



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 156
6010.55-M
SEPTEMBER 24, 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: CONSOLIDATED CHANGE 12-002

CONREQ: 16091

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: 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. 168.

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cn=FAZZINI.ANN.NOREEN.1199802271
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**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 21 PAGE(S)
DISTRIBUTION: 6010.55-M**

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

CHANGE 156
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REMOVE PAGE(S)

CHAPTER 1

Section 6, pages 1 and 2

CHAPTER 4

Section 4, pages 1 through 7

CHAPTER 12

Section 2, pages 1 through 8

Section 8, pages 1 through 4

INSERT PAGE(S)

Section 6, pages 1 and 2

Section 4, pages 1 through 7

Section 2, pages 1 through 8

Section 8, pages 1 through 4

SUMMARY OF CHANGES

CHAPTER 1

1. Section 6. This change updates the reimbursement percentage from 65% to 85% Physician Assistants who perform services as Assistant Surgeons. See 32 CFR 199.14(j)(1)(ix).

CHAPTER 4

1. Section 4. This change requires that TRICARE process the claim as second payer for services provided in a Department of Veterans Affairs (DVA) facility.

CHAPTER 12

1. Section 2. This change aligns the definition of the term homebound in the home health prospective payment system with the definition in 32 CFR 199.2.
1. Section 8. This change aligns the definition of the term homebound in the home health prospective payment system with the definition in 32 CFR 199.2.

REIMBURSEMENT OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CERTIFIED PSYCHIATRIC NURSE SPECIALISTS

ISSUE DATE: July 9, 1990

AUTHORITY: [32 CFR 199.14\(j\)\(1\)\(x\)](#)

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 Physician Assistant (PA), and Nurse Practitioner (NP), and Certified Psychiatric Nurse Specialists (CPNS) services to be reimbursed?

III. POLICY

A. The allowable charge for the services of the above listed providers may not exceed 85% of the allowable charge for a comparable service rendered by a physician. The employing physician of a PA must be an authorized TRICARE provider.

1. When the employing physician of a PA is not participating in a TRICARE/CHAMPUS reimbursement plan at less than the allowable charge determined under the provisions of [Chapter 1, Section 1](#), the allowable charge for the PA service may not exceed 85% of the allowable charge for the physician calculated in accordance with these provisions. When the PA and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit components), the allowable charge for the procedure (to include both the services of the physician and PA) may not exceed the allowable charge for the procedure rendered by a physician.

2. When the employing physician is participating in a TRICARE/CHAMPUS reimbursement plan at less than the allowable charge as calculated in [paragraph III.A.1.](#) above, the allowable charge for the PA service may not exceed 85% of the reduced allowable charge for the physician unless the reimbursement plan has specifically included use of PAs in the negotiated rates.

B. **For services provided prior to July 27, 2012**, the allowable charge for PA services performed as an assistant-at-surgery may not exceed 65% of the allowable charge for a

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physician serving as an assistant surgeon when authorized as TRICARE/CHAMPUS benefits in accordance with the provisions of [32 CFR 199.4\(c\)\(3\)\(iii\)](#), and subject to the procedures for calculation contained in [paragraph III.A.1.](#) and [paragraph III.A.2.](#), with the applicability of 65% to PA services.

C. For services provided on or after July 27, 2012, the allowable charge for PA services performed as an assistant-at-surgery may not exceed 85% of the allowable charge for a physician serving as an assistant surgeon when authorized as TRICARE benefits in accordance with the provisions of [32 CFR 199.4\(c\)\(3\)\(iii\)](#).

D. The allowable charge for NP services performed as an assistant-at-surgery may not exceed 85% of the allowable charge for a physician serving as an assistant surgeon.

E. The procedure or service performed by the PA is billed by the supervising or employing physician, billing it as a separately identified line item (e.g., PA Office Visit) and accompanied by the assigned PA provider number.

