



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 154  
6010.55-M  
JULY 26, 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:** 2012 CLARIFICATIONS - HOME INFUSION, SKILLED NURSING FACILITY (SNF), PROSTHETICS, OSTEOPOROSIS, THERAPEUTIC SHOES, ORTHOTICS, AND APPLIED BEHAVIORAL ANALYSIS (ABA)

**CONREQ:** 15905

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

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

**EFFECTIVE DATE:** 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. 161.**

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

**ATTACHMENT(S): 17 PAGE(S)  
DISTRIBUTION: 6010.55-M**

**CHANGE 154**  
**6010.55-M**  
**JULY 26, 2012**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 15, pages 1 and 2

**CHAPTER 3**

Table of Contents, page i

Section 6, pages 1 and 2

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**CHAPTER 8**

Section 2, pages 15 and 16

**INDEX**

pages 7 through 10, 15, and 16

**INSERT PAGE(S)**

Section 15, pages 1 and 2

Table of Contents, page i

Section 6, pages 1 and 2

Section 7, pages 1 through 3

Section 2, pages 15 through 17

pages 7 through 10, 15, and 16

**SUMMARY OF CHANGES**

**CHAPTER 1**

1. Section 15. Clarifies the payment of drugs provided as part of Home Infusion therapy.

**CHAPTER 3**

2. Table of Contents. Updated Section 6 and added Section 7.
3. Section 6. Clarifies the processing and payment of Home Infusion claims before January 30, 2012.
4. Section 7. Clarifies the processing and payment of Home Infusion claims on or after January 30, 2012.

**CHAPTER 8**

5. Section 2. Clarifies language on Skilled Nursing Facility (SNF) enteral feedings and adds coverage of SNF ancillary services not covered under inpatient SNF PPS.

**INDEX**

6. Updated Chapter 3, Section 6's reference and added Chapter 3, Section 7's reference.



## LEGEND DRUGS AND INSULIN

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(d\)\(3\)\(vi\)](#)

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### I. APPLICABILITY

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

### II. ISSUE

How are legend drugs and insulin to be reimbursed?

### III. POLICY

A. Pricing of legend drugs (those drugs that require a prescription by law) and insulin will depend on the claimant: beneficiary (consolidated drug claim) or provider (vendor pharmacy or physician).

B. For beneficiary submitted claims, reimbursement is to be based on the billed charge. For vendor pharmacy (participating provider) submitted claims, the allowable charge for outpatient prescription drugs paid to a vendor pharmacy will be the acquisition cost (taking into account the strength, quantity, and generic/nongeneric status) plus a flat amount determined by the contractor for each prescription. This fixed fee does not apply to insulin. The acquisition cost should include the sales tax.

C. The acquisition cost of drugs for participating providers, i.e., vendor pharmacies, physicians, etc., is to be determined from **a schedule of allowable charges based on the Average Wholesale Price (AWP)**.

D. Allergy preparations are custom made in a laboratory and are not considered prescription drugs. Since the cost of these allergy preparations are not found in **a schedule of allowable charges based on the AWP**, reimbursement will be based on the allowable charge methodology. The prevailing will include both the cost of the drug and the administrative fee. An allowance of a separate additional charge for an "office visit" would not be warranted where the services rendered did not really constitute a regular office visit.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 1, SECTION 15

LEGEND DRUGS AND INSULIN

E. The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), National Level II Medicare “J” codes are to be priced using the following.

1. Drugs (except for home infusion drugs) administered other than oral method, including chemotherapy drugs, are to be priced from the “J” code pricing file.
2. Drugs that do not appear on the “J” code pricing file will be priced at the lesser of billed charges or 95% of the AWP.
3. Home infusion drugs provided prior to January 30, 2012: Home infusion drugs will be paid the lesser of the billed amount or 95% of the AWP retroactive back to April 1, 2005. However, this retroactive coverage will not require the contractors to research their claims history and adjust previously submitted home infusion drug claims unless brought to their attention by a provider or other person with an interest in the claim. Home infusion drugs will be billed using the appropriate “J” code or any other appropriate HCPCS coding for home infusion drugs not appearing on the “J” code pricing file along with a specific National Drug Code (NDC). The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug’s AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., “J”, “Q”, and “S” codes) for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA)-approved and have specific NDCs for pricing.
4. Home infusion drugs provided on or after January 30, 2012: Home infusion drugs must be provided in accordance with the TRICARE Policy Manual (TPM), Chapter 8, Section 20.1. Home infusion drugs will be paid the lesser of the billed amount or 95% of the AWP only in cases where the home infusion drug is not available through the TRICARE Pharmacy (TPharm), or the beneficiary is not required by the TPM, Chapter 8, Section 20.1 to obtain the drug from the TPharm. Home infusion drugs not provided through the TPharm will be billed using the appropriate “J” code or any other appropriate HCPCS coding for home infusion drugs not appearing on the “J” code pricing file along with a specific NDC. The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug’s AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., “J”, “Q”, and “S” codes) for reporting purposes as long as the drugs are FDA-approved and have specific NDCs for pricing.

