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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 63
6010.55-M
JULY 17, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: REVISED PAPER CLAIMS FORMS

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): Changes to the TSM, TPM, TOM, & TRM in
accordance with the MCSC contracts (paragraph C-7.21.3) and the TDEFIC contract
(paragraph C-3.1). TRICARE requires that contractors and their claims processors
accept and process the nationally recognized paper claims forms and their
successors.

EFFECTIVE AND IMPLEMENTATION DATE: August 31, 2007.

This change is made in conjunction with Aug 2002 TOM, Change No. 52, Aug 2002
TPM, Change No. 60, and Aug 2002 TSM, Change No. 47.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 191 PAGE(S)
DISTRIBUTION: 6010.55-M

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REIMBURSEMENT OF COVERED SERVICES PROVIDED BY INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON- INSTITUTIONAL HEALTH CARE PROVIDERS

ISSUE DATE: July 5, 1991

AUTHORITY: [32 CFR 199.6](#) and [32 CFR 199.14\(j\)](#)

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 covered patient related services of individual health care professionals and professionals that would otherwise meet the qualifications of individual professional providers except that they are either employed by or under contract to an institutional provider, and other non-institutional health care providers to be reimbursed?

III. POLICY

A. Covered services provided by all TRICARE authorized individual health care professionals and other non-institutional health care providers are to be reimbursed using the allowable charge methodology unless otherwise stated.

1. This policy applies to all categories of individual health care professionals and professionals that would otherwise meet the qualifications of individual professional providers except that they are either employed by or under contract to an institutional provider, and other non-institutional providers regardless of the patient services provided.

2. This policy applies to all locations, inpatient or outpatient, where services are provided by these providers. These services could be provided by individual health care professionals in a DRG hospital, a DRG exempt hospital, an ambulatory surgery center, or in a facility without a TRICARE/CHAMPUS all-inclusive rate.

NOTE: Facility charges for inpatient and outpatient services will continue to be billed on the **CMS 1450 UB-04**. This would include inpatient services that are and have been included in the reimbursement under the DRG-based payment system or the mental health per diem payment system. Outpatient facility charges would include services that aid the

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individual health care professional provider in the treatment of the patient. These charges may include such services as the use of hospital facilities factoring in overhead costs of utilities, billing, equipment and maintenance costs, insurance, nursing staff, etc., including emergency room services (nonprofessional services), the services of nurses, technicians, and other aides, medical supplies (gauze, oxygen, ointments, dressings, splints, casts, prosthetic devices), and drugs and biologicals which cannot be self-administered.

3. Services provided by individual professional providers of care and other non-institutional health care providers are to be billed only on the CMS 1500 (08/05) or the TRICARE 2642 for payment. Individual health care professionals (e.g. physicians) and non-institutional providers (e.g. suppliers) are to use the CMS 1500 (08/05). Institutional providers (e.g. hospitals) are to use the CMS 1500 (08/05) or the 1450 UB-04 (if adequate CPT coding information is submitted) to bill for the professional component of physicians and other authorized professional providers. Beneficiaries (or their representatives) who complete and file their own claims for individual health care professional and other non-institutional health care provider services may want to use the TRICARE 2642 claim form for payment.

- END -

REIMBURSEMENT OF EMERGENCY INPATIENT ADMISSIONS TO UNAUTHORIZED FACILITIES

ISSUE DATE: September 11, 2000

AUTHORITY: [32 CFR 199.4\(b\)\(7\)](#) and [32 CFR 199.6\(a\)\(1\)](#)

I. ISSUE

To establish guidelines for reimbursement of emergency inpatient admissions to unauthorized facilities.

II. POLICY

A. The contractor may cost-share otherwise covered medically necessary services and supplies rendered in emergency situations by an unauthorized provider. Medically necessary inpatient emergency service are those that are necessary to prevent the death or serious impairment of the health of the patient, and that because of the threat to the life or health of the patient, necessitate the use of the most accessible hospital available that is equipped to furnish the services. In the case of inpatient psychiatric emergencies, payment will be extended when the patient is determined to be at immediate risk or serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

B. When a case qualifies as an emergency at the time of admission to an unauthorized institutional provider and the provider notifies the managed care support contractor of the admission, payment can be extended for medically necessary and appropriate care until a transfer is medically feasible (i.e., coverage will be extended up to the point of discharge or until a medically appropriate and legally authorized transfer can be initiated). The timing of the transfer will be based on the availability of authorized facility beds.

C. Conditions for reimbursement of emergency inpatient admissions to unauthorized facilities.

1. At the time of admission to an unauthorized institutional provider, the beneficiary's condition must meet the definition of medical or psychiatric emergency as prescribed in [32 CFR 199.2](#).

2. The contractor must be notified as soon as possible after the emergency admission (preferably within 24 hours) so that arrangements can be made to transfer the beneficiary once the emergency no longer exists, or until such time as a medically appropriate and/or legally authorized transfer can be initiated.

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3. The provider must submit the necessary medical records and other documentation required in the processing and payment of emergency inpatient admissions. These records are essential in substantiating that an emergency condition did exist at the time of the admission and that care provided to the beneficiary after the emergency no longer existed, but before a medically appropriate transfer could be initiated, was medically necessary. Refusal to submit the appropriate medical documentation will result in the denial of payment for the entire stay in the facility, including the emergency portion of the patient's care.

4. A determination must also be made that treatment was received at the most accessible (closest) hospital available that was equipped to furnish the medically necessary care.

D. Reimbursement guidelines for emergency inpatient admissions to unauthorized facilities.

1. Billed charges will be paid for all medically necessary care up until such time as an appropriate and/or legally authorized transfer can be initiated by the contractor. Payment will only be made if there was a true medical/psychiatric emergency as defined in [32 CFR 199.2](#), at the time of admission and only for that care extending beyond stabilization of the patient (care extending beyond the emergency treatment of the patient), as long as it was deemed medically necessary and appropriate.

2. The copayment/cost-share for an inpatient emergency admission to an unauthorized facility is dependent on the eligibility and enrollment status of the beneficiary at the time the services are rendered. Refer to [Chapter 2, Section 1](#), for inpatient beneficiary copayments/cost-shares.

3. Conditions for direct payment to an unauthorized facility.

a. The signature-on-file procedure may be used as a means of ensuring patient confidentiality, while at the same time allowing direct payment to the facility. This procedure involves incorporating the following language into the permanent records of TRICARE beneficiaries for whom the facility is seeking payment under emergency provision [32 CFR 199.6\(a\)\(2\)](#).

"I request payment of authorized benefits to me or on my behalf for any services furnished me by (**Name of Provider**), including physician services. I authorize any holder of medical or other information about me to release that information in accordance with the provisions of The Alcohol, Drug Abuse and Mental Health Administration Reorganization Act, Public Law 102-321 and Privacy Act of 1974."

b. Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The [CMS 1450 UB-04](#) instructions shall be followed for certifying signature on file, except that the permanent hospital record containing a release statement will be recognized. The unauthorized facility will be responsible for ensuring that the beneficiary's

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signature is on file, attesting to the above language as soon as possible after the emergency crisis has passed (i.e., after patient stabilization).

4. If the signature-on-file procedure is not utilized by the unauthorized provider, payment must be made directly to the beneficiary.

- END -

SAMPLE STATE AGENCY BILLING AGREEMENT

STATE AGENCY BILLING AGREEMENT

BETWEEN

THE STATE OF _____
(State Name)

DEPARTMENT OF _____
(Name Of Executive Level Department)

(Name of State Medicaid Agency, if different)

AND

THE TRICARE MANAGEMENT ACTIVITY (TMA)

The purpose of this agreement is to provide a billing procedure to enable the State to claim reimbursement from the TRICARE Management Activity (TMA), for payments for TRICARE covered medical services made by a State Medicaid Agency, on behalf of recipients who were also eligible for TRICARE at the time the services were rendered. Medical services are defined by Title XIX of the Social Security Act, and the State Plan for Medical Assistance on file at the appropriate Regional Office of the Centers for Medicare and Medicaid Services. When a beneficiary is eligible for both TRICARE and Medicaid, [32 CFR 199.8](#) establishes TRICARE as the primary payor.

I

TMA agrees, through its designated Managed Care Support (MCS) contracts, to:

A. Reimburse the State Agency for claims under the following conditions:

1. The claim is filed no later than one year following the date of service or the date of discharge for inpatient services. Waivers to the claims filing deadline shall be granted by the MCS contractor for the State requesting the waiver. The contractor shall review the request for waiver against limited waiver circumstances.

2. The claim contains the necessary information as defined in [paragraph IID](#).

3. The claim is signed either by the recipient/beneficiary (patient) or by a designated State official on behalf of the patient; and if the latter, the State official may sign each claim individually or attach a signed statement to each batch of claims submitted for reimbursement at the same time. A "batch" of claims is defined as those claims submitted under a single covering document and shall not include more than two hundred fifty (250) claims. A separate certification document shall be submitted for each two hundred fifty (250) or fewer claims.

B. Provide the State with complete remittance advice in the form of an Explanation of Benefits (EOB). Consistent with the capabilities of each MCS contractor, the EOB shall include a claim identification number supplied by the State.

II

The State Agency agrees to:

A. Submit claims to the MCS contractor on an approved claim form or in an acceptable electronic media. The State Agency may submit documentation of the services rendered as an attachment to the claim form. The attached documentation must contain the required information as listed in Section D. below, unless the required information is also entered on the face of the claim. In no case shall any document or attachment be sent which does not clearly identify the patient. The attached documentation of services shall follow the basic format specified in item 24 of the CMS 1500 (08/05) or CMS 1450 UB-04 claim forms. If the services of more than one provider are included on an attachment, the name and address of the provider of each service or group of services shall be clearly indicated.

B. If the State has a standard format which it uses for coordinating benefits which does not substantially follow the format of the claim forms, then the State may negotiate with the MCS contractor on a nonconforming format. However, the agreement must be approved by TMA and any extra processing expense must be borne by the State and will be paid directly to the MCS contractor.

C. Reimburse TRICARE for all claims, where the patient is subsequently found to have been ineligible for TRICARE coverage on the date of service or which was found to have been incorrectly paid or submitted as a result of audit. The State will cooperate with TMA and other Federal Government investigative or audit agencies by making any required records available for review upon request.

D. Provide the MCS contractor with adequate information for accurate processing of each claim submitted, in accordance with the requirement of each claim form. If the CMS 1450 UB-04 is used, it will be submitted using the National Standard Codes. At a minimum, the following data elements must be included or attached:

1. Patient's name, address (at the time of service), and date of birth.
2. Sponsor's name, Social Security Number, and relationship to patient.
3. Date(s) medical service(s) was (were) received.
4. Amount billed by the provider for each service.
5. Amount paid by Medicaid for each service.

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

ISSUE DATE:

AUTHORITY:

I. GENERAL

A. TRICARE reimbursement of a non-network individual health care professional or other non-institutional health care provider shall be determined under the allowable charge method specified in [Chapter 1, Section 7](#) and [Chapter 5, Section 1](#). Other methodologies, such as the use of fee schedules, must be proposed in writing and approved by the Director, TRICARE Management Activity (TMA) (or his designee). The procedures below, are not required for reimbursement of the network provider of care. The contractor and network providers are free to negotiate any mutually agreeable reimbursement mechanism which complies with state and federal laws. Any agreement, however, in which the methodology deviates from the accepted contract proposal methodology and which is detrimental to the TRICARE beneficiary or to the government may be rejected by the Executive Director, TMA.

B. Unless otherwise stated in the TRICARE Policy Manual, inpatient or outpatient services rendered by all individual professional providers and suppliers must be billed on the CMS 1500 (08/05), except as indicated in [paragraphs D.](#) and [E.](#) below. This requirement also applies to individual professional providers employed by or under contract to an institution. When inpatient services are rendered by a provider employed by or under contract to a participating institution, the services must be billed on a participating basis. The billed charges for institutional-based providers shall be included in the calculation of the prevailings.

C. Contractors are not required to individually certify the professional providers employed by or under contract to an institutional provider billing for their services under the institution's federal tax number since these providers are not recognized as authorized TRICARE providers because of their "contracted" status ([32 CFR 199.6\(c\)\(1\)](#)). However, reimbursement for services of institutional-based professional providers is limited to the services of those providers that would otherwise meet the qualifications of individual professional providers except that they are either employed by or under contract to an institutional provider. Institutional-based professional services are subject to the allowable charge methodology; see [32 CFR 199.14\(j\)](#). For TED/TEPRV reporting, refer to the TRICARE Systems Manual, [Chapter 2](#).

D. Some institutions are required to include the institutional-based professional charges on the CMS 1450 UB-04 claim form. The contractor's system must recognize these charges as noncovered institutional charges when the CMS 1450 UB-04 indicates professional

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component charges using Value Code "05" (see the CMS 1450 UB-04 Instructions Manual, FL 39 - 41). Value code "05" indicates that the charges are included on the CMS 1450 UB-04 and will also be billed separately on the CMS 1500 (08/05). The CMS 1450 UB-04 may be used by institutional providers and Home Health Care Agencies to bill for professional services. The CMS 1450 UB-04 must include all the required information needed to process the professional services and reimburse the services using the allowable charge payment methodology, to include any negotiated rates. The contractors shall contact any Home Health Care Agency that has requested to bill for professional services on the CMS 1450 UB-04 to assist them with the proper billing requirements, e.g., CPT-4 procedure codes, name of the actual provider, etc.

E. Professional charges can be billed on a CMS 1450 UB-04, either on the same claim as the facility charges or on a separate claim. If professional charges are submitted on the same CMS 1450 UB-04 claim form as other outpatient facility charges, the contractor may require the provider to submit them on a separate claim form.

II. ALLOWABLE CHARGE METHOD

A. General

1. The TRICARE allowable charge for a service or supply shall be the lowest of the billed charge, the prevailing charge, or the Medicare Economic Index (MEI) adjusted prevailing charge (known as the maximum allowable prevailing charge). The profiled amount (the prevailing charge or the maximum allowable prevailing charge, whichever is lower) to be used is based upon the date of service. Regardless of the profiled amount, no more than the billed amount may ever be allowed.

NOTE: If, under a program approved by the Executive Director, TMA, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges. When calculating the TRICARE allowable charge, use the discounted charge in place of the provider's actual billed charge unless the discounted amount is above the billed charge. When the discounted amount is above the billed charge, the actual billed charge shall be used.

2. The contractor has primary responsibility for determining allowable charges according to the law, the Regulation, and the broad principles and policy guidelines issued.

3. Allowable charge determinations made by contractors are not normally reviewed by TMA on a case-by-case basis. However, TMA will review allowable charge determinations of contractors through profile analysis, sample case review and periodic review of profile development procedures. Therefore, each contractor is to maintain, in accessible form, the following data:

a. The charge data used to develop prevailing charges. For every prevailing charge, this must include a list identifying each provider whose charges were used in developing the prevailing charge as well as the provider's charges. The list is to be arrayed in ascending order by the amount of the billed charges.

contractor. Non-network RTCs (see the TRICARE Operations Manual, [Chapter 4](#)) shall be reimbursed based on the rate established by TMA, using the methodology specified in [Chapter 7, Section 4](#).

VII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS

A. General

1. Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA regardless of whether they are provided in a freestanding ambulatory surgical center (ASC), in a hospital outpatient clinic, or in a hospital emergency room.

2. TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

3. Contractors are required to maintain only two sets of rates on their on-line systems at any time.

4. Professional services related to ambulatory surgical procedures will be reimbursed under the instructions for individual health care professionals and other non-institutional health care providers in [Chapter 3, Section 1](#).

5. See [Chapter 9, Section 1](#) for additional instructions.

B. Payment Procedures. All rate calculations will be performed by TMA (or its data contractor) and will be provided to each contractor. In pricing a claim, the contractor will be required to identify the zip code of the facility which provided the services (for the actual location, not the billing address, etc.) and the procedure(s) performed. The contractor shall use the zip code to MSA crosswalk to identify the rates applicable to that facility and then will select the rate applicable to the procedure(s) performed. Multiple procedures are to be reimbursed in accordance with the instructions in the TRICARE Policy Manual. Surgical procedures (both institutional and professional) will be subject to the multiple surgery guidelines and modifier requirement as prescribed under [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for services rendered on or after implementation of the Outpatient Prospective Payment System (OPPS).

C. Claims Form Requirements. Claims for facility charges must be submitted on a **CMS 1450 UB-04**. Claims for professional charges may be submitted on either a **CMS 1450 UB-04** or a **CMS 1500 (08/05)** claim form. The preferred form is the **CMS 1500 (08/05)**. When professional services are billed on a **CMS 1450 UB-04**, the information on the **CMS 1450 UB-04** should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

VIII. CLAIM ADJUSTMENTS

Facilities may not submit a late charge bill (frequency 5 in the third position of the bill type). They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 (replacement of a prior claim) or frequency 8 (void/cancel of a prior claim). Claims submitted with a frequency code of 7 or 8 should report the original claim number in Form Locator 64 on the CMS 1450 UB-04 claim form.

IX. PROPER REPORTING OF CONDITION CODES

Hospitals should report valid Condition Codes on the CMS 1450 UB-04 claim form as necessary.

A. Condition Codes are reported in FLs 18-28 when applicable.

B. The following are two examples of condition code reporting:

1. **Condition Code G (zero)** identifies when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

a. Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

b. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

2. **Condition Code 41** identifies a claim being submitted for Partial Hospitalization Program (PHP) Services.

- END -

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CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 4: Services, of all other providers not found in category 2, provided in a non-facility including provider offices, home settings, and all other non-facility settings.

b. Linking the site of service with the payment category. The contractor is responsible for linking the site of service with the proper payment category. The rates of payment are found on the CMAC file that are supplied to the contractor by TRICARE Management Activity (TMA) through its contractor that calculates the CMAC rates.

c. Payment of facility charges when the 0510 and 0760 series revenue codes are billed.

(1) Effective for services on or after April 1, 2005, payment of 0510 and 0760 series revenue codes shall begin. Payment would be made as billed unless a discounted negotiated rate can be obtained for OPSS exempt providers.

(2) Effective for services on or after implementation of OPSS, payment of 0510 and 0760 series revenue codes will be based on the HCPCS codes submitted on the claim and reimbursed under the OPSS.

d. Informing the provider community of the pricing changes for 2005. The contractors are to inform the provider community of the pricing changes based on site of service beginning April 1, 2005, for services rendered on or after this date. Medicare has been using site of service for some time. TMA would simply be adopting this pricing from Medicare. Contractors may need to renegotiate agreements with providers reflecting this change.

e. Services and procedure codes not affected by site of service. Anesthesia services, laboratory services, component pricing services such as radiology, and "J" codes are some of the more common services and codes that will not be affected by site of service.

f. CMAC history files. The contractor is to retain and maintain previous years CMAC files for historical purposes. Since the 2005 CMAC file format is different, it will be more difficult to link to the previous years CMAC files.

4. Multiple Surgery Discounting. Professional surgical procedures which are reimbursed under the CMAC payment methodology will be subject to the same multiple surgery guidelines and modifier requirement as prescribed under the OPSS for services rendered on or after implementation of OPSS. Refer to [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

- END -

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CHAPTER 6, SECTION 2

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL DESCRIPTION OF SYSTEM)

narrative and revise the numerical code accordingly. Contractors are not required to make this comparison on every claim. Precedence should be given to the narrative code in those cases where a difference is identified as the result of editing, prepayment review, or other action that would identify a discrepancy. If an adjustment is subsequently necessary because the numerical code was, in fact, correct, the adjustment should be submitted under an RPM a reason for adjustment code indicating that there was no contractor error.

(2) It is the hospital's responsibility to submit the information necessary for the contractor to assign a discharge to a DRG.

(3) When the discharge data is inadequate (i.e., the contractor is unable to assign a DRG based on the submitted data), the contractor is to develop the claim for the additional information.

(4) In some cases the "admitting diagnosis" may be different from the principal diagnosis. Although the admitting diagnosis is not required to assign a DRG to a claim, it may be needed to determine if a nonavailability statement (NAS) is required for mental health admissions (see the TRICARE Policy Manual, [Chapter 1, Section 6.1](#)).

(5) For neonatal claims only (other than normal newborns), the following rules apply.

(a) If a neonate (patient age 0 - 28 days at admission) is premature, the appropriate prematurity diagnosis code must be used as a principal or secondary diagnosis. The prematurity diagnosis codes are: ICD-9-CM code 764.0 - 764.9, slow fetal growth and fetal malnutrition, and 765.0 - 765.1, disorders relating to short gestation and unspecified low birth weight.

(b) Where a prematurity diagnosis code is used, a fifth digit value of 1 through 9 must be used in the principal or secondary diagnosis to specify the birth weight. A value of 0 will result in the claim being grouped to DRG 470, and the claim will be denied. If no fifth digit is used, the Grouper will ignore that diagnosis code and the claim will be denied.

(c) If a neonate is not premature, a prematurity diagnosis code must not be used. The Grouper will automatically assign a birth weight of "> 2499 grams" and assign the appropriate PM-DRG. If the birth weight is less than 2500 grams, the birth weight must be provided in the "remarks" section of the [CMS 1450 UB-04](#).

(d) If there is more than one birth weight on the claim, the Grouper will assign the claim to DRG 470, and the claim will be denied.

(e) All claims for beneficiaries less than 29 days old upon admission (other than normal newborns) will be assigned to a PM-DRG, except those classified to DRGs 103, 480, 495, 512, and 513.

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HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL DESCRIPTION OF SYSTEM)

c. Each discharge will be assigned to only one DRG (related, except as provided in the next two paragraphs, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

d. When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the contractor is to develop the claim to assure that the data are not the result of miscoding by either the contractor or the hospital. Where the procedure and medical condition are supported by the services and the procedure is unrelated to the principal diagnosis, the claim will be assigned to DRG 468, Unrelated OR Procedure.

e. When the discharge data submitted by a hospital result in assignment of a DRG which may need to be reviewed for coverage (e.g., DRG 380, abortion without dilation and curettage, which does not meet the TRICARE/CHAMPUS requirements for coverage), the contractor is to review the claim to determine if other diagnoses or procedures which were rendered concurrently are covered. If other covered services were rendered, the contractor shall change the principal diagnosis to the most logical alternative covered diagnosis, delete the abortion diagnosis and procedure from the claim so that it does not result in a more complex DRG, and regroup the claim.

For example, if a claim is grouped into DRG 380 and the abortion is not covered, but a tubal ligation was performed concurrently, the contractor should change the principal diagnosis to that for the tubal and delete the abortion from the procedures performed. If no covered services were rendered, the claim must be denied, and all related ancillary and professional services which are submitted separately must also be denied.

(1) Contractors are not normally required to review all diagnoses and procedures to determine their coverage. Contractors are required to develop for medical necessity only if the principal diagnosis is generally not covered but potentially could be. Deletion of a diagnosis and/or procedure is required only when the principal diagnosis or procedure is not covered.

(2) The only exception to the above paragraph is for abortions. Since abortions are statutorily excluded from coverage in most cases, the contractor is to ensure that payment is not affected by a noncovered abortion diagnosis or procedure whether it is principal or secondary. In all cases where payment would be affected, the abortion data is to be deleted from the claim.

C. Beneficiary Eligibility

1. Change of eligibility status.

a. Payment when eligibility changes. If a beneficiary is eligible for TRICARE/CHAMPUS coverage during any part of his/her inpatient confinement, except for the following cases, the claim shall be processed as if the beneficiary was eligible for the entire stay.

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CHAPTER 6, SECTION 3

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM
(BASIS OF PAYMENT)

a. Criteria for qualifying for interim payments. In order to qualify for interim payments the following conditions must be met. If a condition is not met, e.g., the claim is received out of chronological order, the claim is to be denied.

- (1) It must be for a claim received on or after October 1, 1988.
- (2) The patient has been in the hospital at least 60 days.
- (3) Multiple claims for single individuals must be submitted in chronological order.

b. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill.

c. Contractor actions on interim claims. Contractors will process the initial claim as a complete claim and each subsequent claim as an adjustment. However, the interim claims are only a method of facilitating cash flow to providers, and the final bill is still the final accounting on the hospital stay. Therefore, upon receipt of the final bill, the contractor is required to review the entire claim to ensure that it has been correctly paid and to ensure that the cost-share has been correctly determined.

E. Inpatient operating costs. The TRICARE/CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1. Operating costs for routine services, such as the costs of room, board, therapy services (physical, speech, etc.), and routine nursing services as well as supplies (e.g., pacemakers) necessary for the treatment of the patient;
2. Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients (the professional component of these services is not included and can be billed separately);
3. Take-home drugs for less than \$40;
4. Special care unit operating costs (intensive care type unit services); and
5. Malpractice insurance costs related to services furnished to inpatients.

F. Discharges and transfers.

1. Discharges. Subject to the provisions of [paragraph III.F.2.](#) and [3.](#) below, a hospital inpatient is considered discharged from a hospital paid under the TRICARE/CHAMPUS DRG-based payment system when:

- a. The patient is formally released from the hospital; or
- b. The patient dies in the hospital.

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HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM
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c. The patient is transferred to a hospital or unit that is excluded from the TRICARE/CHAMPUS DRG-based payment system under the provisions of [Chapter 6, Section 4](#). Such cases can be identified by [Form Locator \(FL\) 17](#) on the [CMS 1450 UB-04](#) claim form. For discharges with an admission date prior to October 1, 1998, if anything other than "02" is entered, the contractor is to process the claim as a discharge. All claims coded "02" are to be processed as transfers unless there is specific reason for not doing so (e.g., the case is classified into DRG No. 601). For discharges with an admission date on or after October 1, 1998, such cases shall no longer be processed as a discharge, but as a transfer, if the claim contains one of the qualifying DRGs listed in [paragraph III.F.4.](#), and the patient is transferred to one of the settings outlined in [paragraph III.F.3.](#)

2. Acute care transfers. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital is:

a. Paid under the TRICARE/CHAMPUS DRG-based payment system (such instances will result in two or more claims); or

b. Excluded from being paid under the TRICARE/CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the TRICARE/CHAMPUS DRG-based payment system under [Chapter 6, Section 4](#) (such instances will result in two or more claims); or

c. Authorized as a [Designated Provider \(DP\)](#) [formerly [Uniformed Services Treatment Facilities \(USTFs\)](#)] or a Veterans Administration hospital.

3. Postacute care transfers. A discharge of a hospital inpatient is considered to be a transfer for purposes of this subsection when the patient's discharge is assigned to one of the qualifying DRGs listed in [paragraph III.F.4.](#), below and the discharge is made under any of the following circumstances:

a. To a hospital or distinct part hospital unit excluded from the TRICARE/CHAMPUS DRG-based payment system as described in [Chapter 6, Section 4](#). Claims shall be coded 05, 62, or 63 in [FL 17](#) on the [CMS 1450 UB-04](#) claim form. Effective April 1, 2004, claims shall be coded 65 in [FL 17](#) for psychiatric hospitals and units.

b. To a skilled nursing facility. Claims shall be coded 03 or 61 in [FL 17](#) on the [CMS 1450 UB-04](#) claim form.

c. To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. Claims shall be coded 06 in [FL 17](#) on the [CMS 1450 UB-04](#) claim form. Claims coded 06 with a condition code of 42 or 43 in [FL 18](#) shall be processed as a discharge instead of a transfer.

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CHAPTER 7, ADDENDUM C

PARTICIPATION AGREEMENT FOR SUBSTANCE USE DISORDER REHABILITATION FACILITY (SUDRF)
SERVICES FOR TRICARE/CHAMPUS BENEFICIARIES

The SUDRF must have a written emergency transportation agreement with at least one ambulance company, which specifies the estimated transportation time to each backup hospital.

(j) Not bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization.

(k) Not bill the beneficiary for services excluded on the basis of [32 CFR 199.4\(g\)\(1\)](#) (not medically necessary), [\(g\)\(3\)](#) (inappropriate level of care), or [\(g\)\(7\)](#) (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question had been determined to be noncovered by TRICARE/CHAMPUS. (A general statement signed at admission relative to financial liability does not fill this requirement.)

(l) Prior to initiation of this agreement, and annually thereafter, conduct a self assessment of its compliance with the TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders as issued by the Executive Director, TMA, and notify the Executive Director, TMA of any matter regarding which the facility is not in compliance with such standards.

3.4 QUALITY OF CARE

(a) The SUDRF shall assure that any and all eligible beneficiaries receive substance use treatment that complies with the standards in [Article 3.3](#), above, and the TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders.

(b) The SUDRF shall provide substance use treatment in the same manner to TRICARE/CHAMPUS beneficiaries as it provides to all patients to whom it renders services.

(c) The SUDRF shall not discriminate against TRICARE/CHAMPUS beneficiaries in any manner including admission practices or provisions of special or limited treatment.

3.5 BILLING FORM

The SUDRF shall use the [CMS 1450 UB-04](#) billing form (or subsequent editions) for inpatient services, and the [CMS 1500 \(08/05\)](#) claim form for partial hospitalization or outpatient services. The SUDRF shall identify SUDRF care on the billing form in the remarks block by stating "SUDRF care".

3.6 COMPLIANCE WITH TMA UTILIZATION REVIEW ACTIVITIES

Under the terms of this agreement, the SUDRF shall:

(a) Appoint a single individual within the facility to serve as the point of contact for conducting utilization review activities with TMA or its designee. This individual must have a clinical background and be capable of directly responding to questions from professionally qualified reviewers. The SUDRF will inform TMA in writing of the designated individual.

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CHAPTER 7, ADDENDUM C

PARTICIPATION AGREEMENT FOR SUBSTANCE USE DISORDER REHABILITATION FACILITY (SUDRF)
SERVICES FOR TRICARE/CHAMPUS BENEFICIARIES

(b) Obtain precertification for all inpatient or partial hospitalization services to be rendered to TRICARE/CHAMPUS beneficiaries within the facility.

(c) Promptly provide medical records and other documentation required in support of the utilization review process upon request by TMA or its designee. Confidentiality considerations are not valid reasons for refusal to submit medical records on any TRICARE/CHAMPUS beneficiary. Failure to comply with documentation requirements will usually result in the denial of certification of care.

(d) Maintain medical records, including the clinical formulation, progress notes, and master treatment plan, in compliance with TRICARE/CHAMPUS standards and regulations.

3.7 PROFESSIONAL STAFF ORGANIZATION

The SUDRF shall follow a medical model for all services and shall vest ultimate authority for planning, developing, implementing and monitoring all clinical activities in a psychiatrist or licensed doctoral level psychologist. The management of medical care will be vested in a physician. The course of treatment is prescribed and supervised by a qualified mental health professional who meets TRICARE/CHAMPUS requirements as an individual professional provider as specified in [32 CFR 199.6](#) and who operates within the scope of his or her license.

