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TRICARE
MANAGEMENT ACTIVITY

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**CHANGE 1
6010.58-M
MARCH 13, 2008**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)**

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.58-M, issued February 2008.

CHANGE TITLE: CONSOLIDATED UPDATE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes in Aug 2002 TRICARE Reimbursement Manual (TRM), 6010.55-M. The changes are a routine change to clarify cost-sharing for hearing aids (Aug 2002 TRM, Change 70), a correction (Aug 2002 TRM, Change 71), and the 2008 Home Health Care Prospective Payment System (HHC PPS) updates (Aug 2002 TRM, Change 72). This change also includes corrections for minor errors/clarifications.

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

This change is made in conjunction with Feb 2008 TOM, Change No. 1, Feb 2008 TPM, Change No. 1, and Feb 2008 TSM, Change No. 1.

**Reta Michak
Chief, Office of Medical Benefits and
Reimbursement Systems**

**ATTACHMENT(S): 74 PAGE(S)
DISTRIBUTION: 6010.58-M**

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REMOVE PAGE(S)

CHAPTER 2

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APPENDIX A

pages 1 through 26

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Chapter 2, Section 1

Cost-Shares And Deductibles

Shield or Operation Desert Storm, the deductible shall be the amount specified in [paragraph 1.3.1.2](#), for care rendered after October 1, 1991.

Note: The provisions of [paragraph 1.3.1.5](#), also apply to family members of service members who were killed in the Gulf, or who died subsequent to Gulf service; and to service members who retired prior to October 1, 1991, after having served in the Gulf war, and to their family members.

1.3.1.6 Effective December 8, 1995, the annual TRICARE deductible has been waived for family members of selected reserve members called to active duty for 31 days or more in support of Operation Joint Endeavor (the Bosnia peacekeeping mission). Under a nationwide demonstration, TRICARE may immediately begin cost-sharing in accordance with standard TRICARE rules. These beneficiaries will be eligible to use established TRICARE Extra network providers at a reduced cost-share rate. Additionally, in those areas where TRICARE is in full operation, selected reserve members called to active duty for 31 days or more will have the option of enrolling their families in TRICARE Prime.

Note: This demonstration is effective December 8, 1995, and is in effect until such time as Executive Order 12982 expires. TRICARE eligible beneficiaries other than family members of reservists called to active duty in support of Operation Joint Endeavor are not eligible for participation. This demonstration is limited to the annual TRICARE Standard and Extra deductible; other TRICARE cost-sharing continues to apply. All current TRICARE rules, unless specifically provided otherwise, will continue to apply.

Note: Initially the option to enroll in TRICARE Prime was limited to family members of selected reserve members who were called to active duty for 179 days or more. This changed to 31 days or more as of March 10, 2003.

Note: Claims for these beneficiaries are to be paid from financially underwritten funds and reported as such. TMA periodically will calculate and reimburse the contractors for the additional costs incurred as a result of waiving the deductibles on these claims.

1.3.1.7 Adjustment of Excess. Any beneficiary identified under [paragraphs 1.3.1.4](#), [1.3.1.5](#), and [1.3.1.6](#), who paid any deductible in excess of the amounts stipulated is entitled to an adjustment of any amount paid in excess against the annual deductible required under those paragraphs.

1.3.1.8 The deductible amounts identified in this section shall be deemed to have been satisfied if the catastrophic cap amounts identified in [Section 2](#) have been met for the same fiscal year in which the deductible applies.

1.3.2 Deductible Amount: Inpatient Care

None.

1.3.3 Cost-share Amount

1.3.3.1 Outpatient Care

1.3.3.1.1 ADFM or Authorized NATO Beneficiary. The cost-share for outpatient care is 20% of the allowable amount in excess of the annual deductible amount. This includes the professional

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Cost-Shares And Deductibles

charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC or birthing center.

1.3.3.1.2 Other Beneficiary. The cost-share applicable to outpatient care for other than active duty and authorized NATO family member beneficiaries is 25% of the allowable amount in excess of the annual deductible amount. This includes: partial hospitalization for alcohol rehabilitation; professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC.

1.3.3.2 Inpatient Care

1.3.3.2.1 ADFM: Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the daily charge the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater. (Please reference daily rate chart below.)

FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

PERIOD	DAILY CHARGE
October 1, 2000 - September 30, 2001	\$11.45
April 1, 2001 - Present (for Prime ADFMs only)	\$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	\$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	\$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	\$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	\$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	\$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	\$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	\$15.15

Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.

1.3.3.2.2 Other Beneficiaries: For services exempt from the DRG-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (i.e., residential treatment centers (RTCs)), the cost-share shall be 25% of the allowable charges.

1.3.3.3 Cost-Shares: Maternity

1.3.3.3.1 Determination. Maternity care cost-share shall be determined as follows:

1.3.3.3.1.1 Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

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Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 6)	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
AMBULANCE SERVICES When medically necessary as defined in the TRICARE Policy Manual (TPM) and the service is a covered benefit.	\$0 copayment per visit.	\$0 copayment per visit.	\$20 copayment per occurrence.	ADFMs: Cost-share--15% of the fee negotiated by 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.
EMERGENCY SERVICES Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	\$0 copayment per visit.	\$0 copayment per visit.	\$30 copayment per emergency room visit.1		
DME, HEARING AIDS FOR ADFMs, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS (If dispensed for use outside of the office or after the home visit.)	\$0 copayment per visit.	\$0 copayment per visit.	Cost-share - 20% of the fee negotiated by the contractor.		

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Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 6)	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<p>HOME HEALTH CARE Part-time or intermittent skilled nursing and home health aide services, physical, speech, & occupational therapy, medical social services, routine and non-routine medical services. Note: DME, osteoporosis drugs, pneumococcal pneumonia, influenza virus and hepatitis B vaccines, oral cancer drugs, antiemetic drugs, orthotics, prosthetics, enteral and parenteral nutritional therapy and drugs/biologicals administered by other than oral methods are services that can be paid in addition to the prospective payment amount subject to applicable copayment/ cost-sharing and deductible amounts.</p>	\$0 copayment.	\$0 copayment.	\$0 copayment.	\$0 cost-share.	\$0 cost-share.
<p>HOSPICE CARE Note: A separate cost-share may be (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.</p>					