F. The procedure or service performed by the NP or CPNS is billed by the NP or CPNS. Unlike a PA, a NP or CPNS can bill on their own behalf. Like the PA, the NP or CPNS shall bill using an assigned NP or CPNS provider number.

IV. EFFECTIVE DATES

A. Reimbursement of PA services is effective for services rendered on or after July 1, 1990.

B. Reimbursement of NP services as stated above is effective for services rendered on or after September 1, 2003.

C. Reimbursement of CPNS services shall be 85% of the allowable amounts for physicians effective for services rendered on or after June 1, 2007.

- END -

SPECIFIC DOUBLE COVERAGE ACTIONS

ISSUE DATE:

AUTHORITY: [32 CFR 199.8](#)

I. TRICARE AND MEDICARE

A. Medicare Always Primary To TRICARE. In any double coverage situation involving Medicare and TRICARE, Medicare is always primary. When services are provided by a resource sharing provider in an MTF to a beneficiary age 65 years and older, reimbursement shall be in accordance with the resource sharing agreement. No TRICARE for Life funds are available for resource sharing within an MTF.

B. Premium Health Insurance. Certain persons age 65 years and older who were not previously entitled to Medicare Part A, "Hospital Insurance Benefits," became eligible to enroll in Part A after June 30, 1973, under the premium Health Insurance provision of the 1972 Amendment to the Social Security Act. Entitlement to Part A secured under these circumstances does not result in a loss of TRICARE benefits.

C. Procedures. TRICARE beneficiaries who become entitled to Medicare Part A, based on age, do not lose TRICARE eligibility if they are enrolled in Medicare Part B. Special double coverage procedures are used for these claims in order to minimize out-of-pocket expenditures for these beneficiaries. These special procedures are used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. The following sections set forth the amounts that TRICARE will pay if the beneficiary is covered by Medicare and TRICARE. If a third coverage is involved, TRICARE will be last payer and payments by the third coverage will reduce the amounts of TRICARE payment that are set forth below. In all cases where TRICARE is the primary payer, all claims processing requirements are to be followed. Additionally, when a beneficiary becomes eligible for Medicare during any part of his/her inpatient admission, the hospital claim shall be submitted to Medicare first and TRICARE/CHAMPUS payment (using non-financially underwritten funds) will be determined under the normal double coverage procedures.

1. Services that are a benefit under both Medicare and CHAMPUS.

a. If the service or supply is a benefit under both Medicare and TRICARE, the beneficiary will have no out-of-pocket expense. For these claims TRICARE will resemble a Medicare supplement. That is, the allowable amount under Medicare will be used as the TRICARE allowable, and TRICARE payment will equal the remaining beneficiary liability after Medicare processes the claim without regard to any TRICARE deductible and cost-

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share amounts that would otherwise be assessed. For example, if it is the first claim of the year and the billed charge is \$50 (which is also the amount both Medicare and TRICARE allow on the claim), Medicare will apply the entire amount to the Medicare deductible and pay nothing. In this case, TRICARE will pay the full \$50 so that the beneficiary has no out-of-pocket expense. Similarly, if Medicare pays an amount that is greater than what TRICARE normally would allow for a network provider, TRICARE will still pay any Medicare deductible and cost-sharing amounts, even if that represents payments in excess of the normal TRICARE allowable amount.

NOTE: It is not necessary for the contractor to price these claims, since the Medicare allowable becomes the TRICARE allowable, and TRICARE payment is based on the remaining beneficiary liability. The contractor need only verify eligibility and coverage in processing the claim. Contractors will not be required to duplicate Medicare's provider certification, medical necessity, referral, authorization, and potential duplicate editing.

b. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare cannot make any payment because the beneficiary has exhausted Medicare benefits, TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares. For example, TRICARE is primary payer for inpatient care beyond 150 days.

c. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare cannot make any payment because the beneficiary receives services overseas where Medicare will not make any payment, TRICARE will process the claim as a primary payer with any applicable deductibles and cost-shares. Since the contractor knows that Medicare cannot make any payment on such claims, the contractor can process the claim without evidence of processing by Medicare. Even though Medicare cannot make payment overseas, beneficiaries receiving care overseas must still purchase Part B of Medicare in order to maintain their TRICARE eligibility.

d. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare does not make any payment because the service or supply is not medically necessary, TRICARE cannot make any payment on the claim. In such cases, the contractor is to deny the claim. The beneficiary/provider must file an appeal with Medicare. If Medicare subsequently reverses its medical necessity denial, Medicare will make payment on the claim and it can then be submitted to TRICARE for payment of any remaining beneficiary liability. If Medicare does not reverse its medical necessity denial, the claim cannot be paid by TRICARE. TRICARE will not accept appeals in any case but will advise the beneficiary to appeal through Medicare.

e. Effective for services on or after March 1, 2007, if the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare does not make any payment because the provider has a private contract with the beneficiary (also referred to as "opting out" of Medicare), TRICARE will process the claim as a second payer. In such cases, the TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge). In cases where the beneficiary's access to medical care is limited (i.e., under served areas), the TRICARE contractor may waive the second payer status for the services of a Medicare opt-out provider and pay the claim as the primary payer. In most cases, under served areas will be identified

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by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the Centers for Medicare and Medicaid Services (CMS) web site at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

NOTE: Under the TRICARE Provider Reimbursement Demonstration Project for the State of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

f. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare denies payment based on their Competitive Bidding Program (CBP) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), the TRICARE contractor shall process the claim as second payer for otherwise covered items of DMEPOS. In such cases, the TRICARE payment shall be the amount TRICARE would have paid had Medicare processed and paid the claim. Public use files containing the competitive bid single payment amounts per Healthcare Common Procedure Coding System (HCPCS) code are posted on the CMS' competitive bidding contractor's web site: <http://www.dme.competitivebid.com/palmetto/cbic.nsf/DocsCat/Home>. TRICARE contractors shall identify the competitive bid single payment amount using the above CMS web site to identify what Medicare would have allowed had the beneficiary followed Medicare's rules. Implementation of Medicare's DMEPOS CBP pricing is effective January 1, 2011.

g. Effective October 28, 2009, TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination awarded upon appeal remain eligible and are considered to have coverage under the TRICARE program (see the TRICARE Operations Manual (TOM), [Chapter 22, Section 1, paragraph 2.6.](#)) for the retroactive months of their entitlement to Medicare Part A, notwithstanding the gap in coverage between Medicare Part A and Part B effective dates. For previously processed claims and claims for dates of service before the beneficiary's original Medicare Part B effective date (which corresponds with the date of issuance of the retroactive determination by the Social Security Administration), jurisdiction remains with the contractor that processed the claim. Recoupment actions shall not be initiated and existing actions should be terminated. Out-of-jurisdiction rules apply to claims for dates of service on or after the original Medicare Part B effective date. These claims should be forwarded to the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor for action. Medicare becomes primary payer effective as of the original Medicare Part B effective date. Eligible beneficiaries are required to keep Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A.

2. Services that are a benefit under Medicare but not under TRICARE. TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

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3. Services that are a benefit under TRICARE but not under Medicare. If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor knows that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply.

4. Services that are provided in a Department of Veterans Affairs (DVA) facility. If services or supplies are provided in a TRICARE authorized DVA hospital pursuant to the TRICARE Policy Manual (TPM), Chapter 11, Section 2.1, Medicare will make no payment. In such cases TRICARE will process the claim as a second payer. The TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge).

NOTE: In order to achieve status as a TRICARE authorized provider, DVA facilities must comply with the provisions of the TPM, Chapter 11, Section 2.1.

5. Services that are provided in a non-Department of Defense (DoD) government facility. If services or supplies are provided in a TRICARE authorized non-DoD government facility (with the exception of a DVA hospital see paragraph I.C.4.), Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

6. Services provided by a Medicare at-risk plan. If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries co-pay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

7. Beneficiary Cost-Shares. Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost shares for services received from network providers shall be TRICARE Extra cost shares. Services received from non-network providers shall be TRICARE Standard cost shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TRICARE for Life (TFL) population.