3.8 PROFESSIONAL STAFF QUALIFICATIONS

The SUDRF shall comply with requirements for professional staff qualifications stated in the TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders, and [32 CFR 199.6](#).

(a) The Chief Executive Officer (CEO) shall possess a master's degree in business administration, nursing, social work, or psychology, or shall meet similar educational requirements as prescribed by the Executive Director of TMA and shall have five years' administrative experience in the field of mental health.

(b) Professional staff who perform assessments and/or treat patients have a background in chemical dependency and, when applicable, experience in treating adolescents with substance use disorders.

ARTICLE 4

PAYMENT PROVISIONS

4.1 RATE STRUCTURE: DETERMINATION OF RATE

As specified in [32 CFR 199.14\(a\)\(1\)\(ii\)\(F\)](#), effective for admissions on or after July 1, 1995, SUDRFs are subject to the Diagnosis-Related-Group-based (DRG-based) payment

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CHAPTER 7, ADDENDUM E

PARTICIPATION AGREEMENT FOR RESIDENTIAL TREATMENT CENTER (RTC)

(k) Prior to initiation of this agreement, and annually thereafter, conduct a self assessment of its compliance with the TRICARE/CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders as issued by the Executive Director, TMA, and notify the Executive Director, TMA of any matter regarding which the facility is not in compliance with such standards.

3.4 QUALITY OF CARE

(a) The RTC shall assure that any and all eligible beneficiaries receive residential treatment center services that comply with the standards in [Article 3.3](#) above and the TRICARE/CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders.

(b) The RTC shall provide residential treatment center services in the same manner to TRICARE/CHAMPUS beneficiaries as it provides to all patients to whom it renders services.

(c) The RTC shall not discriminate against TRICARE/CHAMPUS beneficiaries in any manner including admission practices or provisions of special or limited treatment.

3.5 BILLING FORM

(a) The RTC shall use the **CMS 1450 UB-04** billing form (or subsequent editions).

(b) RTCs shall identify RTC care on the billing form in the remarks block by stating "RTC care".

(c) RTCs shall identify on the billing form those days that patient was absent from the facility. This includes therapeutic absences as well as unplanned absences.

(d) Charges for geographically distant family therapy must be billed in the RTC patient's name and be authorized by TMA or designee.

3.6 COMPLIANCE WITH TMA UTILIZATION REVIEW ACTIVITIES

Under the terms of this agreement, the RTC shall:

(a) Appoint a single individual within the RTC to serve as the point of contact for conducting utilization review activities with TMA or its designee. This individual must have a clinical background and be capable of directly responding to questions from professionally qualified reviewers. The RTC will inform TMA in writing of the designated individual.

(b) Obtain precertification for all care to be rendered within the RTC. Failure to obtain precertification will subject the facility to payment reductions according to [32 CFR 199.15\(b\)\(4\)\(iii\)](#).

(c) Promptly provide medical records and other documentation required in support of the utilization review process upon request by TMA or its designee. Confidentiality considerations are not valid reasons for refusal to submit medical records on

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PARTICIPATION AGREEMENT FOR RESIDENTIAL TREATMENT CENTER (RTC)

any TRICARE/CHAMPUS beneficiary. Failure to comply with documentation requirements will result in the denial of certification of care and/or termination of provider status.

(d) Maintain medical records, including progress notes, clinical formulation, and the master treatment plan, in compliance with TRICARE/CHAMPUS standards and regulations.

3.7 PROFESSIONAL STAFF ORGANIZATION

The RTC shall follow a medical model for all services and shall vest ultimate authority for planning, developing, implementing and monitoring all clinical activities in a psychiatrist or licensed doctoral level psychologist. The management of medical care will be vested in a physician. Clinicians providing individual, group, and family therapy meet TRICARE/CHAMPUS requirements as qualified mental health providers as defined in [32 CFR 199.6](#), and operate within the scope of their licenses.

3.8 PROFESSIONAL STAFF QUALIFICATIONS

The RTC shall comply with requirements for professional staff qualifications stated in the TRICARE/CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders and [32 CFR 199.6](#).

The Chief Executive Officer (CEO) shall have five years' administrative experience in the field of mental health and shall possess a master's degree in business administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Executive Director, TMA.

ARTICLE 4

PAYMENT PROVISIONS

4.1 RATE STRUCTURE: DETERMINATION OF RATE

The TRICARE/CHAMPUS rate is the per diem rate that TRICARE/CHAMPUS will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a TRICARE/CHAMPUS-approved RTC, and approved by TMA or a designee. The per diem rate will be calculated according to [32 CFR 199.14\(f\)](#).

(c) Effective for care on or after April 1, 1995, the per diem amount may not exceed a cap of the 70th percentile of all established Federal fiscal year 1994 RTC rates nationally, weighted by total TRICARE/CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, and updated to FY95. For Federal fiscal years 1996 and 1997, the cap shall remain unchanged. For Federal fiscal years after fiscal year 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medical prospective payment system.

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ineligible for consideration for authorized provider status for a two year period. Termination of authorized PHP status will be pursuant to [Article 13](#) of this agreement.

(c) The PHP shall not be considered an authorized provider nor may any benefits be paid to the PHP for any services provided prior to the date the PHP is approved by the Executive Director, TMA, or a designee as evidenced by signature on the participation agreement.

3.2 LIMIT ON RATE BILLED

(a) The PHP agrees to limit charges for services to beneficiaries to the rate set forth in this agreement.

(b) The PHP agrees to charge only for services to beneficiaries that qualify within the limits of law, regulation, and this agreement.

3.3 ACCREDITATION AND STANDARDS

The PHP hereby agrees to:

(a) Comply with the Standards for Psychiatric Partial Hospitalization Programs, as promulgated by the Executive Director, TMA.

(b) Be licensed to provide PHP services within the applicable jurisdiction in which it operates.

(c) Be specifically accredited by and remain in compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services (formerly the Consolidated Standards Manual)

(d) Accept the allowable partial hospitalization program rate, as provided in [Chapter 13, Section 2, paragraph III.G.](#), as payment in full for services provided.

(e) Comply with all requirements of [32 CFR 199.4](#) applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters.

(f) Be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted.

(g) Ensure that all mental health services are provided by qualified mental health providers who meet the requirements for individual professional providers. (Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification, and experience requirements for a qualified mental health provider but are actively working toward licensure or certification,

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may provide mental health services within the per diem rate but the individual must work under the direct clinical supervision of a fully qualified mental health provider employed by the PHP.) All other program services will be provided by trained, licensed staff.

(h) Ensure the provision of an active family therapy component which ensures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by an authorized mental health provider.

(i) Have a written agreement with it's affiliated hospital specifying that the hospital will accept any and all beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with an ambulance company which specifies the estimated transport time to it's affiliated hospital.

(j) Not bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization.

(k) Not bill the beneficiary for services excluded on the basis of [32 CFR 199.4\(g\)\(1\)](#) (not medically necessary), [\(g\)\(3\)](#) (inappropriate level of care) or [\(g\)\(7\)](#) (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question has been determined as noncovered. (A general statement signed at admission as to financial liability does not fill this requirement.)

(l) Prior to the initiation of this agreement, and annually thereafter, conduct a self-assessment of its compliance with the Standards for Psychiatric Partial Hospitalization Programs, and notify the Executive Director, TMA, of any matter regarding which the facility is not in compliance with such standards.

3.4 QUALITY OF CARE

(a) The PHP shall assure that any and all eligible beneficiaries receive partial hospitalization services which comply with standards in [Article 3.3](#) above and the Standards for Psychiatric Partial Hospitalization Programs.

(b) The PHP shall provide partial hospitalization services in the same manner to beneficiaries as it provides to all patients to whom it renders services.

(c) The PHP shall not discriminate against beneficiaries in any manner including admission practices or provisions of special or limited treatment.

3.5 BILLING FORM

The PHP shall use the [CMS 1450 UB-04](#) billing form (or subsequent editions). PHPs shall identify PHP care on the billing form in the remarks block by stating "PHP care".

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ineligible for consideration for authorized provider status for a two year period. Termination of authorized PHP status will be pursuant to [Article 13](#) of this agreement.

(c) The PHP shall not be considered an authorized provider nor may any benefits be paid to the PHP for any services provided prior to the date the PHP is approved by the Executive Director, TMA, or a designee as evidenced by signature on the participation agreement.

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(a) Comply with the Standards for Psychiatric Partial Hospitalization Programs, as promulgated by the Executive Director, TMA.

(b) Be licensed to provide PHP services within the applicable jurisdiction in which it operates.

(c) Be specifically accredited by and remain in compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services (formerly the Consolidated Standards Manual)

(d) Accept the allowable partial hospitalization program rate, as provided in [32 CFR 199.14\(a\)\(2\)\(ix\)](#), as payment in full for services provided.

(e) Comply with all requirements of [32 CFR 199.4](#) applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters.

(f) Be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted.

(g) Ensure that all mental health services are provided by qualified mental health providers who meet the requirements for individual professional providers. (Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification, and experience requirements for a qualified mental health provider but are actively working toward licensure or certification,

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may provide mental health services within the per diem rate but the individual must work under the direct clinical supervision of a fully qualified mental health provider employed by the PHP.) All other program services will be provided by trained, licensed staff.

(h) Ensure the provision of an active family therapy component which ensures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by an authorized mental health provider.

(i) Have a written agreement with at least one backup authorized hospital which specifies that the hospital will accept any and all beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(j) Not bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization.

(k) Not bill the beneficiary for services excluded on the basis of [32 CFR 199.4\(g\)\(1\)](#) (not medically necessary), [\(g\)\(3\)](#) (inappropriate level of care) or [\(g\)\(7\)](#) (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question has been determined as noncovered. (A general statement signed at admission as to financial liability does not fill this requirement.)

(l) Prior to the initiation of this agreement, and annually thereafter, conduct a self-assessment of its compliance with the Standards for Psychiatric Partial Hospitalization Programs, and notify the Executive Director, TMA, of any matter regarding which the facility is not in compliance with such standards.

3.4 QUALITY OF CARE

(a) The PHP shall assure that any and all eligible beneficiaries receive partial hospitalization services which comply with standards in [Article 3.3](#) above and the Standards for Psychiatric Partial Hospitalization Programs.

(b) The PHP shall provide partial hospitalization services in the same manner to beneficiaries as it provides to all patients to whom it renders services.

(c) The PHP shall not discriminate against beneficiaries in any manner including admission practices or provisions of special or limited treatment.

3.5 BILLING FORM

The PHP shall use the [CMS 1450 UB-04](#) billing form (or subsequent editions). PHPs shall identify PHP care on the billing form in the remarks block by stating "PHP care".

hospital. TRICARE and Medicare do make exceptions to this “within 30 days” rule for those cases that require future therapy after 30 days (e.g., a hip fracture patient who can’t do weight-bearing exercises until after 30 days). TRICARE will follow Centers for Medicare and Medicaid Services (CMS) policy as provided in the Medicare Benefit Policy Manual, Chapter 8. Any application of the Medicare Benefit Policy Manual to TRICARE shall be subject to TRICARE requirements in the law, 32 CFR Part 199, and TRICARE manuals. The Medicare Benefit Policy Manual (Publication # 100-02) is an Internet Only Manual (IOM) and can be accessed at <http://www.cms.hhs.gov/manuals>. When TRICARE is the primary payer, it will be the responsibility of the contractor to determine whether the beneficiary has had a qualifying 3-day inpatient stay and has met the thirty-day discharge standard. The contractor will use the information in blocks 35 & 36 of CMS 1450 UB-04 to make this determination. If blocks 35 & 36 of CMS 1450 UB-04 is blank, the SNF claim will be denied unless the patient was involuntarily disenrolled from Medicare+Choice plan (see paragraph IV.C.4. below). The contractor will calculate the length of stay based on the SNF actual admission date provided on the CMS 1450 UB-04 claim form. Any adverse TRICARE determinations involving medical necessity issues will be appealable to TRICARE whenever TRICARE is the primary payer. However, a denial based on the factual dispute (not the medical necessity) of SNF benefit for failure to meet the 3-day prior hospitalization of “within 30 days” requirement is not appealable. Any factual disputes surrounding the 3-day prior hospitalization or “within 30 days” requirement can be submitted to the TRICARE contractor for an administrative review.

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

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

Note to paragraph IV.C.4.: With regard to the requirement that the skilled services must be for a medical condition that was treated during the qualifying 3-day hospital stay, it will generally be presumed that this requirement is met if the qualifying 3-day hospital requirement is met. When the facts which come to the attention of the contractor/claims processor in their normal review process indicate that the skilled services are not related to any of the diagnoses treated during the qualifying hospital stay, the SNF claim may be denied.

5. TRICARE reimbursement will follow Medicare’s SNF prospective payment system (PPS) methodology and assessment schedule. However, if the SNF admission

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

precedes the TRICARE implementation date of SNF PPS (regardless of the discharge date), all claims for that admission will be processed using the payment methodology as provided in [Chapter 8, Section 1, paragraph III.A.](#)

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

7. The MDS is a set of clinical and functional status measures that provides the basis for the Resource Utilization Group (RUG)-III classification system and the PPS. Nursing facilities must collect these data on each of their residents at prescribed intervals and upon any significant change in physical or mental condition. The MDS data are then used to classify residents into one of the SNF case-mix RUGs based on their clinical characteristics, functional status and expected resource needs. Until December 31, 2005, there were 44 RUGs (see [Addendum A, Figure 8-A-1](#)). Effective January 1, 2006, 9 additional RUGs were added for a total of 53 RUGs (see [Addendum A, Figure 8-A-2](#)).

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

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

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

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

10. SNFs are not required to automatically transmit MDS assessment data to the TRICARE contractors. However, the TRICARE contractor, at its discretion, may collect the

MDS assessment data from SNFs for assessments done after the 90th day or when TRICARE is the primary payer. MDS forms and relevant background information may be found on the following websites:

<http://www.cms.gov/medicaid/mds20/man-form.asp>

<http://www.cms.gov/medicaid/mds20/mds0900b.pdf>

For the most part, TRICARE will function as a secondary payer to Medicare under SNF PPS in which case there is no need to collect the MDS assessment data. When TRICARE is primary payer, the TRICARE contractors, at their discretion, may collect the MDS assessment data from SNFs for audit and tracking purposes. TRICARE contractor, at its discretion, may require documentation for adjudication of a SNF claim when TRICARE is primary payer.

11. SNF staff will input the MDS assessment data into the MDS RUG-III grouper. The Grouper will then generate an appropriate three-digit RUG-III code. A complete listing of three-digit RUG-III codes with corresponding definitions is included in [Addendum A](#). To supplement the 3-digit RUG-III code, the SNF will add the appropriate two-digit modifier to indicate the reason for the MDS assessment before submitting the claim for payment. The 3-digit RUG-III code and the two-digit modifier make up the five-digit Health Insurance Prospective Payment System (HIPPS) code. The assessment indicators and the HIPPS code information related to SNF are available at http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/02_hippscodes.asp. The SNF will enter the HIPPS code on the **CMS 1450 UB-04** claim form in the HCPCS code field that corresponds with the Revenue Code 022. After the 100th day, for TRICARE patients, SNFs will use an appropriate three-digit RUG-III code with a TRICARE-specific two-digit modifier that makes up the HIPPS code. The TRICARE-specific two-digit modifiers will be as follows:

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

12. Upon completion of the requisite HIPPS coding, when TRICARE is the primary payer, the SNF will submit the claim to the TRICARE claims processor for payment only after the beneficiary has been admitted, has satisfactorily met the qualifying coverage criteria and has had an appropriate MDS assessment completed. When TRICARE is the secondary payer, the claim will be submitted in accordance with standard billing procedures.

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CHAPTER 8, SECTION 2

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

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

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

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

c. The MDS data are used to classify residents into one of the case-mix RUGs. (The latest version of this classification system is RUG-III). Each of these RUG-III subgroups is assigned a relative weight factor (when applicable) to determine the nursing component and the therapy component of the total PPS rate. The relative weight factor reflects the costliness of providing services to residents in that group relative to the average costliness of residents across all groups. The relative weight factor is multiplied by the applicable nursing or therapy base rate (urban or rural) which results in the nursing component and the therapy component of the total rate. Patients who are expected to be more resource-intensive (based on the MDS assessment), are assigned to a RUG-III category that carries a higher relative weight factor. The non-case-mix component is not adjusted. The total PPS payment rate is the sum of the nursing component, the therapy component and the non-case-mix component. The labor portion of the total PPS payment rate is then adjusted for geographic variation in wages using the wage index. Contractors are not required to do these calculations as all of these calculations are automated in using the RUG-III pricer software. For illustration purposes, the per diem rate **computation** is included as [Addendum B \(FY 2007\)](#).

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

e. The cost of the services listed below will be excluded from the SNF PPS rate. These services may be billed directly and paid separately using TRICARE rates. The

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.

D. SNF PPS will apply to TAMP beneficiaries.

E. SNF PPS will apply to CHCBP beneficiaries.

F. 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.

G. 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.

H. 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 SCHIP Benefits Improvement and Protection Act of 2000 [Pub. L. 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 as provided in [Chapter 8, Section 1, paragraph III.A](#). 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.

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I. 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.

J. **The Waiver of Liability provisions in the TRICARE Policy Manual (TPM), Chapter 1, Section 4.1 apply to SNF cases.**

- END -

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CHAPTER 9, SECTION 1

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT PRIOR TO IMPLEMENTATION OF OPPTS, AND THEREAFTER, FREESTANDING ASC REIMBURSEMENT

h. The rates were updated by 0.9% effective November 1, 2001. This update included the wage indexes as updated by Medicare.

i. The rates were updated by 3.0% effective November 1, 2002. This update included the wage indexes as updated by Medicare.

j. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in [paragraph III.A.4.d](#). However, we used 100 claims rather than 25 claims to calculate a rate for individual procedures, because it produced more statistically valid results while still resulting in calculated rates for about 83% of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0% and included the wage indexes as updated by Medicare.

k. The rates were reduced by 2.0% effective April 1, 2004.

B. Reimbursement for procedures not in [Addendums A and B](#). Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with [Chapter 1, Section 25](#) if performed in a hospital. Effective January 28, 2000, ambulatory surgery procedures that are not in [Addendums A and B](#), and are performed in either a freestanding ASC or hospital may be cost-shared, but only if doing so results in no additional costs to the program.

C. Claims for Ambulatory Surgery.

1. Claims for facility charges must be submitted on a [CMS 1450 UB-04](#). Claims for professional charges may be submitted on either a [CMS 1450 UB-04](#) or a [CMS 1500 \(08/05\)](#) claim form. The preferred form is the [CMS 1500 \(08/05\)](#). When professional services are billed on a [CMS 1450 UB-04](#), the information on the [CMS 1450 UB-04](#) should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

2. Claim Data.

a. Billing Data. The claim must identify all procedures which were performed (by CPT-4 or HCPCS code) and indicate if the bill is for facility charges or professional charges. (If the claim is submitted on a [CMS 1450 UB-04](#), the procedure code will be shown in Form Locator (FL) 44.)

b. TRICARE Encounter Data (TED). All ambulatory surgery services are to be reported on the TED using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists.

D. Wage Index Changes. If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

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E. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to emergency room services are to be followed.

- END -

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c. Independent attending physician services are not considered a part of the hospice benefit and are not figured into the cap amount calculations. The provider will bill for these services on a CMS 1500 (08/05) using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions.

D. Authorized Providers

1. Social workers, hospice counselors, and home health aides which are not otherwise authorized providers of care under Basic Program may provide those services necessary for the palliation or management of terminally ill patients electing hospice coverage. These services are part of a package of services for which there is single all-inclusive rate for each day of care.

2. Hospice programs must be Medicare certified and meet all Medicare conditions of participation (42 CFR 418) in relation to patients in order to receive payment under the TRICARE program.

NOTE: The hospice program will be responsible for assuring that the individuals rendering hospice services meet the qualification standards specified in Section 2. The contractor will not be responsible for certification of individuals employed by or contracted with a hospice program.

E. Implementing Instructions

Since this issuance only deals with a general overview of the hospice benefit the following cross referencing is provided to facilitate access to specific implementing instructions within Sections 1 through 4:

IMPLEMENTING INSTRUCTIONS/SECTION

General Overview/Chapter 11, Section 1

Coverage/Benefits/Chapter 11, Section 2

- Core Services
- Non-Core Services
- Continuous Care
- Short-term Inpatient Care
- Counseling Services

Conditions for Coverage/Chapter 11, Section 3

- Election Process
- Certification Process
- Treatment Plan Requirements
- Provider Certification
- Participation Agreement

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CHAPTER 11, SECTION 1

HOSPICE REIMBURSEMENT - GENERAL OVERVIEW

IMPLEMENTING INSTRUCTIONS/SECTION (CONTINUED)

Reimbursement/[Chapter 11, Section 4](#)

Levels of Care
Reimbursement Methodology
Examples of Reimbursement
Payment of Physicians
Voluntary Services
Cap Amount
Inpatient Limitation
Administrative Review
Hospice Reporting Requirement
Limited Cost-Sharing
Criteria for Medical Review

Rate Information

National Rates Cap Amount

for FY 2005 ([Chapter 11, Addendum A \(FY 2005\)](#))
for FY 2006 ([Chapter 11, Addendum A \(FY 2006\)](#))
for FY 2007 ([Chapter 11, Addendum A \(FY 2007\)](#))

Urban Wage Indexes

for FY 2005 ([Chapter 11, Addendum B \(FY 2005\)](#))
for FY 2006 ([Chapter 11, Addendum B \(FY 2006\)](#))
for FY 2007 ([Chapter 11, Addendum B \(FY 2007\)](#))

Rural Wage Indexes

for FY 2005 ([Chapter 11, Addendum C \(FY 2005\)](#))
for FY 2006 ([Chapter 11, Addendum C \(FY 2006\)](#))
for FY 2007 ([Chapter 11, Addendum C \(FY 2007\)](#))

Crosswalk Of Counties By States

for FY 2006 ([Chapter 11, Addendum D \(FY 2006\)](#))

Certification Documents

Participation Agreement ([Chapter 11, Addendum E](#))

IV. EFFECTIVE DATE

Implementation of the hospice program is effective for admissions occurring on or after June 1, 1995. Unless specified differently in sections of this instruction, this is to be considered the effective date for reimbursement of hospice care.

- END -

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i. Covered services not related to the treatment of the terminal condition for which hospice care was elected and provided during a hospice election period may be billed to the contractor for nonhospice reimbursement.

(1) These services are billed by the provider in accordance with existing procedures as a new admission subject to standard reimbursement methodologies.

(2) The contractor will identify and review all nonhospice inpatient claims for beneficiaries who have elected hospice care to make sure that:

(a) For nonrelated hospital admissions, nonhospice coverage is provided to a beneficiary only when hospitalization was for a condition not related to his or her terminal illness; and

(b) For conditions related to a beneficiary's terminal illness, the claims were denied.

NOTE: Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition.

j. The beneficiary may receive inpatient hospice care (both general and respite) in a military treatment facility (MTF) without revocation of an election as long as the following conditions are met:

(1) The attending MTF physician is involved in the overall treatment planning of the hospice patient; i.e., a part of the interdisciplinary group responsible for determining the scope and frequency of services needed to meet the patient's and family's needs.

(2) The hospice program for which the election is granted maintains ultimate professional management of the patient while in the MTF; i.e., services provided in the MTF setting are coordinated with the hospice medical staff.

(3) The MTF inpatient care is strictly palliative in nature and in keeping with the overall hospice treatment plan.

2. Election Statements.

a. A beneficiary who elects to receive hospice care must file an election statement with a particular hospice. Each hospice must design and print its own election statement to include the following information:

(1) Identification of the particular hospice that will provide care to the individual;

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(2) Individual's or representative's acknowledgment that he or she has been given a full understanding of hospice care;

(3) Individual's or representative's acknowledgment that he or she understands that certain other services are waived by the election;

(4) Effective date of election; and

(5) Signature of the individual or representative.

b. An election statement may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

NOTE: "Representative" means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is found to be mentally incompetent.

c. The hospice representative must make sure that the required election statement is in the clinical records before signing the Notice of Admission (the CMS 1450 UB-04 is used for this purpose). The representative must also enter the admission date, which must be the same date as the effective date of the hospice election.

3. Contractor Notification. The hospice must notify the contractor of the initiation, change or revocation of any election.

a. Election initiation. The Form CMS 1450 UB-04, Uniformed Institutional Billing Form, will be used as an admission and election notice.

(1) When a beneficiary is admitted for hospice services, items 1, 4, 5, 8, 9, 10, 11, 12, 45 line 23, 58, 60, 67, 76 and 78 must be completed by the hospice for which the beneficiary has elected to receive care.

NOTE: Items 1, 4, 5, 8, 9, 10, 11, 12, 45 line 23, 58, 60, 67, 76 and 78 are the only items that should be completed on the Notice of Admission (CMS 1450 UB-04). Billing for actual services should be done on a separate CMS 1450 UB-04.

(2) The completed form must be sent to the contractor having jurisdictional authority for that particular hospice program.

NOTE: Since the managed care support contractor is responsible for providing all health care to beneficiaries residing within its contract area, election information should be submitted to the managed care support contractor regardless of where the care is provided; e.g., if the beneficiary from a managed care support area receives hospice care outside the contract area, the election notification should be sent to the managed care support contractor rather than the contractor having regional jurisdiction.

(3) The admission and election notice (CMS 1450 UB-04) should be submitted to the contractor as soon as possible after admission of a beneficiary. If any of the

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items are absent, normal development procedures should be followed (refer to [paragraph III.B.4.e.](#) below for specific information requirements).

(4) The information may be forwarded by mail or telephone depending upon the facility's arrangement with the contractor.

(5) The following are detailed instructions for completing the admission notice (CMS 1450 UB-04):

Item 1. Provider Name, Address, and Telephone Number Required.

Enter name, city, state, and ZIP code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations.

Item 4. Type of Bill Required. Enter the three-digit type of bill code: 81A or 82A as appropriate.

Code Structure

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

1 - Hospice (Nonhospital Based)

2 - Hospice (Hospital Based)

3rd Digit - Frequency

A - Admission Notice

Definition: Notify the contractor responsible for processing your claims of the beneficiary's election of hospice benefits by forwarding Form CMS 1450 UB-04.

Item 5. Federal Tax Number. Enter Tax Identification Number (TIN) or employer identification number (EIN) and the sub-ID assigned by the contractor.

Item 8. Patient's Name Required. Show the patient's name with the surname first, first name, and middle initial, if any.

Item 9. Patient's Address Required. Show the patient's full mailing address including street name and number or RFD, city, state, and ZIP code.

Item 10. Patient's Birthdate Required. Show the month, day, and year of birth numerically as MM-DD-YY. If the date of birth cannot be obtained after a reasonable effort, leave this field blank.

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Item 11. Patient's Sex Required. Show and "M" for male or an "F" for female.

Item 12. Admission Date Required. Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

EXAMPLE: The hospice election (admission) is January 1, 1994. The physician's certification is dated January 10, 1994. The hospice admission date for coverage and billing is January 8, 1994. The first benefit period will end 90 days from January 8, 1994.

Item 38. Transferring Hospice I.D. Required. Only when the admission is for a patient who has changed an election from one hospice to another.

Item 58A, B, C. Insured's Name Required. If the primary payer(s) is other than TRICARE, enter the name of person(s) carrying other insurance in 58A or 58A and 58B as recorded on ID card. If TRICARE is primary, enter the sponsor's name as recorded on the ID card, in line 58A.

Item 60A, B, C. Certificate/Social Security Number/Health Insurance Claim/Identification Number. If primary payer(s) is other than TRICARE, enter the unique ID number assigned by the primary payer to the person(s) carrying other insurance in line 60A or 60A and 60B. Enter the sponsor's social security number in line 60B or 60C if TRICARE patient; or enter the NATO in line 60B or 60C if a NATO beneficiary.

Item 67. Principle Diagnosis Code Required. Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the patient's admission.

Item 76. Attending Physician I.D. Required. Enter the name, number and address of the licensed physician normally expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment. Use item 94 "Remarks" for additional space for recording this information.

Item 78. Other Physician I.D. Required. Enter the word "employee" or "nonemployee" here to describe the relationship that the patient's attending physician has with the hospice program.

Items 85 & 86. Provider Representative Signature and Date Required. Deleted From UB-04, see FL 45, line 23. A hospice representative makes sure that the required physician's certification and a signed hospice election statement are in the records.

b. Contractor's Reply to Notice of Admission. The reply to the notice of admission is furnished according to the contractor's arrangements with the particular hospice program. Whether the reply is given by telephone, mail or wire, it is based upon the

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contractor's query of DEERS. The purpose of the reply is to inform the hospice that the admission has been received and that the beneficiary is eligible for coverage under TRICARE.

c. Change of Election. The second (receiving) hospice will use Item 38 of the admission notice to indicate a change of election from one hospice program to another.

(1) When a receiving hospice submits an admission notice involving a patient who changed from one hospice to another, this item reflects the transferring hospice's complete name, address, and provider number (refer to Item 38 above).

(2) This information is to alert the contractor that the hospice admission continues a hospice benefit period rather than beginning a new one.

d. Revocation of Election. The contractor will be notified of the beneficiary's revocation of his or her hospice election through Item 31 of the CMS 1450 UB-04.

CODE	TITLE	DEFINITION
42	Termination of Hospice Care	The date the patient's hospice care ends. Care may be terminated by a change in the hospice election to another hospice, a revocation of the hospice election, or death. Show termination code 42 in item 32.

4. Monitoring of Elections.

a. The contractor will have to develop and maintain a screen for the tracking of elections made by beneficiaries. The screen will include:

(1) The specific election period (two 90-day periods, one 30-day period and a final period of unlimited duration);

(2) The inclusive dates for which hospice care will be covered; and

(3) Revocations and transfers between hospice programs.

b. The above information will be reported to the contractors by use of the CMS 1450 UB-04 (for both Admission Notice and billing).

c. Once the beneficiary elects hospice care he/she waives all rights to standard TRICARE coverage except for services unrelated to the terminal illness.

d. An election must be onfile in order for coverage to be extended under the hospice benefit.

NOTE: It is assumed that this tracking mechanism will be similar to that of the low volume mental health providers where an authorization must be on file in order for payment to be extended.

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e. After the contractor has determined that an election (inclusive dates) is on file for the dates of service submitted on the claim, it will be priced according to the provisions established in [Chapter 11, Section 4](#).

