/01/2007	A4461, A4463	NRS
A4463	Surgical dressing holder, reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4481	Tracheostoma filter	10/01/2000	B-00-50			NRS
A4554	Disposable underpads	10/01/2000	B-00-50	01/01/2001	N/A	NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4622	Tracheostomy or laryngectomy	10/01/2000	B-00-50	01/01/2004	A7520, A7521, A7522	NRS
A4623	Tracheostomy inner cannula	10/01/2000	B-00-50			NRS
A4625	Trach care kit for new	10/01/2000	B-00-50			NRS
A4626	Tracheostomy cleaning brush	10/01/2000	B-00-50			NRS
A4649	Surgical supplies	10/01/2000	B-00-50			NRS
A4656	Needle, any size, each	01/01/2003	AB-02-137	01/01/2006	A4215	NRS
A4657	Syringe, with or without needle, each	01/01/2003	AB-02-137			NRS
A4712	Sterile water inj per 10 ml	01/01/2003	AB-02-137	01/01/2004	N/A	NRS
A4930	Sterile, gloves per pair	01/01/2003	AB-02-137			NRS
A4932	Rectal thermometer, reusable, any type, each	01/01/2007	Tr.1082			NRS
A5051	Pouch clsd w barr attached	10/01/2000	B-00-50			NRS
A5052	Clsd ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5053	Clsd ostomy pouch faceplate	10/01/2000	B-00-50			NRS
A5054	Clsd ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5055	Stoma cap	10/01/2000	B-00-50			NRS
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	01/01/2012	2317			NRS
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each	01/01/2012	2317			NRS
A5061	Pouch drainable w barrier at	10/01/2000	B-00-50	10/01/2002	K0567, K0568	NRS
A5061 (5)	Pouch drainable w barrier at	01/01/2003	AB-02-137			NRS
A5062	Drnble ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5063	Drain ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5071	Urinary pouch w/barrier	10/01/2000	B-00-50			NRS
A5072	Urinary pouch w/o barrier	10/01/2000	B-00-50			NRS
A5073	Urinary pouch on barr w/flng	10/01/2000	B-00-50			NRS
A5081	Continent stoma plug	10/01/2000	B-00-50			NRS
A5082	Continent stoma catheter	10/01/2000	B-00-50			NRS
A5093	Ostomy accessory convex inse	10/01/2000	B-00-50			NRS
A5102	Beside drain btl w/wo tube	10/01/2000	B-00-50			NRS
A5105	Urinary suspensory	10/01/2000	B-00-50			NRS
A5112	Urinary leg bag	10/01/2000	B-00-50			NRS
A5113	Latex leg strap	10/01/2000	B-00-50			NRS
A5114	Foam/fabric leg strap	10/01/2000	B-00-50			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A5119	Skin barrier wipes box pr	10/01/2000	B-00-50	01/01/2006	A5120	NRS
A5120	Skin barrier, wipes or swabs, each	01/01/2006	Tr. 710			NRS
A5121	Solid skin barrier 6x6	10/01/2000	B-00-50			NRS
A5122	Solid skin barrier 8x8	10/01/2000	B-00-50			NRS
A5123	Skin barrier with flange	10/01/2000	B-00-50	10/01/2002	K0570, K0571	NRS
A5126	Disk / foam pad +or-	10/01/2000	B-00-50			NRS
A5131	Appliance cleaner	10/01/2000	B-00-50			NRS
A5149	Incontinence / ostomy supply	10/01/2000	B-00-50	01/01/2001	A4335, A4421	NRS
A6010	Collagen based wound filler, dry foam	01/01/2002	AB-01-128			NRS
A6011	Collagen gel/paste wound fil	01/01/2003	AB-02-137			NRS
A6020	Collagen wound dressing	10/01/2000	B-00-50			NRS
A6021	Collagen dressing <= 16 sq in	01/01/2001	AB-01-65			NRS
A6022	Collagen drsg> 6 <= 48 sq in	01/01/2001	AB-01-65			NRS
A6023	Collagen dressing > 48 sq in	01/01/2001	AB-01-65			NRS
A6024	Collagen dsgr wound filler	01/01/2001	AB-01-65			NRS
A6025	Gel sheet for dermal or epidermal application (e.g. silicone, hydrogel, other)	01/01/2004	Tr.8	01/01/2006	N/A	NRS
A6154	Wound pouch each	10/01/2000	B-00-50			NRS
A6196	Alginate dressing <= 16 sq in	10/01/2000	B-00-50			NRS
A6197	Alginate drsg > 16 <= 48 sq	10/01/2000	B-00-50			NRS
A6198	Alginate dressing > 48 sq	10/01/2000	B-00-50			NRS
A6199	Alginate drsg wound filler	10/01/2000	B-00-50			NRS
A6200	Compos drsg <= 16 no bdr	10/01/2000	B-00-50			NRS
A6201	Compos drsg > 16 <= 48 no bdr	10/01/2000	B-00-50			NRS
A6202	Compos drsg > 48 no bdr	10/01/2000	B-00-50			NRS
A6203	Composite drsg <= 16 sq	10/01/2000	B-00-50			NRS
A6204	Composite drsg > 16 <= 48 sq in	10/01/2000	B-00-50			NRS
A6205	Composite drsg > 48 sq	10/01/2000	B-00-50			NRS
A6206	Contact layer <= 16 sq	10/01/2000	B-00-50			NRS
A6207	Contact layer > 16 <= 48 sq	10/01/2000	B-00-50			NRS
A6208	Contact layer > 48 sq	10/01/2000	B-00-50			NRS
A6209	Foam drsg <= 16 sq in w/o bdr	10/01/2000	B-00-50			NRS
A6210	Foam drg > 16 <= 48 sq in w/o b	10/01/2000	B-00-50			NRS
A6211	Foam drg > 48 sq in w/o brdr	10/01/2000	B-00-50			NRS
A6212	Foam drg <= 16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6213	Foam drg > 16 <= 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6214	Foam drg > 48 sq in w/bdr	10/01/2000	B-00-50			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A6215	Foam dressing wound filler	10/01/2000	B-00-50			NRS
A6219	Gauze <= 16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6220	Gauze > 16 <= 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6221	Gauze > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6222	Gauze <= 16 in no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6223	Gauze > 16 <= 48 no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6224	Gauze > 48 in no w /sal w/ o b	10/01/2000	B-00-50			NRS
A6228	Gauze <= 16 sq in water / sal	10/01/2000	B-00-50			NRS
A6229	Gauze > 16 <= 48 sq in watr / sal	10/01/2000	B-00-50			NRS
A6230	Gauze > 48 sq in water / salne	10/01/2000	B-00-50			NRS
A6231	Hydrogel dsq<= 16 sq in	01/01/2001	AB-01-65			NRS
A6232	Hydrogel dsq> 16 <= 48 sq in	01/01/2001	AB-01-65			NRS
A6233	Hydrogel dressing > 48 sq in	01/01/2001	AB-01-65			NRS
A6234	Hydrocolld drg <= 16 w / o bdr	10/01/2000	B-00-50			NRS
A6235	Hydrocolld drg > 16 <= 48 w / o b	10/01/2000	B-00-50			NRS
A6236	Hydrocolld drg > 48 in w / o b	10/01/2000	B-00-50			NRS
A6237	Hydrocolld drg <= 16 in w / bdr	10/01/2000	B-00-50			NRS
A6238	Hydrocolld drg > 16 <= 48 w / bdr	10/01/2000	B-00-50			NRS
A6239	Hydrocolld drg > 48 in w / bdr	10/01/2000	B-00-50			NRS
A6240	Hydrocolld drg filler paste	10/01/2000	B-00-50			NRS
A6241	Hydrocolloid drg filler dry	10/01/2000	B-00-50			NRS
A6242	Hydrogel drg <= 16 in w / o bdr	10/01/2000	B-00-50			NRS
A6243	Hydrogel drg > 16 <= 48 w / o bdr	10/01/2000	B-00-50			NRS
A6244	Hydrogel drg > 48 in w / o bdr	10/01/2000	B-00-50			NRS
A6245	Hydrogel drg <= 16 in w / bdr	10/01/2000	B-00-50			NRS
A6246	Hydrogel drg > 16 <= 48 in w / b	10/01/2000	B-00-50			NRS
A6247	Hydrogel drg > 48 sq in w / b	10/01/2000	B-00-50			NRS
A6248	Hydrogel dressing	10/01/2000	B-00-50			NRS
A6251	Absorpt drg <= 16 sq in w / o b	10/01/2000	B-00-50			NRS
A6252	Absorpt drg > 16 <= 48 w / o bdr	10/01/2000	B-00-50			NRS
A6253	Absorpt drg 48 sq in w / o b	10/01/2000	B-00-50			NRS
A6254	Absorpt drg <= 16 sq in w / bdr	10/01/2000	B-00-50			NRS
A6255	Absorpt drg > 16 <= 48 in w / bdr	10/01/2000	B-00-50			NRS
A6256	Absorpt drg > 48 sq in w / bdr	10/01/2000	B-00-50			NRS
A6257	Transparent film <= 16 sq in	10/01/2000	B-00-50			NRS
A6258	Transparent film > 16 <= 48 in	10/01/2000	B-00-50			NRS
A6259	Transparent film > 48 sq in	10/01/2000	B-00-50			NRS
A6261	Wound filler gel / paste / oz	10/01/2000	B-00-50			NRS
A6262	Wound filler dry form / gram	10/01/2000	B-00-50			NRS
A6266	Impreg gauze no h20 / sal / yard	10/01/2000	B-00-50			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A6402	Sterile gauze <= 16 sq in	10/01/2000	B-00-50			NRS
A6403	Sterile gauze > 16 <= 48 sq in	10/01/2000	B-00-50			NRS
A6404	Sterile gauze > 48 sq in	10/01/2000	B-00-50			NRS
A6405	Sterile elastic gauze / yd	10/01/2000	B-00-50			NRS
A6406	Sterile non-elastic gauze / yd	10/01/2000	B-00-50			NRS
A6407	Packing strips, non-impregnated, up to 2 inches, per lin yd	01/01/2004	Tr. 8			NRS
A6410	Sterile eye pad	01/01/2003	AB-02-137			NRS
A6412	Eye patch, occlusive, each	01/01/2007	Tr.1082			NRS
A6440	Zinc Paste >=3" <5" w/roll	4/01/2003	AB-03-002			NRS
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width > or = 3" and < 5", per yard	01/01/2004	Tr. 8			NRS
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	01/01/2004	Tr. 8			NRS
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6457	Tubular dressing with or without elastic, any width, per linear yard	01/01/2006	Tr. 710			NRS
A7040	One way chest drain valve	01/01/2005	Tr. 340			NRS
A7041	Water seal drainage container and tubing for use with implanted chest tube	01/01/2005	Tr. 340			NRS
A7043	Vacuum drainage bottle & tubing	01/01/2003	AB-02-137			NRS
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	01/01/2005	Tr. 340			NRS
A7501	Tracheostoma valve w diaphra	01/01/2001	AB-01-65			NRS
A7502	Replacement diaphragm/fplate	01/01/2001	AB-01-65			NRS
A7503	HMES filter holder or cap	01/01/2001	AB-01-65			NRS