Pharmacy Benefits Program - Cost-Shares

PHARMACY PAYMENT MATRIX

TRICARE Pharmacy (TPharm) Copayments/Cost-Shares In The United States (Including Puerto Rico, Guam, The U.S. Virgin Islands, American Samoa, and The Northern Marianna Islands)			
PLACE OF SERVICE (POS)	FORMULARY		NON-FORMULARY (TIER 3)
	GENERIC (TIER 1)	BRAND NAME (TIER 2)	
Military Treatment Facility (MTF) Pharmacy (up to a 90-day supply)	\$0	\$0	Not Applicable
TRICARE Mail Order Pharmacy (TMOP) (up to a 90-day supply)	\$3	\$9	\$22*
TRICARE Retail Pharmacy (TRRx) Network Pharmacy (up to a 30-day supply)	\$3	\$9	\$22*
TRRx Non-Network Pharmacy (up to a 30-day supply) Note: Beneficiaries using non-network pharmacies may have to pay the total amount of their prescription first and then file a claim to receive partial reimbursement.	For those who are not enrolled in TRICARE Prime: \$9 or 20% of total cost, whichever is greater, after deductible is met (E1-E4: \$50/person; \$100/family; all others, including retirees, \$150/person, \$300/family) TRICARE Prime: 50% cost-share after Point of Service (POS) deductibles (\$300 per person, \$600 per family deductible)		For those who are not enrolled in TRICARE Prime: \$22 or 20% of total cost, whichever is greater, after deductible is met (E1-E4: \$50/person; \$100/family; all others, including retirees, \$150/person, \$300/family) TRICARE Prime: 50% cost-share after POS deductibles (\$300 per person, \$600 per family deductible)
* If medical necessity is established for a non-formulary drug, patients may qualify for the \$9 copayment for up to a 30-day supply in the TRRx or a 90-day supply in the TMOP Program.			

- END -

Hospital And Other Institutional Reimbursement

Issue Date:
Authority:

1.0 INTRODUCTION

TRICARE reimbursement of a non-network institutional health care provider shall be determined under the TRICARE Diagnosis Related Group (DRG)-based payment system as outlined in [Chapter 6](#) or other TRICARE-approved method. For network providers, the contractor is free to negotiate rates that would be less than the rates established under the TRICARE DRG-based payment system or other approved TRICARE method.

2.0 PAYMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION (CAP/DME) COST

2.1 General

The contractor will make an annual payment to each hospital subject to the TRICARE DRG-based payment system (except children's hospitals) which requests reimbursement for CAP/DME. The payment will be computed based on [Chapter 6, Section 8](#). These procedures will apply to all types of CAP/DME payments (including active duty). **All CAP/DME payments will be in accordance with payment instructions in Section G of the contract.**

3.0 INPATIENT MENTAL HEALTH HOSPITAL, PARTIAL HOSPITALIZATION, AND RESIDENTIAL TREATMENT CENTER (RTC) FACILITY RATES

Each fiscal year, contractors shall submit inpatient mental health, partial hospitalization (half day-three to five hours and full day-six or more hours) and RTC rates by facility.

4.0 BILLED CHARGES/SET RATES

When a hospital or institution is not covered by a mandatory payment methodology (i.e., DRGs, inpatient mental health), the contractor shall reimburse for institutional care received from providers on the basis of billed charges, if reasonable for the area and type of institution, or on the basis of rates set by statute or some other arrangement. The basic guidance shall be that the beneficiary's share shall not be increased above that which would have been required by payment of a reasonable billed charge.

4.1 Verification Of Billed Services

Reimbursement of billed charges should be subjected to tests of reasonableness performed by the contractor. These tests should be used to protect against both inadvertent and intentional

practices of overbilling and/or supplying of excessive services. The contractor should verify that no mathematical errors have been made in the bill.

4.2 Use Of Local Or State Regulatory Authority Allowed Charges

There are instances in which a local or state regulatory authority, in an attempt to control costs, has established allowable charges for the citizens of a community or state. If such allowable charges have been extended to TRICARE beneficiaries by consent, agreement, or law, and if they are generally (not on a case by case basis) less than TRICARE would otherwise reimburse, the contractor should use such rates in determining TRICARE reimbursement. However, if a state creates a reimbursement system which would result in payments greater than the hospital's normal billed charges, the contractor should not use the state-determined amounts.

4.3 Discounts Or Reductions

Contractors should attempt to take advantage of all available discounts or rate reductions when they do not conflict with other requirements of the Program. When such a discount or charge reduction is available but the contractor is uncertain whether it would conform to its TRICARE contract, TMA should be contacted for direction.

4.4 All-Inclusive Rate Providers

All-inclusive rates may be reimbursed if the contractor verifies that the provider cannot adequately itemize its bills to provide the normally required TRICARE Encounter Data (TED). Further, the contractor must ensure that appropriate revenue codes are included on the claim (as well as all other required Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 information), even though itemized charges are not required to be associated with the revenue codes. When a contractor reimburses a provider based on an all-inclusive rate, the contractor shall maintain documentation of its actions in approving the all-inclusive rate. The documentation must be available to TMA upon request. (Also, see [Chapter 1, Section 22](#).)

5.0 REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS (ASCs)

5.1 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 ASC, in a hospital outpatient clinic, or in a hospital emergency room.

5.2 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.

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

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Hospital And Other Institutional Reimbursement

5.4 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 [Section 1](#).

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

6.0 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 (FL) 64 on the CMS 1450 UB-04 claim form.

7.0 PROPER REPORTING OF CONDITION CODES

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

7.1 Condition codes are reported in FLs 18-28 when applicable.

7.2 The following are two examples of condition code reporting:

7.2.1 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.

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

7.2.2 Condition Code 41 identifies a claim being submitted for Partial Hospitalization Program (PHP) services.

- END -

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Chapter 8, Section 2

Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

4.3.5 TRICARE reimbursement will follow Medicare's SNF PPS methodology and assessment schedule. However, if the SNF admission 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 [Section 1, paragraph 3.1](#).

4.3.6 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.

4.3.7 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](#)).

4.3.8 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.

4.3.9 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:

4.3.9.1 Is not self-limiting (i.e., the condition will not normally resolve itself without further clinical intervention);

4.3.9.2 Impacts on more than one area of the resident's health status; and

4.3.9.3 Requires interdisciplinary review or revision of the care plan.

Note: 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.

4.3.10 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

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Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

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 web sites:

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

<http://www.cms.hhs.gov/MinimumDataSets20/>

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.

4.3.11 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 three 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 three 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

4.3.12 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.