C. Certification Process. There must be written certification in the medical record that the TRICARE beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

1. Timing of Certification. The hospice must obtain written certification of terminal illness for each of the election periods described in [paragraph III.B.](#), even if a single election continues in effect for two, three or four periods.

a. Timing Requirements Prior to August 5, 1997.

(1) Except as provided in [paragraph III.C.2.a.\(2\)](#) below, the hospice must obtain the written certification no later than two calendar days after the period begins.

(2) For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

b. Timing Requirements On or After August 5, 1997.

(1) Physician certification continues to be required no later than 2 days after hospice care begins, but written certification need only be on file in the patient's record prior to submission of a claim to the contractor.

(2) The above requirement applies to beneficiaries who have been previously discharged during a fourth benefit period and were being certified for hospice care again to begin a 60-day benefit period.

2. Sources of Certification. Physician certification is required for both initial and subsequent election periods.

a. For the initial 90-day period, the hospice must obtain certification as prescribed in [paragraph III.C.](#), above, from:

(1) The individual's attending physician if the individual has an attending physician; and

(2) The medical director of the hospice or the physician member of the hospice interdisciplinary group.

b. For subsequent periods, the only requirement is certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group.

3. Failure to meet the above time frames will result in denial of coverage/payment for those days of care preceding the date of signature on the certification statements.

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EXAMPLE: The hospice election is January 1, 1998. The physician's certification is dated January 10, 1998. The hospice admission date for coverage and billing is January 8, 1994. The first hospice benefit period will end 90 days from January 8, 1998.

4. The hospice representative must make sure that the physician's certification is obtained prior to signing the Notice of Admission (the CMS 1450 UB-04 is used for this purpose). The representative must also enter the admission date which must be the same date as the effective date of the hospice election.

5. Although the contractor does not require the actual certification statement for processing of hospice claims as a part of the permanent clinical records, it will be reviewed during post-payment medical review.

D. Treatment Plan.

1. In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care.

2. At least one of the persons involved in developing the initial plan must be a nurse or physician.

3. The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

4. The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment.

NOTE: A meeting of group members is not required within this 2-day period; input may be provided by telephone. Medical directions and physician members of the interdisciplinary group are no longer required to be employed by the hospice. These physicians can now be under contract with the hospice. However, hospices retain professional management responsibilities for these services and must ensure that they are furnished in a safe and effective manner by qualified persons.

5. Hospice services must be consistent with the plan of care for coverage to be extended.

6. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

7. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

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8. The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

E. Medical Review Process.

1. The contractor is required to request and review medical records (post-payment medical review), including the written plan of care, to assure the services were:

- a. Covered hospice services;
- b. Stipulated in the plan(s) of care;
- c. Necessary for the palliation or management of the beneficiary's terminal illness; and
- d. Appropriately classified for payment purposes.

NOTE: The accuracy of the billing and appropriateness of care will be looked at as part of the contractor medical review process. The contractor will only be responsible for looking for trends/patterns on a random sampling of claims.

2. Hospice programs will be required to submit all medical records and documentation to the claims processing contractor within 30 days of the date of their request. Failure to submit the contractor requested information will result in recoupment of the claim payment.

3. Although a plan of care will not be needed for the processing of claims, it will be reviewed retrospectively as part of the medical records. The contractor will review the initial plan and all changes through the post-payment medical review process.

F. Provider Certification.

1. Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR 418) relative to TRICARE patients in order to receive payment under the TRICARE program. The hospice program can be either a public agency or private organization (or a subdivision thereof) which:

- a. Is primarily engaged in providing the care and services described in [Chapter 11, Section 2](#) and makes such services available on a 24-hour basis.
- b. Provides bereavement counseling for the immediate family or terminally ill individuals.
- c. Provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency or organization must:

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The continuous home care rate of \$252.50 was figured by dividing the adjusted rate (i.e., the adjusted wage component plus nonwage component) by 24 hours and multiplying that amount by the actual number of hours rendered.

(5) In situations where accumulative hours cannot be associated with specific dates of service and the average number of hours per day is equal to or greater than eight hours it can be assumed that the eight-hour minimum has been met for each of the dates of service for continuous home care.

EXAMPLE: A hospice billed for 24 hours of continuous home care over a four day period. Since the average number of hours was less than 8 hours per day (24 hours divided by 4 days equals 6 hours per day), development would be required. If the number of hours had been 32 hours or more it could have been assumed that the beneficiary had received 8 or more hours for each day of continuous home care billed on the CMS 1450 UB-04.

c. Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care.

(1) Payment for respite care may be made for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge.

(2) Payment for the sixth and any subsequent days is to be made at the routine home care rate.

EXAMPLE: TRICARE reimbursement for 12 days of inpatient respite care provided on March 10, 1995, through March 21, 1995 in Cheyenne, Wyoming:

Respite Rate (5 days)

Wage Component Subject to Index	x Index for Cheyenne	= Adjusted Wage Component
\$50.68	x 0.9565	= \$48.48

Adjusted Wage Component	+ Nonwage Component	= Adjusted Rate	x 5 days Maximum	= Routine Rate
\$48.48	+ \$42.95	= \$91.43	x 5	= \$457.15

Routine Home Care Rate (7 days)

Wage Component Subject to Index	x Index for Cheyenne	= Adjusted Wage Component
\$62.19	x 0.9565	= \$59.49

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$$\begin{array}{rclclcl}
 \text{Adjusted Wage} & + & \text{Nonwage} & = & \text{Adjusted} & \times & \text{7 days} & = & \text{Routine} \\
 \text{Component} & & \text{Component} & & \text{Rate} & & \text{Home Care} & & \text{Rate} \\
 \\
 \$59.49 & & + \$28.32 & & = \$87.81 & \times & 7 & & = \$614.67
 \end{array}$$

TRICARE Payment for Respite Care

$$\begin{array}{rclcl}
 \text{Respite Rate} & + & \text{Routine Home Care} & = & \text{Payment for 12 days} \\
 \text{for 5 days} & & \text{Rate for 7 days} & & \text{of Respite Care} \\
 \\
 \$457.15 & + & \$614.67 & & = \$1,071.82
 \end{array}$$

Since respite care is limited to a maximum of 5 days, the remaining 7 days were figured using the routine home care rate. The payment amounts for both respite and routine home care were combined to establish a payment amount for the 12 days of inpatient care.

NOTE: Respite care can only be provided on an occasional basis and then only if it is part of the overall treatment plan. The interdisciplinary treatment group has the responsibility of determining the appropriateness and frequency of respite care. Only those respite days which are actually paid at the inpatient respite rate will be counted toward the inpatient limitation; e.g., a respite stay of 15 days will only be reimbursed for 5 days of inpatient respite care, and as such, only those five days will be counted toward the inpatient limitation.

d. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge.

EXAMPLE: TRICARE reimbursement for 15 days of general inpatient care from December 15, 1994, through December 29, 1994, in Las Cruces, NM.

$$\begin{array}{rclclcl}
 \text{Wage Component} & & \times & \text{Index for} & & = & \text{Adjusted Wage} \\
 \text{Subject to Index} & & & \text{Las Cruces} & & & \text{Component} \\
 \\
 \$257.75 & & \times & 0.9417 & & = & \$242.72 \\
 \\
 \text{Adjusted Wage} & + & \text{Nonwage} & = & \text{Adjusted} & \times & \text{15 General} & = & \text{Routine} \\
 \text{Component} & & \text{Component} & & \text{Rate} & & \text{Inpatient Care} & & \text{Rate} \\
 \\
 \$242.72 & + & \$144.92 & = & \$387.64 & \times & 15 & = & \$5,814.60
 \end{array}$$

2. Area Wage Adjustment. An area wage index will be applied to the wage portion of the applicable national hospice rate for each day of care.

a. Area wage indexes to be used in the calculation of hospice rates for care/ services.

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(1) Wage indexes in Chapter 11, Addendum B (urban), will be used in the adjustment of rates for hospice programs located within designated urban areas.

(2) Wage indexes in Chapter 11, Addendum B (urban and blended), will be used in the adjustment of rates for hospice programs located within select areas for FY 2006.

(3) Wage indexes in Chapter 11, Addendum C (rural), will be used in the adjustment of rates for hospice programs located within designated rural areas.

NOTE: The above Medicare area wage adjustments are reflected in each of the rate calculation examples under levels of reimbursement (refer to [paragraph III.A.1.](#), above.) The wage index factors which are to be used for hospice care (Chapter 11, Addendum B (urban) and Chapter 11, Addendum C (rural)) are different than those being used for DRGs and mental health per diems. These wage index factors have been in use since the inception of the Medicare hospice benefit in 1983.

3. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

4. Physician reimbursement. Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

a. Physicians employed by, or contracted with, the hospice.

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are paid in addition to the adjusted national payment rate.

(a) Physician services will be reimbursed an amount equivalent to 100 percent of the TRICARE allowable charge; i.e., hospice based physician services (direct hands-on care) are not subject to standard TRICARE cost-sharing and deductible provisions.

(b) Physician payments will be counted toward the hospice cap limitation.

b. Individual attending physician. Patient care services rendered by an individual attending physician (a physician who is not considered employed by, or under contract with, the hospice) are not part of the hospice benefit.

(1) Reimbursement of services.

(a) Attending physician may bill in his/her own right.

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(b) The definition of attending physician, effective December 2003, is expanded to include nurse practitioner for patient care services. The nurse practitioner may not certify the beneficiary as terminally ill.

(c) Services will be subject to the appropriate allowable charge methodology.

(d) Reimbursement is not counted toward the cap limitation.

(2) Coordination of services.

(a) Services provided by an individual attending physician must be coordinated with any direct care services provided by hospice physicians. This coordination will be assessed as part of the post-payment medical review process.

(b) The hospice must notify the contractor of the name of the physician or nurse practitioner whenever the attending physician is not a hospice employee.

NOTE: The hospice will notify the contractor of the name of the attending physician or nurse practitioner as part of the information to be supplied on the admission notice (CMS 1450 UB-04). Refer to Items 76 and 77, Section 3. The independent attending physician or nurse practitioner is the only outside provider that may provide care to the hospice patient. The contractor will not be expected to monitor this billing, since it is submitted independently of the hospice.

c. Voluntary services. No payment will be allowed for physician services furnished voluntarily (both physicians employed by and under contract with the hospice and individual attending physicians). Physicians may not discriminate against beneficiaries; e.g., designate all services rendered to non-TRICARE patients as volunteer and at the same time bill for TRICARE patients.

5. Cap on overall reimbursement. Each TRICARE-approved hospice program will be subject to a cap on aggregate TRICARE payments from November 1 through October 31 of each year, hereafter known as "the cap period".

a. Calculation/application of cap amount. The contractor will calculate and apply the cap amount at the end of each cap period using the following guidelines:

(1) The "cap amount" is calculated by multiplying the number of TRICARE beneficiaries electing hospice care (numbers of beneficiaries electing hospice care during the period beginning September 28 of the previous cap year through September 27 of the current cap year) during the period by a statutory amount determined each year by the Centers for Medicare and Medicaid Services (CMS).

(2) The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, the initial cap calculations for newly certified hospices cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October

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31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

(3) The aggregate cap amount will be compared with total actual TRICARE payments made during the same cap period.

(a) "Total payment" refers to payment for services furnished during the cap year beginning November 1 and ending October 31, regardless of when payment is actually made.

(b) Payments are measured in terms of all payments made to hospices on behalf of all TRICARE beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap (i.e., all TRICARE beneficiaries within a particular hospice program).

(c) Payments made to a hospice for an individual electing hospice care on October 5, 1994, pertaining to services rendered in the cap year beginning November 1, 1994, and ending October 31, 1995, would be counted as payments made during that cap year (November 1, 1994 - October 31, 1995), even though the individual would not be counted in the calculation of the cap for that year. The individual would, however, be counted in the cap calculation for the following year, because the election occurred after September 27.

(4) The hospice will be responsible for reporting the number of TRICARE beneficiaries electing hospice care during the "cap period" to the contractor. This must be done within 30 days after the end of the "cap period".

(5) The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

(6) The adjusted cap amount will be obtained by TMA from the Centers for Medicare and Medicaid Services (CMS) prior to the end of each cap period and provided to the contractors.

(7) Payments in excess of the cap amount must be refunded by the hospice program.

b. Determining number of elections: The following rules must be adhered to by the hospice in determining the number of TRICARE beneficiaries who have elected hospice care during the period:

(1) The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

(2) The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing TRICARE beneficiary during the current cap year.

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(3) Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

(4) There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different TRICARE-certified hospices. A calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

(a) The contractor having jurisdiction over the hospice program in which the beneficiary dies or exhausts the hospice benefit will be responsible for determining the proportionate length of stay for all preceding hospices.

(b) The contractor will also be responsible for disseminating this information to any other contractors having jurisdiction for hospices in which the beneficiary was previously enrolled.

NOTE: While it is assumed that crossing of contractor jurisdictional areas (care in hospices located in different jurisdictional areas) will be relatively rare, there is no question that it will occasionally happen. Care in another jurisdictional area can only be detected if it is reported in the admission notice or detected upon retrospective (post payment) medical review; e.g., in the case of a change in election, the second (receiving) hospice will use Item 38 (CMS 1450 UB-04) of the admission notice to indicate the transferring hospice's complete name, address, and provider number. The method of reporting will be left up to the individual contractor. The information should be shared with the other contractors as soon as possible after the demise of the beneficiary so that the other contractors have ample time to adjust the elections used in calculating the hospice's cap amount. The contractor will have to maintain this information for end of the year reconciliation (figuring of cap amounts).

(c) Each contractor will then adjust the number of beneficiaries reported by these hospices based on the latest information at the time the cap is applied.

EXAMPLE: John Smith, a TRICARE beneficiary, initially elects hospice care from Hospice A on September 2, 1994. Mr. Smith stays in Hospice A until October 2, 1994 (30 days) at which time he changes his election and enters Hospice B. Mr. Smith stays in Hospice B for 70 days until his death on December 11, 1994. The contractor having jurisdiction over Hospice B will be responsible for determining the proportionate number of TRICARE beneficiaries to be reported by each hospice that delivered hospice services to Mr. Smith. This contractor determines that the total length of hospice stay for Mr. Smith is 100 days (30 days in Hospice A and 70 days in Hospice B). Since Mr. Smith was in Hospice A for 30 days, Hospice A should count 0.3 of a TRICARE beneficiary for Mr. Smith in its hospice cap calculation (30 days divided by 100 days). Hospice B should count 0.7 of a TRICARE

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beneficiary in its cap calculation (70 days divided by 100 days). The contractor servicing Hospice B will make these determinations and notify the contractor servicing Hospice A of its determination. These contractors will then be responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

c. Readjustment of cap amount. Readjustment may be required if information previously unavailable to the contractor at the time the hospice cap is applied subsequently becomes available.

EXAMPLE: Using the previous example, if the contractor servicing Hospice A had calculated and applied the hospice cap on November 30, 1994, information would not have been available at that time to adjust the number of beneficiaries reported by Hospice A, since Mr. Smith did not die until December 11, 1994. The contractor servicing Hospice A would have to recalculate and reapply the hospice cap to Hospice A based on the information it later received from the contractor servicing Hospice B. The cap for Hospice A after recalculation would then reflect the proper beneficiary count of 0.3 for Mr. Smith.

d. Apportionment of election between cap years. The following guidelines will be followed when more than one TRICARE-certified hospice provides care to the same individual, and the care overlaps two cap years:

(1) Each contractor must determine in which cap year the fraction of a beneficiary should be reported.

(a) If the beneficiary entered the hospice before September 28, the fractional beneficiary would be included in the current cap year.

(b) If the beneficiary entered the hospice after September 27, the fractional beneficiary would be included in the following cap year.

EXAMPLE: Continuing with the case cited in the examples above, Hospice A would include 0.3 of a TRICARE beneficiary in its cap calculation for the cap year beginning November 1, 1994, and ending October 31, 1995, since Mr. Smith entered Hospice A before September 28, 1995. Hospice B would include 0.7 of a TRICARE beneficiary in its cap calculation for the cap year beginning November 1, 1995, and ending October 31, 1996, since Mr. Smith entered hospice B after September 27, 1995.

(2) Where services are rendered by two different hospices to one TRICARE patient, and one of the hospices is not certified by TRICARE, no proportional application is necessary. The contractor will count one patient and use the total cap for the certified hospice.

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e. Hospice participation at any time other than beginning of cap year (November 1). In those situations where a hospice begins participation in TRICARE at any time other than the beginning of a cap year (November 1), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used.

EXAMPLE: 10/01/1992 - Hospice A is Medicare certified.
10/01/1992 to 10/31/1993 - First cap period (13 months) for Hospice A.
Statutory cap for first TRICARE cap year (11/01/1992 - 10/31/1993)
Statutory cap for second TRICARE cap year (11/01/1993 - 10/31/1994)
Weighted average cap calculation for Hospice A:
One month (10/01/1993 - 10/31/1993) at \$12,248 = \$12,248
12 months (11/01/1993 - 10/31/1994) at \$12,846 = \$154,152
13-month period (rounded) (\$12,248 + \$154,152) = \$166,400
divided by 13 = \$12,800
The \$12,800 amount is the weighted average cap amount used in the initial cap calculation for Hospice A for the period October 1, 1993 through October 31, 1994.

NOTE: If Hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.

6. Inpatient limitation. Payments for inpatient hospice care are subject to a limitation on the number of days of inpatient care furnished to a TRICARE patient.

a. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all TRICARE beneficiaries during the same period.

b. The inpatient limitation will be applied once each year, at the end of the hospice's "cap period" (11/01 - 10/31).

c. If the contractor (who is responsible for processing the claims) determines that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days.

NOTE: The accuracy of the billing and the appropriateness of the care will be looked at as part of the contractor medical review process. The contractor will only be responsible for looking for trends/patterns on a random sampling of claims.

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a. The information/data for calculation of the cap amount and inpatient limitation will come directly off of the data report form which must be submitted to the contractor within 30 days after the end of the cap period (i.e., by December 1st of each year).

(1) The contractors will not be responsible for validation of this information unless there is a request for reconsideration by one of the hospice programs.

(2) Adjustments to these end of the year calculations should be minimal since the hospice will be reporting total payments received and receivable for the cap period.

(3) Payments for hospital based physicians (billed by the hospice program on the **CMS 1450 UB-04**) will be subject to the cap amount; i.e., it will be figured into hospice payments made during the cap period.

(4) Independent attending physician or nurse practitioner services are not considered a part of the hospice benefit and are not figured into the cap amount calculations. The provider will bill for the services on a CMS 1500 (**08/05**) using appropriate CPT codes.

b. The contractor will have 30 days (until January 1st of each year) in which to calculate and apply the cap and inpatient amounts to each TRICARE approved hospice within its jurisdictional area. The contractor will request a refund from those hospice programs found to exceed the calculated amounts.

(1) The contractor will be given discretion in developing its own recoupment letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed under [paragraph III.A.10](#).

(2) Refund checks will be sent to the TMA Contract Resource Management Directorate (RM). If the hospice fails to submit the refund, the contractor will issue two additional demand letters which will be sent out at appropriate intervals as required by the TRICARE Operations Manual. Copies of the demand letters will not be sent to the beneficiary, and providers will not be placed on offset to collect overpayments. If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, recoupment cases will be transferred to TMA in compliance with the TRICARE Operations Manual.

NOTE: It is anticipated that the number of recoupments will be relatively low based on past Medicare experience; e.g., one Medicare carrier reported that only two hospice programs exceeded the cap and inpatient limitations during the previous cap period (November 1, 1992 through October 31, 1993) in its jurisdictional area.

10. Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy -- with respect to matters which the hospice has a right to review -- is at least \$1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in [32 CFR 199.10](#). A request for

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reconsideration must be filed no later than the 180th calendar days following the date the hospice received notice of the contractor's determination.

NOTE: The methods and standards for calculation of the hospice payment rates established by TRICARE, as well as questions as to the validity of the applicable law, regulations or TRICARE decisions, are not subject to administrative review (the appeal procedures of [32 CFR 199.10](#)).

11. Billing procedures.

a. Completion of the Uniform Bill (CMS 1450 UB-04) for hospice care. The following is information needed for completion of those items required for the billing of hospice care. Items not listed need not be completed unless otherwise required in double coverage situations.

(1) Item 1. Provider Name, Address, and Telephone Number Required. Enter name, city, state, and zip code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations.

(2) Item 4. Type of Bill Required. This three-digit code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care (referred to as a "frequency" code).

CODE STRUCTURE	
1ST DIGIT - TYPE OF FACILITY	
08 - Special (Hospice)	
2ND DIGIT - CLASSIFICATION	
1 - Hospice (Nonhospital Based) 2 - Hospice (Hospital Based)	
3RD DIGIT - FREQUENCY DEFINITION	
1 - Admit Through Discharge Claim	Use this code for a bill encompassing an entire course of hospice treatment for which you expect reimbursement; i.e., no further bills will be submitted for this patient.
2 - Interim - First Claim	Use this code for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	Use this code for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (item 6) is the discharge date or date of death.

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(22) Item 78. Other Physician I.D. Required. Enter the word “employee” or “nonemployee” to describe the relationship that the patient’s attending physician has with the hospice program.

(23) Item 80. Remarks. Enter any remarks needed to provide information not shown elsewhere on the bill but which are necessary for proper payment.

(24) Items 85 & 86. Provider Representative Signature and Date. Deleted from UB-04, see FL 45, line 23. A hospice representative makes sure that the required physician’s certification and a signed election statement are in the records before submitting the CMS 1450 UB-04.

12. Special Processing and Reporting Requirements.

a. The various levels of hospice care will be considered institutional care for payment and reporting purposes. The special rate code “P” (TRICARE Systems Manual (TSM), Chapter 2, Section 2.8) will be designated for the four levels of hospice care.

b. The conventional coding for hospice care on the CMS 1450 UB-04, item 4, is a four digit numerical code designating the type of bill required.

(1) For institutional reporting purposes the first two digits will be converted to the appropriate Type of Institution code provided in the TSM, Chapter 2, Addendum D. Code 81 will be converted to 78 (non-hospital based hospice) and code 82 will be converted to 79 (hospital based hospice).

(2) The third digit will be reported on a separate institutional reporting field (Frequency Code), TSM, Chapter 2, Section 2.5.

c. Type of institution codes 78 and 79 along with the special processing code # (TSM, Chapter 2, Addendum D) will allow hospice institutional claims to by-pass all cost-sharing edits.

d. The revenue code 0657 will be used to identify the charges for services furnished to patients by physicians employed by, or receiving compensation from the hospice.

(1) Physician procedure codes (CPT codes) will be entered in item 44 of the CMS 1450 UB-04 to the right of the revenue code 0657 (item 42). The CPT codes are required in order that the contractor may make allowable charge (CMAC) determinations when reimbursing hospice physicians.

(2) Hospice professional services will be paid at 100 percent of the allowed charge.

(3) Place of service code 34 (TSM, Chapter 2, Section 2.7) along with the special processing code # will allow hospice non-institutional claims (hospice physician charges) to by-pass all cost-sharing edits and to be paid at 100 percent of the allowed charge (CMAC).

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e. Institutional services (i.e., routine home care-651, continuous home care-652, inpatient respite care-655, and general inpatient care-656) will be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) will be reported on a non-institutional claim format. The claim will be split for reporting purposes.

f. Patient care services rendered by an independent attending physician or nurse practitioner (physician or nurse practitioner who is not considered employed by, or under contract with the hospice) are not considered a part of the hospice benefit, and as such, will be billed in his/her own right.

(1) Independent attending physician or nurse practitioner services will be subject to standard TRICARE allowable charge methodology (i.e., subject to standard deductible and cost-sharing provisions).

(2) The physician speciality code (TRICARE Systems Manual, [Chapter 2, Addendum C](#)) will be reported on the TED.

13. Billing for Covered TRICARE Services Unrelated to Hospice Care.

a. Any covered TRICARE services not related to the treatment of the terminal condition for which hospice care was elected, which are provided during a hospice period, are billed to the contractor for non-hospice reimbursement.

b. Non-hospice services are billed by the provider in accordance with existing claims processing procedures under the TRICARE Basic program.

c. The contractor will identify and review all inpatient claims for beneficiaries who have elected hospice care to make sure that for:

(1) Nonrelated hospital admissions, nonhospice TRICARE coverage is provided to a beneficiary only when hospitalization was for a condition not related to his or her terminal illness; and

(2) Conditions related to a beneficiary's terminal illness, the claims were denied.

NOTE: Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition. The treatment of these related conditions is part of the overall hospice benefit, and as such, cannot be billed under TRICARE standard, except for services of an attending physician who is not employed by, or under contract with, the hospice program.

14. Frequency of hospice billing. While inpatient billing is generally deferred until discharge, hospice programs may bill patient stays requiring longer than 30 days in 30-day

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interdisciplinary team no later than two days after the period begins. If written certification cannot be obtained within two calendar days, then oral certification must be obtained within two calendar days, followed by written certification no later than eight calendar days after hospice care is initiated.

(2) Recertification is required for any subsequent periods (for periods two, three and four) of hospice care for which the beneficiary is eligible. The hospice medical director or staff physician will be responsible for recertifying TRICARE/CHAMPUS beneficiaries for subsequent election periods. A written certification must always be in the medical records not later than two days after hospice care is initiated.

(b) Design and print its own election statements to include the following information:

(1) identification of the particular hospice that will provide care to the individual;

(2) individual's or representative's acknowledgment that he or she has been given a full understanding of hospice care;

(3) individual's or representative's acknowledgment that he or she understands that certain TRICARE/CHAMPUS services are waived by the election;

(4) effective date of election; and

(5) signature of the individual or representative.

(c) Assure that an election statement is in the clinical records prior to signing the Notice of Admission. This includes the admission date, which must be the same date as the effective date of the hospice election. The hospice program must notify the contractor of the initiation, change or revocation of any election.

(d) Establish a written plan of care on the same day that a member of the basic interdisciplinary group assesses the patient's needs. The attending physician and medical director or physician designee must review the initial plan of care and provide their input within two calendar days following the day of the assessment.

2.4 CERTIFICATION REQUIREMENTS

The hospice program certifies and attaches hereto documentation that:

(a) it is Medicare approved and meets all Medicare conditions of participation (42 CFR 418); and

(b) is licensed pursuant to any applicable state or local law.

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2.5 QUALITY OF CARE

(a) The hospice program shall assure that any and all eligible beneficiaries receive hospice services that are reasonable and necessary for the palliation or management of a terminal illness and meet the conditions for coverage as established in [Article 2.3](#) above.

(b) The hospice program shall provide hospice services in the same manner to TRICARE/CHAMPUS beneficiaries as it provides to all patients to whom it renders services.

(c) The hospice shall not discriminate against TRICARE/CHAMPUS beneficiaries in any manner, including admission practices or provisions of special or limited treatment.

2.6 BILLING FORM

(a) The hospice program shall use the **CMS 1450 UB-04** billing form (or subsequent editions.) Hospice care shall be identified in item 4 of this form.

(b) The **CMS 1450 UB-04** billing form (or subsequent editions) will also be used as an admission notice. This notice will be used to notify the contractor of the initiation, change or revocation of an election.

2.7 COMPLIANCE WITH TMA MEDICAL REVIEW ACTIVITIES

(a) Submit all medical records and documentation to the contractor and, where applicable, to the Peer Review Organization within 30 days of the date of their request.

(b) Failure to submit the requested information will result in denial of the claim.

2.8 STAFF QUALIFICATIONS

The hospice shall comply with requirements for professional staff qualifications as established in [32 CFR 199.4](#) and [32 CFR 199.6](#).

ARTICLE 3

PAYMENT PROVISIONS

3.1 The hospice program agrees to accept reimbursement at one of four predetermined national TRICARE/CHAMPUS rates ([32 CFR 199.14\(g\)](#)) adjusted for regional wage differences using appropriate Medicare wage indices as payment in full, except for physician-directed patient services and applicable cost-shares. The hospice will be reimbursed for an amount applicable to the type and intensity of the services furnished (i.e., routine home care, continuous home care, inpatient respite care and general inpatient care) to the TRICARE/CHAMPUS beneficiary on a particular day.

HOME HEALTH CARE

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ADDENDUM K	HAVEN Reference Manual
ADDENDUM K	HAVEN Reference Manual
ADDENDUM L	(CY 2004)Annual HHA PPS Rate Updates - Calendar Year 2004
ADDENDUM L	(CY 2005)Annual HHA PPS Rate Updates - Calendar Year 2005
ADDENDUM L	(CY 2006)Annual HHA PPS Rate Updates - Calendar Year 2006
ADDENDUM M	(FY 2004)Annual HHA PPS Wage Indices For FY 2004 Updates - Fiscal Year 2003
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- (1) Durable medial equipment;
- (2) FDA approved injectable drugs for osteoporosis;
- (3) Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;
- (4) Oral cancer drugs and antiemetics;
- (5) Orthotics and prosthetics;
- (6) Ambulance services operated by the HHA;
- (7) Enteral and parenteral supplies and equipment; and
- (8) Other drugs and biologicals administered by other than oral method.

2. Conditions for Coverage.

a. 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; and
- (3) The beneficiary qualifies for coverage of home health services. To qualify for TRICARE coverage of any home health services, the beneficiary must meet each of the criteria specified below:
 - (a) Be confined to the home;
 - (b) Services are provided under a plan of care established and approved by a physician;
 - (c) Is under the care of the physician who signs the plan of care and the physician certification;
 - (d) Needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or has continued need for occupational therapy;
 - (e) TRICARE is the appropriate payer; and
 - (f) The services for which payment is claimed are not otherwise excluded from HHA PPS payment.