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CHAPTER 12, ADDENDUM B

HOME HEALTH (HH) CONSOLIDATED BILLING CODE LIST - NON-ROUTINE SUPPLY (NRS) CODES

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A7504	Tracheostoma HMES filter	01/01/2001	AB-01-65			NRS
A7505	HMES or trach valve housing	01/01/2001	AB-01-65			NRS
A7506	HMES/trachvalve adhesivedisk	01/01/2001	AB-01-65			NRS
A7507	Integrated filter & holder	01/01/2001	AB-01-65			NRS
A7508	Housing & Integrated Adhesiv	01/01/2001	AB-01-65			NRS
A7509	Heat & moisture exchange sys	01/01/2001	AB-01-65			NRS
A7520	Tracheostomy/laryngectomy tube, non-cuffed	01/01/2004	Tr. 8			NRS
A7521	Tracheostomy/laryngectomy tube, cuffed	01/01/2004	Tr. 8			NRS
A7522	Tracheostomy/laryngectomy tube, stainless steel	01/01/2004	Tr. 8			NRS
A7523	Tracheostomy shower protector, each	01/01/2004	Tr. 8			NRS
A7524	Tracheostomy stent/stud/button, each	01/01/2004	Tr. 8			NRS
A7525 (8)	Tracheostomy mask, each	01/01/2004	Tr. 8	01/01/2004		NRS
A7526 (8)	Tracheostomy tube collar/holder, each	01/01/2004	Tr. 8	01/01/2004		NRS
A7527	Tracheostomy/laryngectomy tube plug/stop, each	01/01/2005	Tr. 340			NRS
G0193	Endoscopic study swallow functn	01/01/2001	AB-01-65			Therapy
G0194	Sensory testing endoscopic stud	01/01/2001	AB-01-65			Therapy
G0195	Clinical eval swallowing funct	01/01/2001	AB-01-65			Therapy
G0196	Eval of swallowing with radio opa	01/01/2001	AB-01-65			Therapy
G0197	Eval of pt for prescip speech devi	01/01/2001	AB-01-65			Therapy
G0198	Patient adapation & train for spe	01/01/2001	AB-01-65			Therapy
G0199	Reevaluation of patient use spec	01/01/2001	AB-01-65			Therapy
G0200	Eval of patient prescip of voice p	01/01/2001	AB-01-65			Therapy
G0201	Modi for training in use voice pro	01/01/2001	AB-01-65			Therapy
G0279	Excorp shock tx, elbow epi	01/01/2003	AB-02-137			Therapy
G0280	Excorp shock tx other than	01/01/2003	AB-02-137			Therapy
G0281	Elec stim unattend for press	01/01/2003	AB-02-137			Therapy
G0282	Elect stim wound care not pd	01/01/2003	AB-02-137			Therapy
G0283	Elec stim other than wound	01/01/2003	AB-02-137			Therapy
G0329	Electromagntic tx for ulcers	10/01/2004	Tr. 226			Therapy
K0280	Extension drainage tubing	10/01/2000	B-00-50	01/01/2001	A4331	NRS
K0281	Lubricant catheter insertion	10/01/2000	B-00-50	01/01/2001	A4332	NRS
K0407	Urinary cath skin attachment	10/01/2000	B-00-50	01/01/2001	A4333	NRS
K0408	Urinary cath leg strap	10/01/2000	B-00-50	01/01/2001	A4334	NRS
K0409	Sterile H2O irrigation solut	10/01/2000	B-00-50	01/01/2001	A4319	NRS
K0410	Male ext cath w / adh coating	10/01/2000	B-00-50	01/01/2001	A4324	NRS

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HOME HEALTH (HH) CONSOLIDATED BILLING CODE LIST - NON-ROUTINE SUPPLY (NRS) CODES

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
K0411	Male ext cath w / adh strip	10/01/2000	B-00-50	01/01/2001	A4325	NRS
K0561	Non-pectin based ostomy paste	10/01/2002	AB-02-092	01/01/2003	A4405	NRS
K0562	Pectin based ostomy paste	10/01/2002	AB-02-092	01/01/2003	A4406	NRS
K0563	Ext wear ost skn barr < 4sq	10/01/2002	AB-02-092	01/01/2003	A4407	NRS
K0564	Ext wear ost skn barr > 4sq	10/01/2002	AB-02-092	01/01/2003	A4408	NRS
K0565	Ost skn barr w flng < 4sq	10/01/2002	AB-02-092	01/01/2003	A4409	NRS
K0566	Ost skn barr w flng > 4sq	10/01/2002	AB-02-092	01/01/2003	A4410	NRS
K0567	1 pc drainable ost pouch	10/01/2002	AB-02-092	01/01/2003	A5061	NRS
K0568	1 pc cnvx drainabl ost pouch	10/01/2002	AB-02-092	01/01/2003	A5061	NRS
K0569	2 pc drainable ost pouch	10/01/2002	AB-02-092	01/01/2003	A4413	NRS
K0570	Ostomy skn barr w flng <4sq	10/01/2002	AB-02-092	01/01/2003	A4414	NRS
K0571	Ostomy skn barr w flng > 4sq	10/01/2002	AB-02-092	01/01/2003	A4415	NRS
K0574	Ostomy pouch filter	10/01/2002	AB-02-092	01/01/2003	A4368	NRS
K0575	Ost pouch rustle free mat	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0576	Ostomy pouch comfort panel	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0577	Ostomy pouch odor barrier	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0578	Urinary pouch faucet/drain	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0579	Ost pouch absorbent material	10/01/2002	AB-02-092	01/01/2003	A4422	NRS
K0580	Ost pouch locking flange	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0581	Ost pch clsd w barrier/fltr	01/01/2003	AB-02-137	01/01/2004	A4416	NRS
K0582	Ost pch w bar/bltinconv/fltr	01/01/2003	AB-02-137	01/01/2004	A4417	NRS
K0583	Ost pch clsd w/o bar w fltr	01/01/2003	AB-02-137	01/01/2004	A4418	NRS
K0584	Ost pch for bar w flange/flt	01/01/2003	AB-02-137	01/01/2004	A4419	NRS
K0585	Ost pch clsd for bar w lk fl	01/01/2003	AB-02-137	01/01/2004	A4420	NRS
K0586	Ost pch for bar w lk fl/fltr	01/01/2003	AB-02-137	01/01/2004	A4423	NRS
K0587	Ost pch drain w bar & filter	01/01/2003	AB-02-137	01/01/2004	A4424	NRS
K0588	Ost pch drain for barrier fl	01/01/2003	AB-02-137	01/01/2004	A4425	NRS
K0589	Ost pch drain 2 piece system	01/01/2003	AB-02-137	01/01/2004	A4426	NRS
K0590	Ost pch drain/barr lk flng/f	01/01/2003	AB-02-137	01/01/2004	A4427	NRS
K0591	Urine ost pouch w faucet/tap	01/01/2003	AB-02-137	01/01/2004	A4428	NRS
K0592	Urine ost pouch w bltinconv	01/01/2003	AB-02-137	01/01/2004	A4429	NRS
K0593	Ost urine pch w b/bltin conv	01/01/2003	AB-02-137	01/01/2004	A4430	NRS
K0594	Ost pch urine w barrier/tapv	01/01/2003	AB-02-137	01/01/2004	A4431	NRS
K0595	Os pch urine w bar/fange/tap	01/01/2003	AB-02-137	01/01/2004	A4432	NRS
K0596	Urine ost pch bar w lock fln	01/01/2003	AB-02-137	01/01/2004	A4433	NRS
K0597	Ost pch urine w lock flng/ft	01/01/2003	AB-02-137	01/01/2004	A4434	NRS
K0614	chem/antiseptic solution, 8oz.	10/01/2003	AB-03-096			NRS
K0620	tubular elastic dressing	10/01/2003	AB-03-096			NRS
K0621	gauze, non-impreg pack strip	10/01/2003	AB-03-096	01/01/2004	A6407	NRS

- END -



## HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM (HIPPS) TABLES FOR PRICER

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Refer to the TRICARE Management Activity (TMA) web site (<http://www.tricare.osd.mil/tma/rates.aspx>) for the HIPPS Tables for the Pricer.

- END -



CHAPTER 12  
ADDENDUM L (CY 2012)

**ANNUAL HHA PPS RATE UPDATES - CALENDAR YEAR 2012**

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(Final payment amounts per 60-day episodes ending on or after January 1, 2012 and before January 1, 2013 - Continuing Calendar Year (CY) update.)