8. Application of Catastrophic Cap. Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

D. End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age - Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

II. TRICARE AND MEDICAID

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to

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resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See [Chapter 1, Section 20](#).

III. MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see [Chapter 4, Section 1](#)).

IV. TRICARE AND VA

Eligibility for health care through the VA for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the VA and is also eligible for TRICARE, he/she may use either TRICARE or Veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same episode of care through the VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

V. TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or injury might be work related, the contractor will process the claim following the provisions as provided in TOM, Chapter 11, Section 5, [paragraphs 5.0](#) and [6.0](#) and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

VI. TRICARE AND SUPPLEMENTAL INSURANCE PLANS

A. Not Considered Double Coverage. Supplemental or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service Health Maintenance Organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

B. Income Maintenance Plans. Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, length of stay, or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income

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maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

C. Other Secondary Coverage. Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation and policy and are subject to the usual double coverage requirements.

VII. SCHOOL COVERAGE - SCHOOL INFIRMARY

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

VIII. TRICARE AND PREFERRED PROVIDER ORGANIZATIONS

See [Chapter 1, Section 26](#).

IX. DOUBLE COVERAGE AND EXTENDED CARE HEALTH OPTION (ECHO)

All double coverage rules and procedures which apply to claims under the basic program are also to be applied to ECHO claims. All local resources must be considered and utilized before TRICARE benefits under the ECHO may be extended. If an ECHO beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximums established in TPM, [Chapter 9](#). The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

NOTE: The requirements of [paragraph IX](#), notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act (IDEA) in accordance with the Individualized Family Service Plan (IFSP) and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

X. PRIVATELY-PURCHASED, NON-GROUP COVERAGE

Privately-purchased, non-group health insurance coverage is considered double coverage.

XI. LIABILITY INSURANCE

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential Third Party Liability (TPL) (see the TOM, [Chapter 11, Section 5](#)). The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act (FMCRA), if the Other Health Insurance (OHI) does not cover all expenses.

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XII. TRICARE AND PRE-PAID PRESCRIPTION PLANS

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

XIII. TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

XIV. SURROGATE ARRANGEMENTS

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy may be cost-shared only as a secondary payer, and only after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother's medical care. If brought to the contractor's attention, the requirements of TOM, [Chapter 11, Section 5, paragraph 2.10](#), would apply.

- END -

HOME HEALTH CARE - BENEFITS AND CONDITIONS FOR COVERAGE

ISSUE DATE:

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

I. APPLICABILITY

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

II. ISSUE

The benefits and conditions for coverage under home health care.

III. POLICY

A. Conditions for Coverage of Home Health Services. Home health agency (HHA) services are covered by TRICARE when the following criteria are met:

1. The person to whom the services are provided is an eligible TRICARE beneficiary.
2. The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the TRICARE program.
3. The beneficiary qualifies for coverage of home health services.
4. To qualify for TRICARE coverage of any home health services, the patient must meet each of the criteria specified below:

o. Patient Confined to the Home. As defined in 32 CFR 199.2, a patient is considered homebound when a beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment -- including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the state -- shall not disqualify an individual from being considered to be confined to his/her home. Any other absence of an individual from the home shall not disqualify an individual if the absence is

infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for nonmedical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. **An exception is made to the above homebound definitional criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories is written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.**

(1) Home health agencies (HHAs) are responsible for demonstrating that the adult day-care center is licensed or certified/accredited as part of determining whether the patient is homebound for purposes of TRICARE eligibility. Examples of information that could demonstrate licensure or certification/accreditation include: the license/certificate of accreditation number of the adult day care center; the effective date of the license/certificate of accreditation; and the name of the authority responsible for the license/certificate of accreditation of the adult day care center.

