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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 78
6010.55-M
JUNE 17, 2008

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: HOME HEALTH PROSPECTIVE PAYMENT SYSTEM
(HH PPS) UPDATE - CALENDAR YEAR 2008

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): TRICARE Reimbursement Manual (TRM) guidelines
which will allow continued use of an abbreviated assessment tool required in the
coding and payment of home health claims for children under the age of 18 or for
maternity cases. This package provides clarification regarding the coding.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting
Officer.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

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

CHANGE 78
6010.55-M
JUNE 17, 2008

REMOVE PAGE(S)

CHAPTER 12

Section 4, pages 9 - 12 and 21 - 33
Addendum S, pages 3 - 5

INSERT PAGE(S)

Section 4, pages 9 - 12 and 21 - 34
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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 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. Refined Case-Mix Model for Home Health Episodes Beginning On or After January 1, 2008.

This four equation case-mix model recognizes and differentiates payment for EOCs based on whether a patient is in what is considered to be an early (first or second episode in a sequence of adjacent episodes) or later (the third episode and beyond in a sequence of adjacent episodes) EOC as well as recognizing whether a patient was a high therapy (14 or more therapy visits) or low therapy (13 or fewer therapy visits) case. The refined case-mix model replaces the current single therapy threshold of 10 visits with three therapy thresholds (6, 14, and 20 visits) and expands the case-mix variables to include scores for certain wound and skin conditions, additional primary diagnosis groups such as pulmonary, cardiac and cancer diagnoses and certain secondary diagnoses. This methodology better accounts for the higher resource use per episode and the different relationship between clinical conditions and resource use that exists in later episodes.

1. New HIPPS Code Structure Under HH PPS Case-Mix Refinement.

a. For HH PPS episodes beginning on or after January 1, 2008, the distinct five position alphanumeric home health HIPPS is created as follows:

(1) The first position is no longer a fixed value. The refined HH PPS uses a four equation case-mix model which assigns differing scores in the clinical, functional and services domains based on whether an episode is an early or later episode in a sequence of adjacent episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores.

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

(3) The fifth position indicates a severity group for NRS. The HH PPS grouper software will assign each episode into one of six NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number of one through six before submitting the claim.

(4) The first four positions of the HIPPS code submitted on the final claim must match what was on the RAP. The fifth digit may vary (i.e., where the HHA initially

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anticipated the use of NRS during the episode only to subsequently find out that they were not required - the supply indicator may need to be changed if no supplies were provided).

FIGURE 12-4-6 NEW HIPPS CODE STRUCTURE UNDER HH PPS CASE-MIX REFINEMENT

	POSITION #1	POSITION #2	POSITION #3	POSITION #4	POSITION #5		DOMAIN LEVELS
	GROUPING STEP	CLINICAL DOMAIN	FUNCTION DOMAIN	SERVICE DOMAIN	SUPPLY GROUP - SUPPLIES PROVIDED	SUPPLY GROUP - SUPPLIES NOT PROVIDED	
Early Episodes (First & Second)	1 (0-13 Visits)	A (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	S (Severity Level: 1)	1 (Severity Level: 1)	= min
	2 (14-19 Visits)	B (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	T (Severity Level: 2)	2 (Severity Level: 2)	= low
Late Episodes (Third & later)	3 (0-13 Visits)	C (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	U (Severity Level: 3)	3 (Severity Level: 3)	= mod
	4 (14-19 Visits)			N (HHRG: S4)	V (Severity Level: 4)	4 (Severity Level: 4)	= high
Early or Late Episode	5 (20+ Visits)			P (HHRG: S5)	W (Severity Level: 5)	5 (Severity Level: 5)	= max
					X (Severity Level: 6)	6 (Severity Level: 6)	
	6 thru 0	D thru E	I thru J	Q thru R	Y thru Z	7 thru 0	Expansion values for future use

b. Examples of HIPPS coding structure based on Figure 12-4-6:

(1) First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level = HIPPS code 1AFKS.

(2) Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity level 3 = HIPPS code 4CHMV.

(3) Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score is high and supply severity level 4, but supplies were not provided due to a special circumstance = HIPPS code 5BHN4.

c. Each HIPPS code represents a distinct payment amount, without any duplication of payment weights across codes.

d. The new HIPPS coding structure has resulted in 153 case-mix groups represented by the first four positions of the code. Each of these case-mix groups can be combined with a NRS severity level, resulting in 918 HIPPS codes in all (i.e., 153 case-mix times six NRS severity levels). With two values representing supply levels (1-6 in cases where NRS's are not associated with the first four positions of the HIPPS code and S-X where they

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are), there are actually 1836 new HIPPS codes. Refer to [Addendum J3](#) (for episodes beginning on or after January 1, 2008) for a complete listing of HH PPS case-mix refined HIPPS codes (all five positions) with associated weights.