F. A separate payment shall be made for the pharmacy compounding and dispensing services under HCPCS S9430.

- END -

## OPERATIONAL REQUIREMENTS

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1	Reimbursement Of Individual Health Care Professionals And Other Non-Institutional Health Care Providers
2	Hospital And Other Institutional Reimbursement
3	Discounts
4	Payment Reduction
5	Reimbursement Administration
6	Processing And Payment Of Home Infusion Claims <b>Before January 30, 2012</b>
7	<b>Processing And Payment Of Home Infusion Claims On Or After January 30, 2012</b>



## PROCESSING AND PAYMENT OF HOME INFUSION CLAIMS BEFORE JANUARY 30, 2012

ISSUE DATE: November 9, 2009

AUTHORITY: [32 CFR 199.2](#) and [32 CFR 199.6\(f\)](#)

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### I. ISSUE

Requirements for processing and payment of home infusion claims **for home infusion services provided before January 30, 2012.**

### II. POLICY

#### A. General.

Home infusion companies eligible for Corporate Services Provider (CSP) status as set forth in the TRICARE Policy Manual (TPM), [Chapter 11, Section 12.1](#) will be paid under the CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system on a fee-for-service basis for otherwise-covered professional services provided by TRICARE-authorized individual providers employed by or under contract with a freestanding corporate entity. Reimbursement of covered services, along with related drugs and supplies, will be made directly to the TRICARE-authorized corporate services provider under its own tax identification number. Payment will be allowable for services rendered in the authorized CSP's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional service structure; i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates. Additional expenses by providers due to travel will also not be covered.

#### B. Processing and Payment Procedures.

The contractor shall use the following processing and payment procedures for adjudication of home infusion claims.

1. TRICARE has been statutorily mandated under 10 United States Code (USC) 1079(h) to pay health care professional and other non-institutional health care providers, to the extent practicable, in accordance with the same reimbursement rules as Medicare. The Agency, in compliance with the above statutory mandate adopted the Medicare Modernization Act (MMA) provisions for physician reimbursement which inadvertently reduced home infusions drug payment from 95% of the Average Wholesale Price (AWP) to Average Sales Price (ASP) plus a given percentage as part of a routine CMAC update (April

1, 2005). Since Medicare's conversion to ASP for Part B physician reimbursement mandated under MMA was not intended for coverage of home infusion drugs (i.e., home infusion drugs were specifically exempted from the ASP conversion), [Chapter 1, Section 15, paragraph III.F.](#), was revised for payment of home infusion drugs at 95% of AWP retroactive back to April 1, 2005. As a result, home infusion drugs must be billed using an appropriate "J" code along with a specific National Drug Code (NDC) for pricing. The Healthcare Common Procedure Coding System (HCPCS) "J" code will facilitate Agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA) approved and have a specific NDC for pricing. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP. Refer to [Chapter 1, Section 15](#) for payment of drugs administered by other than oral method.

2. Separate payment will be allowed for supplies that are billed in association with a home infusion visit (e.g., supply codes A4221 / A4222 / A4223 will be paid separately from associated home infusion visits (Current Procedural Terminology (CPT)<sup>1</sup> procedure codes 99601 and 99602)). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

3. Infused drugs administered in an Ambulatory Infusion Suite (AIS) will not qualify for exception to Medicare drug pricing (ASP plus six percent) since they are not being administered in a home setting.

4. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will develop all home infusion claims with Medicare denial code PR-50 to determine whether or not the denial code was simply put on the claims because of non-coverage or whether it was used because the services were truly not medically necessary and as such, subject to the provisions under [Chapter 4, Section 4, paragraph I.C.1.d.](#) TRICARE should pay as primary if the services are medically necessary. Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

### III. EXCLUSION

"S" codes [Temporary National Codes (Non-Medicare)] are used by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services and supplies for which there are no national codes but which are needed by the private sector to implement policies, programs or claims processing. These codes are not recognized by Medicare and are reserved solely for evolving technologies under the TRICARE program until permanent HCPCS/CPT codes can be assigned. As a CSP, home infusion companies are limited to the payment of professional services and drug and supplies provided in the direct treatment of a TRICARE eligible beneficiary. Payment is not allowed for the overall administrative charges/expenses incorporated into the home infusion "S" code per diems.

- END -

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## PROCESSING AND PAYMENT OF HOME INFUSION CLAIMS ON OR AFTER JANUARY 30, 2012

ISSUE DATE: November 9, 2009

AUTHORITY: [32 CFR 199.2](#) and [32 CFR 199.6\(f\)](#)

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### I. ISSUE

Requirements for processing and payment of home infusion claims for home infusion services provided on or after January 30, 2012.

### II. POLICY

#### A. General.

Effective January 30, 2012, home infusion services must be preauthorized and provided in accordance with the TRICARE Policy Manual (TPM), [Chapter 8, Section 20.1](#). Home infusion companies eligible for Corporate Services Provider (CSP) status as set forth in the TPM, [Chapter 11, Section 12.1](#) will be paid under the CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system on a fee-for-service basis for otherwise-covered professional services provided by TRICARE-authorized individual providers employed by or under contract with a freestanding corporate entity. Reimbursement of covered services, along with related drugs and supplies, will be made directly to the TRICARE-authorized corporate services provider under its own tax identification number. Payment will be allowable for services rendered in the authorized CSP's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional service structure; i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates. Additional expenses by providers due to travel will also not be covered.