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

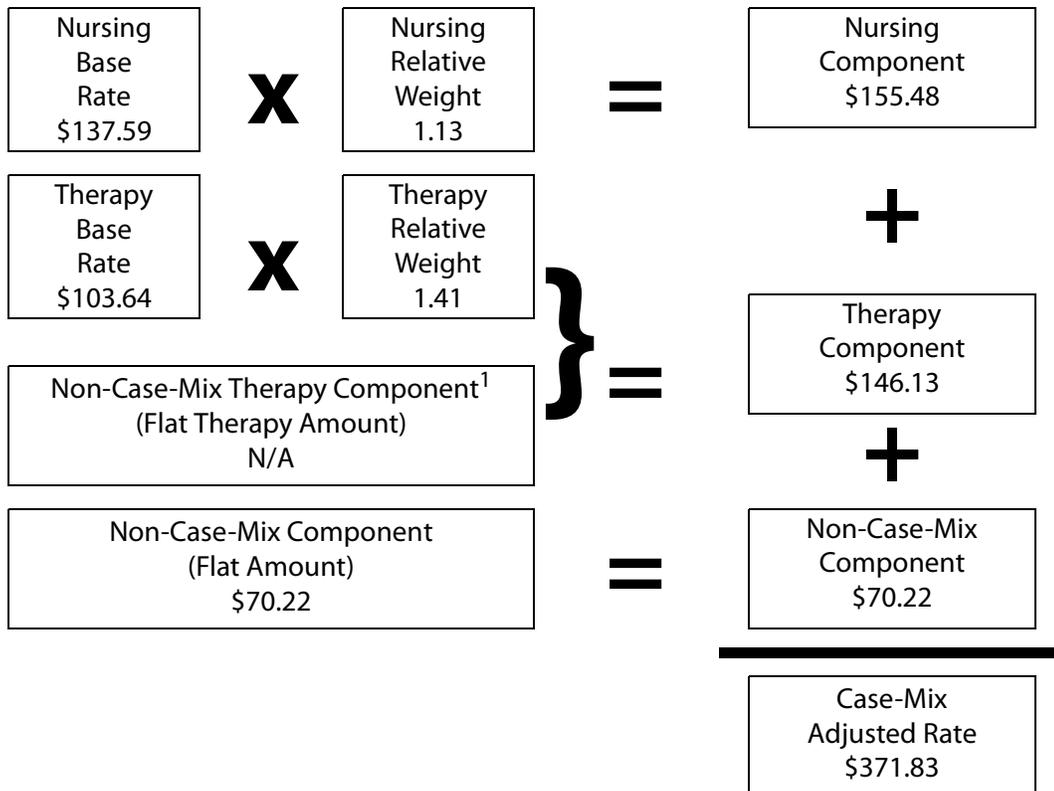
4.3.13.1 The PPS payment rates will cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).

Illustration Of Per Diem Rate Calculations For Skilled Nursing Facility (SNF) - FY 2006

The following illustration is for the first quarter of FY 2006 (October 1, 2005 through December 31, 2005) only. The illustration(s) for the rest of FY 2006 are provided in [Figure 8.B.2006-2](#).

FIGURE 8.B.2006-1 ILLUSTRATION OF PER DIEM RATE CALCULATIONS FOR AN URBAN SNF IN STATE COLLEGE, PA FOR RUG-III SERVICE CATEGORY SUBGROUP CODE - RVC FOR OCTOBER 1, 2005 - DECEMBER 31, 2005 (RUG-44)

Step 1: Calculate Case-Mix Adjusted PPS Per Diem Rate By RUG-III Category Code



¹ The non-case-mix therapy component (flat therapy amount) of \$13.65 for urban SNFs and \$14.58 for rural SNFs does not apply to the RVC RUG-III category nor any of the other 13 rehabilitation RUG-III categories (ones that have a first letter of "R"). For non-rehabilitation RUG-III categories, the flat therapy amount replaces the weighted therapy amount.

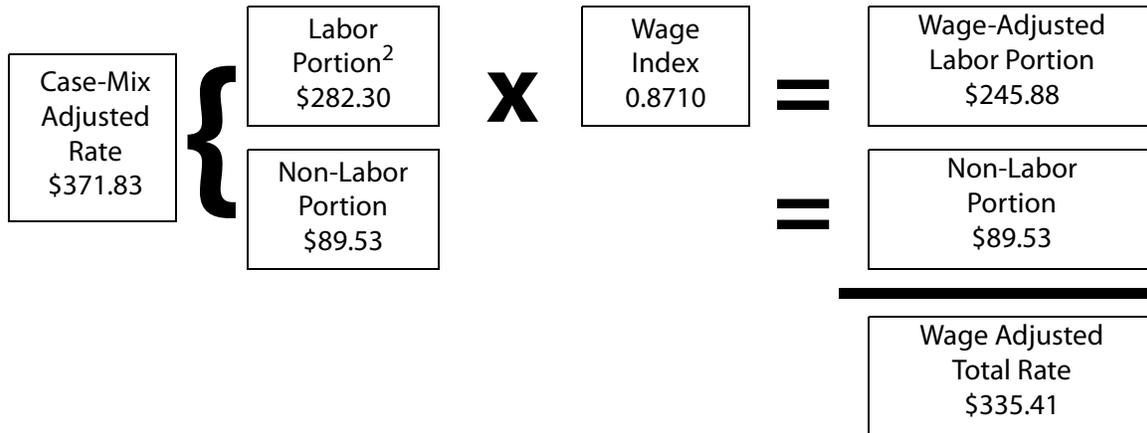
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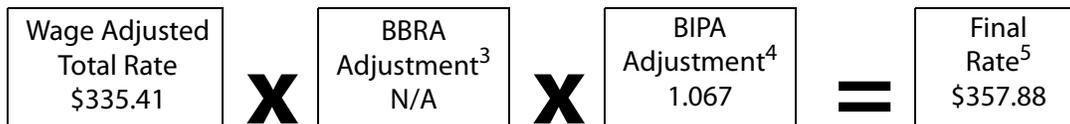
Illustration Of Per Diem Rate Calculations For Skilled Nursing Facility (SNF) - FY 2006

FIGURE 8.B.2006-1 ILLUSTRATION OF PER DIEM RATE CALCULATIONS FOR AN URBAN SNF IN STATE COLLEGE, PA FOR RUG-III SERVICE CATEGORY SUBGROUP CODE - RVC FOR OCTOBER 1, 2005 - DECEMBER 31, 2005 (RUG-44)

Step 2: Calculate Wage Adjusted Federal Per Diem Rate



Step 3: Calculate Payment Adjustments



² The wage index adjustment is applied to the labor related portion of the rate, which is 75.922% of the total case-mix adjusted rate for FY 2006.

³ The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) provides a 20% increase to the Wage Adjusted Total Rate for 12 RUGs-III groups (ones that have a first letter of "S" or "C").

⁴ All 14 rehabilitation RUGs receive a 6.7% increase to the Wage Adjusted Total Rate (Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA)).

⁵ Effective for services furnished on or after October 1, 2004, SNF claims with a principal diagnosis code of 042 (AIDS) will receive a 128% increase in the case-mix adjusted amount instead of the BBRA/BIPA adjustments (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)).