C. New Subsystems and Coding Requirements.

1. HHA PPS will operate on the platform of existing TRICARE claims processing systems.
2. HHA PPS will employ claims formats such as the paper and electronic CMS 1450 UB-04 and related transaction formats -- no new fields will be added to either the remittance or the claim form.
3. Episode, as the payment unit, will also become the unit of tracking in claims systems.
4. Some new subsystems will be created and others modified to mesh with existing claims processing systems.
 - a. The contractor's authorization process (including data entering screens) will be used in designating primary provider status and maintaining and updating the episode information/history of each beneficiary. The managed care authorization system will be used in lieu of Medicare's remote access inquiry system [Health Insurance Query for HHAs (HIQH)]. The data requirements for tracking beneficiary episodes over time are found in Section 5 ("Home Health Benefit Coverage and Reimbursement - Authorization Process").
 - b. Eighty (80) Home Health Resource Groups (HHRGs) for claims will be determined at HHAs by inputting OASIS data (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment) into a Home Assessment Validation and Entry (HAVEN) System. The HAVEN software package contains a Grouper module that will generate a HHRG for a particular 60-day episode of care based upon the beneficiary's condition, functional status and expected resource consumption. Updated versions of this software package may be downloaded from the CMS website. An abbreviated assessment will be conducted for TRICARE beneficiaries who are under the age of eighteen or receiving maternity care from a Medicare certified HHA. This will require the manual completion and scoring of a HHRG Worksheet for pricing and payment under the HHA PPS. OASIS assessments are not required for authorized care in non-Medicare certified HHAs that qualify for corporate services provider status under TRICARE (i.e., HHAs which have not sought Medicare certification due to the specialized beneficiary categories they service, such as patients receiving maternity care and beneficiaries under the age of 18).
 - c. All HHA PPS claims will run through Pricer software, which, in addition to pricing HIPPS codes for HHRGs, will maintain six national standard visit rates to be used in outlier and LUPA determinations.
 - d. Episodes paid under HHA PPS will be restricted to homebound beneficiaries under existing Plans of Care (POCs); i.e., CMS 1450 UB-04 type of bill (TOB) 032X and 033X. However, 034X bills will be used by HHAs for services not bundled into HHA PPS rates.
 - e. Requests for Anticipated Payment will be submitted using TOB 0322 only.
 - f. The claim for an episode (TOB 0329) will be processed in the claims processing system as an adjustment to the Request for Anticipated Payment (RAP) triggering full or

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final episode payment, so that the claim will become the single adjusted or finalized claim for an episode in claims history -- claims will be able to be adjusted by HHAs after submission.

g. There will not be late charge bills (TOB 0325 or 0335) under HHA PPS -- services can only be added through adjustment of the claim (TOB 0327 or 0337).

h. New codes will appear on standard formats under HHA PPS.

i. The TOB frequency code of "9" has been created specifically for HHA PPS billing.

j. A 0023 revenue code will appear on both RAPs and claims, with new HIPPS codes for HHRGs in the HCPCs field of a line item.

k. Source of Admission codes "B" (transfer from another HHA) and "C" (discharge and readmission to the same HHA) have been created for HHA PPS billing.

5. The wage indexes used for the HHA PPS are the same as those used in calculation of acute inpatient hospital DRG amounts, except they lag behind by one full year.

6. CMS 1450 UB-04 line itemization will have to be expanded to 450 lines for the reporting of services and supplies rendered during the extended 60-day episode period.

7. HHA PPS claims will be exempt from commercial claim auditing software.

D. Reimbursement. The adoption of the Medicare HHA prospective payment system will replace the retrospective physician-oriented fee-for-service model currently used for payment of home health services under TRICARE. Under the new prospective payment system, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's plan of care. Other health services including, but not limited to, DME and osteoporosis drugs may receive reimbursement outside of the prospective payment system. A fixed case-mix and wage adjusted 60-day episode payment will also be paid to Medicare-certified HHAs providing home health services to beneficiaries who are under the age of 18 and/or receiving maternity care. However, this payment amount will be determined through the manual completion and scoring of an abbreviated assessment form. The 23 items in this assessment will provide the minimal amount of data necessary for generating a HIPPS code for payment under the HHA PPS (see Chapter 12, Section 4, paragraph III.E. for more details regarding this abbreviated assessment process). HHAs for which there is no Medicare-certification due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of beneficiaries under the age of 18 or receiving maternity care) will be reimbursed in accordance with payment provisions established under the corporate services provider class (see the TRICARE Policy Manual (TPM), Chapter 11, Section 12.1 for payment provisions that apply to HHAs qualifying for coverage under this class of provider).

E. Authorized Providers.

1. Bachelor of Science (BS) medical social workers, social worker assistants, and home health aides that are not otherwise authorized providers under the Basic Program may provide home health services to TRICARE beneficiaries that are under a home health plan of care authorized by a physician. The services are part of a package of services for which there is a fixed case-mix and wage-adjusted 60-day episode payment.

2. Home Health Agencies must be Medicare certified and meet 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)] in order to receive payment under the HHA PPS for home health services under the TRICARE program.

NOTE: The HHA will be responsible for assuring that all individuals rendering home health services meet the qualification standards specified in [Section 2](#). The contractor will not be responsible for certification of individuals employed by or contracted with a **HHA**.

3. HHAs for which Medicare-certification is not available due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of TRICARE eligible beneficiaries that are under the age of 18 or receiving maternity care) must meet the qualifying conditions for corporate services provider status as specified in the **TPM, Chapter 11, Section 12.1**. Those specialized HHAs qualifying for corporate services provider status will be reimbursed in accordance with the provisions outlined in [Chapter 12, Section 4, paragraph III.E.1.b](#).

F. Transition to HHA PPS.

1. As of the first day of health care delivery of the new contract, all HHAs must bill all services delivered to homebound TRICARE beneficiaries under a home health plan of care under HHA PPS. The HHA PPS applies to claims billed on a **CMS 1450 UB-04**, with Form Locator 4 (FL 4) Type of Bill (TOB) **032X** or **033X**. HHAs will still occasionally bill TRICARE using TOB **034X**, but these claims will not be subject to PPS payment. If an HHA has beneficiaries already under an established plan of care prior to this date, the open claims for services on or before (TBD) must be closed and submitted for payment under the standard TRICARE fee-for-service allowable charge methodology. Claims for services on or after (TBD) will be processed and paid under the HHA PPS. Under no circumstances should a HHA claim span payment systems. Claims for services dates spanning payment systems will be returned to the provider for splitting.

2. The MCSCs will identify all beneficiaries receiving home health care services 60 days prior to implementation of the HHA PPS and notify them and the HHA of any change in their benefit (i.e., changes in coverage of services or reimbursement), with the exception of beneficiaries that were under the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) on or before December 28, 2001, and those grandfathered under the Home Health Care Demonstration. The MCSCs will be expected to work with the HHAs and beneficiaries toward a smooth transition to the new HHA PPS.

lists of procedures will be issued annually in conjunction with the release of the yearly HCPCS update:

(a) [Addendum B](#) - list of non-routine supply codes.

(b) [Addendum C](#) - list of therapy codes.

c. Services exempt from home health consolidated billing (i.e., services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of treatment):

(1) Durable Medical Equipment (DME).

(a) DME can be billed as a home health service or as a medical/other health service.

(b) DME will be paid in accordance with the reimbursement guidelines set forth in [Chapter 1, Section 11](#), less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

(c) DME may be billed by a supplier to a contractor on a CMS 1500 (08/05) claim form or billed by a HHA on a CMS 1450 UB-04 using bill types 032X, 033X and 034X as appropriate. While the contractors' systems will allow either party to submit these claims, the following requirements will be initiated in order to prevent duplicative billing:

1 HHA providers required to submit line item dates on DME items.

2 Providers instructed to bill each month's DME rental as a separate line item.

3 HHAs allowed to bill DME not under a Plan of Care (POC) on the 034X type bill.

(d) Crossover edits will be developed to prevent duplicate billing of DME.

1 Since consolidated billing does not apply to DME, claims for equipment not authorized by the contractor will be denied. Appropriate appeal rights will apply.

2 DME can be billed by other than the Primary HHA under HHA PPS system when authorized by the contractor (i.e., by supplier/vendor or other HHA).

3 System must be able to identify duplicative billing based on dates of services.

(2) Osteoporosis Drugs.

(a) Osteoporosis drugs are subject to home health consolidated billing, even though they are paid outside the 60-day episode amount. When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them.

(b) Osteoporosis Injections as a HHA Benefit.

1 Cover FDA approved injectable drugs for osteoporosis for female beneficiaries.

2 Only injectable drugs that meet the requirement have the generic name of calcitonin-salmon or calcitonin-human.

(c) Payment is based on the average wholesale price of the drug determined from the Drug Topics Blue Book, less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

1 The drug is billed on a CMS 1450 UB-04 under bill type 034X with revenue code 0636 and HCPCS code J0630.

2 The cost of administering the drug is included in the charge for the visit billed under bill type 032X or 033X, as appropriate.

3 If the service dates on the 034X claim fall within a HHA PPS episode that has been approved for a beneficiary, the system must edit to assure that the provider number on the 034X claim matches the provider number in the authorization. This is to reflect that, although the osteoporosis drug is paid separately from the HHA PPS episode rate, it is included in consolidated billing requirements.

(3) Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines.

(a) General Billing Requirements.

1 Bill on CMS 1450 UB-04 using type of bill 034X and revenue code 636 for the vaccine and revenue code 0771 for administration of the vaccine.

2 The vaccine and its administration may be on the same claim form (i.e., there is no requirement for a separate bill).

3 The following HCPCS codes will be used in billing for vaccines:

α 90657 - Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular injection use;

2 Bill on CMS 1450 UB-04, type of bill 34X.

a Enter revenue code 0636 in FL 42, the name and HCPCS of the oral drug in FLs 43 and 44, and the name of the tablets or capsules in FL 46 of the CMS 1450 UB-04.

b An exception is made for 50mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units.

c Complete the remaining items in accordance with regular billing instructions.

d A cancer diagnosis must be entered in FLs 67 A-Q of the CMS 1450 UB-04 for coverage of an oral cancer drug.

(5) Antiemetic Drugs.

(a) TRICARE pays for self-administrable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of TRICARE covered oral anticancer chemotherapeutic agents when a likelihood of vomiting exists.

1 Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anticancer drug in high doses for longer periods are not covered.

2 Self-administered antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption.

3 Payment.

a The reasonable cost of the self-administered antiemetic drugs furnished by a provider (i.e., the average wholesale price determined from the Drug Topics Blue Book) less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

b Bill on CMS 1450 UB-04, type of bill 034X.

(1) Enter revenue code 0636 in FL42.

(2) Enter one of the following HCPCS codes in FL 44, as appropriate:

(a) K0415 - Prescription antiemetic drug, oral, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified; or

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(b) K0416 - Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified.

(3) Enter the name of the self-administered drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit.

(4) Complete the remaining items in accordance with regular billing instructions.

(5) TRICARE does not pay for a visit solely for administration of self-administered antiemetic drugs in conjunction with oral anticancer drugs.

(6) Orthotics and prosthetics, can be billed as a home health service or as a medical/other health service.

(a) Orthotics and prosthetics may be billed by a supplier to a contractor on a claim form CMS 1500 (08/05) or billed by a HHA on a CMS 1450 UB-04 using bill types 032X, 033X and 034X as appropriate.

(b) Payment will be paid in accordance with the reimbursement guidelines set forth in Chapter 1, Section 11, less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

(7) Enteral and Parenteral Nutritional Therapy.

(a) Enteral and parenteral supplies and equipment can be billed as a home health service or as a medical and other health service.

(b) Payment is based on the reasonable purchase cost less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

(c) Enteral and Parenteral supplies and equipment may be billed by a supplier to a contractor on a claim form CMS 1500 (08/05) or billed by a HHA on a CMS 1450 UB-04 using bill types 032X, 033X and 034X as appropriate.

(8) Drugs and Biologicals Administered By Other Than Oral Method.

(a) TRICARE will allow payment in addition to the prospective payment amount for drugs and biologicals administered by other than an oral method (i.e., drugs and biologicals that are injected either subcutaneous, intramuscular, or intravenous) when:

- 1 Prescribed by a physician or practitioner;
- 2 Approved by the FDA; and

3 Reasonable and necessary for the individual patient.

(b) Billing Methods.

1 The HHA may bill for the drugs/biologicals on a CMS 1450 UB-04 under bill type 034X with revenue codes 025X or 063X and Health Care Financing Administration Common Procedure Coding System (HCPCS) National Level II Medicare “J” codes; or

2 The home infusion company and/or pharmacy delivering the medication for home administration may bill the contractor directly using the CMS Form 1500 claim form with appropriate NDC or HCPCS coding.

3 The contractors’ systems will allow either party to submit these claims, but will not allow duplicative billing.

(c) Payment.

1 The reasonable cost of the drugs/biologicals furnished by a provider (refer to Chapter 1, Section 15, paragraph III.E. for the pricing of home infusion drugs furnished through a covered item of durable medical equipment) less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

2 The cost of administering the drug is included in the charge for the visit billed under bill type 032X or 033X, as appropriate.

(9) Ambulance Transfers.

(a) Payment will be allowed outside the 60-day episode amount for ambulance services furnished directly by a HHA or provided under arrangement between a HHA and ambulance company.

(b) HHA ambulance services will be billed on CMS 1450 UB-04, using bill type 034X, revenue code 054X and an appropriate base rate and/or mileage HCPCS code in FL 44 for each ambulance trip. Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, revenue code 054X must be reported on two separate and consecutive line items to accommodate both the ambulance service (base rate) and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (i.e., a patient is on board) one-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are not reported.

(c) In the case where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered using the appropriate service and mileage HCPCS.

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(d) Payment of HHA ambulance services will be based on statewide prevailing (both for service and mileage) less an appropriate cost-share /copayment and deductible (refer to [Figure 12-2-1](#) for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

d. Cost-Sharing/Copayments. The following table provides the applicable cost-shares/copayments for services exempt from home health consolidated billing (i.e., services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of treatment). Refer to [Chapter 2, Addendum A, paragraph II. and III.](#), for TRICARE Extra and Standard annual fiscal year deductibles.

FIGURE 12-2-1 COPAYMENTS/COST-SHARES FOR SERVICES REIMBURSED OUTSIDE THE HHA PPS WHEN RECEIVING HOME HEALTH SERVICES UNDER A PLAN OF CARE

BENEFITS	TRICARE PRIME PROGRAM			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1-E4	E5 & ABOVE			
Durable Medical Equipment (DME), Orthotic and Prosthetic Devices	0% of the fee negotiated by the contractor.	0% of the fee negotiated by the contractor.	20% of the fee negotiated by the contractor	ADFMs: Cost-share --15% of the fee negotiated by the contractor Retirees, their Family Members & Survivors: Cost-share -- 20% of the fee negotiated by the contractor.	ADFMs: Cost-share -- 20% of the allowable charge Retirees, their Family Members & Survivors: Cost-share -- 25% of the allowable charge.
Osteoporosis Injections					
Oral Cancer Drugs					
Antiemetic Drugs					
Drugs and Biologicals Administered By Other Than Oral Method					
Enteral and Parenteral Therapy					
Influenza, Pneumococcal Pneumonia, and Hepatitis B Vaccines	\$0 copayment per occurrence	\$0 copayment per occurrence	\$0 copayment per occurrence		
Ambulance	\$0 copayment per occurrence	\$0 copayment per occurrence	\$20 copayment per occurrence		

- END -

3. Encoding of OASIS Data.

a. Once the assessment is completed and OASIS data items collected by the qualified skilled professional (i.e., the nurse or therapist responsible for coordinating or completing the assessment), data can be encoded directly by the skilled professional or by a clerical staff member from a hard copy of a completed OASIS. Non-clinical staff may not assess patients or complete assessment items; however, clerical staff or data entry operators may enter the OASIS data collected by the skilled professional into the computer. HHAs must also comply with requirements safeguarding the confidentiality of patient identifiable information. HHAs may take up to 7 days after collection to enter it into their computer systems.

b. To enter the data, HHAs will operate the Home Assessment Validation Entry (HAVEN) software program and run the OASIS data set through the CMS-specified edits. This process involves using HAVEN or HAVEN-like software to review the data for accuracy and consistency, making any necessary changes and finalizing the data. HAVEN will accommodate data entry of OASIS items from all required time points. Seven days are allowed to encode, edit and lock OASIS data, as that is believed to be a reasonable amount of time to expect agencies to complete this task while ensuring accuracy of data.

c. The agency must enter the OASIS data and identify any information that does not pass the specified edits; that is, any missing, incorrect, or inconsistent data. Editing and locking functions are automatically performed using the HAVEN software.

d. Once the OASIS information is encoded, HHAs will “lock” the data; i.e., use their software to review and edit it to create a file that will be transmitted to the State agency or other entity approved to receive this transmission. Since State agency validation of non-Medicare/non-Medicaid OASIS files have been delayed, transmission of TRICARE locked files will not be required at this time. HHAs will, however, still be responsible for the collection and encoding of OASIS data. This information will provide a mechanism for objectively measuring facility performance and quality. It will also be used to support the HHA prospective payment system (i.e., generate the HIPPS code and claim-OASIS matching key output required on the CMS 1450 UB-04 claim form for pricing).

e. Since encoded OASIS data must accurately reflect the patient’s status at the time the information is collected, HHAs must ensure that data items on its own clinical record match the encoded data.

f. The required OASIS data set is available on the HCFA website located at <http://www.hcfa.gov/medicaid/oasis/oasisdat.htm>. The HHA can access the website and download the required OASIS data set for each data collection time point; i.e., start of care, resumption of care following an inpatient facility stay, follow-up, discharge (not to an inpatient facility), transfer to inpatient facility (with or without agency discharge), and death at home. CD updates of the HAVEN software package will also be available to the contractors upon issuance by CMS.

4. Case Management Responsibilities. It is recognized that while an abbreviated OASIS assessment may facilitate payment under the HHA PPS, it does not adequately reflect the management oversight required to ensure quality of care for beneficiaries under the age

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of 18 and obstetrical patients. As a result, the contractors will have to continue to case manage these beneficiary categories through the use of appropriate evaluation criteria as required under the specific terms of their contract to ensure the quality and appropriateness of home health services (e.g., the use of Interqual criteria for managing the appropriateness of home health services). Contractor involvement will even be more critical in cases where home health services are provided in non-Medicare home health agencies (i.e., those home health agencies for which Medicare certification is not available due to the beneficiary categories they serve. Refer to [Chapter 12, Section 4, paragraph III.E.](#) for the hierarchical placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of 18 or receiving maternity care.

5. Transition.

a. As of **the first day of health care delivery of the new contract**, all HHAs should be conducting comprehensive assessments and updates at the required time points, and incorporating the OASIS data set, with the exception of those beneficiaries receiving maternity care, beneficiaries under the age of 18 and beneficiaries receiving only housekeeping/chore services. Medicare-certified HHAs are 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. Assessments are not required for TRICARE beneficiaries who are under the age of 18 or receiving maternity care in a HHA eligible for provider status under the corporate services provider classification (i.e., those HHAs for which Medicare certification is not available due to the special beneficiary categories they serve). Refer to [Chapter 12, Section 4, paragraph III.E.](#) for the hierarchical placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of 18 or receiving maternity care.

b. Specific details of the OASIS collection, encoding, and transmission process are addressed in the OASIS User's Manual. Each HHA should have an OASIS User's manual. Updates of the OASIS User's Manual are posted as needed on the OASIS website at <http://www.hcfa.gov/medicare/hsqb/oasis/oasishmp.htm>.

- END -

3. Case-Mix Grouper. A case-mix grouper is used for assigning a severity level within each of the above dimensions and for classifying the beneficiary into one of 80 Home Health Resource Groups (HHRG). For example, the patient with high clinical severity (C3), high functional severity (F3), and moderate service utilization (S2) would be placed in the "C3F3S2" HHRG. The other HHRGs are derived in a similar manner. The HHRG indicates the extent and severity of the beneficiary's home health needs reflected in its relative case-mix weight (cost weight). The case-mix weight indicates the group's relative resource use and cost of treating different patients. The standardized prospective payment rate is multiplied by the beneficiary's assigned HHRG case-mix weight to come up with the 60-day episode payment.

4. Therapy Hours Verification. The total case-mix adjusted episode payment is based on elements of the OASIS data set, including the therapy hours or visits provided over the course of the episode. The number of therapy hours or visits projected at the start of the episode, entered in OASIS, will be confirmed by the hour or visit information submitted on the claim for the episode. Though therapy hours or visits are only adjusted with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mixed adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the contractors processing home health claims perform pricing, including wage index adjustments on both episode split percentage payments.

5. HHRG Updating. Since Outcome and Assessment Information Sets (OASIS) - B Supplemented - provides the core data elements necessary to classify a beneficiary into one of the 80 HHRGs, it must be updated upon: 1) start of care; 2) resumption of care after an inpatient stay; 3) follow-up or recertification for a new episode of care; or 3) transfer, discharge, or death of the beneficiary. Software programs are available for coding and validating OASIS data.

6. HHRG Reporting on Claim. Home health claims submitted for payment under PPS will be required to include a code that indicates the HHRG for the episode. However, the 6-character HHRG label will not be entered on the claim. Instead, a 5-character code called a "Health Insurance Prospective Payment System" or "HIPPS" code will be used. The HIPPS code indicates not only the HHRG to which the episode was assigned, but also which, if any, of the domains had OASIS items with missing or otherwise invalid data. Health Insurance Prospective Payment System (HIPPS) codes thus represent specific patient characteristics (or case-mix) on which TRICARE payment determinations are made. For HHAs, a specific set of these payment codes represents case-mix groups based on research into utilization and resource use patterns. They are used in association with special revenue codes used on CMS 1450 UB-04 claim forms for institutional providers. Attached at [Addendum I](#) is a worksheet that can be used in manually computing the HIPPS code from the original OASIS data.

a. Composition of HIPPS Codes for HHA PPS.

(1) The HIPPS Code is a distinct 5-position, alphanumeric code.

(a) The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.

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(b) The second, third and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. The second through fourth positions of the HHA PPS HIPPS code will only allow alphabetical characters.

(c) The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper based on a system of defaults where OASIS data is incomplete. This position does not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position will only allow numeric characters. Codes with a fifth position value other than "1" are produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

(d) The HHRG to HIPPS code crosswalk is summarized in [Figure 12-4-5](#) below:

FIGURE 12-4-5 HHRG TO HIPPS CODE CROSSWALK

(CLINICAL) POSITION #2	(FUNCTIONAL) POSITION #3	(SERVICE) POSITION #4	POSITION #5	DOMAIN LEVEL
A (HHRG: C0)	E (HHRG: F0)	J (HHRG: S0)	1 = 2nd, 3rd & 4th positions computed	= min
B (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	2 = 2nd position derived	= low
C (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	3 = 3rd position derived	= mod
D (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	4 = 4th position derived	= high
	I (HHRG: F4)		5 = 2nd & 3rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4th positions derived	
			8 = 2nd, 3rd & 4th positions derived	
		N thru Z	9, 0 (expansion values for future use)	

(2) The 80 HHRGs are represented in the claims system by 640 HIPPS codes - eight codes for each HHRG; but only one of the eight, with a final digit of "1", indicates a complete data set.

(3) The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, all eight codes for that HHRG will be priced identically by the Pricer software.

(4) HIPPS codes created using this structure are only valid on claim lines with revenue code 023.

(5) Examples of HIPPS Codes:

(a) HAEJ1 would indicate a patient whose HHRG code is minimal clinical severity, minimal functional severity, and minimal service severity. All items in all domains had valid data, so all the codes were computed.

(b) HCFM5 would indicate a patient whose HHRG code is moderate clinical severity, low functional severity, and high service severity, and the codes for the functional and service domains were derived because some of the items in each of those domains had responses which were invalid.

(6) A complete list of HHRGs and corresponding HIPPS codes is presented at [Chapter 12, Addendum J](#).

D. Grouper Linkage of Assessment with Payment.

1. HHAs are required to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool.

2. Grouper software determines the appropriate HHRG for payment of a HHA PPS 60-day episode from the results of an OASIS submission for a beneficiary as input, or "grouped" in this software. Grouper outputs HHRGs as HIPPS (Health Insurance Prospective Payment System) coding.

3. Grouper will also output a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and a Grouper Version Number that is not used in billing.

4. Under HHA PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims.

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

Medicare-certified HHAs will be required to conduct abbreviated assessments for TRICARE beneficiaries who are under the age of eighteen or receiving maternity care for payment under the HHA PPS. This will require the manual completion and scoring of a Home Health Resource Group (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 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). The claims-OASIS matching key is reported in **Form Locator (FL) 44** of the **CMS 1450 UB-04**.

1. The following hierarchy will be adhered to in the placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of eighteen 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 plan of care.)

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.

F. 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

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Payment (RAP), and the final in response to a claim. Added together, the initial and final payments equal 100 percent 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 percent in response to the RAP, and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments will equal 50 percent 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 plan of care for initial payment, it is required prior to claim submission for final payment.

G. 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 home health agencies for FY 97. 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 episode of care in 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 97 and 98. The prospective payment rates for all 6 disciplines were summed to arrive at a total non-standardized prospective payment amount per 60-day episode of care.

b. [Figure 12-4-6](#) 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 non-routine medical supplies, Part B therapies and OASIS implementation and ongoing costs.

FIGURE 12-4-6 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

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FIGURE 12-4-6 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS (CONTINUED)

DISCIPLINES	TOTAL COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	AVER. # VISITS PER 60-DAYS	HOME HEALTH PROSPECTIVE PAYMENT RATE
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: \$2,338.90					
ADJUSTMENTS:					
1) Average cost per episode for non-routine medical supplies included in the home health benefit and reported as costs on the cost report					\$43.54
2) Average payment per episode for non-routine medical supplies possibly unbundled and billed separately for Part B					\$6.08
3) Average payment per episode for Part B therapies					\$17.76
4) Average payment per episode for OASIS one time adjustment for form changes					\$5.50
5) Average payment per episode for ongoing OASIS adjustment costs					\$4.32
Total Non-Standardized Prospective Payment Amount for 60-day Episode for FY 2001 Plus Medical Supplies, Part B Therapies and OASIS \$2,416.01					

c. The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in [Figure 12-4-7](#) 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 12-4-7 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	\$2,115.30

(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 [Addendum L \(CY 2004\)](#), [Addendum L \(CY 2005\)](#), and [Addendum L \(CY 2006\)](#).

(2) The standardized prospective payment amount per 60-day episode of care 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.

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

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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 have 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 Chapter 12, Addendums L and M.

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 [Addendum L \(CY 2004\)](#), [Addendum L \(CY 2005\)](#), and [Addendum L \(CY 2006\)](#). These rate adjustments are also integral data elements used in updating the Pricer.

(3) Three iterations of wage indexes will also be maintained in [Addendum M \(FY 2004\)](#), [Addendum M \(CY 2005\)](#), and [Addendum M \(CY 2006\)](#) 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) **P**artial-**E**pisode **P**ayment (PEP) adjustments; 2) **S**ignificant-**C**hange-**I**n-**C**ondition Payment (SCIC) adjustments; 3) **L**ow **U**tilization **P**ayment (LUPA) adjustments; and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

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

(1) Partial-Episode Payment Adjustment (PEP). The PEP adjustment is used to accommodate payment for episodes of care 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 episode of care; or 2) beneficiary discharged after meeting all treatment goals in the original plan of care and subsequently readmitted to the same HHA before the end of the 60-day episode of care. 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 plan of care must be terminated with no anticipated need for additional home health services. A new 60-day episode of care would have to be initiated upon return to a home health agency, requiring a physician's recertification of the plan of care, 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 episode of care. 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 episode of care and subsequently returned to the same HHA on day 40. However, the first billable visit (i.e., a physician ordered visit under a new plan of care) did not occur until day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original plan of care 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 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 partial-episode payment 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) Significant-Change-In-Condition (SCIC) Payment Adjustment. The full-episode payment amount is adjusted if the beneficiary experiences a significant change in

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condition during a 60-day episode that was not envisioned in the initial treatment plan. It reflects a proportional payment adjustment for both the time prior to and after the significant change in condition and results in the assignment of a new HHRG. The new HHRG is assigned based on the HHA's revised OASIS assessment, accompanied by appropriate changes in the physician's plan of care. The apportionment of payment is a two-part process. The first part involves determining the proportion of the 60-day episode prior to the significant change in condition and multiplying it by the original episode payment amount. The second part entails the multiplying of the remaining proportion of the 60-day episode after the significant change in condition by the new episode payment level initiated through the certification and assessment process. For example, a Denver, CO HHA assigns a beneficiary to HHRG C2F1S2 that equals \$3,970.20. The beneficiary's first billable day is day 1. The beneficiary experiences a significant change in condition on day 16. The last billable service day prior to the significant change in condition was day 18. The HHA completes a new OASIS assessment and obtains the necessary physician orders to change the case-mix assignment to HHRG C3F2S3, which equals \$5,592.96. The HHA starts rendering services under the revised plan of care and at the new case-mix level on day 22. Days 1 through 18 are used in calculating the first part of the SCIC adjustment, while days 22 through 60 are used in calculating the second part of the SCIC adjustment. The following steps are used in calculating significant-change-in-condition payment adjustment:

STEP 1: Multiply the proportion of the 60-day episode before the SCIC by the original episode payment amount.

$$(\text{Day 1 - Day 18}) 18/60 \times \$3,970.20 = \$1,191.06$$

STEP 2: Multiply the remaining proportion of the 60-day episode after the SCIC by the new episode payment amount.

$$(\text{Day 22 - Day 60}) 39/60 \times \$5,592.96 = \$3,635.42$$

STEP 3: Add the episode payment amounts from Steps #1 & #2 above to obtain the total SCIC adjustment.

$$(\$1,191.06 + \$3,635.42) = \boxed{\$4,826.48}$$

(3) Low-Utilization Payment Adjustment (LUPA). 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 episode of care. 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) nonroutine medical supplies paid under a home health plan of care; 2) nonroutine medical supplies 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 12-4-8](#) below.

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FIGURE 12-4-8 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for non-routine medical supplies*	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
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 non-routine medical supplies reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.

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 12-4-3 above) 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 low-utilization payment adjustment. The following steps are used in calculating the low-utilization payment adjustment:

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 amounts in Chapter 12, Addendums L, M, and N.

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

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - CLAIMS AND BILLING SUBMISSION UNDER HHA PPS

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 describe the procedures involved in submitting Requests for Anticipated Payments and claims for 60-day episodes of care under the HHA PPS.

III. POLICY

A. Episode Payment. Payment for a 60-day episode of care will usually be made in two parts (initial and final), the first paid in response to a Request for Anticipated Payment, (RAP) and the last in response to a claim. Added together, the first and last payment will equal 100 percent of the established episode payment amount based upon patient severity and resource utilization. The following are billing procedure guidelines for RAPs and claims under the HHA PPS:

1. Requests for Anticipated Payments (RAPs). HHAs are required to submit the following data elements on a request for anticipated payment under the home health PPS. Effective for dates of service on or after **the first day of health care delivery of the new contract**, home health services under a plan of care will be paid based on a 60-day episode of care. To receive the first part of the HHA PPS split payment, HHAs must submit a request for anticipated payment (RAP) with coding as described below:

a. After assessment, and once a physician's verbal orders for home care have been received and documented, a plan of care has been established, and the first service visit under that plan has been delivered, the HHA can submit a request for anticipated payment, or RAP.