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

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

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

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

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

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

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

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FIGURE 12-4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES

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

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

1. Medicare-certified HHAs will be required to conduct abbreviated assessments for TRICARE beneficiaries who are under the age of 18 or receiving maternity care for payment under the HHA PPS. This will require the manual completion and scoring of a HHRG Worksheet (refer to [Chapter 12, Addendum I](#) for copy of worksheet). The HIPPS code generated from this scoring process will be submitted on the CMS 1450 UB-04 for pricing and payment. This abbreviated 23 item assessment (as opposed to the full 79 item comprehensive assessment) will provide the minimal amount of data necessary for reimbursement under the HHA PPS. This is preferable, from an integrity standpoint, to dummifying up the missing data elements on the comprehensive assessment. HHAs will also be responsible for collecting the OASIS data element links necessary in reporting the claims-OASIS matching key (i.e., the 18 position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight-positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The claims-OASIS matching key is reported in FL 44 of the CMS 1450 UB-04.

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

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

b. The second, third, and fourth positions of the HIPPS code (alphabetical characters) will be assigned based on the scoring of the 23 OASIS items reflected in the HHRG Worksheet in [Addendum I](#). The OASIS items for use in this abbreviated assessment scoring will be available on the CMS web site (<http://www.cms.hhs.gov/HomeHealthQualityInits/>) as indicated in [Addendum G2](#). However, since Clinical Severity Domain category "C0", Function Status Domain category "F0", and Service Utilization Domain category "S0" are no longer recognized as part of the refined HIPPS coding structure they will default to "C1", "F1", and "S1", respectively, in establishing reimbursement under the abbreviated assessment for TRICARE beneficiaries who are under the age of 18 or receiving maternity care.

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

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

position treatment authorization code that is normally required for the processing and payment of home health claims subject to the full-blown OASIS assessment.

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

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

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

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

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

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

(4) There are also regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems

as long as they do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies.

G. Split Payments (Initial and Final Payments).

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

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

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

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

H. Calculation of Prospective Payment Amounts.

1. National 60-Day Episode Payment Amounts.

a. Medicare, in establishment of its prospective payment amount, included all costs of home health services derived from audited Medicare cost reports for a nationally representative sample of HHAs for Fiscal Year (FY) 1997. Base-year costs were adjusted using the latest available market basket increases between the cost reporting periods contained in the database and September 30, 2001. Total costs were divided by total visits in establishing an average cost per visit per discipline. The discipline specific cost per visit was then multiplied by the average number of visits per discipline provided within a 60-day EOC in the establishment of a home health prospective payment rate per discipline. The 60-day utilization rates were derived from Medicare home health claims data for FY 1997 and 1998. The prospective payment rates for all six disciplines were summed to arrive at a total non-standardized prospective payment amount per 60-day EOC.

b. [Figure 12-4-14](#) provides the calculations involved in the establishment of the non-standardized prospective payment amount per 60-day episode in FY 2001, along with adjustments for NRS, Part B therapies and OASIS implementation and ongoing costs.

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FIGURE 12-4-14 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS

DISCIPLINES	TOTAL COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	AVER. # VISITS PER 60-DAYS	HOME HEALTH PROSPECTIVE PAYMENT RATE
Home Health Aide Services	\$5,915,395,602	141,682,907	\$ 41.75	13.40	\$559.45
Medical Social Services	458,571,353	2,985,588	153.59	0.32	49.15
Occupational Therapy	444,691,130	4,244,901	104.76	0.53	55.52
Physical Therapy	2,456,109,303	23,605,011	104.05	3.05	317.35
Skilled Nursing Services	12,108,884,714	127,515,950	94.96	14.08	1,337.04
Speech Pathology Service	223,173,331	1,970,399	113.26	0.18	20.39
Total Non-Standardized Prospective Payment Amount Per 60-Day Episode for FY 2001: \$2,338.90					
ADJUSTMENTS:					
1) Average cost per episode for NRS included in the home health benefit and reported as costs on the cost report					\$43.54
2) Average payment per episode for NRS 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 12-4-15](#) 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 12-4-15 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 \(CY 2006\)](#), [Addendum L \(CY 2007\)](#), and [Addendum L \(CY 2008\)](#).