Source: 70 FR 45046; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006; Final Rule. August 4, 2005.

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Chapter 12, Section 1

Home Health Benefit Coverage And Reimbursement - General Overview

3.2.7 Implementing Instructions

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

IMPLEMENTING INSTRUCTIONS	
POLICIES	
General Overview	Section 1
Benefits and Conditions for Coverage	Section 2
Assessment Process	Section 3
Reimbursement Methodology	Section 4
Primary Provider Status and Episodes of Care	Section 5
Claims and Billing Submission Under HHA PPS	Section 6
Pricer Requirements and Logic	Section 7
Medical Review Requirements	Section 8
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Primary Components of Home Health Assessment	Addendum E
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OASIS Items Used for Assessments Of 60-Day Episodes Beginning Prior To January 1, 2008	Addendum G1
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HAVEN Reference Manual	Addendum K
Annual HHA PPS Rate Updates	
Calendar Year 2006	Addendum L (CY 2006)
Calendar Year 2007	Addendum L (CY 2007)
Calendar Year 2008	Addendum L (CY 2008)

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Home Health Benefit Coverage And Reimbursement - General Overview

IMPLEMENTING INSTRUCTIONS (CONTINUED)

Annual HHA PPS Wage Index Updates	
Calendar Year 2006	Addendum M (CY 2006)
Calendar Year 2007	Addendum M (CY 2007)
Calendar Year 2008	Addendum M (CY 2008)
Data Elements Used On Determination Of Outlier Payments	Addendum N
Diagnoses Associated with Diagnostic Categories Used in Case-Mix Scoring (CY 2008)	Addendum O
Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model	Addendum P
Code Table for Converting Julian Dates to Two Position Alphabetic Values	Addendum Q
Examples of Claims Submissions Under Home Health Agency Prospective Payment System (HHA PPS)	Addendum R
Input/Output Record Layout	Addendum S
Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008	Addendum T

- END -

3.1.2.6 Upon completion of every 60-day episode, if the patient is receiving continuous home health care (HHC) from the same HHA, the beneficiary's physician is responsible for re-certification of the POC.

3.2 Comprehensive Assessment Requirement

As a condition for participation under TRICARE, HHAs must conduct a comprehensive assessment that identifies the patient's need for home care, and that meets the patient's medical, nursing, rehabilitative, social and discharge planning needs. The HHAs must use the most current standard core data set (i.e., the OASIS), when evaluating adult, non-maternity patients. This requirement underscores the importance of a systematic patient assessment in improving quality of care and patient outcomes. The comprehensive assessment of the patient, in which patient needs are identified, is a crucial step in the establishment of a POC. In addition, a comprehensive assessment identifies patient progress toward desired outcomes or goals of the care plan. The importance of the assessment process has been further accentuated by its critical role in calculating the appropriate prospective payment amounts for HHC.

3.2.1 Applicability

3.2.1.1 The comprehensive assessment and reporting regulations (i.e., OASIS collection, encoding, and transmission requirements) apply to any HHA required to meet Medicare conditions for participation and are applied to all patients of that HHA unless otherwise specified. This includes Medicare, Medicaid, Managed Care, and private pay patients serviced by the agencies. It also includes Medicaid waiver and State plan patients to the extent they do not fall into one of the three exception categories listed below. The comprehensive assessment and reporting regulations are required by the State to meet Medicare conditions of participation.

3.2.1.2 Medicare's requirement to conduct comprehensive assessments that include OASIS data items applies to each patient of the agency receiving home health services, except for the following:

- Patients under the age of 18;
- Patients receiving maternity services;
- Patients receiving housekeeping or chore services only; and
- Patients receiving personal care services only.

3.2.1.3 However, the encoding and transmission requirements for non-Medicare and non-Medicaid patients receiving skilled care are delayed until a system to mask their identity is developed and implemented. Until such a system is developed and implemented, HHAs must meet all other requirements of the comprehensive assessment regulation, including conducting start of care comprehensive assessments and updates at the required time points on all non-Medicare and non-Medicaid patients receiving skilled services using the required OASIS data items. This means that only the requirements to encode and transmit OASIS data is delayed. The collection of OASIS data as part of the comprehensive assessment process, and updates at the required time points, are required in order to ensure quality of care for all patients and to encourage the use of OASIS as the basis for care planning.

3.2.1.4 Due to the delay in State agency validation of transmitted OASIS data for non-Medicare/non-Medicaid patients, HHAs will only be responsible for the collection and encoding of OASIS data

for TRICARE beneficiaries receiving services under a HHA's POC. Encoding will be required to generate the appropriate Health Insurance Prospective Payment System (HIPPS) code and claims-OASIS matching key output necessary to process and pay the HHA claim. Post-payment validation will be utilized to ensure that the HIPPS code generated by the Home Assessment Validation Entry (HAVEN) Grouper software is reflective of the patient's true condition, and that the services were actually rendered. Validation may be accomplished either manually through the use of The Home Health Resource Group (HHRG) Worksheet and accompanying OASIS instruction manual, or through the use of an automated accuracy protocol designed to assist medical review of home health claims submitted by HHAs who are being paid under the HHA Prospective Payment System (PPS). The Regional Home Health Intermediary (RHHI) Outcomes and Assessment Information Set Verification Protocol for Review of HHA Prospective Payment Bills (ROVER) utilizes medical records to verify that information contained in a HHA-completed OASIS is reflective of the patient's condition. Both methods will guide medical review staff through the clinical records, allowing the reviewer to document whether or not the case-mix OASIS items are validated by the information contained in the records. A HIPPS code will also be computed based on the reviewer's responses and compared to the HIPPS code assigned by the HHA. The reviewer can either accept the HIPPS billed by the provider, or adjust the claim as necessary.

3.2.1.5 Abbreviated assessments will be required for TRICARE eligible beneficiaries who are under the age of eighteen or receiving maternity care from Medicare certified HHAs (i.e., HHAs 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)] in order to receive payment under the HHA PPS. Refer to [Section 4, paragraph 3.4](#) for more details regarding the abbreviated OASIS data requirements for reimbursement of these beneficiary categories. The above patient categories will not be exempt from OASIS data collection if under a POC established by a physician.

3.2.1.6 A patient who is under age 18 and turns 18 while under the care of an HHA is to receive a full comprehensive assessment (including OASIS) at the next appropriate time point.

3.2.2 Data Collection

3.2.2.1 Patient assessment data may be collected through a combination of methods, including interaction with patient/family, observation, and measurement. When used in combination, these methods provide a full picture of the patient's health status. The following addenda provide the primary components of a home care patient assessment, along with the standard data sets used in assessing the patient's condition for reimbursement under the HHA PPS:

- [Addendum E](#) - primary components of a home care patient assessment.
- [Addendum F](#) - Outcome and Assessment Information Set (OASIS-B1).
- [Addendums G1](#) and [G2](#) - OASIS items used for **assessments of 60-day episodes**.