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b. An episode will be opened on the system and visible in the automated authorization (on the expanded authorization screen) with the receipt and processing of the RAP.

c. RAPs, or in special cases, claims, must be submitted for initial HHA PPS episodes, subsequent HHA PPS episodes, or in transfer situations to start a new HHA PPS episode when another episode is already open at a different agency.

d. HHAs should submit the RAP as soon as possible after care begins in order to ensure prompt data entry into the contractor's authorization screen.

e. RAPs are submitted on the CMS 1450 UB-04 billing under Type of Bill (Form Locator 4) 0322.

f. RAPs incorporate the information output by Grouper for HHA PPS in addition to other claim elements. While TRICARE requires very limited information on RAPs, RAPs do not require charges for TRICARE. However, HHAs have the option of reporting service lines in addition to the TRICARE requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected reimbursement amount to aid balancing in accounts receivable systems. TRICARE will not use charges on a RAP to determine reimbursement, or for later data collection.

g. Once coding is complete, and at least one billable service has been provided in the episode, RAPs or claims are to be submitted to contractors processing TRICARE home health RAPs and claims.

h. Pricer software will determine the first of the two HHA PPS split percentage payments for the episode, which is made in response to the RAP.

i. Although submitted on a CMS 1450 UB-04 and resulting in TRICARE payment for home services, the RAP is not considered a TRICARE home health claim and is not subject to many of the stipulations applied to such claims in regulations. In particular, RAPs are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode, and these claims are still subject to the payment of interest if clean and delayed in processing. Each RAP must be based on a current **Outcome and Assessment Information Set (OASIS)**-based case mix. A RAP and a claim will usually be submitted for each episode period. Each claim must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode, or 60 days after the paid date of the RAP (whichever is greater), an offset recoupment will be initiated on future claims. A message will be placed on the RAP **Explanation Of Benefits (EOB)** that offset recoupment will occur if the claim is not received within 60 days of the RAP payment, recognizing that offset recoupment would ultimately depend on the HHA's claims volume (e.g., auto offset would not be feasible in low claims volume situations).

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(26) FL 37. Internal Control Number (ICN)/Document Control Number (DCN) Required. If canceling a RAP, HHAs must enter the control number assigned to the original RAP here. ICN/DCN is not required in any other case. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payers B and C on lines B and C, respectively, in FL 37.

(27) FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required.

(28) FLs 39-41. Value Codes and Amounts Required. Home Health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

(a) Code 61. Location Where Service is Furnished (HHA and Hospice). MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

(b) Since the value amount is a nine-position field, enter the four-digit MSA in the nine-position field in the following manner. Enter an MSA for Puerto Rico (9940) as 000994000, and the MSA for Abilene, TX (0040) as 000004000. Note that the two characters to the right of the assumed decimal point are always zeros.

(c) Optional. Enter any NUBC approved value code to describe other values that apply to the RAP.

1 Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollar and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

2 If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b". Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

(29) FL 42 and 43 Revenue Code and Revenue Description Required. One revenue code line is required on the RAP. This line is used to report a single Health Insurance Prospective Payment System (HIPPS) code (defined under FL44) which is the basis of the anticipated payment. The required revenue code and description for HHA PPS RAPs are as follows:

(a) Rev. Code **023**. Home Health Services.

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(b) Return the TRICARE reimbursement for the RAP in the total charges field (FL 47) of the 023 revenue code line. HHAs must zero fill FL 47.

(c) Optional. HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HHA PPS claims except another 023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

(d) Revenue codes **058X** and **059X** will no longer be accepted with covered charges on TRICARE home health RAPs under HHA PPS. Revenue code **0624** (investigational devices) will no longer be accepted at all on TRICARE home health RAPs under HHA PPS.

(e) HHAs may continue to report a "Total" line, with revenue care 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. However, the contractors' systems must overlay this amount with the total reimbursement for the RAP.

(30) FL 44. HCPCS/Rates Required. On the **022** revenue code line, HHAs must report the HIPPS code for which anticipated payment is being requested.

(a) Definition. HIPPS rate codes represent specific patient characteristics (or case mix) on which TRICARE payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among various provider types. HIPPS codes are used in association with special revenue codes used on **CMS 1450 UB-04** claim forms for institutional providers. One revenue code is defined for each prospective payment system that calls for HIPPS codes. Currently, revenue code 022 is reserved for the **Skilled Nursing Facility Prospective Payment System** (SNF PPS) and revenue code 023 is reserved for the HHA PPS.

(b) HIPPS codes are placed in Form Locator (FL) 44 ("HCPCS/rate") on the form itself. The associated revenue codes are placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim. HIPPS codes are alphanumeric codes of five digits.

(c) Under the home health prospective payment system, which requires the use of HIPPS codes, a case-mix adjusted payment for up to 60 days of care will be made using one of 80 Home Health Resource Groups (HHRG). On TRICARE claims these HHRGs will be represented as HIPPS codes. These HIPPS codes are determined based on assessment made using the OASIS. Grouper software run at the HHA site will use specific data elements from the OASIS data set and assign beneficiaries to a HIPPS code. The Grouper will output the HIPPS code which HHAs must enter in FL 44 on the claim.

(d) HHA HIPPS codes are five position alphanumeric codes: the first digit is a static "H" for home health, the second, third and fourth (alphabetical) positions represent the level of intensity respective to the clinical, functional and service domains of the OASIS. The fifth position (numeric) represents which of the three domains in the HIPPS

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code were either calculated from complete OASIS data or derived from incomplete OASIS data. A value of "1" in the fifth position should indicate a complete data set that will be accepted by the State Repository for OASIS data. Both HHA PPS RAPs and claims must be correct to reflect the HIPPS code accepted by the State repository. Lists of current HIPPS codes used for billing during a specific Federal fiscal year are published in the TRICARE Policy Manual.

(e) Optional. If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code.

(31) FL 45. Service Date Required. On the 023 revenue code line, HHAs report the date of the first billable service provided under the HIPPS code reported on that line.

(c) If the claim "From" date in FL 6 also matches the admission date in FL 17, edit to ensure that the service date on the 023 line of the RAP matches the claim "From" date.

(b) Optional. If additional revenue codes are submitted on the RAP, report service dates as appropriate to that revenue code.

(32) FL 46. Units of Service Optional. Units of service are not required (i.e., must be zero or blank) on the 023 revenue code line. If additional revenue codes are submitted on the RAP, HHAs report units of service as appropriate to the revenue code.

(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.

(c) Optional. If additional revenue codes are submitted on the RAP, report any necessary charge amounts to meet the requirements of other payers or your billing software.

(b) TRICARE claims systems will not make any payment determinations based upon submitted charge amounts.

(34) FL 48. Non-Covered Charges Not Required. Report non-covered charges only on HHA PPS claims, not RAPs.

Examples. The following provides examples of revenue code lines as HHAs should complete them, based on the reporting requirements above.

Report the required 023 line as follows:					
FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
023	HAEJ1	100101		0.00	

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Report additional revenue code lines as follows:					
FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
550	G0154	100101	1	150.00	

(35) FL 49. (Untitled) Not Required.

(36) 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. Do not make conditional payments for TRICARE Secondary Payer (MSP) situations based on the RAP.

(37) 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 a TRICARE provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number indicating patient status 06. This claim will be paid a PEP adjustment.

(b) Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases, report the new provider number in this field.

(38) 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 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.

(39) FLs 53A, B, and C. Assignment of Benefits Certification Indicator Not Required.

(40) FLs 54A, B, and C. Prior Payments Not Required.

(41) FLs 55A, B, and C. Estimated Amount Due Not Required.

(42) FL 56. (Untitled) Not Required.

(43) FL 57. (Untitled) Not Required.

(44) 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 care or other TRICARE notice.

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(45) FLs 59A, B, and C. Patient's Relationship to Insured Not Required.

(46) 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.

(47) FLs 61A, B, and C. Group Name Not Required.

(48) FLs 62A, B, and C. Insurance Group Number Not Required.

(49) FL 63. Treatment Authorization Code Required. HHAs must enter the claims-OASIS matching key output by the Grouper software. This data element links the RAP 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). Verify that eighteen numeric values are reported in this field.

(a) The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen 1's.

(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.

(50) FL 64. Employment Status Code Not Required.

(51) FL 65. Employer Name Not Required.

(52) FL 66. Employer Location Not Required.

(53) FL 67. Principal Diagnosis Code Required. HHAs must 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.

The ICD-9 codes and principle 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).

(54) FLs 68-75. Other Diagnoses Codes Required. HHAs must enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the

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establishment of the plan of care. These codes must 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-P 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).

(b) 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 M0240 on the OASIS, or on the CMS Form 485, from item 13, may be reported in FLs 67A-Q on the RAP if they are reported in the narrative from item 21 of the CMS Form 485.

(55) FL 69. Admitting Diagnosis Not Required.

(56) FL 72. E-Code Not Required.

(57) FL 73. (Untitled) Not Required.

(58) FL 74. Principal Procedure Code and Date Not Required.

(59) FL 74 a-e. Other Procedure Codes and Dates Not Required.

(60) FL 76. Attending/Requesting Physician I.D. Required. HHAs must enter the UPIN and name of the attending physician who has established the plan of care with verbal orders. Deny the RAP if the UPIN indicated in this field is on the sanctioned provider list.

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.

(61) FL 78 Other Physician I.D. Not Required.

(62) FL 80. Remarks Required. Remarks are necessary when canceling a RAP, to indicate the reason for the cancellation.

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

2. Claims Submission and Processing. HHAs are required to submit the following claims detail for final payment under the HHA PPS:

a. The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier.

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b. HHAs may not submit this claim until after all services provided in the episode are reflected on the claim and the plan of care and any subsequent verbal order have been signed by the physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

c. HH claims must be submitted with a new type of bill - 329.

d. NUBC approved "source of admission" and "patient status codes" are required on the claim.

e. The through date of the claim equals the date of the last service provided in the episode unless the patient status is 30, in which case the through date should be day 60.

f. Providers may submit claims earlier than the 60th day if the POC goals are met and the patient is discharged, or the beneficiary died. The episode will be paid in full unless there is a readmission of a discharged beneficiary, or a transfer to another HHA prior to the day after the HHA PPS period end date.

g. Providers may submit claims earlier than the 60th day if the beneficiary is discharged with the goals of the POC met; and if readmitted or if transferred to another HHA, the episode will be paid as a PEP.

h. If the beneficiary goes into the hospital through the end of the episode, the episode is paid in full whether the patient is discharged or not.

i. A PEP is given if a transfer situation, or if all treatment goals are reached with discharge and there is a readmission within the 60-day episode. PEPs are shown on the claim by patient status code 06.

j. Providers will report all SCICs occurring in one 60-day episode on the same claim.

k. The dates on 023 lines on all claims will be the date of the first service supplied at that level of care.

l. Late charge submissions are not allowed on claims under HHA PPS. Claims must be adjusted instead.

m. Claim will be paid as a LUPA if there are four or less visits total in an episode, regardless of changes in HIPPS code.

n. The HHA PPS claim will include elements submitted on the RAP, and all other line item detail for the episode, including, at a provider's option, any durable medical equipment, oxygen or prosthetics and orthotics provided, even though this equipment will be paid in addition to the episode payment. The only exception is billing of osteoporosis drugs, which will continue to be billed separately on 34X claims by providers with episodes open. Pricer will determine claim payment as well as RAP payment for all PPS.

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- o. The claim will be processed as a debit/credit adjustment against the record created by the RAP.
- p. The related remittance advice will show the RAP payment was recouped in full and a 100% payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.
- q. Claims for episodes may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100% payment is made in the next calendar or fiscal year, at that year's rates. Claim payment rates are determined using the statement "through" date on the claim.
- r. HHAs should be aware that HHA PPS claims will be processed in the TRICARE claims system as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims. As the claim is processed, the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net reimbursement on the claim can be easily understood.
- s. Coding Required for a HHA PPS Claim is as follows:
 - (1) Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number Required. The minimum entry is the agency's name, city, state, and ZIP code. The post office number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the TRICARE provider number (FL 51) to verify provider identity.
 - (2) FL 2. (Untitled) Not Required.
 - (3) FL 3. Patient Control Number Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.
 - (4) FL 4. Type of Bill Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bills accepted for HHA PPS requests for anticipated payment are any combination of the codes listed below:
 - (a) Code Structure (only codes used to bill TRICARE are shown).
 - 1 1st Digit - Type of Facility 3 - Home Health
 - 2 2nd Digit - Bill Classification (Except Clinics and Special Facilities) 2 - Hospital Based or Inpatient.

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NOTE: While the bill classification of 3, defined as "Outpatient," may also be appropriate to a HHA PPS claim depending upon a beneficiary's eligibility, HHAs are encouraged to submit all claims with bill classification 2.

3 3rd Digit - Frequency

a 7 - Replacement of Prior Claim - Used to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims may be submitted at any point within the timely filing period after the payment of the original claim.

b 8 - Void/Cancel of a Prior Claim - Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP and claim must be submitted for the episode to be paid.

c 9 - Final Claim for a HHA PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7 or 8.

d HHA PPS claims are submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." Late charge bills, submitted with frequency "5," are not accepted under HHA PPS. To add services within the period of a paid HH claim, an adjustment must be submitted.

(5) FL 5. Federal Tax Number Required.

(6) FL 6. Statement Covers Period (From-Through) Required. The beginning and ending dates of the period covered by this claim. The "From" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "Through" date must be 59 days after the "From" date. The patient status code in FL 22 must be 30 in these cases. In cases where the beneficiary has been discharged or transferred within the 60-day episode period, report the date of discharge in accordance with your internal discharge procedures as the "Through" date. If a discharge claim is submitted due to change of intermediary, see FL 22 below. If the beneficiary has died, report the date of death in the through date. Any NUBC approved patient status code may be used in these cases. You may submit claims for payment immediately after the claim "Through" date. You are not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care. Submit all dates in the format MMDDYYYY.

(7) FL 7. Covered Days Not Required.

(8) FL 8. Non-covered Days Not Required.

(9) FL 9. Coinsurance Days Not Required.

(10) FL 10. Lifetime Reserve Days Not Required.

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(11) FL 12. Patient's Name Required. Enter the patient's last name, first name, and middle initial.

(12) FL 13. Patient's Address Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

(13) FL 14. Patient's Birthdate Required. Enter the month, day, and year of birth (MMDDYYYY) of the patient. If the full correct date is not known, leave blank.

(14) FL 15. Patient's Sex Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

(15) FL 16. Patient's Marital Status Not Required.

(16) FL 17. Admission Date Required. Enter the same date of admission that was submitted on the RAP for the episode (MMDDYYYY).

(17) FL 18. Admission Hour Not Required.

(18) FL 19. Type of Admission Not Required.

(19) FL 20. Source of Admission Required. Enter the same source of admission code that was submitted on the RAP for the episode.

(20) FL 21. Discharge Hour Not Required.

(21) FL 22. Patient Status Required. Enter the code that most accurately describes the patient's status as of the "Through" date of the bill period (FL 6).

CODE STRUCTURE :	
CODE	DEFINITION
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of another organized home health service organization, or discharged and readmitted to the same home health agency within a 60-day episode period

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(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.

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

(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

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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.

(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.

Report the multiple 023 lines in a SCIC situation as follows:					
FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
023	HAEJ1	100101		0.00	
023	HAFM1	100101		0.00	

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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.

(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

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- (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.

(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.

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(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”).

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.

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(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).

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

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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).

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

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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 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:

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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.

c Exceptions are not expected to occur frequently, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS for an episode).

d 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 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.

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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.

(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):

RAP	CLAIM
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

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RAP	CLAIM
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:

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

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(a) 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

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

(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

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HHA PPS

(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.

(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

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HHA PPS

FIRST EPISODE (RAP)	CLAIM	START OF NEXT EPISODE (RAP)
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
Creates HH Episode in authorization system	Closes HH Episode in authorization system
Triggers initial percentage payment	Triggers final percentage payment

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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.

(a) 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.

(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

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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, "1111111111111111", 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.

(g) FL 15, source of admission, and treatment authorization code, FL 63, should be unprotected for no-pay bills.

DEFINITIONS AND ACRONYM TABLE

ITEM	COMMENTS
Admission Date	For HHA PPS, date of first service of episode or first service in a period of continuous care (multiple episodes) placed in Form Locator (FL) 12 of the CMS 1450 UB-04 found in TRICARE and/or NUBC (National Uniform Billing Committee) manuals. CMS manuals can be found on the web site (www.hcfa.gov/pRubforms/p2192toc.htm).
Claim	Second of two "bookends" at opening and closing of HHA PPS episode to receive one of two split percentage payments.
CMS	The Centers for Medicare and Medicaid Services, the Federal Agency administering the TRICARE program and the federal portions of Medicaid and the Child Health Program.
CMS 1450	CMS's version of the CMS 1450 UB-04.
CMS 1500	The Claim form, in either paper or electronic version (NSF), used by most non-institutional health care providers and suppliers to bill TRICARE. Published as CMS Form 1500 (08/05).
DME	Durable Medical Equipment. Billed by revenue codes and/or HCPCS. Paid by CMS according to CMS DME fee schedule accessible on the web site (www.hcfa.gov/stat/pubfiles.htm)
Episode	60-day unit of payment for HHA PPS.
Grouper	A software module that "groups" information for payment classification; for HHA PPS, data from the OASIS assessment tool is grouped to form Gars and output HIPPS codes. Specifications for the HHA PPS Grouper are posted on the web site (www.hcfa.gov/medicare/hhmain.htm), and the Grouper module is also built into PPS-compatible versions of HAVEN software automating the OASIS assessment tool.
HCFA	The Health Care Financing Administration, the Federal Agency administering the TRICARE program and the federal portions of Medicaid and the Child Health Program.
HCPCS Code(s)	HCFA Common Procedural Coding System. Coding for services or items used on the CMS 1450 UB-04 in FL 44 or CMS 1500 (08/05) claim forms. A list of HCPCS is accessible on the web site (www.hcfa.gov/stat/pubfiles.htm).
HHA	Home Health Agency(ies)
(H)HRG	Home Health Resource Group. One of 80 HH episode payment rates.

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CHAPTER 12, ADDENDUM A
DEFINITIONS AND ACRONYM TABLE

ITEM	COMMENTS
HIPPS	Health Insurance Prospective Payment System. Procedural coding used in FL 44 of the CMS 1450 UB-04 in association with certain CMS prospective payment systems (skilled nursing facility, home health). Eight (8) HIPPS are assigned to each of the HHRGs for HHA PPS.
Inquiry System (HIQH)	An on-line transaction system providing information on HHA PPS episodes for specific TRICARE beneficiaries for HHAs and hospices. Like the current HIQA eligibility inquiry system, this system will be based on batch claim data available in the Common Working File, a component of TRICARE claims processing systems, available to providers via their contractors.
Line Item	Service or item-specific detail of claim. Contains repeated entries of FLs 42-48 on CMS 1450 UB-04.
LUPA	Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates instead of HHRGs.
National Standard Per Visit Rates	National rates for each of the 6 home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers.
No-RAP LUPAs	A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less.
OASIS	Outcome Assessment Information Set. The HH assessment instrument required by CMS.
Outlier	An addition to a full episode payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold. HHA PPS outliers are computed as part of TRICARE claims payment by Pricer for all non-LUPA episodes.
Patient Status Code	FL 17 of the CMS 1450 UB-04 describing patient status at discharge/end of period; of note for HHA PPS in the code list filling this location: "01" = "discharge to home/self", "06" = "discharged/transferred home/HHA care" and "30" = "still a patient").
PEP	Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharge with readmissions).
POC	Plan of care. TRICARE HH services for homebound beneficiaries must have a physician-established plan (see 485 below).
P/O(S)	Prosthetics and orthotics
PPS	Prospective Payment System. TRICARE payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.

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CHAPTER 12, ADDENDUM A

DEFINITIONS AND ACRONYM TABLE

ITEM	COMMENTS
Pricer	Software modules in TRICARE claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems.
RAP	Request for Anticipated Payment. First of two “bookends” at opening and closing of HHA PPS episode to receive one or two split percentage payments. Note: although the RAP uses a CMS 1450 UB-04, it is not a claim according to TRICARE statutes, and is not subject to the payment floor, among other differences from claims.
Revenue Code	Payment codes for services or items placed in FL 42 of the CMS 1450 UB-04. Note that a new revenue code 023 will be used on a distinct line item when billing episode payments (HIPPS in HCPCs field, separate line items for visits and supplies follow on claim); an “x” in the last digit of three digit revenue codes means that value can vary from 0-9.
RHHI	Regional Home Health Intermediary. Five (5) fiscal intermediaries nationally designated to process TRICARE home health and hospice claims.
SCIC	Significant Change in Condition (adjustment). When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG pro-rated to the number of service days delivered under the HHRG, and all pro-rated amounts added for the final episode payment.
Source of Admission Code	FL 15 of the CMS 1450 UB-04; of note are new codes for HHA PPS: “B” = “transfer from another home health facility”, and “C” = “readmission to the same HHA”.
TOB	Type of Bill (i.e., 032x, 034x). Coding representing the nature of each CMS 1450 UB-04 claim (i.e., type of benefit, such as homebound home health; payment source, such as specific TRICARE trust fund; and frequency of bill, such as initial or cancellation) -- and “x” in the last digit of numeric three digit type of bill means that value can be from 0-9.
UB-92	The claim or bill form, in either paper or electronic version, used by most institutional health care providers. Published by CMS as the CMS 1450 UB-04, but the standard itself is maintained by a non-governmental body: the National Uniform Billing Committee.
485	CMS form number for Plan of Care (see POC above).

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CHAPTER 12, ADDENDUM D

CMS FORM 485 - HOME HEALTH CERTIFICATION AND PLAN OF CARE DATA ELEMENTS

Using the ICD-9-CM coding guidelines, the HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. Prior to the effective date of HHPPS, V codes are acceptable as principle and secondary diagnoses. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition. After the implementation of HHPPS, the principle diagnosis must match on the physician certified POC, the Outcome and Assessment Information Set (OASIS) and the **CMS 1450 UB-04**. In addition, V codes are NOT acceptable as principle or first secondary diagnoses but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code.

EXAMPLES: (Prior to the effective date of HHPPS) 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the principle diagnosis since V57.1 does not specify the type or location of the fracture.

2) Patient is surgically treated for a malignant neoplasm of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the proposed services.

EXAMPLE: (After the effective date of HHPPS) 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis and may enter V57.1 as a second secondary diagnosis or in field 21.

2) Patient is surgically treated for a malignant neoplasm of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Even though V55.3 is more specific to the nature of the proposed service, the HHA must use code 153.2 as the principle diagnosis and may use V55.3 as a second secondary diagnosis or in field 21.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established POC.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

12 Surgical Procedure, Date, ICD-9-CM Code The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.52, Partial Hip Replacement, 060998).

If a surgical procedure was not performed or is not relevant to the POC, N/A is inserted. The addendum is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

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CHAPTER 12, ADDENDUM D

CMS FORM 485 - HOME HEALTH CERTIFICATION AND PLAN OF CARE DATA ELEMENTS

- 13 Other Pertinent Diagnoses: Enter all pertinent diagnoses, both narrative and ICD-9-CM Dates of Onset/ Exacerbation, ICD-9-CM Code codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established, or which developed subsequently, or that affect the treatment of care. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC.

These diagnoses can be changed to reflect changes in the patient's condition however, they must match the diagnoses listed on the OASIS and the CMS 1450 UB-04 and conform with the ICD-9-CM coding guidelines.

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. However, there may be exceptions to this rule, dictated by ICD-9-CM coding sequencing requirements. For example, if a principle diagnosis exists which dictates the utilization of a specific secondary diagnosis, then the agency should list this secondary diagnosis first in the list of "other pertinent diagnoses". If there are more than four pertinent secondary diagnoses, use an addendum to list them. Enter N/A if there are no pertinent diagnoses.

The date reflects either the date of onset if it is a new diagnosis or the date of the most recent exacerbation of a previous diagnosis. Note that the date of onset or exacerbation must be as close to the actual date as possible. If the date is unknown, note the year and place 00s in the month or day if not known.

- 14 DME and Supplies All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require use of the specific supplies. The HHA enters in this item non-routine supplies that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley, catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require use of non-routine supplies which would vary by patient. Therefore, the non-routine supplies would be listed.

If the HHA lists a commonly used commercially packaged kit, it is not required to list the individual components. However, if there is a question of cost or content, the contractor can request a breakdown of kit components.

Contractors should reference [Section 2](#) for a definition of non-routine supplies.

The HHA also lists DME ordered by the physician that will be billed to Medicare. The HHA enters N/A if no supplies or DME are billed.

- 15 Safety Measures The physician's instructions for safety measures are listed.
- 16 Nutritional Requirements The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total Parenteral Nutrition (TPN) can be listed under this item or under medications if more space is needed.

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

Due to the size of [Figure 12-O-1](#), please go to the next page.

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CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-1 REQUEST FOR ANTICIPATED PAYMENT (RAP) - NON-TRANSFER SITUATION

1 Your Agency Name		2		3a PAT. CNTL #		4 TYPE OF BILL	
Address				b. MED REC #		322	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM	
						7 COVERS PERIOD THROUGH	
						10012000 10012000	
8 PATIENT NAME a Doe Jane M			9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000				
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
03151920		F		10012000		1	
14 TYPE		15 SRC		16 DRG		17 STAT	
						30	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37			
38		41 CODE		42 CODE		43 CODE	
		61		1900 00			
44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES	
1 0023 HH Services		10012000				0 00	
2 0001						0 00	
3							
4							
5							
6							
7							
8							
9							
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21							
22							
23							
PAGE OF		CREATION DATE		TOTALS			
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				123456789A			
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
		A 200010012000093001					
66 1629 67		A B C D E F G H		I J K L M N O P Q		68	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
						76 ATTENDING NPI A12345	
						LAST Green FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
						LAST FIRST	
80 REMARKS		b1CC a		b		78 OTHER NPI	
						LAST FIRST	
		c		d		79 OTHER NPI	
						LAST FIRST	

UB-04 CMS-1450

APPROVED OMB NO.

NUBC National Uniform Billing Committee LIC9213257

THE 'CERTIFICATIONS' ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-4 RAP - DISCHARGE/RE-ADMIT

Note: Source of Admission (FL 15) is a C, which indicates that this beneficiary was discharged from your HHA, but was readmitted within the same 60-day episode.

1 Your Agency Name		2		3a PAT. CNTRL #		4 TYPE OF BILL	
Address				b. MED REC. #		3X2	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM	
						COVERS PERIOD THROUGH	
8 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street Anywhere ST 50000	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC 16 DRG 17 STAT	
03151920		F		10162000		C 30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
a		b		c		d	
b		c		d		e	
38		41 CODE		42 VALUE CODES AMOUNT		43 CODE	
		a 61		1900 00		44 VALUE CODES AMOUNT	
		b				45 VALUE CODES AMOUNT	
		c				46 VALUE CODES AMOUNT	
		d				47 VALUE CODES AMOUNT	
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 0023		HH Services		HAEJ1		10162000	
2 0001						0 00	
3						0 00	
4							
5							
6							
7							
8							
9							
10							
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19							
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21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
B						54 PRIOR PAYMENTS	
C						55 EST. AMOUNT DUE	
						56 NPI	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				123456789A			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 200010162000101401							
B							
C							
66 1629		67		A		B	
DX				C		D	
				E		F	
				G		H	
				I		J	
				K		L	
				M		N	
				O		P	
				Q		R	
				S		T	
				U		V	
				W		X	
				Y		Z	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
		a		b		c	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
		DATE		DATE		DATE	
						76 ATTENDING NPI A12345	
						QUAL	
						LAST Green	
						FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
		DATE		DATE		DATE	
						QUAL	
						LAST	
						FIRST	
80 REMARKS		81 CC				78 OTHER NPI	
		a				QUAL	
		b				LAST	
		c				FIRST	
		d				79 OTHER NPI	
						QUAL	
						LAST	
						FIRST	

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THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-5 RAP - CANCELLATION

Note: The Type of Bill (TOB) changes to end in an 8, a Claim Change Reason Code (e.g., D5) is included, and the RHI's Internal Control Number (ICN) that identified the original RAP is included.

1 Your Agency Name		2		3a PAT. CNTRL #		4 TYPE OF BILL	
Address				b. MED REC. #		328	
City		ST		Zip		5 FED. TAX NO	
						6 STATEMENT FROM	
						7 COVERS PERIOD THROUGH	
						10012000	
						10012000	
8 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street	
						Anywhere ST 50000	
b				c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION	
03151920		F		10012000		13 HR 14 TYPE 15 SRC	
						16 DRG 17 STAT	
						30 D5	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
						35 CODE	
						OCCURRENCE SPAN FROM THROUGH	
						36 OCCURRENCE SPAN FROM THROUGH	
						37	
						2001952340508	
38		41 CODE		VALUE CODES AMOUNT		42 CODE	
		a 61		1900 00		43 CODE	
		b				44 VALUE CODES AMOUNT	
		c				45 CODE	
		d				46 VALUE CODES AMOUNT	
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 0023		HH Services		HAEJ1		10012000	
2 0001							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
B						54 PRIOR PAYMENTS	
C						55 EST. AMOUNT DUE	
						56 NPI	
						57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				123456789A			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 200010012000093001							
B							
C							
66 1629 67		A		B		C	
D		E		F		G	
H		I		J		K	
L		M		N		O	
P		Q		R		S	
T		U		V		W	
X		Y		Z		68	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		d	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
						76 ATTENDING NPI A12345	
						LAST Green	
						FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
						LAST	
						FIRST	
80 REMARKS		81 CC		78 OTHER NPI		QUAL	
		a					
		b				LAST	
		c				FIRST	
		d				79 OTHER NPI	
						QUAL	
						LAST	
						FIRST	

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CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-8 CLAIM - SIGNIFICANT CHANGE IN CONDITION (SCIC) SITUATION

Note: Two HIPPS Codes appear on this claim due to a SCIC.