Home Health Agency Prospective Payment System (HHA PPS) - Determination of Standard HHA PPS amounts

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for CY 2012 that the standard prospective payment amount be increased by a factor equal to the applicable home health market basket update for HHAs.

**National 60-Day Episode Payment Amounts - CY 2012**

In order to calculate the CY 2012 national standardized 60-day episode, the CY 2011 national standardized 60-day episode payment of \$2,192.07 was increased by the CY 2012 home health market basket update percentage of 1.4% (which reflects a 1% reduction applied to the 2.4% market basket update factor, as mandated by the Affordable Care Act) and reduced by 3.79% to account for the change in case-mix that is not related to the real change in patient acuity levels as reflected in [Figure 12-L-2012-1](#):

**FIGURE 12-L-2012-1 NATIONAL 60-DAY EPISODE PAYMENT RATE UPDATED BY THE HOME HEALTH MARKET BASKET UPDATE FOR CY 2012, BEFORE CASE-MIX ADJUSTMENT AND WAGE ADJUSTED BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY**

CY 2011 National Standardized 60-day Episode Payment Rate	Multiply by CY 2012 HH PPS payment update percentage (1.4%).	Reduce by 3.79% for nominal change in case-mix.	CY 2012 of 1.4% National Standardized 60-day Episode Payment Rate
\$2,192.07	x 1.014	x 0.9621	\$2,138.52

**National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2012**

The CY 2011 national per-visit amounts were increased by the CY 2012 home health payment update percentage of 1.4%. National per-visit rates are not subjected to the nominal increase

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ANNUAL HHA PPS RATE UPDATES - CALENDAR YEAR 2012

in case-mix. The final updated CY 2012 national per-visit rates per discipline are reflected in [Figure 12-L-2012-2](#):

**FIGURE 12-L-2012-2 NATIONAL PER-VISIT RATES FOR LUPAS (NOT INCLUDING THE LUPA ADD-ON PAYMENT AMOUNT FOR A BENEFICIARY'S ONLY EPISODE OR THE INITIAL EPISODE IN A SEQUENCE OF ADJACENT EPISODES) AND OUTLIER CALCULATIONS UPDATED BY THE CY 2012 HH PPS PAYMENT UPDATE PERCENTAGE, BEFORE WAGE INDEX ADJUSTMENT**

Home Health Discipline	CY 2011 Per-visit payment amounts per 60-day episode.	Multiply by the HH PPS payment update percentage (1.4%).	CY 2012 Per-visit Amount.
Home Health Aide	\$50.42	x 1.014	\$50.12
Medical Social Services	178.46	x 1.014	177.39
Occupational Therapy	122.54	x 1.014	121.80
Physical Therapy	121.73	x 1.014	121.00
Skilled Nursing	111.32	x 1.014	110.65
Speech-Language Pathology	132.27	x 1.014	131.48

**Payment of LUPA Episodes**

Payment for LUPA episodes changed in CY 2008 in that for LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode, an additional payment amount is added to the LUPA payment. The [Figure 12-L-2012-2](#) per-visit rate noted above are before that additional payment is added to the LUPA payment, and are the per-visit rates paid to all other LUPA episodes and used in computing outlier payments. LUPA episodes that occur as the only episode or initial episode in a sequence of adjacent episodes are adjusted by adding an additional amount to the LUPA payment before adjusting for wage index. For CY 2011, that amount was \$93.31. This additional LUPA amount was updated in the same manner as the national standardized 60-day episode payment amount and the per-visit rates as is reflected in [Figure 12-L-2012-3](#).

**FIGURE 12-L-2012-3 CY 2012 LUPA ADD-ON PAYMENT AMOUNTS**

CY 2011 LUPA Add-on Payment Amount	Multiply by the HH PPS payment update percentage (1.4%).	CY 2012 LUPA add-on Amounts
\$93.31	x 1.014	\$92.75

**Severity Non-Routine Medical Supplies (NRS) System**

Beginning in CY 2008, to ensure that the variation in NRS is more appropriately reflected in the HHA PPS, the original portion (\$49.62) of the HHA PPS base rate that accounted for NRS, was replaced with a system that pays for NRS based on six severity groups. Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The CY 2011 NRS conversion factor was updated for CY 2012 by the

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

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ANNUAL HHA PPS RATE UPDATES - CALENDAR YEAR 2012

CY 2012 HH PPS payment update percentage of 1.4% as reflected in [Figure 12-L-2012-4](#). The NRS conversion factor for CY 2012 is \$53.28.

**FIGURE 12-L-2012-4 NON-ROUTINE MEDICAL SUPPLY (NRS) CONVERSION FACTOR FOR CY 2012**

CY 2011 NRS Conversion Factor	Multiply by the HH PPS payment update percentage (1.4%).	CY 2012 NRS Conversion Factor
\$52.54	x 1.014	\$53.28

The payment amounts, using the above computed CY 2012 NRS conversion factor (\$53.28), for the various severity levels based on the updated conversion factor are calculated in [Figure 12-L-2012-5](#).

**FIGURE 12-L-2012-5 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR CY 2012**

Severity Level	Points (Scoring)	Relative Weight	NRS Payment Amount
1	0	0.2698	\$14.37
2	1 to 14	0.9742	51.91
3	15 to 27	2.6712	142.32
4	28 to 48	3.9686	211.45
5	49 to 98	6.1198	326.06
6	99+	10.5254	560.79

**Labor And Non-Labor Percentages**

For CY 2012, the labor percent is 77.082%, and the non-labor percent is 22.918%

**Outlier Payments**

Under the HHA PPS, outlier payments are made for episodes for which the estimated cost exceeds a threshold amount. The wage adjusted Fixed Dollar Loss (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. The FDL ratio which is used in calculating the FDL amount has been retained for CY 2012 at 0.67.

**Outcome and Assessment Information Set (OASIS)**

OASIS-C is a modification to the OASIS that HHAs must collect in order to participate in the TRICARE program. Implementation of OASIS-C is required effective January 1, 2010.

**Temporary 3% Rural Add-On for the HHA PPS**

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, enacted on December 8, 2003 and as amended by Section 3131(c) of the Affordable Care Act) provides an increase of 3% of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), for episodes and visits ending on or after April 1, 2010 and before January 1, 2016. The 3% rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the LUPA add-on

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payment amount, and the NRS conversion factor when home health services are provided in rural (non-Core Based Statistical Area (CBSA)) areas. The applicable case-mix and wage index adjustments are subsequently applied. Episodes that qualify for the 3% rural add-on will be identified by a CBSA code that begins with '999'.

**National 60-Day Episode Payment Amounts for Rural, Non-CBSA Areas**

In order to calculate the national standardized 60-day episode payment for beneficiaries residing in a rural area, the CY 2012 national standardized 60-day episode payment of \$2,138.52 was increased by 3%.

**FIGURE 12-L-2012-6 CY 2012 PAYMENT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA, BEFORE CASE-MIX ADJUSTMENT AND WAGE INDEX ADJUSTMENT**

CY 2011 National standardized 60-day episode payment rate	Multiplied by the 3% rural add-on.	CY 2012 national standardized 60-day episode payment rate
\$2,138.52	x 1.03	\$2,202.68

**CY 2012 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment**

The CY 2012 national per-visit amounts were increased by 3% for beneficiaries who reside in rural areas.

**FIGURE 12-L-2012-7 CY 2012 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA, BEFORE WAGE INDEX ADJUSTMENT**

Home Health Discipline	CY 2012 Per-visit rate.	Multiplied by 3% rural add-on.	Total CY 2012 Per-visit rate for a rural areas.
Home Health Aide	\$51.13	x 1.03	\$52.66
Medical Social Services	180.96	x 1.03	186.39
Occupational Therapy	124.26	x 1.03	127.99
Physical Therapy	123.43	x 1.03	127.13
Skilled Nursing	112.88	x 1.03	116.27
Speech-Language Pathology	134.12	x 1.03	138.14

**Payment of LUPA Episodes for Beneficiaries Who Reside in Rural Areas**

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted in [Figure 12-L-2012-7](#) are before that additional payment is added to the LUPA amount. The CY 2012 LUPA add-on payment was increased by 3% for beneficiaries who reside in rural areas.

**FIGURE 12-L-2012-8 CY 2012 LUPA ADD-ON PAYMENT AMOUNT FOR SERVICES PROVIDED IN A RURAL AREA**

CY 2012 LUPA Add-On Payment.	Multiplied by the 3% rural add-on.	Total CY 2012 LUPA add-on amount for rural areas.
\$94.62	x 1.03	\$97.46

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**Payment for NRS**

Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The NRS conversion factor for CY 2012 payments was increased by 3% for beneficiaries who reside in rural areas.

**FIGURE 12-L-2012-9 CY 2012 NRS CONVERSION FACTOR FOR BENEFICIARIES WHO RESIDE IN A RURAL AREA**

CY 2012 NRS Conversion Factor	Multiplied by the 3% rural add-on.	Total CY 2012 NRS conversion factor for rural areas.
\$53.28	x 1.03	\$54.88

The payment amounts, using the above computed NRS conversion factor (\$54.88), for the various severity levels based on the updated conversion factor are calculated in [Figure 12-L-2012-10](#).

**FIGURE 12-L-2012-10 CY 2012 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR BENEFICIARIES RESIDING IN A RURAL AREA**

Severity Level	Points (Scoring)	Relative Weight	Total NRS payment amount for rural areas.
1	0	0.2698	\$14.81
2	1 to 14	0.9742	53.46
3	15 to 27	2.6712	146.60
4	28 to 48	3.9686	217.80
5	49 to 98	6.1198	335.85
6	99+	10.5254	577.63

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CHAPTER 12  
ADDENDUM M (CY 2012)

ANNUAL HHA PPS WAGE INDEX UPDATES - CALENDAR YEAR  
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<sup>1</sup> All counties within the State are classified as urban, with the exception of Puerto Rico. Puerto Rico has areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for CY 2012.