3.2.2.2 Patient assessment data is required at specific time points to keep them current and useful in planning care. These time points include:

3.2.2.2.1 Initial Assessment Visit

3.2.2.2.1.1 The initial visit is performed to determine the immediate care and support needs of the patient. This visit is conducted within 48 hours of referral, or within 48 hours of a patient's return home from an inpatient stay, or on the physician-ordered start of care date.

3.4.2 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.

3.4.3 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.

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

3.5 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.

3.5.1 New HIPPS Code Structure Under HH PPS Case-Mix Refinement

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

- 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.
- 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
- 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.

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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

3.5.1.2 Examples of HIPPS coding structure based on [Figure 12.4-6](#):

- First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level = HIPPS code 1AFKS.
- Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity level 3 = HIPPS code 4CHMV.
- 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.

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

3.5.1.4 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 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.

3.8.2.1 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.

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

3.8.2.2 SCIC Payment Adjustment

3.8.2.2.1 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

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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.

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

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

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

Step 3: Add the episode payment amounts from Steps 1 and 2 to obtain the total SCIC adjustment.

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

3.8.2.2.2 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.

3.8.2.3 LUPA

3.8.2.3.1 For Episodes Beginning Prior To January 1, 2008

3.8.2.3.1.1 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 LOW-UTILIZATION PAYMENT ADJUSTMENTS

HOME HEALTH DISCIPLINE TYPE	AVERAGE COST PER VISIT				STANDARDIZATION FACTOR FOR WAGE INDEX	OUTLIER ADJUSTMENT FACTOR	PER VISIT PAYMENT AMOUNTS PER 60-DAY EPISODE FOR FY 2001
	FROM THE PPS AUDIT SAMPLE	FOR NON-ROUTINE MEDICAL SUPPLIES*	FOR ONGOING OASIS ADJUSTMENT COSTS	FOR ONE-TIME OASIS SCHEDULING CHANGE			
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.

3.8.2.3.1.2 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 12.4-3](#)) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

Note: Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and Fixed Dollar Loss (FDL) amounts in [Addendums L \(CY 2006\)](#), [L \(CY 2007\)](#), [L \(CY 2008\)](#), [M \(CY 2006\)](#), [M \(CY 2007\)](#), [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
Total unadjusted payment amount			\$287.27

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

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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.
 $(\$227.36 + \$64.15) = \mathbf{\$291.51}$

3.8.2.3.2 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, an additional add-on payment will be made. A lump-sum established in regulation and updated annually will be added to these claims. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit. The additional amount for CY 2008 is \$87.93.

3.8.2.4 Therapy Threshold Adjustment

3.8.2.4.1 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.

3.8.2.4.2 For Episodes Beginning On Or After January 1, 2008.

3.8.2.4.2.1 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.

3.8.2.4.2.2 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.

3.8.3 Calculation of Outlier Payments

3.8.3.1 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 EOC. 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.

3.8.3.2 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 EOCs. 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:

3.8.3.2.1 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.

$$\text{Labor Portion} = (.77668 \times \$4,131.61) = \$3,208.94$$

$$\text{Non-Labor Portion} = (.22332 \times \$4,131.61) = \$922.68$$

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.

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

3.8.3.2.2 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.

$$\text{Labor Portion} = (.77668 \times \$2,390.29) = \$1,856.49$$

$$\text{Non-Labor Portion} = (.22332 \times \$2,390.29) = \$533.80$$

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.

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

3.8.3.2.3 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.

$$\text{Skilled Nursing Visits} \quad (54 \times \$95.79) = \$5,172.66$$

$$\text{Home Health Aide Visits} \quad (48 \times \$43.37) = \$2,081.76$$

$$\text{Physical Therapy Visits} \quad (6 \times \$104.74) = \$628.44$$

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

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

$$\text{Labor Portion} = (.77668 \times \$5,172.66) = \$4,017.50$$

$$\text{Non-Labor Portion} = (.22332 \times \$5,172.66) = \$1,155.16$$

- Wage-adjusted labor portion of imputed costs.

Chapter 12

Addendum B

Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4212	Non coring needle or stylet	10/01/2000	B-00-50			NRS
A4213	20+ cc syringe only	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4213 (5)	Syringe, Sterile, 20 cc or greater	01/01/2007	Tr.1082			NRS
A4215	sterile needle	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4215 (5)	Needle, sterile, any size, each	01/01/2007	Tr.1082			NRS
A4216	Sterile water/saline up to 10ml	01/01/2004	Tr.8			NRS
A4217	Sterile water/saline 500ml	01/01/2004	Tr.8			NRS
A4244	Alcohol or peroxide, per pint	01/01/2007	Tr.1082			NRS
A4245	Alcohol wipes, per box	01/01/2007	Tr.1082			NRS
A4246	Betadine or phisohex solution, per pint	01/01/2007	Tr.1082			NRS
A4247	Betadine or iodine swabs/wipes, per box	01/01/2007	Tr.1082			NRS
A4248	Chlorhexidine, containing antiseptic, 1ml	01/01/2004	Tr.8			NRS
A4310	Insert tray w/o bag/cath	10/01/2000	B-00-50			NRS
A4311	Catheter w/o bag 2-way latex	10/01/2000	B-00-50			NRS
A4312	Cath w/o bag 2-way silicone	10/01/2000	B-00-50			NRS
A4313	Catheter w/bag 3-way	10/01/2000	B-00-50			NRS
A4314	Cath w/drainage 2-way latex	10/01/2000	B-00-50			NRS
A4315	Cath w/drainage 2-way silcne	10/01/2000	B-00-50			NRS
A4316	Cath w/drainage 3-way	10/01/2000	B-00-50			NRS
A4319	Sterile H2O irrigation solut	01/01/2001	AB-01-65	01/01/2004	A4216, A4217	NRS
A4320	Irrigation tray	10/01/2000	B-00-50			NRS
A4321	Cath therapeutic irrig agent	10/01/2000	B-00-50			NRS
A4322	Irrigation syringe	10/01/2000	B-00-50			NRS
A4323	Saline irrigation solution	10/01/2000	B-00-50	01/01/2004	A4216, A4217	NRS
A4324	Male ext cath w/adh coating	01/01/2001	AB-01-65	01/01/2005	A4349	NRS
A4325	Male ext cath w/adh strip	01/01/2001	AB-01-65	01/01/2005	A4349	NRS
A4326	Male external catheter	10/01/2000	B-00-50			NRS
A4327	Fem urinary collect dev cup	10/01/2000	B-00-50			NRS
A4328	Fem urinary collect pouch	10/01/2000	B-00-50			NRS