#### B. Processing and Payment Procedures.

The contractor shall use the following processing and payment procedures for adjudication of home infusion claims.

1. In cases where the drug is not available from the TRICARE Pharmacy (TPharm), or the beneficiary is not required to obtain the drug from the TPharm, as described in the TPM, [Chapter 8, Section 20.1](#), this paragraph describes the pricing for the home infusion drug. TRICARE has been statutorily mandated under 10 United States Code (USC) 1079(h) to pay health care professional and other non-institutional health care providers, to the extent

practicable, in accordance with the same reimbursement rules as Medicare. The Agency, in compliance with the above statutory mandate adopted the Medicare Modernization Act (MMA) provisions for physician reimbursement which inadvertently reduced home infusions drug payment from 95% of the Average Wholesale Price (AWP) to Average Sales Price (ASP) plus a given percentage as part of a routine CMAC update (April 1, 2005). Since Medicare's conversion to ASP for Part B physician reimbursement mandated under MMA was not intended for coverage of home infusion drugs (i.e., home infusion drugs were specifically exempted from the ASP conversion), [Chapter 1, Section 15, paragraph III.F.](#), was revised for payment of home infusion drugs at 95% of AWP retroactive back to April 1, 2005. As a result, home infusion drugs must be billed using an appropriate "J" code along with a specific National Drug Code (NDC) for pricing. The Healthcare Common Procedure Coding System (HCPCS) "J" code will facilitate Agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA) approved and have a specific NDC for pricing. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP. Refer to [Chapter 1, Section 15](#) for payment of drugs administered by other than oral method. Payment of home infusion drugs provided by the TPharm are subject to the policies and requirements of the TPharm contract.

2. Separate payment will be allowed for supplies that are billed in association with a home infusion visit (e.g., supply codes A4221 / A4222 / A4223 will be paid separately from associated home infusion visits (Current Procedural Terminology (CPT)<sup>1</sup> procedure codes 99601 and 99602)). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

3. Infused drugs administered in an Ambulatory Infusion Suite (AIS) will not qualify for exception to Medicare drug pricing (ASP plus six percent) since they are not being administered in a home setting.

4. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will develop all home infusion claims with Medicare denial code PR-50 to determine whether or not the denial code was simply put on the claims because of non-coverage or whether it was used because the services were truly not medically necessary and as such, subject to the provisions under [Chapter 4, Section 4, paragraph I.C.1.d.](#) TRICARE should pay as primary if the services are medically necessary. Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

### III. EXCLUSION

"S" codes [Temporary National Codes (Non-Medicare)] are used by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services and supplies for which there are no national codes but which are needed by the private sector to implement policies, programs or claims processing. These codes are not recognized by Medicare and are reserved solely for evolving technologies under the TRICARE program until permanent HCPCS/CPT codes can be assigned. As a CSP, home infusion companies are limited to the payment of professional services and drug and

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supplies provided in the direct treatment of a TRICARE eligible beneficiary. Payment is not allowed for the overall administrative charges/expenses incorporated into the home infusion "S" code per diems.

- END -



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CHAPTER 8, SECTION 2  
SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

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

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

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

E. SNF PPS will apply to TAMP beneficiaries.

F. SNF PPS will apply to CHCBP beneficiaries.

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

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

I. Swing Bed Providers.

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

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

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

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

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

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

**L. Enteral Feedings Alone May Not Qualify For TRICARE Coverage Of SNF Services**

The need for enteral feedings may not, alone, provide a sufficient basis for obtaining TRICARE coverage of care provided in a SNF. Enteral feedings are not services that can be provided only at a SNF level of care. The SNF extended care benefit covers relatively short-term care as a continuation of treatment begun in the hospital. The initiation of enteral feedings or provision of skilled care needed to manage documented difficulties or complications with the feedings may be considered skilled services that qualify for SNF care. However, once a beneficiary is stabilized for routine enteral feedings, a lower level of care may be more appropriate, such as a home care setting or assisted living facility, with non-licensed family members or facility staff trained to provide feedings and only intermittent involvement of nursing personnel needed to provide oversight. The appropriate level of care is subject to medical necessity review.

**M. Billing TRICARE for Outpatient SNF Services When TRICARE Has Denied Inpatient SNF PPS Or Continued Services**

When no TRICARE inpatient SNF PPS program payment is possible, otherwise covered medically necessary services and supplies may be allowed under TRICARE's outpatient benefit. However, nursing care provided in a SNF setting is not billable under the TRICARE outpatient benefit. For TRICARE dual eligible beneficiaries, Medicare is primary payer for all Medicare Part B services; therefore, the SNF will need to bill CMS for these outpatient SNF services, rather than first submitting a claim to TRICARE. (See [Chapter 4](#),

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Section 4.)

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