CBSA CODE	NON-URBAN AREA	WAGE INDEX	CBSA CODE	NON-URBAN AREA	WAGE INDEX
01	Alabama.....	0.7260	41	Rhode Island <sup>1</sup> .....	-----
02	Alaska.....	1.2846	42	South Carolina.....	0.8277
03	Arizona.....	0.8826	43	South Dakota.....	0.8300
04	Arkansas.....	0.7194	44	Tennessee.....	0.7734
05	California.....	1.2194	45	Texas.....	0.7934
06	Colorado.....	1.0126	46	Utah.....	0.8719
07	Connecticut.....	1.1287	47	Vermont.....	0.9709
08	Delaware.....	1.0008	48	Virgin Islands.....	0.7505
10	Florida.....	0.8361	49	Virginia.....	0.7817
11	Georgia.....	0.7547	50	Washington.....	1.0231
12	Hawaii.....	1.1200	51	West Virginia.....	0.7371
13	Idaho.....	0.7531	52	Wisconsin.....	0.8977
14	Illinois.....	0.8426	53	Wyoming.....	0.9433
15	Indiana.....	0.8551	65	Guam.....	0.9611
16	Iowa.....	0.8618			
17	Kansas.....	0.8041			
18	Kentucky.....	0.7825			
19	Louisiana.....	0.7749			
20	Maine.....	0.8581			
21	Maryland.....	0.9291			
22	Massachusetts.....	1.3962			
23	Michigan.....	0.8295			
24	Minnesota.....	0.9107			
25	Mississippi.....	0.7539			
26	Missouri.....	0.7673			
27	Montana.....	0.8615			
28	Nebraska.....	0.8872			
29	Nevada.....	0.9637			
30	New Hampshire.....	1.0441			
31	New Jersey <sup>1</sup> .....	-----			
32	New Mexico.....	0.8878			
33	New York.....	0.8152			
34	North Carolina.....	0.8288			
35	North Dakota.....	0.7295			
36	Ohio.....	0.8455			
37	Oklahoma.....	0.7848			
38	Oregon.....	1.0337			
39	Pennsylvania.....	0.8450			
40	Puerto Rico <sup>1</sup> .....	0.4047			

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<sup>2</sup> At this time, there are no hospitals in these urban areas on which to base a wage index. Therefore, the urban wage index value is based on the average wage index of all urban areas within the State.

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
10180	Abilene, TX.....	0.8444
	Callahan, TX	
	Jones, TX	
	Taylor, TX	
10380	Aguadilla-Isabela-San Sebastian, PR .....	0.3611
	Aguada, PR	
	Aguadilla, PR	
	Anasco, PR	
	Isabela, PR	
	Lares, PR	
	Moca, PR	
	Rincon, PR	
	San Sebastian, PR	
10420	Akron, OH.....	0.8814
	Portage, OH	
	Summit, OH	
10500	Albany, GA.....	0.8687
	Baker, GA	
	Dougherty, GA	
	Lee, GA	
	Terrell, GA	
	Worth, GA	
10580	Albany-Schenectady-Troy, NY .....	0.8680
	Albany, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
10740	Albuquerque, NM.....	0.9550
	Bernalillo, NM	
	Sandoval, NM	
	Torrance, NM	
	Valencia, NM	
10780	Alexandria, LA	0.8026
	Grant, LA	
	Rapides, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ .....	0.9260
	Warren, NJ	
	Carbon, PA	
	Lehigh, PA	
	Northampton, PA	
11020	Altoona, PA .....	0.8917
	Blair, PA	
11100	Amarillo, TX.....	0.8714

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
	Armstrong, TX	
	Carson, TX	
	Potter, TX	
	Randall, TX	
11180	Ames, IA.....	1.0009
	Story, IA	
11260	Anchorage, AK.....	1.2133
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN .....	0.9266
	Madison, IN	
11340	Anderson, SC.....	0.8524
	Anderson, SC	
11460	Ann Arbor, MI .....	1.0128
	Washtenaw, MI	
11500	Anniston-Oxford, AL .....	0.7979
	Calhoun, AL	
11540	Appleton, WI .....	0.9226
	Calumet, WI	
	Outagamie, WI	
11700	Asheville, NC.....	0.8918
	Buncombe, NC	
	Haywood, NC	
	Henderson, NC	
	Madison, NC	
12020	Athens-Clarke, GA .....	0.9642
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
	Oglethorpe, GA	
12060	Atlanta-Sandy Springs-Marietta, GA .....	0.9575
	Barrow, GA	
	Bartow, GA	
	Butts, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	Dawson, GA	
	DeKalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Haralson, GA	
	Heard, GA	
	Henry, GA	
	Jasper, GA	

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	Lamar, GA		12980	Battle Creek, MI.....	0.9935
	Meriwether, GA			Calhoun, MI	
	Newton, GA		13020	Bay City, MI.....	0.8927
	Paulding, GA			Bay, MI	
	Pickens, GA		13140	Beaumont-Port Arthur, TX .....	0.8723
	Pike, GA			Hardin, TX	
	Rockdale, GA			Jefferson, TX	
	Spalding, GA			Orange, TX	
	Walton, GA		13380	Bellingham, WA .....	1.1748
12100	Atlantic City-Hammonton, NJ .....	1.1033		Whatcom, WA	
	Atlantic, NJ		13460	Bend, OR .....	1.1395
12220	Auburn-Opelika, AL.....	0.7877		Deschutes, OR	
	Lee, AL		13644	Bethesda-Rockville-Frederick, MD.	1.0305
12260	Augusta-Richmond, GA-SC .....	0.9529		Frederick, MD	
	Burke, GA			Montgomery, MD	
	Columbia, GA		13740	Billings, MT .....	0.8576
	McDuffie, GA			Carbon, MT	
	Richmond, GA			Yellowstone, MT	
	Aiken, SC		13780	Binghamton, NY.....	0.8731
	Edgefield, SC			Broome, NY	
12420	Austin-Round Rock-San Marcos, TX .....	0.9535		Tioga, NY	
	Bastrop, TX		13820	Birmingham-Hoover, AL.....	0.8436
	Caldwell, TX			Bibb, AL	
	Hays, TX			Blount, AL	
	Travis, TX			Chilton, AL	
	Williamson, TX			Jefferson, AL	
12540	Bakersfield-Delano, CA.....	1.1817		St. Clair, AL	
	Kern, CA			Shelby, AL	
12580	Baltimore-Towson, MD .....	1.0151	13900	Walker, AL	
	Anne Arundel, MD			Bismarck, ND.....	0.7232
	Baltimore, MD			Burleigh, ND	
	Carroll, MD			Morton, ND	
	Harford, MD		13980	Blacksburg-Christiansburg-Radford, VA .....	0.8281
	Howard, MD			Giles, VA	
	Queen Anne's, MD			Montgomery, VA	
	Baltimore City, MD			Pulaski, VA	
12620	Bangor, ME.....	0.9979		Radford City, VA	
	Penobscot, ME		14020	Bloomington, IN.....	0.8725
12700	Barnstable Town, MA .....	1.2838		Greene, IN	
	Barnstable, MA			Monroe, IN	
12940	Baton Rouge, LA .....	0.8523		Owen, IN	
	Ascension, LA		14060	Bloomington-Normal, IL .....	0.9477
	East Baton Rouge, LA			McLean, IL	
	East Feliciana, LA		14260	Boise City-Nampa, ID .....	0.9279
	Iberville, LA			Ada, ID	
	Livingston, LA			Boise, ID	
	Pointe Coupee, LA			Canyon, ID	
	St. Helena, LA			Gem, ID	
	West Baton Rouge, LA			Owyhee, ID	
	West Feliciana, LA		14484	Boston-Quincy, MA .....	1.2283

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	Norfolk, MA		16580	Champaign-Urbana, IL .....	0.9890
	Plymouth, MA			Champaign, IL	
	Suffolk, MA			Ford, IL	
14500	Boulder, CO.....	1.0086		Piatt, IL	
	Boulder, CO		16620	Charleston, WV .....	0.8144
14540	Bowling Green, KY .....	0.8599		Boone, WV	
	Edmonson, KY			Clay, WV	
	Warren, KY			Kanawha, WV	
14740	Bremerton-Silverdale, WA .....	1.1288		Lincoln, WV	
	Kitsap, WA			Putnam, WV	
14860	Bridgeport-Stamford-Norwalk, CT	1.2914	16700	Charleston-North Charleston-Summerville, SC.....	0.9063
	Fairfield, CT			Berkeley, SC	
15180	Brownsville-Harlingen, TX.....	0.9173		Charleston, SC	
	Cameron, TX			Dorchester, SC	
15260	Brunswick, GA .....	0.9068	16740	Charlotte-Gastonia-Rock Hill, NC-SC .....	0.9321
	Brantley, GA			Anson, NC	
	Glynn, GA			Cabarrus, NC	
	McIntosh, GA			Gaston, NC	
15380	Buffalo-Niagara Falls, NY .....	0.9750		Mecklenburg, NC	
	Erie, NY			Union, NC	
	Niagara, NY			York, SC	
15500	Burlington, NC .....	0.8665	16820	Charlottesville, VA.....	0.9188
	Alamance, NC			Albemarle, VA	
15540	Burlington-South Burlington, VT ...	1.0021		Fluvanna, VA	
	Chittenden, VT			Greene, VA	
	Franklin, VT			Nelson, VA	
	Grand Isle, VT			Charlottesville City, VA	
15764	Cambridge-Newton-Framingham, MA.....	1.1210	16860	Chattanooga, TN-GA .....	0.8740
	Middlesex, MA			Catoosa, GA	
15804	Camden, NJ.....	1.0202		Dade, GA	
	Burlington, NJ			Walker, GA	
	Camden, NJ			Hamilton, TN	
	Gloucester, NJ			Marion, TN	
15940	Canton-Massillon, OH.....	0.8939		Sequatchie, TN	
	Carroll, OH		16940	Cheyenne, WY .....	0.9844
	Stark, OH			Laramie, WY	
15980	Cape Coral-Fort Myers, FL .....	0.9341	16974	Chicago-Joliet-Naperville, IL .....	1.0600
	Lee, FL			Cook, IL	
16020	Cape Girardeau-Jackson, MO-IL ....	0.8672		DeKalb, IL	
	Alexander, IL			DuPage, IL	
	Bollinger, MO			Grundy, IL	
	Cape Girardeau, MO			Kane, IL	
16180	Carson City, NV.....	1.0597		Kendall, IL	
	Carson City, NV			McHenry, IL	
16220	Casper, WY.....	1.0117		Will, IL	
	Natrona, WY		17020	Chico, CA .....	1.1094
16300	Cedar Rapids, IA .....	0.8831		Butte, CA	
	Benton, IA		17140	Cincinnati-Middletown, OH-KY-IN.....	0.9430
	Jones, IA				
	Linn, IA				