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A4329	external catheter start set	10/01/2000	B-00-50	01/01/2002	N/A	NRS
A4330	Stool collection pouch	10/01/2000	B-00-50			NRS
A4331	Extension drainage tubing	01/01/2001	AB-01-65			NRS
A4332	Lubricant for cath insertion	01/01/2001	AB-01-65			NRS
A4333	Urinary cath anchor device	01/01/2001	AB-01-65			NRS
A4334	Urinary cath leg strap	01/01/2001	AB-01-65			NRS
A4335	Incontinence supply	10/01/2000	B-00-50			NRS
A4338	Indwelling catheter latex	10/01/2000	B-00-50			NRS
A4340	Indwelling catheter special	10/01/2000	B-00-50			NRS
A4344	Cath index foley 2 way	10/01/2000	B-00-50			NRS
A4346	Cath indw foley 3 way	10/01/2000	B-00-50			NRS
A4347	Male external catheter	10/01/2000	B-00-50	01/01/2005	A4349	NRS
A4348	Male ext cath extended wear	01/01/2001	AB-01-65	01/01/2007		NRS
A4349	Male ext catheter, with or without adhesive, disposable, each	01/01/2005	Tr. 340	01/01/2007		NRS
A4351	Straight tip urine catheter	10/01/2000	B-00-50			NRS
A4352	Coude tip urinary catheter	10/01/2000	B-00-50			NRS
A4353	Intermittent urinary cath	10/01/2000	B-00-50			NRS
A4354	Cath insertion tray w/bag	10/01/2000	B-00-50			NRS
A4355	Bladder irrigation tubing	10/01/2000	B-00-50			NRS
A4356	Ext ureth clmp or compr	10/01/2000	B-00-50			NRS
A4357	Bedside drainage bag	10/01/2000	B-00-50			NRS
A4358	Urinary leg bag	10/01/2000	B-00-50			NRS
A4359	Urinary suspensory w/o leg bag	10/01/2000	B-00-50			NRS
A4361	Ostomy face plate	10/01/2000	B-00-50			NRS
A4362	Solid skin barrier	10/01/2000	B-00-50			NRS
A4363	Ostomy clamp, any type, replacement only, each	01/01/2006	Tr. 710			NRS
A4364	Ostomy/cath adhesive	10/01/2000	B-00-50			NRS
A4365	Ostomy adhesive remover wipe	10/01/2000	B-00-50			NRS
A4366	Ostomy vent, any type, each	01/01/2004	Tr.8			NRS
A4367	Ostomy belt	10/01/2000	B-00-50			NRS
A4368	Ostomy filter	10/01/2000	B-00-50			NRS
A4369	Skin barrier liquid per oz	10/01/2000	B-00-50			NRS
A4370	Skin barrier paste per oz	10/01/2000	B-00-50	10/01/2002	K0561, K0562	NRS
A4371	Skin barrier powder per oz	10/01/2000	B-00-50			NRS
A4372	Skin barrier solid 4x4 equiv	10/01/2000	B-00-50			NRS
A4373	Skin barrier with flange	10/01/2000	B-00-50			NRS
A4374	Skin barrier extended wear	10/01/2000	B-00-50	10/01/2002	K0563, K0564	NRS
A4375	Drainable plastic pch w fcpl	10/01/2000	B-00-50			NRS

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A4376	Drainable rubber pch w fcplt	10/01/2000	B-00-50			NRS
A4377	Drainable plstic pch w/o fp	10/01/2000	B-00-50			NRS
A4378	Drainable rubber pch w/o fp	10/01/2000	B-00-50			NRS
A4379	Urinary plastic pouch w fcpl	10/01/2000	B-00-50			NRS
A4380	Urinary rubber pouch w fcplt	10/01/2000	B-00-50			NRS
A4381	Urinary plastic pouch w/o fp	10/01/2000	B-00-50			NRS
A4382	Urinary hvy plstc pch w/ofp	10/01/2000	B-00-50			NRS
A4383	Urinary rubber pouch w/o fp	10/01/2000	B-00-50			NRS
A4384	Ostomy faceplt/silicone ring	10/01/2000	B-00-50			NRS
A4385	Ost skn barrier sld extwear	10/01/2000	B-00-50			NRS
A4386	Ost skn barrier w flngex wr	10/01/2000	B-00-50	10/01/2002	K0565, K0566	NRS
A4387	Ost clsd pouch w attst barr	10/01/2000	B-00-50			NRS
A4388	Drainable pch w ex wearbarr	10/01/2000	B-00-50			NRS
A4389	Drainable pch w st wearbarr	10/01/2000	B-00-50			NRS
A4390	Drainable pch ex wear convex	10/01/2000	B-00-50			NRS
A4391	Urinary pouch w ex wearbarr	10/01/2000	B-00-50			NRS
A4392	Urinary pouch w st wearbarr	10/01/2000	B-00-50			NRS
A4393	Urine pch w ex wearbar conv	10/01/2000	B-00-50			NRS
A4394	Ostomy pouch liq deodorant	10/01/2000	B-00-50			NRS
A4395	Ostomy pouch solid deodorant	10/01/2000	B-00-50			NRS
A4396	Peristomal hernia supprt blt	10/01/2000	B-00-50			NRS
A4397	Irrigation supply sleeve	10/01/2000	B-00-50			NRS
A4398	Ostomy irrigation bag	10/01/2000	B-00-50			NRS
A4399	Ostomy irrig cone/cath w brs	10/01/2000	B-00-50			NRS
A4400	Ostomy irrigation set	10/01/2000	B-00-50			NRS
A4402	Lubricant per ounce	10/01/2000	B-00-50			NRS
A4404	Ostomy ring each	10/01/2000	B-00-50			NRS
A4405	Nonpectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4406	Pectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4407	Ext wear ost skn barr <=4sq"	01/01/2003	AB-02-137			NRS
A4408	Ext wear ost skn barr >4sq"	01/01/2003	AB-02-137			NRS
A4409	Ost skn barr w flng <=4 sq"	01/01/2003	AB-02-137			NRS
A4410	Ost skn barr w flng >4sq"	01/01/2003	AB-02-137			NRS
A4411	Ostomy skin barrier, solid 4x4 or equiv., extended wear, w/ built-in convexity, each	01/01/2006	Tr. 710			NRS
A4412	Ostomy pouch, drainable, high output, for use on a barrier w/ flange (2 piece system) without filter, each	01/01/2006	Tr. 710			NRS
A4413	2 pc drainable ost pouch w/ filter	01/01/2003	AB-02-137			NRS
A4414	Ostomy skn barr w/ flng < 4sq	01/01/2003	AB-02-137			NRS