1 Your Agency Name		2		3a PAT. CNTL.#		4 TYPE OF BILL	
Address				b. MED REC.#		329	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM COVERS PERIOD THROUGH	
				10012000		11292000	
8 PATIENT NAME a Doe Jane M				9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR	
03151920		F		10012000		1	
14 TYPE		15 SRC		16 DRG		17 STAT	
						30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
41 CODE		42 CODE		43 CODE		44 CODE	
61							
VALUE CODES AMOUNT		VALUE CODES AMOUNT		VALUE CODES AMOUNT		VALUE CODES AMOUNT	
1900 00							
45 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
0023 HH Services		HAEJ1		10012000		0 00	
0023 HH Services		HBFJ4		11102000		0 00	
0550 Skilled Nurse Visit		G0154		10012000		2 150 00	
0570 HH Aide		G0156		10012000		3 75 00	
0550 Skilled Nurse Visit		G0154		10102000		2 150 00	
0570 HH Aide		G0156		10102000		2 75 00	
0420 Physical Therapy		G0151		10152000		3 200 00	
0550 Skilled Nurse Visit		G0154		10202000		2 150 00	
0570 HH Aide		G0156		10202000		2 75 00	
0420 Physical Therapy		G0151		10252000		3 200 00	
0550 Skilled Nurse Visit		G0154		10302000		2 150 00	
0570 HH Aide		G0156		10302000		2 75 00	
0420 Physical Therapy		G0151		11042000		3 200 00	
0550 Skilled Nurse Visit		G0154		11102000		1 150 00	
0570 HH Aide		G0156		11102000		2 75 00	
0420 Physical Therapy		G0151		11142000		3 200 00	
0550 Skilled Nurse Visit		G0154		11202000		2 150 00	
0570 HH Aide		G0156		11202000		3 75 00	
0420 Physical Therapy		G0151		11242000		3 200 00	
0550 Skilled Nurse Visit		G0154		11292000		2 150 00	
0270 Supplies						11 132 58	
0001						43 2632 58	
PAGE OF		CREATION DATE		TOTALS			
50 PAYER		51 HEALTH PL/AN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				123456789A			
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 200010012000093001							
66 DX		67		68			
A 1629		A		B		C	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
						76 ATTENDING NPI A12345	
						LAST Green FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
						LAST FIRST	
80 REMARKS		81 CC a		82		78 OTHER NPI	
		b				LAST FIRST	
		c				79 OTHER NPI	
		d				LAST FIRST	

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CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-9 CLAIM - No-RAP-LOW UTILIZATION PAYMENT ADJUSTMENT (LUPA) CLAIM

In this example, the beneficiary transferred to another HHA. Your HHA provided two services and had not yet submitted the RAP when the beneficiary transferred; therefore, you have a No-RAP-LUPA Claim situation.

1 Your Agency Name		2		3a PAT. CNTRL #		4 TYPE OF BILL	
Address				b. MED REC. #		329	
City		ST		Zip		5 FED. TAX NO	
				6 STATEMENT FROM		7 COVERS PERIOD THROUGH	
				10012000		10032000	
8 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street Anywhere ST 50000	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION	
03151920		F		10012000		13 HR 14 TYPE 15 SRC 16 DRG 17 STAT	
						18 19 20 21	
						22 23 24 25 26 27 28	
						29 ACDT 30 STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
						35 CODE OCCURRENCE SPAN THROUGH	
						36 CODE OCCURRENCE SPAN THROUGH	
						37	
38		41 CODE		VALUE CODES AMOUNT		42 CODE	
		a 61		1900 00		43 CODE	
		b				44 VALUE CODES AMOUNT	
		c				45	
		d				46	
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 0023		HH Services		HAEJ1		10012000	
2 0550		Skilled Nurse Visit		G0154		10012000	
3 0570		HH Aide		G0156		10012000	
4							
5 0001						5	
6						225 00	
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		B 167999		Y		54 PRIOR PAYMENTS	
C						55 EST. AMOUNT DUE	
						56 NPI	
						57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				B 123456789A			
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 200010012000093001							
B							
C							
66		67		A		B	
68		C		D		E	
		F		G		H	
		I		J		K	
		L		M		N	
		O		P		Q	
		R		S		T	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72	
		a		b		c	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
						76 ATTENDING NPI	
						A12345	
						QUAL	
						LAST Green	
						FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
						QUAL	
						LAST	
						FIRST	
80 REMARKS		81 CC		78 OTHER NPI		QUAL	
		a				LAST	
		b				FIRST	
		c				79 OTHER NPI	
		d				QUAL	
						LAST	
						FIRST	

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CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-10 CLAIM ADJUSTMENT

NOTE: The TOB changes to end in a 7, a Claim Change Reason Code (e.g., D9) is included, and the RHHI's ICN that identifies the original claim is included. Remarks are noted in FL 80 at the bottom of the claim.

1 Your Agency Name		2		3a PAT. CNTL #		4 TYPE OF BILL	
Address				b. MED REC. #		327	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM	
				10012000		7 COVERS PERIOD THROUGH	
				11292000			
8 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street	
				Anywhere		ST 50000	
b				c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION	
03151920		F		10012000		13 HR 14 TYPE 15 SRC	
				1		16 DRG	
				30		17 STAT	
				D9		18 19 20 21	
						CONDITON CODES	
						22 23 24 25 26 27 28	
						29 ACCT STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
						35 OCCURRENCE SPAN FROM THROUGH	
						36 OCCURRENCE SPAN FROM THROUGH	
						37	
						2002332340508	
38				41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
				61 1900 00			
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 0023		HH Services		HAEJ1		10012000	
2 0550		Skilled Nurse Visit		G0154		10012000	
3 0570		HH Aide		G0156		10012000	
4 0550		Skilled Nurse Visit		G0154		10102000	
5 0570		HH Aide		G0156		10102000	
6 0420		Physical Therapy		G0151		10152000	
7 0550		Skilled Nurse Visit		G0154		10202000	
8 0570		HH Aide		G0156		10202000	
9 0420		Physical Therapy		G0151		10252000	
10 0550		Skilled Nurse Visit		G0154		10302000	
11 0570		HH Aide		G0156		10302000	
12 0420		Physical Therapy		G0151		11042000	
13 0550		Skilled Nurse Visit		G0154		11102000	
14 0570		HH Aide		G0156		11102000	
15 0420		Physical Therapy		G0151		11142000	
16 0550		Skilled Nurse Visit		G0154		11202000	
17 0570		HH Aide		G0156		11202000	
18 0420		Physical Therapy		G0151		11242000	
19 0550		Skilled Nurse Visit		G0154		11292000	
20 0570		HH Aide		G0156		11292000	
21 0270		Supplies				11 132 58	
22 0001						43 2707 58	
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER		A Medicare		51 HEALTH PLAN ID		167999	
B		C		52 REL INFO		Y	
53 ASG BEN				54 PRIOR PAYMENTS			
55 EST. AMOUNT DUE				56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME		A Doe, Jane M		59 PREL 60 INSURED'S UNIQUE ID		123456789A	
B		C		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		A 200010012000093001		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
B		C					
66 1629 67		A B C D E F G H		68			
I J K L M N O P Q							
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		d	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
DATE		DATE		DATE		76 ATTENDING NPI A12345	
						QUAL	
						LAST Green	
						FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
DATE		DATE		DATE		QUAL	
						LAST	
						FIRST	
80 REMARKS		81 CC		78 OTHER NPI		QUAL	
a		b		LAST		FIRST	
Adjusted line item date of service on last therapy visit - from 11/24							
to 11/25/2000, and changed 15-minute increments from 3 to 4.							
c		d		79 OTHER NPI		QUAL	
				LAST		FIRST	

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CHAPTER 12, ADDENDUM O

EXAMPLES OF CLAIMS SUBMISSION UNDER HHAPPS

FIGURE 12-O-11 CLAIM - CANCELLATION

NOTE: The **TOB** changes to end in an 8, a Claim Change Reason Code (e.g., D6) is included, and the RHHI's **ICN** that identified the original claim is included.

1 Your Agency Name		2		3a PAT. CNTRL #		4 TYPE OF BILL			
Address				b. MED REC. #		328			
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM			
				10012000		7 COVERS PERIOD THROUGH			
						11292000			
8 PATIENT NAME a Doe Jane M				9 PATIENT ADDRESS a 123 Main Street				Anywhere ST 50000	
b		c		d		e			
10 BIRTHDATE		11 SEX		12 DATE		13 HR			
03151920		F		10012000		1			
14 TYPE		15 SRC		16 DRG		17 STAT			
						30			
18		19		20		21			
22		23		24		25			
26		27		28		29 ACCT STATE			
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE			
						35			
35 CODE		36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37			
						2002332340508			
38		41 CODE		42 CODE		43 CODE			
		a 61		1900 00					
b		c		d					
44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES			
1 0023 HH Services		HAEJ1		10012000		0 00			
2 0550 Skilled Nurse Visit		G0154		10012000		2 150 00			
3 0570 HH Aide		G0156		10012000		3 75 00			
4 0550 Skilled Nurse Visit		G0154		10102000		2 150 00			
5 0570 HH Aide		G0156		10102000		2 75 00			
6 0420 Physical Therapy		G0151		10152000		3 200 00			
7 0550 Skilled Nurse Visit		G0154		10202000		2 150 00			
8 0570 HH Aide		G0156		10202000		2 75 00			
9 0420 Physical Therapy		G0151		10252000		3 200 00			
10 0550 Skilled Nurse Visit		G0154		10302000		2 150 00			
11 0570 HH Aide		G0156		10302000		2 75 00			
12 0420 Physical Therapy		G0151		11042000		3 200 00			
13 0550 Skilled Nurse Visit		G0154		11102000		1 150 00			
14 0570 HH Aide		G0156		11102000		2 75 00			
15 0420 Physical Therapy		G0151		11142000		3 200 00			
16 0550 Skilled Nurse Visit		G0154		11202000		2 150 00			
17 0570 HH Aide		G0156		11202000		3 75 00			
18 0420 Physical Therapy		G0151		11242000		3 200 00			
19 0550 Skilled Nurse Visit		G0154		11292000		2 150 00			
20 0570 HH Aide		G0156		11292000		2 75 00			
21 0270 Supplies						11 132 58			
22 0001						43 2707 58			
23 PAGE OF		CREATION DATE		TOTALS					
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN			
A Medicare		167999		Y					
B						54 PRIOR PAYMENTS			
C						55 EST. AMOUNT DUE			
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME			
A Doe, Jane M				123456789A					
B						62 INSURANCE GROUP NO.			
C									
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME					
A 200010012000093001									
B									
C									
66 1629 67		A		B		C			
D		E		F		G			
H		I		J		K			
L		M		N		O			
P		Q		R		S			
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI			
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75			
						76 ATTENDING NPI A12345			
						QUAL			
						LAST Green			
						FIRST Mark			
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI			
						QUAL			
						LAST			
						FIRST			
80 REMARKS		81 CC a		b		78 OTHER NPI			
						QUAL			
						LAST			
						FIRST			
		c		d		79 OTHER NPI			
						QUAL			
						LAST			
						FIRST			

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CHAPTER 13
SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

ISSUE DATE: July 27, 2005

AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPSS Interim Final Rule (IFR).

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 **TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

The billing and coding requirements for reimbursement under the hospital Outpatient Prospective Payment System (OPPS).

III. POLICY

A. To receive TRICARE Reimbursement under the OPPS providers must follow and contractors shall enforce all Medicare specific coding requirements.

NOTE: TMA will develop specific Ambulatory Payment Classifications (APCs) (those beginning with a "T") for those services that are unique to the TRICARE beneficiary population (e.g., maternity care). Reference TMA's OPPS web site at <http://www.tricare.mil/opps> for a listing of TRICARE APCs.

B. Packaging of Services Under APC Groups.

1. The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These costs include, but are not limited to:

- a. Use of an operating suite.
- b. Procedure room or treatment room.
- c. Use of the recovery room or area.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

- d. Use of an observation bed.
- e. Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations.
- f. Supplies and equipment for administering and monitoring anesthesia or sedation.
- g. Intraocular lenses (IOLs).
- h. Capital-related costs.
- i. Costs incurred to procure donor tissue other than corneal tissue.
- j. Incidental services such as venipuncture.
- k. Implantable items used in connection with diagnostic X-ray testing, diagnostic laboratory tests, and other diagnostics.
- l. Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices.

2. Costs associated with certain expensive procedures and services are not packaged within an APC payment rate. Instead, separate APC payment will be made for these particular items and services under the OPPS. Additional payments will be provided for certain packaged medical devices, drugs, and biologicals that are eligible for transitional pass-throughs (i.e., payments for expensive drugs or devices that are temporarily reimbursed in addition to the APC amount for the service or procedure to which they are normally associated), while strapping and casting will be paid under two new APC groupings (0058 and 0059).

a. Costs of drugs, biologicals and devices packaged into APCs to which they are normally associated.

The costs of drugs, biologicals and pharmaceuticals are generally packaged into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished. No separate payment is made under the OPPS for drugs, biologicals and pharmaceuticals whose costs are packaged into the APCs with which they are associated.

(1) For the drugs paid under the OPPS, hospitals can bill both for the drug and for the administration of the drug.

(2) The overhead cost is captured in the administration codes, along with the costs of all drugs that are not paid for separately.

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CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

(3) Each time a drug is billed with an administration code, the total payment thus includes the acquisition cost for the billed drug, the packaged cost of all other drugs and the overhead.

b. Separate payment of drugs, biologicals and devices outside the APC amounts of the services to which they are normally associated.

(1) Special transitional pass-through payments (additional payments) made for at least 2 years, but not more than three years for the following drugs and biologicals:

(a) Current orphan drugs, as designated under section 526 of the Federal Food, Drugs, and Cosmetic Act;

(b) Current drugs and biological agents used for treatment of cancer;

(c) Current radiopharmaceutical drugs and biological products; and

(d) New drugs and biologic agents in instances where the item was not being paid as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPPS payment amount.

NOTE: The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on the **Centers for Medicare and Medicaid Services (CMS)** web site: <http://www.cms.hhs.gov>. The TRICARE contractors will not be required to review applications for pass through payment.

(2) Separate APC payment for drugs and radiopharmaceuticals for which the median cost per line exceeds \$50, with the exception of injectible and oral forms of antiemetics.

(3) Separately payable radiopharmaceuticals, drugs and biologicals classified as "specified covered outpatient drugs" for which payment was made on a pass-through basis on or before December 31, 2002, and a separate APC exists.

(4) Separate payment for new drugs and biologicals that have assigned **Healthcare Common Procedure Coding System (HCPCS)** codes, but that do not have a reference **Average Wholesale Price (AWP)**, approval for pass-through payment or hospital claims data.

(5) Drugs and biologicals that have not been eligible for pass-through status but have been receiving nonpass-through payments since implementation of the Medicare OPPS.

(6) Separate payment for new drugs, biologicals and radiopharmaceuticals enabling hospitals to begin billing for drugs and biologicals that are newly approved by the

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FDA, and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup.

(7) Special APC groups that have been created to accommodate payment for new technologies. The drugs, biologicals and pharmaceuticals that are incorporated into these new technology APCs are paid separately from, and in addition to, the procedure or treatment with which they are associated yet are not eligible for transitional pass-through payment.

(8) New drugs, biologicals and devices which qualify for separate payment under OPPS, but have not yet been assigned to a transitional APC (i.e., assigned to a temporary APC for separate payment of an expensive drug or device) will be reimbursed under TRICARE standard allowable charge methodology. This allowable charge payment will continue until a transitional APC has been assigned (i.e., until CMS has had the opportunity to assign the new drug, biological or device to a temporary APC for separate payment).

NOTE: The contractors will not be held accountable for the development of transitional APC payments for new drugs, biologicals or devices.

c. Corneal tissue acquisition costs.

(1) Corneal tissue acquisition costs not packaged into the payment rate for corneal transplant surgical procedures.

(2) Separate payment will be made based on the hospital's reasonable costs incurred to acquire corneal tissue.

(3) Corneal acquisition costs must be submitted using HCPCS code V2785 (Processing, Preserving and Transporting Corneal Tissue), indicating the acquisition cost rather than the hospital's charge on the bill.

d. Costs for other procedures or services not packaged in the APC payment.

(1) Blood and blood products, including anti-hemophilic agents.

(2) Casting, splinting and strapping services.

(3) Immunosuppressive drugs for patients following organ transplant.

(4) Certain other high cost drugs that are infrequently administered.

NOTE: New APC groups have been created for these items and services, which allows separate payment.

e. Reporting Requirements for Device Dependent Procedures.

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Hospitals are required to bill all device-dependent procedures using the appropriate C-codes for the devices. Following are provisions related to the required use of C-codes:

(1) Hospitals are required to report device category codes on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the claims data used annually to update the OPPS payment rates.

(2) The Outpatient Code Editor (OCE) will include edits to ensure that certain procedure codes are accompanied by an associated device category code:

(a) These edits will be applied at the HCPCS I and II code levels rather than at the APC level.

(b) They will not apply when a procedure code is reported with a modifier 52, 73, or 74 to designate an incomplete procedure.

C. Additional payments under the OPPS.

1. Clinical diagnostic testing (labwork).
2. Administration of infused drugs.
3. Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.
4. Certain high-cost drugs, such as the expensive "clotbuster" drugs that must be given within a short period of time following a heart attack or stroke.
5. Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

D. Payment for patients who die in the emergency department.

1. If the patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPPS for the services furnished.

2. If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

a. If the patient had been admitted as an inpatient, pay under the hospital DRG-based payment system.

b. If the patient was not admitted as an inpatient, pay under the OPPS (an APC-based payment) for the services that were furnished.

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c. If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPPS payment status indicator "C") is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier -CA on the line with the HCPCS code for the inpatient procedure. Payment for all services other than the inpatient procedure designated under OPPS by the status indicator "C", furnished on the same date, is bundled into a single payment under APC 0375.

3. Billing and Payment Rules for Using New Modifier -CA - *Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission.*

a. All the following conditions must be met in order to receive payment for services billed with modifier -CA:

- (1) The status of the patient is outpatient;
- (2) The patient has an emergent, life-threatening condition;
- (3) A procedure on the inpatient list (designated by payment status indicator "C") is performed on an emergency basis to resuscitate or stabilize the patient; and
- (4) The patient dies without being admitted as an inpatient.

b. If all of the conditions for payment are met, the claim should be submitted using a 013X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment status indicator "C"). The hospital should include modifier -CA on the line with the HCPCS code for the inpatient procedure.

NOTE: When a line with a procedure code that has a status indicator (SI) of "C" assigned and has a patient status of "20" (deceased) and one of the modifiers is "CA" (patient dies). The OCE software will change the "SI" of the procedure to "S" and price the line using the adjusted APC rate formula.

c. Payment for all services on a claim that have the same date of service as the HCPCS billed with modifier -CA is made under APC 0375. Separate payment is not allowed for other services furnished on the same date.

E. Medical Screening Examinations.

1. Appropriate emergency department codes will be used for medical screening examinations including ancillary services routinely available to the emergency department in determining whether or not an emergency condition exists.

2. If no treatment is furnished, medical screening examinations would be billed with a low-level emergency department code.

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F. HCPCS/Revenue Coding Required Under OPPS. Hospital outpatient departments should use the CMS 1450 UB-04 Editor as a guide for reporting HCPCS and revenue codes under the OPPS.

G. Treatment of Partial Hospitalization Services. Effective upon implementation of OPPS, hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a per diem payment under the OPPS. Freestanding PHPs (psych and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment.

1. The National Quality Monitoring Contractor (NQMC) shall include in their authorized provider reports to the contractors additional data elements indicating whether the facility is a freestanding PHP (psych or SUDRF) or a hospital-based PHP (psych). The contractors shall identify hospital-based PHPs (SUDRFs) that are subject to the per diem payment under the OPPS.

2. Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in lieu of inpatient psychiatric care in a hospital outpatient department.

3. Services of physicians, clinical psychologists, Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), and Physician Assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services.

4. Payment for PHP (psych) services represents the provider's overhead costs, support staff, and the services of Clinical Social Workers (CSWs) and Occupational Therapists (OTs), whose professional services are considered to be included in the PHP per diem rate. For SUDRFs, the costs of alcohol and addiction counselor services would also be included in the per diem.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs, OTs, and alcohol and addiction counselors.

b. Rather, the hospital's costs associated with the services of CSWs, OTs, and alcohol and addiction counselors will continue to be billed to the contractor and paid through the PHP per diem rate.

5. Per diem is the unit of payment since it defines the structure and scheduling of partial hospitalization services. The established per diem represents the median hospital cost of furnishing a day of partial hospitalization. The following are billing instructions for submission of partial hospitalization claims/services:

a. Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services.

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b. The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services:

FIGURE 13-2-1 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES FOR CY 2003

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I ¹ AND II CODES
0250	Pharmacy	HCPCS code not required
0905	Intensive Outpatient Services - Psychiatric	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
0906	Intensive Outpatient Services - Chemical Dependency	
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
0912	Partial Hospitalization Program - Less Intensive (Half-day PHP)	H0035
0913	Partial Hospitalization Program - Intensive (Full-day PHP)	H0037
0914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829
0915	Group Therapy	90849, 90853, 90857
0916	Family Psychotherapy	90846, 90847, 90849
0918	Psychiatric Testing	96100, 96115, 96117

¹ HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

c. To bill for partial hospitalization services under the hospital OPPTS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

d. The claim must include a mental health diagnosis and an authorization on file for each day of service, along with a designated H-code (i.e., either H0035 for half-day PHP or H0037 for full-day PHP) and its accompanying revenue code, prior to assigning a full- or half-day partial hospitalization APC. Claims that do not meet the above criteria (e.g., claim filed without condition code 41, appropriate H-coding - H0035 or H0037, and/or revenue code) will undergo further prepayment review to ensure that outpatient department mental health procedures do not exceed the full-day partial hospitalization per diem amount; i.e., the sum of the individual mental health APC amounts on any particular day does not exceed

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the full-day partial hospitalization per diem amount. The following are basic reporting requirements for assigning full- and half-day partial hospitalization APCs:

Reporting Requirements for PHP:

- Bill Type 013x
- Mental Health (MH) Primary Diagnosis
- Condition code 41, PH HCPCS, PH revenue code (yes/no)
 - Yes
 - Authorization on File
 - Yes
 - H0035/RC 0912 - APC T0001 (half-day PHP)
 - H0037/RC 0913 - APC 0033 (full-day PHP)
 - No - deny claim
 - No (Bill Type 012x, 013x, 014x without condition code 41)
 - Sum of Mental Health APCs > PHP APC 0033 payment amount on a given day (yes/no)
 - Yes
 - Assign daily MH service payment APC 0034
 - Package all other MH services
 - Apply standard APC payment rule to non-MH services
 - No - Apply standard APC payment rules

(1) Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem amount will be paid.

(2) Specific therapy codes (e.g., coding for family, group and individual psychotherapy) will be reported in addition to designated partial hospitalization codes H0035 and H0037 (refer to Figure 13-2-1 above for specific therapy coding). Specific Mental Health (MH) services will be packaged into a single PHP code for the same date of service with the exception of Electroconvulsive Therapy (ECT).

(3) Only one PHP APC will be paid per day.

(a) If multiples of the same H-code (either H0035 or H0037 but not both) appear on the claim for the same date of service, the first H-code will be designated for APC assignment and all other specific therapy codes will be packaged into the H-code line for remittance reporting.

(b) If both H-codes (H0035 and H0037) appear on the claim for the same date of service, payment will default to the less intensive treatment modality (half-day PHP); i.e., H0035 will be recognized for payment. Other therapy codes reported on the same date of service will be packaged into the less intensive H-code for remittance reporting.

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(4) Non-mental health services submitted on the same day will be processed and paid separately.

(5) Revenue codes 0912 and 0913 must be accompanied by an appropriately designated HCPCS code (refer to Figure 13-2-1 for designated PHP coding). If revenue codes 912 and 913 are submitted without a HCPCS, the line and/or claim will be denied.

(6) Claims that include days that do not meet the above requirements for assignment to a partial hospitalization APC will be identified for further review.

(7) The total amount payable for psychiatric services furnished in a hospital outpatient department (not under the partial hospitalization program) for an individual for one day will be limited to the APC per diem payment amount for full-day partial hospitalization.

(8) Half-day PHP per diem will be priced at 75 percent of the full-day PHP rate.

6. Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under Chapter 7, Section 2.

H. Billing and Payment Requirements for Observation Services.

1. Observation Stays with Diagnoses of Chest Pain, Asthma, Congestive Heart Failure or Maternity.

a. Two new HCPCS codes have been created to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

(1) G0378 -- Hospital observation services, per hour, and

(2) G0379 -- Direct admission of patient for hospital observation care.

b. The determination of whether or not observation services are separately payable under APC 0339 (observation) has been shifted from the hospital billing department to the OPPS claims processing logic.

(1) The hospital will bill HCPCS code G0378 when observation services are provided to any patient admitted to "observation status", regardless of the patient's condition.

(2) In addition to the HCPCS code G0378, hospitals will bill HCPCS code G0379 when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services.

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(3) The above HCPCS (G0378 & G0379) will be assigned a new status indicator "Q" (packaged service subject to separate payment based on criteria) that will trigger the OCE logic during the processing of the claim to determine if the observation service or direct admission service is packaged with the other separately payable hospital services provided, or if a separate APC payment for observation services or direct admission to observation is appropriate.

(4) The units of services reported with HCPCS code G0378 will equal the number of hours the patient is in observation status.

c. Direct admission to observation will continue to be paid at a rate equal to that of a Low Level Clinic Visit (APC 600) when a beneficiary is seen by a physician in the community and then is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339, and under T0002.

(1) In order to receive separate payment for a direct admission into observation (APC 0600), the claim must show:

(a) Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service.

(b) That no service with status indicator "T" or "V" (clinic or emergency department visit) or critical care (APC 0620) were provided on the same day of service as HCPCS code G0379.

(c) The observation care does not qualify for separate payment under APC 0339.

d. Criteria for separate observation payments include:

(1) Documentation of specific ICD-9-CM diagnostic codes.

(a) The beneficiary must have one of four medical conditions: congestive heart failure, chest pain, asthma, or maternity.

(b) The hospital bill must report at least one of the ICD-9-CM diagnoses listed in [Figure 13-2-2](#) through [Figure 13-2-5](#) as the reason for visit or principal diagnosis:

1 The qualifying ICD-9-CM diagnosis code must be reported in Form Locator (FL) 69, Patient Reason for Visit, (FL 70) or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339.

2 If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL

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70) or in the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

FIGURE 13-2-2 REQUIRED DIAGNOSES FOR CHEST PAIN

ICD-9-CM	DESCRIPTION
411.0	Postmyocardial infarction syndrome
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute ischemic heart disease
413.0	Angina decubitus
413.1	Pinzmetal angina
413.9	Other and unspecified angina pectoris
786.05	Shortness of breath
786.50	Chest pain, unspecified
786.51	Precordial pain
786.52	Painful respiration
786.59	Other chest pain

FIGURE 13-2-3 REQUIRED DIAGNOSES FOR ASTHMA

ICD-9-CM	DESCRIPTION
493.01	Extrinsic asthma with status asthmaticus
493.02	Extrinsic asthma with acute exacerbation
493.11	Intrinsic asthma with status asthmaticus
493.12	Intrinsic asthma with acute exacerbation
493.21	Chronic obstructive asthma with status asthmaticus
493.22	Chronic obstructive asthma with acute exacerbation
493.91	Asthma, unspecified with status asthmaticus
493.92	Asthma, unspecified with acute exacerbation

FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE

ICD-9-CM	DESCRIPTION
391.8	Other acute rheumatic heart disease
398.91	Rheumatic heart failure (congestive)
402.01	Malignant hypertensive heart disease with congestive heart failure
402.11	Benign hypertensive heart disease with congestive heart failure
402.91	Unspecified hypertensive heart disease with congestive heart failure

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FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE (CONTINUED)

ICD-9-CM	DESCRIPTION
404.01	Malignant hypertensive heart and renal disease with congestive heart failure
404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11	Benign hypertensive heart and renal disease with congestive heart failure
404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0	Congestive heart failure
428.1	Left heart failure
428.20	Unspecified systolic heart failure
428.21	Acute systolic heart failure
428.22	Chronic systolic heart failure
428.23	Acute or chronic systolic heart failure
428.30	Unspecified diastolic heart failure
428.31	Acute diastolic heart failure
428.32	Chronic diastolic heart failure
428.33	Acute or chronic diastolic heart failure
428.40	Unspecified combined systolic and diastolic heart failure
428.41	Acute combined systolic and diastolic heart failure
428.42	Chronic combined systolic and diastolic heart failure
428.43	Acute or chronic combined systolic and diastolic heart failure
428.9	Heart failure, unspecified

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
V22	Normal pregnancy	
V22.0	Supervision of normal first pregnancy	
V22.1	Supervision of other normal pregnancy	

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
V22.2	Pregnant state, incidental	
V23	Supervision of high-risk pregnancy	
V23.0	Pregnancy with history of infertility	
V23.1	Pregnancy with history of trophoblastic disease	
V23.2	Pregnancy with history of abortion	
V23.3	Grand multiparity	
V23.4	Pregnancy with other poor obstetric history	
V23.41	Pregnancy with history of pre-term labor	
V23.49	Pregnancy with other poor obstetric history	
V23.5	Pregnancy with other poor reproductive history	
V23.7	Insufficient prenatal care	
V23.81	Elderly primigravida	
V23.82	Elderly multigravida	
V23.83	Young primigravida	
V23.84	Young multigravida	
V23.89	Other high-risk pregnancy	
V23.9	Unspecified high-risk pregnancy	
630	Hydatidiform mole	
631	Other abnormal product of conception	
632	Missed abortion	
633.00	Abdominal pregnancy without intrauterine pregnancy	
633.01	Abdominal pregnancy with intrauterine pregnancy	
633.10	Tubal pregnancy without intrauterine pregnancy	
633.11	Tubal pregnancy with intrauterine pregnancy	
633.20	Ovarian pregnancy without intrauterine pregnancy	
633.21	Ovarian pregnancy with intrauterine pregnancy	
633.80	Other ectopic pregnancy without intrauterine pregnancy	
633.81	Other ectopic pregnancy with intrauterine pregnancy	
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy	

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy	
640.0	Threatened abortion	0, 3
640.8	Other specified hemorrhage in early pregnancy	0, 3
640.9	Unspecified hemorrhage in early pregnancy	0, 3
641.0	Placenta previa without hemorrhage	0, 3
641.1	Hemorrhage from placenta previa	0, 3
641.2	Premature separation of placenta	0, 3
641.3	Antepartum hemorrhage associated with coagulation defects	0, 3
641.8	Other antepartum hemorrhage	0, 3
641.9	Unspecified antepartum hemorrhage	0, 3
642.0	Benign essential hypertension complicating pregnancy, childbirth and the puerperium	0, 3
642.1	Hypertension secondary to renal disease, complicating pregnancy, childbirth and the puerperium	0, 3
642.2	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium	0, 3
642.3	Transient hypertension of pregnancy	0, 3
642.4	Mild or unspecified pre-eclampsia	0, 3
642.5	Severe pre-eclampsia	0, 3
642.6	Eclampsia	0, 3
642.7	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension	0, 3
642.9	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium	0, 3
643.0	Mild hyperemesis gravidarum	0, 3
643.1	Hyperemesis gravidarum with metabolic disturbance	0, 3
643.2	Late vomiting of pregnancy	0, 3
643.8	Other vomiting complicating pregnancy	0, 3
643.9	Unspecified vomiting of pregnancy	0, 3
644.0	Threatened premature labor	0, 3

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
644.1	Other threatened labor	0, 3
644.2	Early onset of delivery	0, 3
645.1	Post term pregnancy	0, 3
645.2	Prolonged pregnancy	0, 3
646.0	Papyraceous fetus	0, 3
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension	0, 3
646.2	Unspecified renal disease in pregnancy, without mention of hypertension	0, 3
646.3	Habitual aborter	0, 3
646.4	Peripheral neuritis in pregnancy	0, 3
646.5	Asymptomatic bacteriuria in pregnancy	0, 3
646.6	Infections of genitourinary tract in pregnancy	0, 3
646.7	Liver disorders in pregnancy	0, 3
646.8	Other specified complications of pregnancy	0, 3
646.9	Unspecified complication of pregnancy	0, 3
647.0	Syphilis	0, 3
647.1	Gonorrhea	0, 3
647.2	Other venereal diseases	0, 3
647.3	Tuberculosis	0, 3
647.4	Malaria	0, 3
647.5	Rubella	0, 3
647.6	Other viral diseases	0, 3
647.8	Other specified infectious and parasitic diseases	0, 3
648.0	Diabetes mellitus	0, 3
648.1	Thyroid dysfunction	0, 3
648.2	Anemia	0, 3
648.3	Drug dependence	0, 3
648.4	Mental disorders	0, 3

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
648.5	Congenital cardiovascular disorders	0, 3
648.6	Other cardiovascular diseases	0, 3
648.7	Bone and joint disorders of back, pelvis, and lower limbs	0, 3
648.8	Abnormal glucose tolerance	0, 3
648.9	Other current conditions classifiable elsewhere	0, 3
649.0	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium	0, 3
649.1	Obesity complicating pregnancy, childbirth, or the puerperium	0, 3
649.2	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium	0, 3
649.3	Coagulation defects complicating pregnancy, childbirth, or the puerperium	0, 3
649.4	Epilepsy complicating pregnancy, childbirth, or the puerperium	0, 3
649.5	Spotting complicating pregnancy	0, 3
649.6	Uterine size date discrepancy	0, 3
650	Normal delivery	
651.0	Twin pregnancy	0, 3
651.1	Triplet pregnancy	0, 3
651.2	Quadruplet pregnancy	0, 3
651.3	Twin pregnancy with fetal loss and retention of one fetus	0, 3
651.4	Triplet pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.5	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.6	Other multiple pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.8	Other specified multiple gestation	0, 3
651.9	Unspecified multiple gestation	0, 3
655.0	Central nervous system malformation in fetus	0, 3
655.1	Chromosomal abnormality in fetus	0, 3

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Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
655.2	Hereditary disease in family possibly affecting fetus	0, 3
655.3	Suspected damage to fetus from viral disease in the mother	0, 3
655.4	Suspected damage to fetus from other disease in the mother	0, 3
655.5	Suspected damage to fetus from drugs	0, 3
655.6	Suspected damage to fetus from radiation	0, 3
655.7	Decreased fetal movements	0, 3
655.8	Other known or suspected fetal abnormality, not elsewhere classified	0, 3
655.9	Unspecified	0, 3
656.0	Fetal-maternal hemorrhage	0, 3
656.1	Rhesus isoimmunization	0, 3
656.2	Isoimmunization from other and unspecified blood-group incompatibility	0, 3
656.3	Fetal distress	0, 3
656.4	Intrauterine death	0, 3
656.5	Poor fetal growth	0, 3
656.6	Excessive fetal growth	0, 3
656.7	Other placental conditions	0, 3
656.8	Other specified fetal and placental problems	0, 3
656.9	Unspecified fetal and placental problem	0, 3
657.0	Polyhydramnios	0, 3
658.0	Oligohydramnios	0, 3
658.1	Premature rupture of membranes	0, 3
658.2	Delayed delivery after spontaneous or unspecified rupture of membranes	0, 3
658.3	Delayed delivery after artificial rupture of membrane	0, 3
658.4	Infection of amniotic cavity	0, 3
658.8	Other	0, 3
658.9	Unspecified	0, 3

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(2) Observation time requirements.