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	Dearborn, IN			Harris, GA	
	Franklin, IN			Marion, GA	
	Ohio, IN			Muscogee, GA	
	Boone, KY		18020	Columbus, IN .....	0.9723
	Bracken, KY			Bartholomew, IN	
	Campbell, KY		18140	Columbus, OH .....	0.9994
	Gallatin, KY			Delaware, OH	
	Grant, KY			Fairfield, OH	
	Kenton, KY			Franklin, OH	
	Pendleton, KY			Licking, OH	
	Brown, OH			Madison, OH	
	Butler, OH			Morrow, OH	
	Clermont, OH			Pickaway, OH	
	Hamilton, OH			Union, OH	
	Warren, OH		18580	Corpus Christi, TX .....	0.8677
17300	Clarksville, TN-KY.....	0.8193		Aransas, TX	
	Christian, KY			Nueces, TX	
	Trigg, KY			San Patricio, TX	
	Montgomery, TN		18700	Corvallis, OR.....	1.0898
	Stewart, TN			Benton, OR	
17420	Cleveland, TN.....	0.7674	18880	Crestview-Fort Walton Beach-Destin, FL .....	0.8961
	Bradley, TN			Okaloosa, FL	
	Polk, TN			Cumberland, MD-WV .....	0.7825
17460	Cleveland-Elyria-Mentor, OH.....	0.8941	19060	Allegany, MD	
	Cuyahoga, OH			Mineral, WV	
	Geauga, OH		19124	Dallas-Plano-Irving, TX .....	0.9844
	Lake, OH			Collin, TX	
	Lorain, OH			Dallas, TX	
	Medina, OH			Delta, TX	
17660	Coeur d'Alene, ID .....	0.9367		Denton, TX	
	Kootenai, ID			Ellis, TX	
17780	College Station-Bryan, TX.....	0.9690		Hunt, TX	
	Brazos, TX			Kaufman, TX	
	Burleson, TX			Rockwall, TX	
	Robertson, TX		19140	Dalton, GA .....	0.8374
17820	Colorado Springs, CO .....	0.9846		Murray, GA	
	El Paso, CO			Whitfield, GA	
	Teller, CO		19180	Danville, IL.....	0.9832
17860	Columbia, MO .....	0.8105		Vermilion, IL	
	Boone, MO		19260	Danville, VA.....	0.7896
	Howard, MO			Pittsylvania, VA	
17900	Columbia, SC .....	0.8758		Danville City, VA	
	Calhoun, SC		19340	Davenport-Moline-Rock Island, IA-IL.....	0.9056
	Fairfield, SC			Henry, IL	
	Kershaw, SC			Mercer, IL	
	Lexington, SC			Rock Island, IL	
	Richland, SC			Scott, IA	
	Saluda, SC		19380	Dayton, OH.....	0.9281
17980	Columbus, GA-AL.....	0.9040		Greene, OH	
	Russell, AL				
	Chattahoochee, GA				

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19460	Miami, OH	0.7334	20940	Middlesex, NJ	0.9601				
	Montgomery, OH			Monmouth, NJ					
	Preble, OH			Ocean, NJ					
	Decatur, AL .....			Somerset, NJ					
19500	Lawrence, AL	0.8008	21060	El Centro, CA .....	0.8719				
	Morgan, AL			Imperial, CA					
	Decatur, IL .....			Elizabethtown, KY .....					
19660	Macon, IL	0.8865	21140	Hardin, KY	0.9405				
	Deltona-Daytona Beach-Ormond Beach, FL .....			Larue, KY					
	Volusia, FL			Elkhart-Goshen, IN .....					
19740	Denver-Aurora-Broomfield, CO .....	1.0647	21300	Elkhart, IN	0.8522				
	Adams, CO			Elmira, NY .....					
	Arapahoe, CO			Chemung, NY					
	Broomfield, CO			El Paso, TX .....					
	Clear Creek, CO			El Paso, TX					
	Denver, CO			Erie, PA .....					
	Douglas, CO			Erie, PA					
	Elbert, CO			Eugene-Springfield, OR .....					
	Gilpin, CO			Lane, OR					
	Jefferson, CO			Evansville, IN-KY .....					
	Park, CO			Gibson, IN					
	19780			Des Moines-West Des Moines, IA...		0.9801	21780	Posey, IN	0.8679
				Dallas, IA				Vanderburgh, IN	
Guthrie, IA		Warrick, IN							
Madison, IA		Henderson, KY							
Polk, IA		Webster, KY							
Warren, IA		Fairbanks, AK .....							
19804	Detroit-Livonia-Dearborn, MI .....	0.9511	21820	Fairbanks North Star Borough, AK	1.1322				
	Wayne, MI			Fajardo, PR .....					
20020	Dothan, AL .....	0.7390	21940	Ceiba, PR	0.3823				
	Geneva, AL			Fajardo, PR					
	Henry, AL			Luquillo, PR					
	Houston, AL			Fargo, ND-MN .....					
20100	Dover, DE .....	0.9909	22020	Clay, MN	0.8136				
	Kent, DE			Cass, ND					
20220	Dubuque, IA .....	0.8698	22140	Farmington, NM .....	0.9795				
	Dubuque, IA			San Juan, NM					
20260	Duluth, MN-WI .....	1.0335	22180	Fayetteville, NC .....	0.9213				
	Carlton, MN			Cumberland, NC					
	St. Louis, MN			Hoke, NC					
	Douglas, WI			Fayetteville-Springdale-Rogers, AR-MO .....					
20500	Durham-Chapel Hill, NC .....	0.9699	22220	Benton, AR	0.9263				
	Chatham, NC			Madison, AR					
	Durham, NC			Washington, AR					
	Orange, NC			McDonald, MO					
	Person, NC			Flagstaff, AZ .....					
20740	Eau Claire, WI .....	0.9597	22380	Coconino, AZ	1.2427				
	Chippewa, WI			Flint, MI .....					
	Eau Claire, WI			Genesee, MI					
20764	Edison-New Brunswick, NJ .....	1.0868	22420	Florence, SC .....	0.8217				
			22500						

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	Darlington, SC		24340	Grand Rapids-Wyoming, MI.....	0.9145
22520	Florence, SC	0.7738		Barry, MI	
	Florence-Muscle Shoals, AL .....			Ionia, MI	
	Colbert, AL			Kent, MI	
22540	Lauderdale, AL	0.9291	24500	Newaygo, MI	0.8462
	Fond du Lac, WI.....			Great Falls, MT .....	
	Fond du Lac, WI			Cascade, MT	
22660	Fort Collins-Loveland, CO.....	0.9876	24540	Greeley, CO .....	0.9553
	Larimer, CO			Weld, CO	
22744	Fort Lauderdale-Pompano Beach-Deerfield, Beach, FL.....	1.0160	24580	Green Bay, WI.....	0.9824
	Broward, FL			Brown, WI	
22900	Fort Smith, AR-OK.....	0.7620		Kewaunee, WI	
	Crawford, AR			Oconto, WI	
	Franklin, AR		24660	Greensboro-High Point, NC.....	0.8798
	Sebastian, AR			Guilford, NC	
	Le Flore, OK			Randolph, NC	
	Sequoyah, OK			Rockingham, NC	
23060	Fort Wayne, IN .....	0.9368	24780	Greenville, NC.....	0.9637
	Allen, IN			Greene, NC	
	Wells, IN			Pitt, NC	
	Whitley, IN		24860	Greenville-Mauldin-Easley, SC .....	0.9620
23104	Fort Worth-Arlington, TX .....	0.9525		Greenville, SC	
	Johnson, TX			Laurens, SC	
	Parker, TX			Pickens, SC	
	Tarrant, TX		25020	Guayama, PR.....	0.3730
	Wise, TX			Arroyo, PR	
23420	Fresno, CA.....	1.1281		Guayama, PR	
	Fresno, CA			Patillas, PR	
23460	Gadsden, AL .....	0.7934	25060	Gulfport-Biloxi, MS.....	0.8505
	Etowah, AL			Hancock, MS	
23540	Gainesville, FL .....	0.9375		Harrison, MS	
	Alachua, FL			Stone, MS	
	Gilchrist, FL		25180	Hagerstown-Martinsburg, MD-WV .....	0.9168
23580	Gainesville, GA.....	0.9010		Washington, MD	
	Hall, GA			Berkeley, WV	
23844	Gary, IN .....	0.9193		Morgan, WV	
	Jasper, IN		25260	Hanford-Corcoran, CA.....	1.0700
	Lake, IN			Kings, CA	
	Newton, IN		25420	Harrisburg-Carlisle, PA.....	0.9400
	Porter, IN			Cumberland, PA	
24020	Glens Falls, NY .....	0.8504		Dauphin, PA	
	Warren, NY			Perry, PA	
	Washington, NY		25500	Harrisonburg, VA.....	0.8773
24140	Goldsboro, NC.....	0.8690		Rockingham, VA	
	Wayne, NC			Harrisonburg City, VA	
24220	Grand Forks, ND-MN .....	0.7573	25540	Hartford-West Hartford-East	
	Polk, MN			Hartford, CT .....	1.0700
	Grand Forks, ND			Hartford, CT	
24300	Grand Junction, CO .....	0.9394		Middlesex, CT	
	Mesa, CO			Tolland, CT	