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A4415	Ostomy skn barr w/ flng > 4sq	01/01/2003	AB-02-137			NRS
A4416	Ost pch clsd w barrier/fltr	01/01/2004	Tr. 8			NRS
A4417	Ost pch w bar/bltinconv/fltr	01/01/2004	Tr. 8			NRS
A4418	Ost pch clsd w/o bar w fltr	01/01/2004	Tr. 8			NRS
A4419	Ost pch for bar w flange/ft	01/01/2004	Tr. 8			NRS
A4420	Ost pch clsd for bar w lk fl	01/01/2004	Tr. 8			NRS
A4421 (6)	Ostomy supply misc	10/01/2000	B-00-50		N/A	NRS
A4422	Ost pouch absorbent material	01/01/2003	AB-02-137			NRS
A4423	Ost pch for bar w lk fl/fltr	01/01/2004	Tr. 8			NRS
A4424	Ost pch drain w bar & filter	01/01/2004	Tr. 8			NRS
A4425	Ost pch drain for barrier fl	01/01/2004	Tr. 8			NRS
A4426	Ost pch drain 2 piece system	01/01/2004	Tr. 8			NRS
A4427	Ost pch drain/barr lk flng/f	01/01/2004	Tr. 8			NRS
A4428	Urine ost pouch w faucet/tap	01/01/2004	Tr. 8			NRS
A4429	Urine ost pouch w bltinconv	01/01/2004	Tr. 8			NRS
A4430	Ost urine pch w b/bltin conv	01/01/2004	Tr. 8			NRS
A4431	Ost pch urine w barrier/tapv	01/01/2004	Tr. 8			NRS
A4432	Os pch urine w bar/fange/tap	01/01/2004	Tr. 8			NRS
A4433	Urine ost pch bar w lock fln	01/01/2004	Tr. 8			NRS
A4434	Ost pch urine w lock flng/ft	01/01/2004	Tr. 8			NRS
A4455	Adhesive remover per ounce	10/01/2000	B-00-50			NRS
A4458	Reusable enema bag	01/01/2003	AB-02-137			NRS
A4460	Elastic compression bandage	10/01/2000	B-00-50			NRS
A4461	Surgical dressing holder, non-reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4462	Abdmnl drssng holder/binder	10/01/2000	B-00-50	01/01/2007	A4461, A4463	NRS
A4463	Surgical dressing holder, reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4481	Tracheostoma filter	10/01/2000	B-00-50			NRS
A4554	Disposable underpads	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4622	Tracheostomy or larngectomy	10/01/2000	B-00-50	01/01/2004	A7520, A7521, A7522	NRS
A4623	Tracheostomy inner cannula	10/01/2000	B-00-50			NRS
A4625	Trach care kit for new	10/01/2000	B-00-50			NRS
A4626	Tracheostomy cleaning brush	10/01/2000	B-00-50			NRS
A4649	Surgical supplies	10/01/2000	B-00-50			NRS
A4656	Needle, any size, each	01/01/2003	AB-02-137	01/01/2006	A4215	NRS
A4657	Syringe, with or without needle, each	01/01/2003	AB-02-137			NRS
A4712	Sterile water inj per 10 ml	01/01/2003	AB-02-137	01/01/2004	N/A	NRS
A4930	Sterile, gloves per pair	01/01/2003	AB-02-137			NRS

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A4932	Rectal thermometer, reusable, any type, each	01/01/2007	Tr.1082			NRS
A5051	Pouch clsd w barr attached	10/01/2000	B-00-50			NRS
A5052	Clsd ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5053	Clsd ostomy pouch faceplate	10/01/2000	B-00-50			NRS
A5054	Clsd ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5055	Stoma cap	10/01/2000	B-00-50			NRS
A5061	Pouch drainable w barrier at	10/01/2000	B-00-50	10/01/2002	K0567, K0568	NRS
A5061 (5)	Pouch drainable w barrier at	01/01/2003	AB-02-137			NRS
A5062	Drnble ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5063	Drain ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5071	Urinary pouch w/barrier	10/01/2000	B-00-50			NRS
A5072	Urinary pouch w/o barrier	10/01/2000	B-00-50			NRS
A5073	Urinary pouch on barr w/flng	10/01/2000	B-00-50			NRS
A5081	Continent stoma plug	10/01/2000	B-00-50			NRS
A5082	Continent stoma catheter	10/01/2000	B-00-50			NRS
A5093	Ostomy accessory convex inse	10/01/2000	B-00-50			NRS
A5102	Beside drain btl w/wo tube	10/01/2000	B-00-50			NRS
A5105	Urinary suspensory	10/01/2000	B-00-50			NRS
A5112	Urinary leg bag	10/01/2000	B-00-50			NRS
A5113	Latex leg strap	10/01/2000	B-00-50			NRS
A5114	Foam/fabric leg strap	10/01/2000	B-00-50			NRS
A5119	Skin barrier wipes box pr	10/01/2000	B-00-50	01/01/2006	A5120	NRS
A5120	Skin barrier, wipes or swabs, each	01/01/2006	Tr. 710			NRS
A5121	Solid skin barrier 6x6	10/01/2000	B-00-50			NRS
A5122	Solid skin barrier 8x8	10/01/2000	B-00-50			NRS
A5123	Skin barrier with flange	10/01/2000	B-00-50	10/01/2002	K0570, K0571	NRS
A5126	Disk / foam pad +or-	10/01/2000	B-00-50			NRS
A5131	Appliance cleaner	10/01/2000	B-00-50			NRS
A5149	Incontinence / ostomy supply	10/01/2000	B-00-50	01/01/2001	A4335, A4421	NRS
A6010	Collagen based wound filler, dry foam	01/01/2002	AB-01-128			NRS
A6011	Collagen gel/paste wound fil	01/01/2003	AB-02-137			NRS
A6020	Collagen wound dressing	10/01/2000	B-00-50			NRS
A6021	Collagen dressing <=16 sq in	01/01/2001	AB-01-65			NRS
A6022	Collagen drsg>6<=48 sq in	01/01/2001	AB-01-65			NRS
A6023	Collagen dressing >48 sq in	01/01/2001	AB-01-65			NRS
A6024	Collagen dsgr wound filler	01/01/2001	AB-01-65			NRS
A6025	Gel sheet for dermal or epidermal application (e.g. silicone, hydrogel, other)	01/01/2004	Tr.8	01/01/2006	N/A	NRS