(2) Patients will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if leaving home is medically contraindicated.

(3) Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists:

(a) Patients paralyzed from a stroke who are confined to a wheelchair or require the aid of crutches in order to walk;

(b) Patients who are blind or senile and require the assistance of another person in leaving their place of residence;

(c) Patients who have lost the use of their upper extremities and, therefore, are unable to open doors, use handrails or stairways, etc., and require the assistance of another individual to leave their place of residence;

(d) Patients who have just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, their actions are restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.;

(e) Patients with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity; and

(f) Patients with a psychiatric problem if their illness is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for them to leave home unattended, even if they have no physical limitations.

(g) Aged persons who do not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

(h) Although patients must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there.

1 If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, Skilled Nursing Facility (SNF), or rehabilitation center to provide these services on an outpatient basis.

2 However, even in these situations, for the services to be covered as home health services, the patient must be considered as confined to his/her home and in need of such outpatient services as a homebound patient will generally require; i.e., the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

3 If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the TRICARE Managed Care Support Contractor (MCSC) with the information necessary to establish that the patient is homebound as defined above.

(i) Patient's Place of Residence. A patient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution is a hospital, SNF, or other nursing facility under Medicaid.

1 If a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services since such an institution may not be considered his/her residence.

2 When a patient remains in a participating SNF following his/her discharge from active care, the facility may not be considered his/her residence for purposes of home health coverage.

b. Services Are Provided Under a Plan of Care (POC) Established and Approved by a Physician.

(1) Content of the POC. The term "plan of care" refers to the medical treatment plan established by the treating physician with the assistance of the home health care nurse. The POC must contain all pertinent diagnoses, including patient's mental status, the type of services, supplies, and equipment required, the frequency of the visits to be made,

prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirement, all medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any additional items the HHA or physician chooses to include. It is anticipated that a discipline-oriented POC will be established, where appropriate, by an HHA nurse regarding nursing and home health aide services and by skilled therapists regarding specific therapy treatment. These plans of care may be incorporated within the physician's POC or separately prepared.

(2) Specificity of Orders. The orders on the POC must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

(3) Who Signs the POC. The physician who signs the POC must be qualified to sign the physician certification.

(4) Use of Oral (Verbal) Orders. When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies. The orders must be signed and dated with date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services.

(a) The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist.

(b) Written statements of oral orders must be countersigned and dated by the physician before the HHA bills for the care.

(c) Services which are provided from the beginning of the certification period and before the physician signs the POC are considered to be provided under a POC established and approved by the physician, so long as there is an oral order for the care prior to rendering the services that is documented in the medical record and subsequently included in a signed POC.

(d) Services that are provided in the subsequent certification period are considered to be provided under the subsequent POC where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.

(e) Services that are provided after the expiration of a POC, but before the acquisition of an oral order or a signed POC, cannot be considered to be provided under a POC.

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(f) Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

(5) Frequency of Review of the POC. The POC must be reviewed and signed by the physician who established the POC, in consultation with HHA professional personnel, at least every 62 days. Each review of a patient's POC must contain the signature of the physician and the date of review.

(6) Facsimile Signatures. The POC or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

(7) Alternative Signatures. HHAs that maintain patient records by computer rather than hard copy may use electronic signatures.

(a) However, all such entries must be appropriately authenticated and dated.

(b) Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry.

(c) The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

(8) Termination of the POC. The POC is considered to be terminated if the patient does not receive at least one covered skilled nursing, physical therapy, speech-language pathology service, or occupational therapy visit in a 62-day period unless the physician documents that the interval without such care is appropriate to the treatment of the patient's illness or injury.

c. Under the Care of a Physician. A patient is expected to be under the care of the physician who signs the POC and the physician certification. It is expected, but not required for coverage, that the physician who signs the POC will see the patient, but there is no specified interval of time within which the patient must be seen.

d. Needs Skilled Nursing Care on an Intermittent Basis, or Physical Therapy or Speech-Language Pathology or Has Continued Need for Occupational Therapy.