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25620	Hattiesburg, MS.....	0.7940		Johnson, IN	
	Forrest, MS			Marion, IN	
	Lamar, MS			Morgan, IN	
	Perry, MS			Putnam, IN	
25860	Hickory-Lenoir-Morganton, NC.....	0.8859		Shelby, IN	
	Alexander, NC		26980	Iowa City, IA.....	1.0070
	Burke, NC			Johnson, IA	
	Caldwell, NC			Washington, IA	
	Catawba, NC		27060	Ithaca, NY.....	0.8819
25980 <sup>2</sup>	Hinesville-Fort Stewart, GA.....	0.8926		Tompkins, NY	
	Liberty, GA		27100	Jackson, MI.....	0.8938
	Long, GA			Jackson, MI	
26100	Holland-Grand Haven, MI.....	0.8523	27140	Jackson, MS.....	0.8172
	Ottawa, MI			Copiah, MS	
26180	Honolulu, HI.....	1.1698		Hinds, MS	
	Honolulu, HI			Madison, MS	
26300	Hot Springs, AR.....	0.9076		Rankin, MS	
	Garland, AR			Simpson, MS	
26380	Houma-Bayou Cane-Thibodaux, LA.....	0.7841	27180	Jackson, TN.....	0.8149
	Lafourche, LA			Chester, TN	
	Terrebonne, LA		27260	Jacksonville, FL.....	0.8882
26420	Houston-Sugar Land-Baytown, TX	0.9945		Baker, FL	
	Austin, TX			Clay, FL	
	Brazoria, TX			Duval, FL	
	Chambers, TX			Nassau, FL	
	Fort Bend, TX			St. Johns, FL	
	Galveston, TX		27340	Jacksonville, NC.....	0.8074
	Harris, TX			Onslow, NC	
	Liberty, TX		27500	Janesville, WI.....	0.9234
	Montgomery, TX			Rock, WI	
	San Jacinto, TX		27620	Jefferson City, MO.....	0.8222
	Waller, TX			Callaway, MO	
26580	Huntington-Ashland, WV-KY-OH.	0.8893		Cole, MO	
	Boyd, KY			Moniteau, MO	
	Greenup, KY			Osage, MO	
	Lawrence, OH		27740	Johnson City, TN.....	0.7796
	Cabell, WV			Carter, TN	
	Wayne, WV			Unicoi, TN	
26620	Huntsville, AL.....	0.8996		Washington, TN	
	Limestone, AL		27780	Johnstown, PA.....	0.8715
	Madison, AL			Cambria, PA	
26820	Idaho Falls, ID.....	0.9336	27860	Jonesboro, AR.....	0.7718
	Bonneville, ID			Craighead, AR	
	Jefferson, ID			Poinsett, AR	
26900	Indianapolis-Carmel, IN.....	0.9662	27900	Joplin, MO.....	0.8227
	Boone, IN			Jasper, MO	
	Brown, IN			Newton, MO	
	Hamilton, IN		28020	Kalamazoo-Portage, MI.....	0.9939
	Hancock, IN			Kalamazoo, MI	
	Hendricks, IN			Van Buren, MI	

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28100	Kankakee-Bradley, IL.....	0.9807		St. Martin, LA	
	Kankakee, IL		29340	Lake Charles, LA	0.7998
28140	Kansas City, MO-KS.....	0.9637		Calcasieu, LA	
	Franklin, KS			Cameron, LA	
	Johnson, KS		29404	Lake County-Kenosha County, IL-WI .....	1.0311
	Leavenworth, KS			Lake, IL	
	Linn, KS			Kenosha, WI	
	Miami, KS		29420	Lake Havasu City-Kingman, AZ....	0.9967
	Wyandotte, KS			Mohave, AZ	
	Bates, MO		29460	Lakeland-Winter Haven, FL.....	0.8432
	Caldwell, MO			Polk, FL	
	Cass, MO		29540	Lancaster, PA .....	0.9439
	Clay, MO			Lancaster, PA	
	Clinton, MO		29620	Lansing-East Lansing, MI .....	1.0477
	Jackson, MO			Clinton, MI	
	Lafayette, MO			Eaton, MI	
	Platte, MO			Ingham, MI	
	Ray, MO		29700	Laredo, TX.....	0.7730
28420	Kennewick-Pasco-Richland, WA ....	0.9582		Webb, TX	
	Benton, WA		29740	Las Cruces, NM.....	0.9106
	Franklin, WA			Dona Ana, NM	
28660	Killeen-Temple-Fort Hood, TX.....	0.9501	29820	Las Vegas-Paradise, NV .....	1.2050
	Bell, TX			Clark, NV	
	Coryell, TX		29940	Lawrence, KS .....	0.8853
	Lampasas, TX			Douglas, KS	
28700	Kingsport-Bristol-Bristol, TN-VA ...	0.7399	30020	Lawton, OK.....	0.8545
	Hawkins, TN			Comanche, OK	
	Sullivan, TN		30140	Lebanon, PA.....	0.8042
	Bristol City, VA			Lebanon, PA	
	Scott, VA		30300	Lewiston, ID-WA .....	0.9067
	Washington, VA			Nez Perce, ID	
28740	Kingston, NY .....	0.9170		Asotin, WA	
	Ulster, NY		30340	Lewiston-Auburn, ME .....	0.9038
28940	Knoxville, TN.....	0.7838		Androscoggin, ME	
	Anderson, TN		30460	Lexington-Fayette, KY.....	0.8833
	Blount, TN			Bourbon, KY	
	Knox, TN			Clark, KY	
	Loudon, TN			Fayette, KY	
	Union, TN			Jessamine, KY	
29020	Kokomo, IN.....	0.9186		Scott, KY	
	Howard, IN			Woodford, KY	
	Tipton, IN		30620	Lima, OH.....	0.9371
29100	La Crosse, WI-MN .....	0.9685		Allen, OH	
	Houston, MN		30700	Lincoln, NE .....	0.9612
	La Crosse, WI			Lancaster, NE	
29140	Lafayette, IN .....	0.9507		Seward, NE	
	Benton, IN		30780	Little Rock-North Little Rock-Conway, AR.....	0.8558
	Carroll, IN			Faulkner, AR	
	Tippecanoe, IN			Grant, AR	
29180	Lafayette, LA.....	0.8319			
	Lafayette, LA				

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30860	Lonoke, AR	0.8592	31700	Iowa, WI	1.0083				
	Perry, AR			Manchester-Nashua, NH.....					
	Pulaski, AR		31740	Hillsborough, NH	0.7912				
	Saline, AR			Manhattan, KS.....					
	Logan, UT-ID.....			Geary, KS					
30980	Franklin, ID	0.8530	31860	Pottawatomie, KS	0.9346				
	Cache, UT			Riley, KS					
	Longview, TX.....			Mankato-North Mankato, MN.....					
	Gregg, TX			Blue Earth, MN					
31020	Rusk, TX	0.9989	31900	Nicollet, MN	0.9215				
	Upshur, TX			Mansfield, OH.....					
	Longview, WA.....			Richland, OH					
31084	Cowlitz, WA	1.2287	32420	Mayaguez, PR.....	0.3676				
	Los Angeles-Long Beach-Glendale, CA.....			Hormigueros, PR					
31140	Los Angeles, CA	0.8900	32580	Mayaguez, PR	0.8878				
	Louisville-Jefferson County, KY-IN			McAllen-Edinburg-Mission, TX.....					
	Clark, IN		32780	Hidalgo, TX	1.0318				
	Floyd, IN			Medford, OR.....					
	Harrison, IN			Jackson, OR					
	Washington, IN		32820	Memphis, TN-MS-AR.....	0.9275				
	Bullitt, KY			Crittenden, AR					
	Henry, KY		32900	DeSoto, MS	1.2424				
	Jefferson, KY			Marshall, MS					
	Meade, KY			Tate, MS					
	Nelson, KY			Tunica, MS					
	Oldham, KY			Fayette, TN					
	Shelby, KY			Shelby, TN					
	Spencer, KY			Tipton, TN					
	Trimble, KY			Merced, CA.....					
	31180			Lubbock, TX.....		0.8794	33124	Merced, CA	1.0085
				Crosby, TX				Miami-Miami Beach-Kendall, FL ...	
Lubbock, TX		Miami-Dade, FL.....							
31340	Lynchburg, VA.....	0.8768	33140	Michigan City-La Porte, IN.....	0.9358				
	Amherst, VA			LaPorte, IN					
	Appomattox, VA		33260	Midland, TX.....	1.0514				
	Bedford, VA			Midland, TX					
	Campbell, VA			33340		Milwaukee-Waukesha-West Allis, WI.....	0.9961		
	Bedford City, VA					Milwaukee, WI			
Lynchburg City, VA	Ozaukee, WI								
31420	Macon, GA.....	0.9122	33460	Washington, WI	1.1105				
	Bibb, GA			Waukesha, WI					
	Crawford, GA			Minneapolis-St. Paul-Bloomington, MN-WI.....					
	Jones, GA			Anoka, MN					
	Monroe, GA			Carver, MN					
31460	Twiggs, GA	0.8114	33460	Chisago, MN	1.1105				
	Madera-Chowchilla, CA.....			Dakota, MN					
31540	Madera, CA	1.1234	33460	Hennepin, MN	1.1105				
	Madison, WI.....			Isanti, MN					
	Columbia, WI			Ramsey, MN					
	Dane, WI								