(a) Observation time must be documented in the medical record.

(b) A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

(c) A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

(d) The number of units reported with HCPCS code G0378 must equal or exceed 8 hours for observation stays with diagnoses of chest pain, asthma or congestive heart failure and a minimum of 4 hours for maternity observations services.

(3) Additional hospital services provided before, during and after receiving observation care.

(a) The hospital must provide on the same day or the day before and report on the same claim for asthma, chest pain and congestive heart failure:

1 An emergency department visit (APC 0310, 0611, or 0612); or

2 A clinic visit (APC 0600, 0601, or 0602); or

3 Critical care (APC 0620); or

4 Direct admission to observation services using HCPCS code G0379 (APC 0600).

NOTE: The above criteria does not apply to maternity observation stays.

(b) No procedure with a "T" status indicator can be reported on the same day or day before observation care is provided.

(4) Ongoing physician evaluation.

(a) The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

(b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

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e. Additional billing requirements.

(1) Separate payment for observation stays that meet the required conditions are only allowed when billed as a 013X bill type.

(2) Observation stays that qualify for separate payment will be reimbursed one observation APC for each qualifying occurrence.

(3) If the period of observation spans more than one calendar day, hospitals should include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation.

(4) If there are multiple maternity observation stays on the same day without condition code G0 or 27 to indicate that the visits were distinct and independent of each other, pay for the first listed observation stay and deny the rest; i.e., line item denial for all subsequent observation stays listed on that particular day.

(5) Do not allow separate payment for any hours a beneficiary spends in observation over 24 hours; all costs beyond 24 hours will be included in the APC payment for observation services.

(6) The previous requirement for specific diagnostic testing for coverage/reimbursement of observation stays was removed. Instead clinical judgement, in combination with an internal and external quality review process, will be relied upon to ensure that appropriate diagnostic testing (which is expected to include some of the previously required diagnostic tests) is provided for patients receiving high quality medically necessary observation care.

(7) Medical review is no longer required for observation stays longer than 24 hours.

(8) All other observation stays (i.e., observation stays that do not meet the criteria/requirements for separate payment under HCPCS Code G0378) will be packaged under the primary procedure.

l. Inpatient Only Procedures.

1. The inpatient list on TMA's OPPS web site at <http://www.tricare.mil/opps> specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

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2. The following criteria are used when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under OPPS:

a. Most outpatient departments are equipped to provide the services to the Medicare population.

b. The simplest procedure described by the code may be performed in most outpatient departments.

c. The procedure is related to codes that we have already removed from the inpatient list.

d. It has been determined that the procedure is being performed in multiple hospitals on an outpatient basis.

3. Under the hospital outpatient PPS, payment will not be made for procedures that are designated as "inpatient only". Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for a list of "inpatient only" procedures.

4. The list will be updated in response to comments as often as quarterly to reflect current advances in medical practice.

5. On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient.

a. Hospitals are instructed to submit an outpatient claim for all services furnished, including the procedure code with status indicator "C" to which a newly designated modifier (-CA) is attached.

b. Such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth) and administration of intravenous fluids and medication prior to the surgical procedure.

c. Because these combined services constitute an episode of care, claims will be paid with a procedure code on the inpatient list that is billed with the new modifier under new technology APC 0375 (Ancillary Outpatient Services when Patient expires). Separate payment will not be allowed for other services furnished on the same date.

d. The -CA modifier is not to be used to bill for a procedure with status indicator "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

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J. APC For Vaginal Hysterectomy.

When billing for vaginal hysterectomies, hospitals must use procedure code 58260, which will be assigned to APC 0202.

K. Billing of Condition Codes Under OPPS.

The CMS 1450 UB-04 claim form allows 11 values for condition codes, however, the OCE can only accommodate seven, therefore, OPPS hospitals should list those condition codes that affect outpatient pricing first.

- END -

PROSPECTIVE PAYMENT METHODOLOGY

ISSUE DATE: July 27, 2005

AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

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 **TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

To describe the payment methodology for hospital outpatient services.

III. POLICY

A. Basic Methodology for Determining Prospective Payment Rates for Outpatient Services.

1. Setting of Payment Rates.

The prospective payment rate for each **Ambulatory Payment Classification (APC)** is calculated by multiplying the APC's relative weight by the conversion factor.

2. Recalibration of Group Weights and Conversion Factor.

a. Relative Weights for Services Furnished on a Calendar Year (CY) basis.

(1) The most recent Medicare claims and facility cost report data are used in recalibrating the relative APC weights for services furnished on a CY basis.

(2) Weights are derived based on median hospital costs for services in the hospital outpatient APC groups. Billed charges are converted to costs and aggregated to the procedure or visit level. Calculation of the median hospital cost per APC group include the following steps:

(a) The statewide **Cost-to-Charge Ratio (CCR)** is identified for each hospital's cost center ("statewide CCRs").

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(b) The statewide CCRs are then crosswalked to revenue centers. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education.

(c) A cost is calculated for every billed line item charged on each claim by multiplying each revenue center charge by the appropriate statewide CCR.

(d) Revenue center changes that contain items integral to performing the procedure or visit are used to calculate the per-procedure or per-visit costs. Following is a list of revenue centers whose charges could be packaged into major **Healthcare Common Procedure Coding System (HCPCS)** codes when appearing in the same claim.

FIGURE 13-3-1 LIST OF REVENUE CENTERS PACKAGED INTO MAJOR HCPCS CODES WHEN APPEARING IN THE SAME CLAIM

REVENUE CODE	DESCRIPTION
0250	Pharmacy, Drugs Requiring Specific Identification, General Class
0251	Generic
0252	Nongeneric
0253	Take Home Drugs
0254	Pharmacy Incident to Other Diagnostic
0255	Pharmacy Incident to Radiology
0257	Nonprescription Drugs
0258	IV Solutions
0259	Other Pharmacy
0260	IV Therapy, General Class
0262	IV Therapy/Pharmacy Services
0263	Supply/Delivery
0264	IV Therapy/Supplies
0269	Other IV Therapy
0270	M&S Supplies
0271	Nonsterile Supplies
0272	Sterile Supplies
0273	Take Home supplies
0275	Pacemaker Drug
0276	Intraocular Lens Source Drug
0277	Oxygen Take Home
0278	Other Implants
0279	Other M&S Supplies

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FIGURE 13-3-1 LIST OF REVENUE CENTERS PACKAGED INTO MAJOR HCPCS CODES WHEN APPEARING IN THE SAME CLAIM (CONTINUED)

REVENUE CODE	DESCRIPTION
0280	Oncology
0289	Other Oncology
0370	General Classification
0371	Anesthesia Incident to Radiology
0372	Anesthesia Incident to Other Diagnostic Services
0374	Acupuncture
0379	Other Anesthesia
0390	Blood Storage and Processing
0391	Blood Administration (e.g., transfusions)
0399	Other Blood Storage and Processing
0621	Supplies Incident to Radiology
0622	Supplies Incident to Other Diagnostic
0623	Surgical Dressings
0624	Investigational Device (IDE)
0631	Single Source
0632	Multiple
0633	Restrictive Prescription
0637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
0700	Cast Room
0709	Other Cast Room
0710	Recovery Room
0719	Other Recovery Room
0720	Labor Room
0721	Labor
0762	Observation Room
0770	General Classification
0771	Vaccine Administration

1 Some instructions have been issued that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenue codes that must be used when billing for devices that qualify for pass-through payments.

NOTE: If the revenue code is not listed above, refer to the TRICARE Systems Manual (TSM), [Chapter 2, Addendum O](#), for reporting requirements.

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2 Where specific instructions have not been issued, contractors should advise hospitals to report charges under the revenue code that would result in the charges being assigned to the same cost center to which the cost of those services were assigned in the cost report.

EXAMPLE: Operating room, treatment room, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organ charges were used in calculating surgical procedure costs. The charges for items such as medical and surgical supplies, drugs and observation were used in estimating medical visit costs.

(e) Costs are standardized for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the current hospital Inpatient Prospective Payment System (IPPS) wage index. 60% is used to represent the estimated portion of costs attributable, on average, to labor.

(f) Standardized labor related cost and the nonlabor-related cost component for each billed item are summed to derive the total standardized cost for each procedure or medical visit.

(g) Each procedure or visit cost is mapped to its assigned APC.

(h) The median cost is calculated for each APC.

(i) Relative payment weights are calculated for each APC, by dividing the median cost of each APC by the median cost for APC 00601 (mid-level clinic visit), Outpatient Prospective Payment System (OPPS) weights are listed on TMA's OPSS web site at <http://www.tricare.mil/opps>.

(j) These relative payment weights may be further adjusted for budget neutrality based on a comparison of aggregate payments using previous and current CY weights.

b. Conversion Factor Update.

(1) The conversion factor is updated annually by the hospital inpatient market basket percentage increase applicable to hospital discharges.

(2) The conversion factor is also subject to adjustments for wage index budget neutrality, differences in estimated pass-through payments, and outlier payments.

3. Payment Status Indicators (SIs).

A payment SI is provided for every code in the HCPCS to identify how the service

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or procedure described by the code would be paid under the hospital OPPS; i.e., it indicates if a service represented by a HCPCS code is payable under the OPPS or another payment system, and also which particular OPPS payment policies apply. One, and only one, SI is assigned to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same SI as the APC to which it is assigned. The following are the payment SIs and descriptions of the particular services each indicator identifies:

d. "A" to indicate services that are paid under some payment method other than OPPS, such as the **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)** fee schedule, or **CHAMPUS Maximum Allowable Charge (CMAC)** reimbursement methodology for physicians.

b. "B" to indicate more appropriate code required for TRICARE OPPS.

c. "C" to indicate inpatient services that are not paid under the OPPS.

d. "E" to indicate items or services are not covered by TRICARE.

e. "F" to indicate acquisition of corneal tissue, which is paid on an allowable charge basis (i.e., paid based on the CMAC reimbursement system or statewide prevalings) and certain **Certified Registered Nurse Anesthetist (CRNA)** services and hepatitis B vaccines that are paid on an allowable charge basis.

f. "G" to indicate drug/biological pass-through that are paid in separate APCs under the OPPS.

g. "H" to indicate pass-through device categories, brachytherapy sources, and radiopharmaceutical agents allowed on a cost basis.

h. "K" to indicate non-pass-through drugs and biologicals and blood and blood products that are paid in separate APCs under the OPPS.

i. "N" to indicate services that are incidental, with payment packaged into another service or APC group.

j. "P" to indicate services that are paid only in **Partial Hospitalization Programs (PHPs)**.

k. "Q" to indicate packaged services subject to separate payment under OPPS.

NOTE: HCPCS codes with SI "Q" are either separately payable or packaged depending on the specific circumstances of their billing. **Outpatient Code Editor (OCE)** claims processing logic will be applied to codes assigned SI "Q" in order to determine if the service will be packaged or separately payable.

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l. "S" to indicate significant procedures for which payment is allowed under the hospital OPPS, but to which the multiple procedure reduction does not apply.

m. "T" to indicate surgical services for which payment is allowed under the hospital OPPS. Services with this payment indicator are the only services to which the multiple procedure payment reduction applies.

n. "V" to indicate medical visits (including clinic or emergency department visits) for which payment is allowed under the hospital OPPS.

o. "W" to indicate invalid HCPCS or invalid revenue code with blank HCPCS.

p. "X" to indicate an ancillary service for which payment is allowed under the hospital OPPS.

q. "Z" to indicate valid revenue code with blank HCPCS and no other SI assigned.

NOTE: The system payment logic looks to the SIs attached to the HCPCS codes and APCs for direction in the processing of the claim. A SI, as well as an APC, must be assigned so that payment can be made for the service identified by the new code. The SIs identified for each HCPCS code and each APC listed on TMA's OPPS web site at <http://www.tricare.mil/opps>.

4. Calculating TRICARE Payment Amount.

a. The national APC payment rate that is calculated for each APC group is the basis for determining the total payment (subject to wage-index adjustment) the hospital will receive from the beneficiary and the TRICARE program. (Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for national APC payment rates.)

b. The TRICARE payment amount takes into account the wage index adjustment and beneficiary deductible and cost-share/copayment amounts.

c. The TRICARE payment amount calculated for an APC group applies to all the services that are classified within that APC group.

d. The TRICARE payment amount for a specific service classified within an APC group under the OPPS is calculated as follows:

(1) Apply the appropriate wage index adjustment to the national payment rate that is set annually for each APC group. (Refer to the Provider File with Wage Indexes on TMA's OPPS home page at <http://www.tricare.mil/opps> for annual **Diagnostic Related Group (DRG)** wage indexes used in the payment of hospital outpatient claims, effective January 1 of each year.)

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(2) Multiply the wage adjusted APC payment rate by the OPPS rural adjustment (1.071) if the provider is a Sole Community Hospital (SCH) in a rural area.

(3) Determine any outlier amounts and add them to the sum of either (1) or (2) above.

(4) Subtract from the adjusted APC payment rate the amount of any applicable deductible and/or cost-sharing/copayment amounts based on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). Refer to Chapter 2, Addendum A for applicable deductible and/or cost-sharing/copayment amounts for Outpatient Hospital Departments and Ambulatory Surgery Centers (ASCs).

e. Examples of TRICARE payments under OPPS based on eligibility status of beneficiary at the time the services were rendered:

(1) Example #1. Assume that the wage adjusted rate for an APC is \$400; the beneficiary receiving the services is an active duty family member enrolled under Prime, and as such, is not subject to any deductibles or copayments.

(a) Adjusted APC payment rate: \$400.

(b) Subtract any applicable deductible:

$$\$400 - \$0 = \$400$$

(c) Subtract the Prime active duty family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$$\$400 - \$0 = \$400 \text{ TRICARE final payment}$$

(d) TRICARE would pay 100% of the adjusted APC payment rate for active duty family members enrolled in Prime.

(2) Example #2. Assume that the wage adjusted rate for an APC is \$400 and the beneficiary receiving the outpatient services is a Prime retiree family member subject to a \$12 copayment. Deductibles are not applied under the Prime program.

(a) Adjusted APC payment rate: \$400.

(b) Subtract any applicable deductible:

$$\$400 - \$0 = \$400$$

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(c) Subtract the Prime retiree family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$$\$400 - \$12 = \$388 \text{ TRICARE final payment}$$

(d) In this case, the beneficiary pays zero (\$0) deductible and a \$12 copayment, and the program pays \$388 (i.e., the difference between the adjusted APC payment rate and the Prime retiree family member copayment).

(3) Example #3. This example illustrates a case in which both an outpatient deductible and cost-share are applied. Assume that the wage-adjusted payment rate for an APC is \$400 and the beneficiary receiving the outpatient services is a standard active duty family member subject to an individual \$50 deductible (active duty sponsor is an E3) and 20% cost-share.

(a) Adjusted APC payment rate: \$400.

(b) Subtract any applicable deductible:

$$\$400 - \$50 = \$350$$

(c) Subtract the standard active duty family member cost-share (i.e., 20% of the allowable charge) from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$$\$350 \times .20 = \$70 \text{ cost-share}$$

$$\$350 - \$70 = \$280 \text{ TRICARE final payment}$$

(d) In this case, the beneficiary pays a deductible of \$50 and a \$70 cost-share, and the program pays \$280, for total payment to the hospital of \$400.

5. Adjustments to APC Payment Amounts.

a. Adjustment for Area Wage Differences.

(1) A wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and labor-related costs across geographical regions with the exception of APCs with SIs "K" and "G". The hospital DRG wage index will be used given the inseparable, subordinate status of the outpatient department within the hospital.

(2) The OPPS will use the same wage index changes as the TRICARE-DRG based payment system, except the effective date for the changes will be January 1 of each year instead of October 1 (refer to the Provider File with Wage Indexes on TMA's OPPS home

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page at <http://www.tricare.mil/opps>. This way only one wage index file will have to be maintained for both the OPPS and DRG-based payment system.

(3) Sixty percent (60%) of the hospital's outpatient department costs are recognized as labor-related costs that would be standardized for geographic wage differences. This is a reasonable estimate of outpatient costs attributable to labor, as it fell between the hospital DRG operating cost labor factor of 71.1% and the ASC labor factor of 34.45%, and is close to the labor-related costs under the inpatient DRG payment system attributed directly to wages, salaries and employee benefits (61.4%).

(4) Steps in Applying Wage Adjusts under OPPS.

(a) Calculate 60% (the labor-related portion) of the national unadjusted payment rate that represents the portion of costs attributable, on average, to labor.

(b) Determine the wage index in which the hospital is located and identify the wage index level that applies to the specific hospital.

(c) Multiply the applicable wage index determined under (b) and (c) by the amount under (a) that represents the labor-related portion of the national unadjusted payment rate.

(d) Calculate 40% (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product in (c). The result is the wage index adjusted payment rate for the relevant wage index area.

(e) If a provider is a SCH in a rural area, or is treated as being in a rural area, multiply the wage adjusted payment rate by 1.071 to calculate the total payment before applying the deductible and copayment/cost-sharing amounts.

(f) Applicable deductible and copayment/cost-sharing amounts would then be subtracted from the wage-adjusted APC payment rate, and the remainder would be the TRICARE payment amount for the services or procedure.

EXAMPLE: A surgical procedure with an APC payment rate of \$300 is performed in the outpatient department of a hospital located in Heartland, USA. The cost-sharing amount for the standard active duty family member is \$60.80 (i.e., 20% of the wage-adjusted APC amount for the procedure). The hospital inpatient DRG wage index value for hospitals located in Heartland, USA, is 1.0234. The labor-related portion of the payment rate is \$180 ($\$300 \times 60\%$), and the nonlabor-related portion of the payment rate is \$120 ($\$300 \times 40\%$). It is assumed that the beneficiary deductible has been met.

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NOTE: Units billed x APC x 60% (labor portion) x wage index (hospital specific) + APC x 40% (nonlabor portion) = adjusted payment rate.

1 Wage-Adjusted Payment Rate (rounded to nearest cent):

$$= (\$180 \times 1.0234) = \$184.21 + \$120 = \$304.21$$

2 Cost-share for standard retiree family member (rounded to nearest cent):

$$= (\$304.21 \times .20) = \$60.84$$

3 Subtract the standard retiree family member cost-share from the wage-adjusted rate to get the final TRICARE payment

$$= (\$304.21 - \$60.84) = \$243.37$$

b. Discounting of Surgical and Terminating Procedures.

(1) OPPS payment amounts are discounted when more than one procedure is performed during a single operative session or when a surgical procedure is terminated prior to completion. Refer to [Chapter 1, Section 16](#) for additional guidelines on discounting of surgical procedures.

(a) Line items with a SI of "T" are subject to multiple procedure discounting unless modifiers 76, 77, 78 and/or 79 are present.

(b) When more than one procedure with payment SI "T" is performed during a single operative session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate.

(c) Fifty percent (50%) of the usual PPS payment amount and beneficiary copayment/cost-share amount would be paid for all other procedures performed during the same operative session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

1 The reduced payment would apply only to the surgical procedure with the lower payment rate.

2 The reduced payment for multiple procedures would apply to both the beneficiary copayment/cost-share and the TRICARE payment.

(2) Hospitals are required to use modifiers on bills to indicate procedures that are terminated before completion.

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(a) Fifty percent (50%) of the usual OPPS payment amount and beneficiary copayment/cost-share will be paid for a procedure terminated before anesthesia is induced.

1 Modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) would identify a procedure that is terminated after the patient has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but before anesthesia is induced (for example, local, regional block(s), or general anesthesia).

2 Modifier -52 (Reduced Services) would be used to indicate a procedure that did not require anesthesia, but was terminated after the patient had been prepared for the procedure, including sedation when provided, and taken to the room where the procedure is to be performed.

(b) Full payment will be received for a procedure that was started but discontinued after the induction of anesthesia, or after the procedure was started.

1 Modifier -74 (Discontinued Procedure) would be used to indicate that a surgical procedure was started but discontinued after the induction of anesthesia (for example, local, regional block, or general anesthesia), or after the procedure was started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient.

2 This payment would recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room of the hospital.

c. Discounting for Bilateral Procedures.

(1) Following are the different categories/classifications of bilateral procedure:

(a) Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

(b) Inherent bilateral (i.e., procedure in and of itself is bilateral).

(c) Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures)).

(2) Terminated bilateral procedures or terminated procedures with units greater than one should not occur, and for type "T" procedures, have the discounting factor set so as to result in the equivalent of a single procedure. Line items with terminated bilateral procedures or terminated procedure with units greater than one are denied.

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(3) For non-type "T" procedures there is no multiple procedure discounting and no bilateral procedure discounting with modifier 50 performed. Line items with SI other than "T" are subject to terminated procedure discounting when modifier 52 or 73 is present. Modifier 52 or 73 on a non-type "T" procedure line will result in a 50% discount being applied to that line.

(4) The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

(5) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

(6) Following are the different discount formulas that can be applied to a line item:

FIGURE 13-3-2 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES

DISCOUNTING FORMULA NUMBER	FORMULAS
1	1.0
2	$(1.0 + D (U - 1))/U$
3	T/U
4	$(1 + D)/U$
5	D
6	TD/U
7	$D (1 + D)/U$
8	2.0

Where:

D = discounting fraction (currently 0.5)

U = number of units

T = terminated procedure discount (currently 0.5)

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(7) The following figure summarizes the application of above discounting formulas:

FIGURE 13-3-3 APPLICATION OF DISCOUNTING FORMULAS

			DISCOUNTING FORMULA NUMBER			
			TYPE "T" PROCEDURE		NON TYPE "T" PROCEDURE	
PAYMENT AMOUNT	MODIFIER 73	MODIFIER 50	CONDITIONAL OR INDEPENDENT BILATERAL	INHERENT OR NON-BILATERAL	CONDITIONAL OR INDEPENDENT BILATERAL	INHERENT OR NON-BILATERAL
Highest	No	No	2	2	1	1
Highest	Yes	No	3	3	3	3
Highest	No	Yes	4	2	8	1
Highest	Yes	Yes	3	3	3	3
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	6	6	3	3
Not Highest	No	Yes	7	5	8	1
Not Highest	Yes	Yes	6	6	3	3

NOTE: For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) will be applied prior to selecting the type "T" procedure with the highest payment amount.

d. Outlier Payments.

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage adjusted APC rate. Only line item services with SIs "P", "S", "T", "V", or "X" will be eligible for outlier payment under OPSS. No outlier payments will be calculated for line item services with SIs "G", "H", "K", "N", and "K", with the exception of blood and blood products.

(1) Outlier payments will be calculated on a service-by-service basis. Calculating outliers on a service-by-service basis was found to be the most appropriate way to calculate outliers for outpatient services. Outliers on a bill basis requires both the aggregation of costs and the aggregation of OPSS payments, thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in no outlier payment being made. While service-based outliers are somewhat more complex to administer, under this method, outlier payments will be more appropriately directed to those specific services for which a hospital incurs significantly increased costs.

(2) Outlier payments are intended to ensure beneficiary access to services by having the TRICARE program share the financial loss incurred by a provider associated with individual, extraordinarily expensive cases.

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(3) Outlier thresholds are established on a CY basis which requires that a hospital's cost for a service exceed the wage adjusted APC payment rate for that service by a specified multiple of the wage adjusted APC payment rate and the sum of the wage adjusted APC rate plus a fixed dollar threshold in order to receive an additional outlier payment. When the cost of a hospital outpatient service exceeds both of these thresholds a predetermined percentage of the amount by which the cost of furnishing the services exceeds the multiple APC threshold will be paid as an outlier.

EXAMPLE: Following are the steps involved in determining if services on a claim qualify for outlier payments using the appropriate CY multiple and fixed dollar thresholds.

STEP 1: Identify all APCs on the claim.

STEP 2: Determine the ratio of each wage adjusted APC payment to the total payment of the claim (assume for this example a wage index of 1.0000).

HCPCS CODE	SI	APC	SERVICE	WAGE ADJUSTED APC PAYMENT RATE	RATIO OF APC TO TOTAL PAYMENT
99284	V	0612	High-level emergency visit	\$224.78	0.4471988
70481	S	0283	CT scan with contrast material	\$255.43	0.5081768
93041	S	0099	EKG	\$22.43	0.0446244

STEP 3: Identify billed charges of packaged items that need to be allocated to an APC.

REVENUE CODE	OPPS SERVICE OR SUPPLY	TOTAL CHARGES
0250	Pharmacy	\$2,986.50
0270	Medical Supplies	\$3,957.80
0350	CT scan	\$3,514.00
0450	ER	\$2,597.00
0730	EKG	\$237.00

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STEP 4: Allocate the billed charges of the packaged items identified in Step #3 to their respective wage adjusted APCs based on their percentages to total payment calculated in Step #2.

APC	RATIO ALLOCATION	OPPS SERVICE	250 (PHARMACY)	270 (MEDICAL SUPPLIES)
0612	0.4471988	High-level emergency visit	\$1,335.56	\$1,769.92
0283	0.5081768	CT scan with contrast material	\$1,517.67	\$2,011.26
0099	0.0446244	EKG	\$133.27	\$176.61

STEP 5: Calculate the total charges for each OPPS service (APC) and reduce them to costs by applying the statewide CCR. Statewide CCRs are based on the geographical CBSA (2 digit = rural, 5 digit = urban). Assume that the outpatient CCR is 31.4%.

APC	OPPS SERVICE	TOTAL CHARGES	TOTAL CHARGES REDUCED TO COSTS (CCR = 0.3140)
0612	High-level emergency visit	\$5,702.48	\$1,790.58
0283	CT scan with contrast material	\$7,042.93	\$2,211.48
0099	EKG	\$546.88	\$171.72

STEP 6: Apply the cost test to each wage adjusted APC service or procedure to determine if it qualifies for an outlier payment. If the cost of a service (wage adjusted APC) exceeds both the APC multiplier threshold (1.75 times the wage adjusted APC payment rate) and the fixed dollar threshold (wage adjusted APC rate plus \$1,250), multiply the costs in excess of the wage adjusted APC multiplier by 50% to get the additional outlier payment.