(1) The patient must need one of the following types of services:

(a) Skilled nursing care that is reasonable and necessary as defined below:

1 Skilled nursing services includes application of professional nursing services and skills by an RN, LPN, or LVN, that are required to be performed under

the general supervision/direction of a TRICARE authorized physician to ensure the safety of the patient and achieve the medically desired result in accordance with accepted standards of practice. Skilled nursing services must also be reasonable and necessary to the treatment of the patient's illness or injury and must be intermittent for coverage under the home health care benefit.

2 General Principles Governing Reasonable and Necessary

Skilled Nursing Care

a A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone; e.g., intravenous and intramuscular injections or insertion of catheters, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

b A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service of the patient, does not make it a skilled service when a nurse provides the service.

c A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

d The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition.

e To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, his/her particular medical needs, and accepted standards of medical and nursing practice.

f A patient's overall medical condition is a valid factor in deciding whether skilled services are needed.

g A patient's diagnosis should never be the sole factor in deciding that a service that patient needs is either skilled or not skilled.

h The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at the time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

i The determination of whether a patient needs skilled nursing care should be based solely upon the patient's unique condition and individual needs, with regard to whether the illness or injury is acute, chronic, terminal or expected to extend over a long period of time. In addition, skilled care may, dependent upon the unique condition of the patient, continue to be necessary for patients whose condition is stable.

3 Application of the Principles to Skilled Nursing Services

a Observation and Assessment of the Patient's Condition.

(1) Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized.

(2) Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such complication or further acute episode. Where indications are such that it is likely that skilled observation and assessment by a licensed nurse will result in changes in treatment of the patient, then the services would be covered.

(3) Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

b Management and Evaluation of a Patient Care Plan. Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose.

c Teaching and Training Activities.

(1) Teaching and training activities which require skilled nursing personnel to teach the patient, the patient's family or caregivers how to manage his/her treatment regimen would constitute nursing services.

(2) Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be

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covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered.

(3) Teaching and training activities that require the skills of a licensed nurse include, but are not limited to the following:

(a) Teaching of self-administration of an injectable medication, or a complex range of medications;

(b) Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to watch for and understand signs of hyperglycemia and hypoglycemia;

(c) Teaching self-administration of medical gases;

(d) Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

(e) Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;

(f) Teaching self-catheterization;

(g) Teaching self-administration of gastrostomy or enteral feedings;

(h) Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

(i) Teaching bowel or bladder training when bowel or bladder dysfunction exists;

(j) Teaching how to perform the Activities of Daily Living (ADL) when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;

(k) Teaching transfer techniques (e.g., from bed to chair) that are needed for safe transfer;

(l) Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;

(m) Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

(n) Teaching prosthesis care and gait training;

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - MEDICAL REVIEW REQUIREMENTS

ISSUE DATE:

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

I. APPLICABILITY

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

II. ISSUE

To provide the needed information regarding medical review under the HHA PPS.

III. POLICY

A. Types of Medical Review. The contractors' medical review process will focus on whether services provided are reasonable and necessary, delivered and coded correctly, and appropriately documented. This will be accomplished through a blend of pre-payment and post-payment reviews conducted on **either** a random/targeted basis.

1. Random reviews will allow the MCSCs to identify normal provider billing practice patterns as well as potential payment errors under the new system.

2. Targeted review may also be focused on areas such as:

- a. Identified program vulnerabilities
- b. Specific aberrancies
- c. Newly participating providers
- d. Other areas as they are identified

B. Documentation Requests. If a Request for Anticipated Payment (RAP) or final claim is selected for medical review, the medical reviewer will issue a request for medical documentation. The documentation request will identify a time frame to respond. An HHA

will not send medical records with the home health claim unless they are requested. Requested documentation may include, but is not limited to, the following information:

1. Valid Plan of Care (POC) (CMS 485). With the advent of the PPS, the POC must be reviewed and signed by the physician every 60 days unless one of the following occurs:
 - a. A beneficiary transfers to another HHA.
 - b. There is a significant change in condition (SCIC) resulting in a change in the case-mix assignment.
 - c. The beneficiary is discharged and returns to the same HHA during the 60-day episode.
2. Physician orders for services not included in the POC.
3. OASIS Assessment (If more than one OASIS assessment was performed during the episode, the additional assessment will be submitted with documentation. The additional assessments are to assist medical reviewers in validating SCICs).
4. Clinical notes for all disciplines.
5. Treatment and flow charts and vital sign records.
6. Weight charts and medication records.
7. Any other home health medical documentation to support payment and coverage.

C. Medical Review Responsibilities. Medical review is a multifaceted process used in determining the following:

1. Verification of eligibility and coverage requirements. The following information should be clearly reflected in the beneficiary's clinical records.

a. The beneficiary is homebound, **as described in 32 CFR 199.2 and paragraph III.A.4.a.**

b. The services must be provided under an established and approved physician Plan of Care (POC). The POC must include the following information:

- (1) Pertinent diagnoses;
- (2) All services, supplies and equipment anticipated during the beneficiary's episode of care; and
- (3) Physician's orders that specify the type and frequency of professional services.

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c. The services and supplies provided to the beneficiary must be medically reasonable and necessary for the treatment of the patient's illness or injury.

d. The HHA must be acting upon a physician certification that is part of a POC (CMS 485).

e. The beneficiary requires intermittent skilled nursing, speech-language pathology, physical therapy, or a continuing need for occupational therapy.

2. OASIS and Medical Necessity Validation. The medical review process will be of particular importance under the HHA PPS because of the lack of front-end validation of the OASIS assessment used in generating the HIPPS code for payment submission. Random post-payment reviews will be used to ensure that the HIPPS code generated by the HAVEN grouper software is reflective of the patient's true condition and that the services are actually rendered.

a. The validation process will guide medical review staff through the clinical records, allowing the reviewer to document whether or not the case-mix OASIS is reflective of the information contained in the medical records. Validation will be accomplished either:

(1) Manually through the use of The Home Health Resource Group (HHRG) Worksheet and accompanying OASIS instruction manual, or

(2) Through the use of an automated accuracy protocol designed to assist medical review of home health claims [The Regional Home Health Intermediary (RHII) Outcomes and Assessment Information Set Verification Protocol for Review of Home Health Agency Prospective Payment Bills (ROVER)].

(a) The ROVER Protocol is a menu-driven Windows-based software application that runs under Microsoft (MS) Access.

(b) The program is designed for personal computer (PC) or laptop use, allowing reviewers to document their assessment of the correct response for each case-mix item and the validation source within the patient record, as well as to input text comments of their findings.

(c) The program guides contractor reviewers through entry of the appropriate data to identify the case being reviewed, their OASIS scores, and documentation sources.

(d) Edit checks, covering out-of-range and missing data, are used to alert the reviewer to incomplete or invalid entries.

(e) After all items are entered, the software can generate a paper report documenting the review, which then can be stored in a case file.

(f) The ROVER software also has an export/import/reporting module that will produce very basic reports to support program administration and providers.

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(g) TRICARE expects the contractors shall use this protocol as a supplement to current medical review procedures.

b. A HHRG and HIPPS will be computed under either validation process (i.e., under either the manual or automated validation processes described above) based on the reviewer's responses and compared to the HHRG and HIPPS assigned by the HHA. The reviewer can then accept the HHRG billed by the provider, or adjust the claim as necessary. A new line-level pricing indicator will be used when a medical reviewer changes a HIPPS.

3. Common Ownership Determinations.

a. If, upon medical review, it is determined that common ownership exists in a transfer situation, the transfer claim will be rejected with a message that the second provider must seek payment under arrangement with the other agency.

b. Medical reviewers will use the automated authorization file (i.e., information on the authorization screen) to monitor discharges to related agencies.

- END -