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	Scott, MN			Rutherford, TN	
	Sherburne, MN			Smith, TN	
	Washington, MN			Sumner, TN	
	Wright, MN			Trousdale, TN	
	Pierce, WI			Williamson, TN	
	St. Croix, WI			Wilson, TN	
33540	Missoula, MT .....	0.9154	35004	Nassau-Suffolk, NY .....	1.2416
	Missoula, MT			Nassau, NY	
33660	Mobile, AL.....	0.8002		Suffolk, NY	
	Mobile, AL		35084	Newark-Union, NJ-PA .....	1.1322
33700	Modesto, CA .....	1.2670		Essex, NJ	
	Stanislaus, CA			Hunterdon, NJ	
33740	Monroe, LA .....	0.7964		Morris, NJ	
	Ouachita, LA			Sussex, NJ	
	Union, LA			Union, NJ	
33780	Monroe, MI .....	0.8727		Pike, PA	
	Monroe, MI		35300	New Haven-Milford, CT.....	1.1556
33860	Montgomery, AL .....	0.8103		New Haven, CT	
	Autauga, AL		35380	New Orleans-Metairie-Kenner, LA	0.9026
	Elmore, AL			Jefferson, LA	
	Lowndes, AL			Orleans, LA	
	Montgomery, AL			Plaquemines, LA	
34060	Morgantown, WV .....	0.8197		St. Bernard, LA	
	Monongalia, WV			St. Charles, LA	
	Preston, WV			St. John the Baptist, LA	
34100	Morristown, TN.....	0.7031		St. Tammany, LA	
	Grainger, TN		35644	New York-White Plains-Wayne, NY-NJ.....	1.3052
	Hamblen, TN			Bergen, NJ	
	Jefferson, TN			Hudson, NJ	
34580	Mount Vernon-Anacortes, WA.....	1.0235		Passaic, NJ	
	Skagit, WA			Bronx, NY	
34620	Muncie, IN .....	0.7817		Kings, NY	
	Delaware, IN			New York, NY	
34740	Muskegon-Norton Shores, MI.....	0.9967		Putnam, NY	
	Muskegon, MI			Queens, NY	
34820	Myrtle Beach-North Myrtle Beach-Conway, SC .....	0.8653		Richmond, NY	
	Horry, SC			Rockland, NY	
34900	Napa, CA.....	1.4511		Westchester, NY	
	Napa, CA		35660	Niles-Benton Harbor, MI.....	0.8653
34940	Naples-Marco Island, FL.....	0.9740		Berrien, MI	
	Collier, FL		35840	North Port-Bradenton-Sarasota-Venice, FL .....	0.9435
34980	Nashville-Davidson-Murfreesboro-Franklin, TN .....	0.9340		Manatee, FL	
	Cannon, TN			Sarasota, FL	
	Cheatham, TN		35980	Norwich-New London, CT.....	1.1227
	Davidson, TN			New London, CT	
	Dickson, TN		36084	Oakland-Fremont-Hayward, CA....	1.6080
	Hickman, TN			Alameda, CA	
	Macon, TN			Contra Costa, CA	
	Robertson, TN		36100	Ocala, FL.....	0.8449

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36140	Marion, FL Ocean City, NJ..... Cape May, NJ	1.0641		Washington, OH Pleasants, WV Wirt, WV	
36220	Odessa, TX..... Ector, TX	0.9809	37700	Wood, WV Pascagoula, MS..... George, MS	0.7885
36260	Ogden-Clearfield, UT ..... Davis, UT Morgan, UT Weber, UT	0.9220	37764	Jackson, MS Peabody, MA..... Essex, MA	1.0698
36420	Oklahoma City, OK..... Canadian, OK Cleveland, OK Grady, OK Lincoln, OK Logan, OK McClain, OK Oklahoma, OK	0.8934	37860	Pensacola-Ferry Pass-Brent, FL..... Escambia, FL Santa Rosa, FL	0.8013
36500	Olympia, WA ..... Thurston, WA	1.1339	37900	Peoria, IL ..... Marshall, IL Peoria, IL Stark, IL Tazewell, IL Woodford, IL	0.8830
36540	Omaha-Council Bluffs, NE-IA ..... Harrison, IA Mills, IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Saunders, NE Washington, NE	0.9864	37964	Philadelphia, PA ..... Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0760
36740	Orlando-Kissimee-Sanford, FL ..... Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9128	38060	Phoenix-Mesa-Glendale, AZ ..... Maricopa, AZ Pinal, AZ	1.0566
36780	Oshkosh-Neenah, WI ..... Winnebago, WI	0.9319	38220	Pine Bluff, AR ..... Cleveland, AR Jefferson, AR Lincoln, AR	0.7700
36980	Owensboro, KY ..... Davies, KY Hancock, KY McLean, KY	0.8202	38300	Pittsburgh, PA..... Allegheny, PA Armstrong, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.8669
37100	Oxnard-Thousand Oaks-Ventura, CA..... Ventura, CA	1.2830	38340	Pittsfield, MA..... Berkshire, MA	1.0616
37340	Palm Bay-Melbourne-Titusville, FL Brevard, FL	0.9042	38540	Pocatello, ID..... Bannock, ID Power, ID	0.9426
37380	Palm Coast, FL..... Flagler, FL	0.9373	38660	Ponce, PR..... Juana Diaz, PR Ponce, PR Villalba, PR	0.4185
37460	Panama City-Lynn Haven-Panama City Beach, FL..... Bay, FL	0.8388	38860	Portland-South Portland-Biddeford, ME ..... Cumberland, ME	0.9661
37620	Parkersburg-Marietta-Vienna, WV-OH.....	0.7647			

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	Sagadahoc, ME		40060	Richmond, VA .....	0.9791
38900	York, ME			Amelia, VA	
	Portland-Vancouver-Hillsboro, OR-WA.....	1.1454		Caroline, VA	
	Clackamas, OR			Charles City, VA	
	Columbia, OR			Chesterfield, VA	
	Multnomah, OR			Cumberland, VA	
	Washington, OR			Dinwiddie, VA	
	Yamhill, OR			Goochland, VA	
	Clark, WA			Hanover, VA	
38940	Skamania, WA			Henrico, VA	
	Port St. Lucie, FL .....	0.9784		King and Queen, VA	
	Martin, FL			King William, VA	
	St. Lucie, FL			Louisa, VA	
39100	Poughkeepsie-Newburgh-Middletown, NY .....	1.1339		New Kent, VA	
	Dutchess, NY			Powhatan, VA	
	Orange, NY			Prince George, VA	
39140	Prescott, AZ.....	1.2261		Sussex, VA	
	Yavapai, AZ			Colonial Heights City, VA	
39300	Providence-New Bedford-Fall River, RI-MA .....	1.0639		Hopewell City, VA	
	Bristol, MA		40140	Petersburg City, VA	
	Bristol, RI			Richmond City, VA	
	Kent, RI			Riverside-San Bernardino-Ontario, CA .....	1.1463
	Newport, RI			Riverside, CA	
	Providence, RI		40220	San Bernardino, CA	
	Washington, RI			Roanoke, VA .....	0.9166
39340	Provo-Orem, UT .....	0.9404		Botetourt, VA	
	Juab, UT			Craig, VA	
	Utah, UT			Franklin, VA	
39380	Pueblo, CO .....	0.8668		Roanoke, VA	
	Pueblo, CO			Roanoke City, VA	
39460	Punta Gorda, FL .....	0.8801	40340	Salem City, VA	
	Charlotte, FL			Rochester, MN .....	1.0802
39540	Racine, WI .....	0.8630		Dodge, MN	
	Racine, WI			Olmsted, MN	
39580	Raleigh-Cary, NC .....	0.9648	40380	Wabasha, MN	
	Franklin, NC			Rochester, NY .....	0.8602
	Johnston, NC			Livingston, NY	
	Wake, NC			Monroe, NY	
39660	Rapid City, SD.....	1.0203		Ontario, NY	
	Meade, SD			Orleans, NY	
	Pennington, SD		40420	Wayne, NY	
39740	Reading, PA.....	0.9212		Rockford, IL .....	0.9938
	Berks, PA			Boone, IL	
39820	Redding, CA .....	1.5584	40484	Winnebago, IL	
	Shasta, CA			Rockingham County-Strafford County, NH.....	1.0185
39900	Reno-Sparks, NV .....	1.0596		Rockingham, NH	
	Storey, NV			Strafford, NH	
	Washoe, NV		40580	Rocky Mount, NC .....	0.9018
				Edgecombe, NC	