APC	WAGE ADJUSTED APC RATE	COSTS	FIXED DOLLAR THRESHOLD (WAGE ADJUSTED APC RATE + \$1,250)	MULTIPLIER THRESHOLD (1.75 x WAGE INDEX APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF WAGE ADJUSTED APC - (1.75 x WAGE ADJUSTED APC RATE) x 0.50
0612	\$224.78	\$1,790.58	\$1,474.78	\$393.37	\$1,397.21	\$698.61
0283	\$255.43	\$2,211.48	\$1,505.43	\$447.00	\$1,764.48	\$882.24
0099	\$22.43	\$171.72	\$1,272.43	\$39.25	\$132.47	-0-**

** Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + \$1,250).

The total outlier payment on the claim was: \$1,580.85.

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e. Rural SCH payments will be increased by 7.1%. This adjustment will apply to all services and procedures paid under the OPPS (SIs "P", "S", "T", "V", and "X"), excluding drugs, biologicals and services paid under the pass-through payment policy (SIs "G", "H", and "K").

(1) The adjustment amount will not be reestablished on an annual basis, but may be reviewed in the future, and if appropriate, may be revised.

(2) The adjustment is budget neutral and will be applied before calculating outliers and copayments/cost-sharing.

B. Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals.

1. Items Subject to Transitional Pass-Through Payments.

a. Current Orphan Drugs.

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

NOTE: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

b. Current Cancer Therapy Drugs, Biologicals and Brachytherapy.

These items are drugs or biologicals that are used in cancer therapy, including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, biphosphonates, and a device of brachytherapy if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

c. Current Radiopharmaceutical Drugs and Biological Products.

A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

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d. New Medical Devices, Drugs, and Biologicals.

New medical devices, drugs, and biologic agents, will be subject to transitional pass-through payment in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPPS payment amount.

2. Items eligible for transitional pass-through payments are generally coded under a Level II HCPCS code with an alpha prefix of "C".

a. Pass-through device categories are identified by SI "H".

b. Pass-through drugs and biological agents are identified by SI "G".

3. Payment of Pass-Through Drugs and Biologicals.

a. Pass-through drugs and biologicals, will be paid a rate equivalent to what would be received in a physician's office setting; i.e., the ASP methodology established under the Medicare physician fee schedule. Following is the applicable payment methodology for transitional pass-through drugs or biologicals:

(1) Calculation of ASP.

(a) The ASP for both multiple and sole source drug products included within the same billing payment code (or HCPCS code) is the volume-weighted average of the manufacturer's ASPs reported across all the National Drug Codes (NDCs) assigned to the HCPCS determined by:

1 Computing the sum of the products (for each National Code assigned to those drug products) of the manufacturer's ASP and the total number of units sold; and

2 Dividing the sum by the sum of the total number of units sold for all NDCs assigned to those drug products.

(b) The ASP is determined without regard to any special packaging, labeling, or identifiers on the dosage form, product or package.

(2) Payment Allowances for Single and Multiple Source Drugs.

(a) Single Source Drugs.

The payment allowance for a single source drug HCPCS code will be equal to the lesser of 106% of the ASP for the HCPCS code or 106% of the wholesale acquisition cost of the HCPCS code, subject to applicable deductible and copayment/cost-sharing and limitations related to widely available market prices and average manufacturer

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prices in the Medicaid drug rebate program. The payment limit may also be adjusted in response to public emergency.

(b) Multiple Source Drugs.

The payment allowance for a multiple source drug included within the same HCPCS code will be equal to 106% of the ASP for the HCPCS code subject to applicable deductible and copayment/cost-sharing, along with the same payment limitations/adjustments as described under the single source drug payment allowance outlined above.

b. Beneficiary copayments/cost-sharing will be based on the entire ASP of the transition pass-through drug or biological.

4. Transitional Pass-Through Device Categories.

a. Excluded Medical Devices.

Equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes that are not implanted or incorporated into a body part, and that are used on more than one patient (that is, are reusable), are excluded from pass-through payment. This material is generally considered to be a part of hospital overhead costs reflected in the APC payments.

b. Included Medical Devices.

(1) The following implantable items may be considered for the transitional pass-through payments:

(a) Prosthetic implants (other than dental) that replace all or part of an internal body organ.

(b) Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

NOTE: Any **Durable Medical Equipment (DME)**, orthotics, and prosthetic devices for which transitional pass-through payment does not apply will be paid under the DMEPOS fee schedule when the hospital is acting as the supplier (paid outside the PPS).

c. Pass-Through Payment Criteria for Devices.

Pass-through payments will be made for new or innovative medical devices that meet the following requirements:

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(1) They were not recognized for payment as a hospital outpatient service prior to 1997 (i.e., payment was not being made as of December 31, 1996). However, the medical device shall be treated as meeting the time constraint (i.e., payment was not being made for the device as of December 31, 1996) if either:

(a) The device is described by one of the initial categories established and in effect, or

(b) The device is described by one of the additional categories established and in effect, and

1 An application under the Federal Food, Drug, and Cosmetic Act has been approved; or

2 The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or

3 The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of the Act.

(2) They have been approved/cleared for use by the Food and Drug Administration (FDA).

(3) They are determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

(4) They are an integral and subordinate part of the procedure performed, are used for one patient only, are surgically implanted or inserted via a natural or surgically created orifice on incision, and remain with that patient after the patient is released from the hospital outpatient department.

(a) Reprocessed single-use devices that are otherwise eligible for pass-through payment will be considered for payment if they meet FDA's most recent regulatory criteria on single-use devices.

(b) It is expected that hospital charges on claims submitted for pass-through payment for reprocessed single-use devices will reflect the lower cost of these devices.

NOTE: The FDA published guidance for the processing of single-use devices on August 14, 2000 - "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals".

(5) They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets.

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(6) They are not materials and supplies such as sutures, clips, or customized surgical kits furnished incidental to a service or procedure.

(7) They are not material such as biologicals or synthetics that may be used to replace human skin.

(8) No existing or previously existing device category is appropriate for the device.

(9) The associated cost is not insignificant in relation to the APC payment for the service in which the innovative medical equipment is packaged.

(10) The new device category must demonstrate that utilization of its devices provide substantial clinical improvement for beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories.

d. Duration of Transitional Pass-Through Payments.

(1) The duration of transitional pass-through payments for devices is for at least 2, but not more than 3 years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category.

(2) The costs of devices no longer eligible for pass-through payments will be packaged into the costs of the procedures with which they are normally billed.

e. General Coding and Billing Instructions and Explanations.

(1) Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-Through Devices Only):

(a) In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices - the device that resulted in fracture and the one that was implanted into the patient.

(b) It is realized that there may be instances where an implant is tried but later removed due to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (e.g., physician implants an anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve a desirable result). In such instances, separate reimbursement will be provided for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

NOTE: This applies to transitional pass-through devices only and not to devices packaged into an APC.

(2) Kits - Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, codes for such kits have not been established. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payment, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

(3) Multiple units - Hospitals must bill for multiple units of items that qualify for transitional pass-through payments, when such items are used with a single procedure, by entering the number of units used on the bill.

(4) Reprocessed devices - Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with the enforcement guidance of the FDA relating to the reprocessing of devices applicable at the time the service is delivered.

f. Calculation of Transitional Pass-Through Payment for a Pass-Through Device.

(1) Device pass-through payment is calculated by applying the statewide CCR to the hospital's charges on the claim and subtracting any appropriate pass-through offset. Statewide CCRs are based on the geographical CBSA (2 digit = rural, 5 digit = urban).

(2) The following are two examples of the device pass-through calculations, one incorporating a device offset amount applicable to CY 2003 and the other only applying the CCR (offsets set to \$0 for CY 2005).

(3) The offset adjustment is applied only when a pass-through device is billed in addition to the APC¹.

Example #1 Transitional Pass-Through Payment Calculation with Offset:

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,200.00

Associated procedure: HCPCS Level I¹ code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard active duty family member who has met his/her yearly deductible)

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Total offset amount to be applied for each APC that contains device costs = \$802.06

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph III.B.4.f.\(4\)](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$$\$1,200 - \$802.06 = \$397.94$$

TRICARE program payment (before wage index adjustment) for APC 0083:

$$\$3,289.42 - \$657.88 = \$2,631.54$$

TRICARE payment for pass-through device C1884 = \$397.94

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54	TRICARE program payment for HCPCS Level I ¹ code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I ¹ code 92982
<u>397.94</u>	Transitional pass-through payment for device
\$3,687.36	Total amount received by the provider

Example #2 Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,500.00

Associated procedure: HCPCS Level I² code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard active duty family member who has met his/her yearly deductible)

Total offset amount to be applied for each APC that contains device costs = \$0.

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph III.B.4.f.\(4\)](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

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$$\$1,500 - \$0 = \$1,500$$

TRICARE program payment (before wage index adjustment) for APC 0083:

$$\$3,289.42 - \$657.88 = \$2,631.54$$

TRICARE payment for pass-through device C1884 = \$1,500

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54	TRICARE program payment for HCPCS Level I ² code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I ² code 92982
<u>1,500.00</u>	Transitional pass-through payment for device
\$4,789.42	Total amount received by the provider

NOTE: Transitional payments for devices (SI=H) are not subject to beneficiary cost-sharing/copayments.

(4) Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

STEP 1: For each APC with an offset multiply the offset by the discount percent (whether it is 50%, 75%, 100% or 200%) and the units of service.

$$(\text{Offset} \times \text{Discount Rate} \times \text{Units of Service})$$

STEP 2: Sum the products of Step 1.

STEP 3: Wage adjust the sum of the products calculated in Step 2.

$$(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) + \text{Step 2 Amount} \times \text{Nonlabor \%}$$

STEP 4: If the units of service from the procedures with offsets are greater than the device units of service, then Step 3 is adjusted by device units divided by procedure offset units.

$$[(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) + (\text{Step 2 Amount} \times \text{Nonlabor \%}) \times (\text{Device Units} \div \text{Offset Procedure Units})]$$

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otherwise

$(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) \text{ Step 2 Amount} \times \text{Non-Labor \%}$

EXAMPLE: If there are 2 procedures with offsets but only 1 device, then the final offset is reduced by 50%.

STEP 5: If there is only one line item with a device, then the amount calculated in Step 4 is subtracted from the line item charge adjusted to cost.

$[\text{Step 4 Amount} - (\text{Line Item Charge} \times \text{State CCR})]$

If there are multiple devices, then the amount from Step 4 is allocated to the line items with devices based on their charges.

$(\text{Line Item Device Charge} \div \text{Sum of Device Charges})$

C. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status.

1. Radiopharmaceuticals, drugs, and biologicals which do not have pass-through status, are paid in one of three ways:

- a. Packaged payment, or
- b. Separate payment (individual APCs), or
- c. Allowable charge.

2. The cost of drugs and radiopharmaceuticals are generally packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished:

a. Hospitals do not receive separate payment for packaged items and supplies; and

b. Hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or services.

3. Although diagnostic and therapeutic radiopharmaceutical agents are not classified as drugs or biologicals, separate payment has been established for them under the same packaging threshold policy that is applied to drugs and biologicals; i.e., the same adjustments will be applied to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

D. Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals.

1. Generally, the cost of drugs and radiopharmaceuticals are packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished. However, packaging for certain drugs and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

2. Payments for drugs and radiopharmaceuticals are packaged into the APCs with which they are billed if the median cost per day for the drug or radiopharmaceutical is less than \$50. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds \$50.

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics.

4. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged.

a. "Specified Covered Outpatient Drugs" Classification

(1) Special classification (i.e., "specified covered outpatient drug") is required for certain separately payable radiopharmaceutical agents and drugs or biologicals for which there are specifically mandated payments.

(2) A "specified covered outpatient drug" is a covered outpatient drug for which a separate APC exists and that is either a radiopharmaceutical agent or drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

(3) The following drugs and biologicals are designated exceptions to the "specified covered outpatient drugs" definition (i.e., not included within the designated category classification):

(a) A drug or biological for which payment was first made on or after January 1, 2003, under the transitional pass-through payment provision.

(b) A drug or biological for which a temporary HCPC code has been assigned.

(c) Orphan drugs.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

b. Payment of Specified Outpatient Drugs, Biological and Radiopharmaceuticals.

(1) Specified outpatient drugs and biologicals will be paid a combined rate of the ASP plus 6% which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS.

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. This is the best proxy for the average acquisition cost of a radiopharmaceutical until better alternative information/data sources become available; e.g., basing payments on mean costs derived from hospital claims or creating charge-based payment rates.

(3) The following payment methods will be employed for separately payable specified outpatient drugs, biologicals and radiopharmaceuticals whose HCPCS codes will be payable for the first time under OPPS but whose codes do not crosswalk to other HCPCS codes previously recognized under the OPPS:

(a) Payment will be based on ASP plus 6% in accordance with the ASP methodology used in the physician office setting.

(b) In the absence of ASP data, the Wholesale Acquisition Cost (WAC) will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95% of the most recent Average Wholesale Prices (AWP).

c. Designated SI.

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the SI "K" - non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

5. Payment for New Drugs and Biologicals With HCPCS Codes and Without Pass-Through Application and Reference AWP or Hospital Claims Data.

a. New drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals will be paid a rate that is equivalent to the payment they would receive in the physician office setting (i.e., the ASP plus 6%).

b. These new drugs and biologicals will be treated the same irrespective of whether pass-through status has been determined. SI "K" will be assigned to HCPCS codes for new drugs and biologicals for which pass-through applications have not been received.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

6. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Nonpass-Through Payment.

a. Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPS under Medicare, but were not eligible for pass-through status; and

(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$50 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

7. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned.

a. The following payment methodology will enable hospitals to begin billing for drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup that could qualify them for pass-through payment under the OPPS:

(1) Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."

(2) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP using Red Book or an equivalent recognized compendium, and process the claim for payment.

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with its approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPS update.

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E. Drug Administration Coding and Payment.

1. The following HCPCS Level I drug administration codes will be assigned to their respective APCs for payment:

FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	A	--
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116
¹ HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.			

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FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs (CONTINUED)

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96521	Refilling and maintenance of portable pump	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
96523	Irrigation of implanted venous access device for drug delivery systems	N	--
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	S	0116
¹ HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.			

2. Only 20 of the 33 drug administration CPT codes are being adopted for billing and payment purposes under OPPS.

3. Six new HCPCS C-codes are being used instead of the remaining 13 CPT codes not recognized under the OPPS. The following C-codes (see [Figure 13-3-5](#)) are being adopted in an effort to minimize the administrative burden of adopting all 33 drug administrative CPT codes.

a. The C-codes will permit straightforward billing of types of pushes for the first hour and then each additional hour of infusion or for each intravenous push.

b. The OCE logic will determine the appropriate payments to make for a single drug administration encounter in one day or multiple separate encounters in the same day.

FIGURE 13-3-5 OPPS DRUG ADMINISTRATION CODES

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour	S	0120
C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)	N	--
C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
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Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

FIGURE 13-3-5 OPPS DRUG ADMINISTRATION CODES (CONTINUED)

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
C8953	Chemotherapy administration, intravenous; push technique	S	0116
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour	S	0117
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)	N	--

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4. The following non-chemotherapy HCPCS codes have also been created that are similar to CPT codes for initiation of prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for services when provided to patients who require extended infusions for non-chemotherapy medications including drugs for pain (see [Figure 13-3-6](#) below).

FIGURE 13-3-6 NON-CHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120

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5. Packaged HCPCS Level I codes for drug administration should continue to be billed to ensure accurate payment in the future. These are bill changes for HCPCS Level I codes with SI = N that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

6. HCPCS Level I³ codes 90772-90774 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

7. Drugs for which the median cost per day is greater than \$50 are paid separately and are not packaged into the payment for the drug administration. Separate payment for drugs with a median cost in excess of \$50 will result in more equitable payment for both the drugs and their administration.

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Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

F. Coding and Payment Policies for Drugs and Supplies.

1. Drug Coding.

a. Drugs for which separate payment is allowed are designated by SI "K" and must be reported using the appropriate HCPCS code.

b. Drugs that are reported without a HCPCS code will be packaged under the revenue center code, under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

c. Drugs billed using revenue code 636 ("Drugs requiring detailed coding") require use of the appropriate HCPCS code, or they will be denied.

d. Reporting charges of packaged drugs is critical because packaged drug costs are used for calculating outlier payments and hospital costs for the procedure and service with which the drugs are used in the course of the annual OPPS updates.

2. Payment for the Unused Portion of a Drug.

a. Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a TRICARE patient, the provider may bill for the amount of the drug discarded, along with the amount administered.

b. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment will be made under OPPS.

EXAMPLE 1: Drug X is available only in a 100-unit size. A hospital schedules three patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen, and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

EXAMPLE 2: An appropriate hospital staff member must administer 30 units of drug X to a patient, and it is not practical to schedule another patient for the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

c. Coding for Supplies.

(1) Supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code.

(2) Charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure, or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

(3) Hospitals should report drugs that are treated as supplies because they are an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

G. Orphan Drugs.

1. Continue to use the following criteria for identifying single indication orphan drugs that are used solely for orphan conditions:

a. The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).

b. The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

2. Twelve single indication orphan drugs have currently been identified as having met these criteria.

3. Payment Methodology.

a. Pay all 12 single indication orphan drugs at the rate of 88% of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106% of ASP would exceed 95% of AWP, payment would be capped at 95% of AWP, which is the upper limit allowed for sole source specified covered outpatient drugs.

H. Vaccines.

1. Hospitals will be paid for influenza, pneumococcal pneumonia and hepatitis B vaccines based on allowable charge methodology; i.e., will be paid the CMAC rate for these vaccines.

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2. Separately payable vaccines other than influenza, pneumococcal pneumonia and hepatitis B will be paid under their own APC.

3. See [Figure 13-3-7](#) below for vaccine administration codes and SIs.

FIGURE 13-3-7 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS

HCPCS LEVEL 1 ¹ CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	X	0350
G0009	Pneumococcal vaccine administration	X	0350
G0010	Hepatitis B vaccine administration	N	--
90465	Immunization admin, under 8 yrs old, with counseling; first injection	N	--
90466	Immunization admin, under 8 yrs old, with counseling; each additional injection	N	--
90467	Immunization admin, under 8 yrs old, with counseling; first intranasal or oral	N	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	X	0353
90472	Immunization admin, each additional vaccine injections	X	0353
90473	Immunization admin, one vaccine by intranasal or oral	N	
90474	Immunization admin, each additional vaccine by intranasal or oral	N	--

¹ HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

l. Payment Policy for Radiopharmaceuticals.

Separately paid radiopharmaceuticals are classified as “specified covered outpatient drugs” subject to the following packaging and payment provisions:

1. The threshold for the establishment of separate APCs for radiopharmaceuticals is \$50.

2. A radiopharmaceutical that is covered and furnished as part of covered outpatient department services for which a HCPCS code has not been assigned will be reimbursed an amount equal to 95% of its AWP.

3. Radiopharmaceuticals will be excluded from receiving outlier payments.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

4. Applications will be accepted for pass-through status; however, in the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, payment will be set for the new radiopharmaceutical as a “specified covered outpatient drug.”

J. Blood and Blood Products.

1. Since the OPPS was first implemented, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. The APCs for these products are intended to recover the costs of the products.

2. Administrative costs for the processing and storage specific to the transfused blood product are included in the APC payment, which is based on hospitals’ charges.

3. Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I⁴ code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

4. Payment rates for blood and blood products will be determined based on median costs. Refer to [Figure 13-3-8](#) for APC assignment of blood and blood product codes.

FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9010		K	Whole blood for transfusion	0950
P9011		K	Split unit of blood	0967
P9012		K	Cryoprecipitate each unit	0952
P9016		K	RBC leukocytes reduced	0954
P9017		K	Plasma 1 donor frz w/in 8 hr	9508
P9019		K	Platelets, each unit	0957
P9020		K	Platelet rich plasma unit	0958
P9021		K	Red blood cells unit	0959
P9022		K	Washed red blood cells unit	0960
P9023		K	Frozen plasma, pooled, sd	0949
P9031		K	Platelets leukocytes reduced	1013
P9032		K	Platelets, irradiated	9500
P9033		K	Platelets leukoreduced irradiated	0968
P9034		K	Platelets, pheresis	9507

⁴ HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9035		K	Platelets pheresis leukoreduced	9501
P9036		K	Platelet pheresis irradiated	9502
P9037		K	Platelet pheresis leukoreduced irradiated	1019
P9038		K	RBC irradiated	9505
P9039		K	RBC deglycerolized	9504
P9040		K	RBC leukoreduced irradiated	0969
P9043		K	Plasma protein fract, 5%, 50 ml	0956
P9044		K	Cryoprecipitate reduced plasma	1009
P9048		K	Granulocytes, pheresis unit	9506
P9051	C1010	K	Blood, L/R, CMV-NEG	1010
P9052	C1011	K	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	K	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	K	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	K	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	K	Blood, L/R, Irradiated	1018
P9057	C1020	K	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	K	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	K	Plasma, frz within 24 hours	0955
P9060	C9503	K	Fresh frozen plasma, ea unit	9503

K. Policies Affecting Payment of New Technology Services.

1. A process was developed that recognizes new technologies that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals and brachytherapy, or current radiopharmaceutical drugs and biologicals products. This process, along with transitional pass-throughs, provides additional payment for a significant share of new technologies.

2. Special APC groups were created to accommodate payment for new technology services. In contrast to the other APC groups, the new technology APC groups did not take into account clinical aspects of the services they were to contain, but only their costs.

3. The SI "K" is used to denote the APCs for drugs, biologicals and pharmaceuticals that are paid separately from, and in addition to, the procedure or treatment with which they are associated, yet are not eligible for transitional pass-through payment.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

4. New items and services will be assigned to these new technology APCs when it is determined that they cannot appropriately be placed into existing APC groups. The new technology APC groups provide a mechanism for initiating payment at an appropriate level within a relatively short time frame.

5. As in the case of items qualifying for the transitional pass-through payment, placement in a new technology APC will be temporary. After information is gained about actual hospital costs incurred to furnish a new technology service, it will be moved to a clinically-related APC group with comparable resource costs.

6. If a new technology service cannot be moved to an existing APC because it is dissimilar clinically and with respect to resource costs from all other APCs, a separate APC will be created for such services.

7. Movement from a new technology APC to a clinically-related APC will occur as part of the annual update of APC groups.

8. The new technology APC groups have established payment rates for the APC groups based on the midpoint of ranges of possible costs; for example, the payment amount for a new technology group reflecting a range of costs from \$300 to \$500 would be set at \$400. The cost range for the groups reflects current cost distributions, and TRICARE reserves the right to modify the ranges as it gains experience under the OPPS.

9. There are two parallel series of technology APCs covering a range of costs from less than \$50 to \$6,000.

a. The two parallel sets of technology APCs are used to distinguish between those new technology services designated with a SI of "S" and those designated as "T". These APCs allow assignment to the same APC group procedures that are appropriately subject to a multiple procedure payment reduction (T) with those that should not be discounted (S).

b. Each set of technology APC groups have identical group titles and payment rates, but a different SI.

c. The new series of APC numbers allow for the narrowing of the cost bands and flexibility in creating additional bands as future needs may dictate. Following are the narrowed incremental cost bands for the two series of new technology APCs:

- (1) From \$0 to \$50 in increments of \$10.
- (2) From \$50 to \$100 in a single \$50 increment.
- (3) From \$100 through \$2,000 in intervals of \$100.
- (4) From \$2,000 through \$6,000 in intervals of \$500.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

10. Beneficiary cost-sharing/copayment amounts for items and services in the new technology APC groups are dependent on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). (Refer to [Chapter 2, Addendum A](#) for applicable deductible cost-sharing/copayment amounts for outpatient hospital services.)

11. Process and Criteria for Assignment to a New Technology APC Group.

a. Services Paid Under New Technology APCs.

(1) Limit eligibility for placement in new technology APCs to complete services and procedures.

(2) Items, material, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC.

(3) A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate), or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy).

(a) In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end.

(b) Drugs, supplies, devices, and equipment in and of themselves are not distinct procedures with a beginning, middle and end. Rather drugs, supplies, devices, and equipment are used in the performance of a procedure.

(4) Unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology.

b. Criteria for determining whether a service will be assigned to a new technology APC.

(1) The most important criterion in determining whether a technology is “truly new” and appropriate for a new APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS Level I and II codes. In other words, a “truly new” service is one that cannot be appropriately described by existing HCPCS codes, and a new HCPCS code needs to be established in order to describe the new procedure.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

(2) The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update; i.e., the item is one service that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.

(3) The service does not qualify for an additional payment under the transitional pass-through provisions.

(4) The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. It is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC.

(5) The service falls within the scope of TRICARE benefits.

(6) The service is determined to be reasonable and necessary.

NOTE: The criterion that the service must have a HCPCS code in order to be assigned to a new technology APC has been removed. This is supported by the rationale that in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, a new HCPCS code will be created that describes the new technology service. The new HCPCS would be solely for hospitals to use when billing under the OPPS.

L. OPPS PRICER.

1. Common PRICER software will be provided to the contractor that includes the following data sources:

- a. National APC amounts
- b. Payment status by HCPCS code
- c. Multiple surgical procedure discounts
- d. Fixed dollar threshold
- e. Multiplier threshold
- f. Device offsets
- g. Other payment systems pricing files (CMAC, DMEPOS, and statewide prevalings)

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

2. The following data elements will be extracted and forwarded to the outpatient PRICER for line item pricing.
 - a. Units;
 - b. HCPCS/Modifiers;
 - c. APC;
 - d. Status payment indicator;
 - e. Line item date of service;
 - f. Primary diagnosis code; and
 - g. Other necessary OCE output.
3. The following data elements will be passed into the PRICER by the contractors:
 - a. Wage indexes (same as DRG wage indexes);
 - b. Statewide cost-to-charge ratios as provided in CMS Final Rule;
 - c. Locality Code: Based on CBSA - 2 digit = rural and 5 digit = urban;
 - d. Hospital Type: Rural Sole community Hospital = 1 and All Others = 0
4. The outpatient PRICER will return the line item APC pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary explanation of benefits (EOB) with exception for an electronic 835 transaction. EOBs and remits will reflect APCs at the line level and will also include indication of outlier payments and pricing information for those services reimbursed under other than OPPS methodology's, e.g., CMAC (SI = A) when applicable.
5. If a claim has more than one service with a SI of "T" (SI of "S" has been removed from this rule), and any lines with SI "T" have less than \$1.01 as charges, charges for all "T" lines will be summed and the charges will then be divided up proportionately to the payment rates for each "T" line (refer to [Figure 13-3-9](#)). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

FIGURE 13-3-9 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$19,999	\$6,000	\$12,000
T	\$1	\$3,000	\$6,000
T	\$0	\$1,000	\$2,000
Total	\$20,000	\$10,000	\$20,000

NOTE: Because total charges here are \$20,000 and the first SI "T" gets \$6,000 of the \$10,000 total payment, the new charge for that line is $\$6,000/\$10,000 \times \$20,000 = \$12,000$.

M. TRICARE Specific Procedures/Services.

1. TRICARE specific APCs have been assigned for half-day PHPs.
2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI "A" (i.e., services that are paid under some payment method other than OPPS) until they can be placed into existing or new APC groups.

N. Validation Reviews.

OPPS claims are not subject to validation review.

O. Hospital Based Birthing Centers.

Hospital based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for procedure code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

- END -

CHAPTER 13
SECTION 4

CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

ISSUE DATE: July 27, 2005

AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

Note: This reimbursement system is tentatively scheduled to become effective 60 days from publication of the OPPS Interim Final Rule (IFR).

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 **TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

To describe additional claims submission and processing requirements.

III. POLICY

Appropriate Bill Types:

A. Bill types subject to **Outpatient Prospective Payment System (OPPS)**.

All outpatient hospital bills (bill types **013X** with condition code 41, **013X** without condition code 41), with the exception of bills from providers excluded under **Chapter 13, Section 1, paragraph III.D.1.b.(5)** will be subject to the OPPS.

B. Reporting Requirements.

1. Payment of outpatient hospital claims will be based on the from date on the claim.

EXAMPLE: Claims with from dates prior to implementation of OPPS will not process as OPPS - this will also apply to version changes and pricing changes.

2. Hospitals should make every effort to report all services performed on the same day on the same claim to ensure proper payment under OPPS.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 4

CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

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C. Procedures for Submitting Late Charges.

1. Hospitals may not submit a late charge bill (frequency 5 in the third position of the bill type) for bill types 013X effective for claims with dates of service on or after implementation of OPPS.

2. They must submit an adjustment bill for any services required to be billed with Healthcare Common Procedure Coding System (HCPCS) codes, units, and line item dates of service by reporting frequency 7 or 8 in the third position of the bill type. Separate bills containing only late charges will not be permitted. Claims with bill type 0137 and 0138 should report the original claim number in Form Location (FL) 64 on the CMS 1450 UB-04 claim form.

3. The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing of Outpatient Code Editor (OCE) under OPPS.

NOTE: The contractors will take appropriate action in those situations where either a replacement claim (TOB 0137) or voided/cancelled claim (TOB 0138) is received without an initial claim (TOB 0131) being on file. Resulting adjustments may result in offset recoupment which would ultimately depend on OPPS claims volume.

D. Claim Adjustments. Adjustments to OPPS claims shall be priced based on the from date on the claim (using the rules and weights and rates in effect on that date) regardless of when the claim is submitted. Contractor's shall maintain at least three (3) years of APC relative weights, payment rates, wage indexes, etc., in their systems. If the claim filing deadline has been waived and the from date is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest APC weights and rates on the contractor's system.

E. Proper Reporting of Condition Code G0 (Zero).

1. Hospitals should report Condition Code G0 on FLs 18-28 when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

2. Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

3. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

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4. Proper reporting of Condition Code G0 allows for proper payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

5. The following figure describes actions the OCE will take when multiple medical visits occur on the same day in the same revenue code center:

FIGURE 13-4-1 ACTIONS TAKEN WHEN MULTIPLE MEDICAL VISITS OCCUR ON THE SAME DAY

EVALUATION & MANAGEMENT (E&M)	REVENUE CENTER	CONDITION CODE	OCE ACTION
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line item with E&M code

F. Clinical Diagnostic Laboratory Services Furnished to Outpatients.

1. Payment for clinical diagnostic laboratory services will not be paid under OPPS.
2. Payment for these services will be made under the CHAMPUS Maximum Allowable Charge (CMAC) System.
3. Hospitals should report HCPCS codes for clinical diagnostic laboratory services.

G. OPPS Modifiers.

TRICARE requires the reporting of HCPCS Level I and II modifiers for accuracy in reimbursement, coding consistency, and editing.

- END -