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

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

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

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

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

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

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

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

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

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

d. Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts 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 [Addendum L \(CY 2006\)](#), [Addendum L \(CY 2007\)](#), [Addendum L \(CY 2008\)](#), [Addendum M \(CY 2006\)](#), [Addendum M \(CY 2007\)](#), and [Addendum M \(CY 2008\)](#).

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 \(CY 2006\)](#), [Addendum L \(CY 2007\)](#), and [Addendum L \(CY 2008\)](#). 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 \(CY 2006\)](#), [Addendum M \(CY 2007\)](#), and [Addendum M \(CY 2008\)](#) 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

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reduced payment amounts are referred to as: 1) PEP adjustments; 2) SCIC adjustments; 3) LUPAs; and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

NOTE: Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) have not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in [Addendum L \(CY 2006\)](#), [Addendum L \(CY 2007\)](#), [Addendum L \(CY 2008\)](#), [Addendum M \(CY 2006\)](#), [Addendum M \(CY 2007\)](#), and [Addendum M \(CY 2008\)](#).

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

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

$$(28/60) = 0.4667$$

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

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

(2) SCIC Payment Adjustment.

(c) For Episodes Beginning Prior To January 1, 2008. The full episode payment amount is adjusted if the beneficiary experiences a SCIC 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 SCIC 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 POC. The apportionment of payment is a two-part process. The first part involves determining the proportion of the 60-day episode prior to the SCIC 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 SCIC 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 SCIC on Day 16. The last billable service day prior to the SCIC 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 POC 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 SCIC 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 and 2 to obtain the total SCIC adjustment.

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

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

(3) LUPA.

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

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1 The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in [Figure 12-4-1](#) plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in [Figure 12-4-16](#).

FIGURE 12-4-16 PER VISIT PAYMENT AMOUNTS FOR LUPAS

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for NRS*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjustment factor	Per-visit payment amounts per 60-day episode for FY 2001
Home Health Aide	\$41.75	\$1.94	\$0.12	\$0.21	0.96674	1.05	\$43.37
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

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

2 The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from [Figure 12-4-16](#)) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

NOTE: Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and Fixed Dollar Loss (FDL) amounts in [Addendum L \(CY 2006\)](#), [Addendum L \(CY 2007\)](#), [Addendum L \(CY 2008\)](#), [Addendum M \(CY 2006\)](#), [Addendum M \(CY 2007\)](#), [Addendum M \(CY 2008\)](#) 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>

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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.

$$\begin{aligned} \text{Labor Portion} &= (\$287.27 \times 0.77668) = \$223.12 \\ \text{Non-labor Portion} &= (\$287.27 \times 0.22332) = \$64.15 \end{aligned}$$

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

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

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

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

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

(4) Therapy Threshold Adjustment.

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

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

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

2 Due to this increased complexity of the payment system regarding therapies, the Pricer software in the claims processing system will re-code all

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

3. Calculation of Outlier Payments.

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

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

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

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

$$(1.9532 \times \$2,115.30) = \$4,131.61$$

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

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$$\begin{aligned}\text{Labor Portion} &= (.77668 \times \$4,131.61) = \$3,208.94 \\ \text{Non-labor Portion} &= (.22332 \times \$4,131.61) = \$922.68\end{aligned}$$

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

$$(0.9086 \times \$3,208.94) = \$2,915.64$$

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

$$(\$2,915.64 + \$922.68) = \boxed{\$3,838.32}$$

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

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

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

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

$$\begin{aligned}\text{Labor Portion} &= (.77668 \times \$2,390.29) = \$1,856.49 \\ \text{Non-labor Portion} &= (.22332 \times \$2,390.29) = \$533.80\end{aligned}$$

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

$$(0.9086 \times \$1,856.49) = \$1,686.80$$

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

$$(\$1,686.80 + \$533.80) = \$2,220.60$$

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

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

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

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

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Skilled Nursing Visits (54 x \$95.79) = \$5,172.66
Home Health Aide Visits (48 x \$43.37) = \$2,081.76
Physical Therapy Visits (6 x \$104.74) = \$628.44

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

1 Skilled Nursing Visits

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

Labor Portion = (.77668 x \$5,172.66) = \$4,017.50
Non-labor Portion = (.22332 x \$5,172.66) = \$1,155.16

b Wage-adjusted labor portion of imputed costs.

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

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

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

2 Home Health Aide Visits

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

Labor Portion = (.77668 x \$2,081.76) = \$1,616.86
Non-labor Portion = (.22332 x \$2,081.76) = \$464.90

b Wage-adjusted labor portion of imputed costs.