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40660	Nash, NC		41660	Tooele, UT	
	Rome, GA .....	0.8838		San Angelo, TX.....	0.8273
40900	Floyd, GA			Irion, TX	
	Sacramento--Arden-Arcade--		41700	Tom Green, TX	
	Roseville, CA .....	1.3777		San Antonio-New Braunfels, TX ....	0.9006
	El Dorado, CA			Atascosa, TX	
	Placer, CA			Bandera, TX	
	Sacramento, CA			Bexar, TX	
	Yolo, CA			Comal, TX	
40980	Saginaw-Saginaw Township			Guadalupe, TX	
	North, MI.....	0.8512		Kendall, TX	
	Saginaw, MI			Medina, TX	
41060	St. Cloud, MN.....	1.0724		Wilson, TX	
	Benton, MN		41740	San Diego-Carlsbad-San Marcos, CA .....	1.1950
	Stearns, MN			San Diego, CA	
41100	St. George, UT.....	0.9070	41780	Sandusky, OH.....	0.8167
	Washington, UT			Erie, OH	
41140	St. Joseph, MO-KS.....	1.0255	41884	San Francisco-San Mateo-Redwood City, CA .....	1.5904
	Doniphan, KS			Marin, CA	
	Andrew, MO			San Francisco, CA	
	Buchanan, MO			San Mateo, CA	
41180	DeKalb, MO		41900	San German-Cabo Rojo, PR.....	0.4612
	St. Louis, MO-IL .....	0.9165		Cabo Rojo, PR	
	Bond, IL			Lajas, PR	
	Calhoun, IL			Sabana Grande, PR	
	Clinton, IL		41940	San German, PR	
	Jersey, IL			San Jose-Sunnyvale-Santa Clara, CA .....	1.6878
	Macoupin, IL			San Benito, CA	
	Madison, IL		41980	Santa Clara, CA	
	Monroe, IL			San Juan-Caguas-Guaynabo, PR....	0.4340
	St. Clair, IL			Aguas Buenas, PR	
	Crawford, MO			Aibonito, PR	
	Franklin, MO			Arecibo, PR	
	Jefferson, MO			Barceloneta, PR	
	Lincoln, MO			Barranquitas, PR	
	St. Charles, MO			Bayamon, PR	
	St. Louis, MO			Caguas, PR	
	Warren, MO			Camuy, PR	
	Washington, MO			Canovanas, PR	
41420	St. Louis City, MO			Carolina, PR	
	Salem, OR.....	1.1224		Catano, PR	
	Marion, OR			Cayey, PR	
	Polk, OR			Ciales, PR	
41500	Salinas, CA .....	1.5604		Cidra, PR	
	Monterey, CA			Comerio, PR	
41540	Salisbury, MD.....	0.9227		Corozal, PR	
	Somerset, MD			Dorado, PR	
	Wicomico, MD			Florida, PR	
41620	Salt Lake City, UT.....	0.9415			
	Salt Lake, UT				
	Summit, UT				

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	Guaynabo, PR		43300	Sherman-Denison, TX .....	0.8011
	Gurabo, PR			Grayson, TX	
	Hatillo, PR		43340	Shreveport-Bossier City, LA .....	0.8505
	Humacao, PR			Bossier, LA	
	Juncos, PR			Caddo, LA	
	Las Piedras, PR			De Soto, LA	
	Loiza, PR		43580	Sioux City, IA-NE-SD .....	0.9538
	Manati, PR			Woodbury, IA	
	Maunabo, PR			Dakota, NE	
	Morovis, PR			Dixon, NE	
	Naguabo, PR			Union, SD	
	Naranjito, PR		43620	Sioux Falls, SD .....	0.9153
	Orocovis, PR			Lincoln, SD	
	Quebradillas, PR			McCook, SD	
	Rio Grande, PR			Minnehaha, SD	
	San Juan, PR			Turner, SD	
	San Lorenzo, PR		43780	South Bend-Mishawaka, IN-MI.....	0.9426
	Toa Alta, PR			St. Joseph, IN	
	Toa Baja, PR			Cass, MI	
	Trujillo Alto, PR		43900	Spartanburg, SC .....	0.9325
	Vega Alta, PR			Spartanburg, SC	
	Vega Baja, PR		44060	Spokane, WA .....	1.0504
	Yabucoa, PR			Spokane, WA	
42020	San Luis Obispo-Paso Robles, CA ..	1.3072	44100	Springfield, IL.....	0.8958
	San Luis Obispo, CA			Menard, IL	
42044	Santa Ana-Anaheim-Irvine, CA.....	1.2042		Sangamon, IL	
	Orange, CA		44140	Springfield, MA.....	1.0247
42060	Santa Barbara-Santa Maria-Goleta, CA.....	1.2246		Franklin, MA	
	Santa Barbara, CA			Hampden, MA	
42100	Santa Cruz-Watsonville, CA.....	1.7111	44180	Hampshire, MA	
	Santa Cruz, CA			Springfield, MO.....	0.8680
42140	Santa Fe, NM.....	1.0660		Christian, MO	
	Santa Fe, NM			Dallas, MO	
42220	Santa Rosa-Petaluma, CA .....	1.6102		Greene, MO	
	Sonoma, CA			Polk, MO	
42340	Savannah, GA .....	0.9095	44220	Webster, MO	
	Bryan, GA			Springfield, OH.....	0.8981
	Chatham, GA			Clark, OH	
	Effingham, GA		44300	State College, PA .....	0.9251
42540	Scranton--Wilkes-Barre, PA .....	0.8328		Centre, PA	
	Lackawanna, PA		44600	Steubenville-Weirton, OH-WV .....	0.7054
	Luzerne, PA			Jefferson, OH	
	Wyoming, PA			Brooke, WV	
42644	Seattle-Bellevue-Everett, WA.....	1.1541	44700	Hancock, WV	
	King, WA			Stockton, CA .....	1.3052
	Snohomish, WA		44940	San Joaquin, CA	
42680	Sebastian-Vero Beach, FL .....	0.9032		Sumter, SC .....	0.7551
	Indian River, FL			Sumter, SC	
43100	Sheboygan, WI.....	0.9303	45060	Syracuse, NY.....	0.9776
	Sheboygan, WI			Madison, NY	
				Onondaga, NY	

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45104	Oswego, NY Tacoma, WA ..... Pierce, WA	1.1384	46540	Utica-Rome, NY ..... Herkimer, NY Oneida, NY	0.8441
45220	Tallahassee, FL ..... Gadsden, FL Jefferson, FL Leon, FL Wakulla, FL	0.8593	46660	Valdosta, GA ..... Brooks, GA Echols, GA Lanier, GA Lowndes, GA	0.7997
45300	Tampa-St. Petersburg-Clearwater, FL ..... Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.9072	46700	Vallejo-Fairfield, CA ..... Solano, CA	1.4636
45460	Terre Haute, IN ..... Clay, IN Sullivan, IN Vermillion, IN Vigo, IN	0.9209	47020	Victoria, TX ..... Calhoun, TX Goliad, TX Victoria, TX	0.8434
45500	Texarkana, TX-Texarkana, AR ..... Miller, AR Bowie, TX	0.7937	47220	Vineland-Millville-Bridgeton, NJ.... Cumberland, NJ	1.0222
45780	Toledo, OH ..... Fulton, OH Lucas, OH Ottawa, OH Wood, OH	0.9148	47260	Virginia Beach-Norfolk-Newport News, VA-NC ..... Currituck, NC Gloucester, VA Isle of Wight, VA James City, VA Mathews, VA Surry, VA York, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.9001
45820	Topeka, KS ..... Jackson, KS Jefferson, KS Osage, KS Shawnee, KS Wabaunsee, KS	0.8818	47300	Visalia-Porterville, CA ..... Tulare, CA	1.0343
45940	Trenton-Ewing, NJ ..... Mercer, NJ	1.0062	47380	Waco, TX ..... McLennan, TX	0.8559
46060	Tucson, AZ ..... Pima, AZ	0.9318	47580	Warner Robins, GA ..... Houston, GA	0.8245
46140	Tulsa, OK ..... Creek, OK Okmulgee, OK Osage, OK Pawnee, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8362	47644	Warren-Troy-Farmington Hills, MI Lapeer, MI Livingston, MI Macomb, MI Oakland, MI St. Clair, MI	0.9625
46220	Tuscaloosa, AL ..... Greene, AL Hale, AL Tuscaloosa, AL	0.8664	47894	Washington-Arlington-Alexandria, DC-VA ..... District of Columbia, DC Calvert, MD Charles, MD	1.0807
46340	Tyler, TX ..... Smith, TX	0.8335			

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	Prince George's, MD			Pender, NC	
	Arlington, VA		49020	Winchester, VA-WV .....	0.9106
	Clarke, VA			Frederick, VA	
	Fairfax, VA			Winchester City, VA	
	Fauquier, VA			Hampshire, WV	
	Loudoun, VA		49180	Winston-Salem, NC .....	0.8343
	Prince William, VA			Davie, NC	
	Spotsylvania, VA			Forsyth, NC	
	Stafford, VA			Stokes, NC	
	Warren, VA			Yadkin, NC	
	Alexandria City, VA		49340	Worcester, MA .....	1.1076
	Fairfax City, VA			Worcester, MA	
	Falls Church City, VA		49420	Yakima, WA .....	1.0433
	Fredericksburg City, VA			Yakima, WA	
	Manassas City, VA		49500	Yauco, PR.....	0.3757
	Manassas Park City, VA			Guanica, PR	
	Jefferson, WV			Guayanilla, PR	
47940	Waterloo-Cedar Falls, IA.....	0.8372		Penuelas, PR	
	Black Hawk, IA			Yauco, PR	
	Bremer, IA		49620	York-Hanover, PA .....	0.9675
	Grundy, IA			York, PA	
48140	Wausau, WI.....	0.8962	49660	Youngstown-Warren-Boardman, OH-PA .....	0.8328
	Marathon, WI			Mahoning, OH	
48300	Wenatchee-East Wenatchee, WA.....	1.0168		Trumbull, OH	
	Chelan, WA			Mercer, PA	
	Douglas, WA		49700	Yuba City, CA .....	1.1808
48424	West Palm Beach-Boca Raton-Boynton Beach, FL .....	0.9823		Sutter, CA	
	Palm Beach, FL			Yuba, CA	
48540	Wheeling, WV-OH.....	0.6735	49740	Yuma, AZ .....	0.9350
	Belmont, OH			Yuma, AZ	
	Marshall, WV				
	Ohio, WV				
48620	Wichita, KS.....	0.8696			
	Butler, KS				
	Harvey, KS				
	Sedgwick, KS				
	Sumner, KS				
48660	Wichita Falls, TX.....	1.0097			
	Archer, TX				
	Clay, TX				
	Wichita, TX				
48700	Williamsport, PA .....	0.8084			
	Lycoming, PA				
48864	Wilmington, DE-MD-NJ.....	1.0662			
	New Castle, DE				
	Cecil, MD				
	Salem, NJ				
48900	Wilmington, NC .....	0.9107			
	Brunswick, NC				
	New Hanover, NC				

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