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

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

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

3 Physical Therapy Visits

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

$$\begin{aligned} \text{Labor Portion} &= (.77668 \times \$628.44) = \$488.10 \\ \text{Non-labor Portion} &= (.22332 \times \$628.44) = \$140.34 \end{aligned}$$

b Wage-adjusted labor portion of imputed costs.

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

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

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

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

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

(4) Calculation of Outlier Payment.

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

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

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

$$(\$1,264.35 \times 0.80) = \boxed{\$1,018.68}$$

(5) Calculation of Total Payment to HHA.

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

$$(\$3,838.32 + \$1,018.68) = \boxed{\$4,857.00}$$

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

Payment under the HHA PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see [Chapter 12, Section 6](#)). However, if

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

- END -

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CHAPTER 12, ADDENDUM S

INPUT/OUTPUT RECORD LAYOUT

FILE POSITION	FORMAT	TITLE	DESCRIPTION
FOR EPISODES BEGINNING PRIOR TO JANUARY 1, 2008			
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data. Payment return codes: 00 Final payment where no outlier applies 01 Final payment where outlier applies 03 Initial percentage payment, 0% 04 Initial percentage payment, 50% 05 Initial percentage payment, 60% 06 LUPA payment only 07 Final payment, Significant Change In Condition (SCIC) 08 Final payment, SCIC with outlier 09 Final payment, PEP 11 Final payment, PEP with outlier 12 Final payment, SCIC within PEP 13 Final payment, SCIC with PEP with outlier Error return codes: 10 Invalid TOB 15 Invalid PEP days 16 Invalid HRG days, > 60 20 PEP indicator invalid 25 Med review indicator invalid 30 Invalid Metropolitan Statistical Area (MSA)/CBSA code 35 Invalid Initial Payment Indicator 40 Dates < October 1, 2000 or invalid 70 Invalid HRG code 75 No HRG present in 1st occurrence 80 Invalid revenue code 85 No revenue code present on 3x9 or adjustment TOB
403-407	9(5)	REVENUE-SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.
408-412	9(5)	REVENUE-SUM 1-6- QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.
413-421	9(7)V9(2)	OUTLIER-PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.

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INPUT/OUTPUT RECORD LAYOUT

FILE POSITION	FORMAT	TITLE	DESCRIPTION
FOR EPISODES BEGINNING ON OR AFTER JANUARY 1, 2008			
431-435	9(3)V9(2)	LUPA-ADD-ON PAYMENT	Output item: The add-on amount to be paid for LUPA claims that are the first episode in a sequence.
436	X	LUPA-SRC-ADM	Input item: The source of admission code on the RAP or claim.
437	X	RECODE-IND	Input item: A recoding indicator set by the contractors' claims processing systems in response to the identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0=default value 1=HIPPS code shows later episode, should be early episode 3=HIPPS code shows early episode, should be later episode
438	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Contractors' systems copy this code from the 10th position of the treatment authorization code. Valid values: 1=early episode 2=late episode
439	X	CLINICAL-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Contractors' systems copy this code from the 11th position of the treatment authorization code.
440	X	FUNCTION-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Contractors' systems copy this code from the 12th position of the treatment authorization code.
441	X	CLINICAL-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Contractors' systems copy this code from the 13th position of the treatment authorization code.
442	X	FUNCTION-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Contractors' systems copy this code from the 14th position of the treatment authorization code.
443	X	CLINICAL-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Contractors' systems copy this code from the 15th position of the treatment authorization code.
444	X	FUNCTION-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Contractors' systems copy this code from the 16th position of the treatment authorization code.
445	X	CLINICAL-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Contractors' systems copy this code from the 17th position of the treatment authorization code.
446	X	FUNCTION-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Contractors' systems copy this code from the 18th position of the treatment authorization code.
447-450	X	FILLER	

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INPUT/OUTPUT RECORD LAYOUT

- Input records on RAPs will include all input items except for “REVENUE” related items, and input records on RAPs will never report more than one occurrence of “HHRG” related items.
- Input records on claims must include all input items.
- Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.
- The claims contractors’ claims processing systems will move the following Pricer output items to the claim record.
- The HRG-PAY amount for each HIPPS code will be placed in the total charges and the covered charges field of the appropriate revenue code 0023 line.
- The OUTLIER-PAYMENT amount, if any.
- If the return code is 06 (indicating a LUPA), the contractors’ claims processing systems will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payment be accurately reflected on the remittance advice.