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A6154	Wound pouch each	10/01/2000	B-00-50			NRS
A6196	Alginate dressing <=16 sq in	10/01/2000	B-00-50			NRS
A6197	Alginate drsg >16 <=48 sq	10/01/2000	B-00-50			NRS
A6198	Alginate dressing > 48 sq	10/01/2000	B-00-50			NRS
A6199	Alginate drsg wound filler	10/01/2000	B-00-50			NRS
A6200	Compos drsg <=16 no bdr	10/01/2000	B-00-50			NRS
A6201	Compos drsg >16<=48 no bdr	10/01/2000	B-00-50			NRS
A6202	Compos drsg >48 no bdr	10/01/2000	B-00-50			NRS
A6203	Composite drsg <= 16 sq	10/01/2000	B-00-50			NRS
A6204	Composite drsg >16<=48 sq in	10/01/2000	B-00-50			NRS
A6205	Composite drsg > 48 sq	10/01/2000	B-00-50			NRS
A6206	Contact layer <= 16 sq	10/01/2000	B-00-50			NRS
A6207	Contact layer >16<= 48 sq	10/01/2000	B-00-50			NRS
A6208	Contact layer > 48 sq	10/01/2000	B-00-50			NRS
A6209	Foam drsg <=16 sq in w/o bdr	10/01/2000	B-00-50			NRS
A6210	Foam drg >16<=48 sq in w/o b	10/01/2000	B-00-50			NRS
A6211	Foam drg > 48 sq in w/o brdr	10/01/2000	B-00-50			NRS
A6212	Foam drg <=16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6213	Foam drg >16<=48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6214	Foam drg > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6215	Foam dressing wound filler	10/01/2000	B-00-50			NRS
A6219	Gauze <= 16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6220	Gauze >16 <=48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6221	Gauze > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6222	Gauze <=16 in no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6223	Gauze >16<=48 no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6224	Gauze > 48 in no w /sal w/ o b	10/01/2000	B-00-50			NRS
A6228	Gauze <= 16 sq in water / sal	10/01/2000	B-00-50			NRS
A6229	Gauze >16<=48 sq in watr / sal	10/01/2000	B-00-50			NRS
A6230	Gauze > 48 sq in water / salne	10/01/2000	B-00-50			NRS
A6231	Hydrogel dsg<=16 sq in	01/01/2001	AB-01-65			NRS
A6232	Hydrogel dsg>16<=48 sq in	01/01/2001	AB-01-65			NRS
A6233	Hydrogel dressing >48 sq in	01/01/2001	AB-01-65			NRS
A6234	Hydrocolld drg <=16 w / o bdr	10/01/2000	B-00-50			NRS
A6235	Hydrocolld drg >16<=48 w / o b	10/01/2000	B-00-50			NRS
A6236	Hydrocolld drg > 48 in w / o b	10/01/2000	B-00-50			NRS
A6237	Hydrocolld drg <=16 in w / bdr	10/01/2000	B-00-50			NRS
A6238	Hydrocolld drg >16<=48 w / bdr	10/01/2000	B-00-50			NRS
A6239	Hydrocolld drg > 48 in w / bdr	10/01/2000	B-00-50			NRS
A6240	Hydrocolld drg filler paste	10/01/2000	B-00-50			NRS

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A6241	Hydrocolloid drg filler dry	10/01/2000	B-00-50			NRS
A6242	Hydrogel drg <=16 in w / o bdr	10/01/2000	B-00-50			NRS
A6243	Hydrogel drg >16<=48 w / o bdr	10/01/2000	B-00-50			NRS
A6244	Hydrogel drg >48 in w / o bdr	10/01/2000	B-00-50			NRS
A6245	Hydrogel drg <= 16 in w / bdr	10/01/2000	B-00-50			NRS
A6246	Hydrogel drg >16<=48 in w / b	10/01/2000	B-00-50			NRS
A6247	Hydrogel drg > 48 sq in w / b	10/01/2000	B-00-50			NRS
A6248	Hydrogel dressing	10/01/2000	B-00-50			NRS
A6251	Absorpt drg <=16 sq in w / o b	10/01/2000	B-00-50			NRS
A6252	Absorpt drg >16 <=48 w / o bdr	10/01/2000	B-00-50			NRS
A6253	Absorpt drg . 48 sq in w / o b	10/01/2000	B-00-50			NRS
A6254	Absorpt drg <=16 sq in w / bdr	10/01/2000	B-00-50			NRS
A6255	Absorpt drg >16<=48 in w / bdr	10/01/2000	B-00-50			NRS
A6256	Absorpt drg > 48 sq in w / bdr	10/01/2000	B-00-50			NRS
A6257	Transparent film <= 16 sq in	10/01/2000	B-00-50			NRS
A6258	Transparent film >16<=48 in	10/01/2000	B-00-50			NRS
A6259	Transparent film > 48 sq in	10/01/2000	B-00-50			NRS
A6261	Wound filler gel / paste / oz	10/01/2000	B-00-50			NRS
A6262	Wound filler dry form / gram	10/01/2000	B-00-50			NRS
A6266	Impreg gauze no h20 / sal / yard	10/01/2000	B-00-50			NRS
A6402	Sterile gauze <= 16 sq in	10/01/2000	B-00-50			NRS
A6403	Sterile gauze>16 <= 48 sq in	10/01/2000	B-00-50			NRS
A6404	Sterile gauze > 48 sq in	10/01/2000	B-00-50			NRS
A6405	Sterile elastic gauze / yd	10/01/2000	B-00-50			NRS
A6406	Sterile non-elastic gauze / yd	10/01/2000	B-00-50			NRS
A6407	Packing strips, non-impregnated, up to 2 inches, per lin yd	01/01/2004	Tr. 8			NRS
A6410	Sterile eye pad	01/01/2003	AB-02-137			NRS
A6412	Eye patch, occlusive, each	01/01/2007	Tr.1082			NRS
A6440	Zinc Paste >=3"<5" w/roll	04/01/2003	AB-03-002			NRS
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width > or = 3" and < 5", per yard	01/01/2004	Tr. 8			NRS
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	01/01/2004	Tr. 8			NRS
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS

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A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6457	Tubular dressing with or without elastic, any width, per linear yard	01/01/2006	Tr. 710			NRS
A7040	One way chest drain valve	01/01/2005	Tr. 340			NRS
A7041	Water seal drainage container and tubing for use with implanted chest tube	01/01/2005	Tr. 340			NRS
A7043	Vacuum drainage bottle & tubing	01/01/2003	AB-02-137			NRS
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	01/01/2005	Tr. 340			NRS
A7501	Tracheostoma valve w diaphra	01/01/2001	AB-01-65			NRS
A7502	Replacement diaphragm/fplate	01/01/2001	AB-01-65			NRS
A7503	HMES filter holder or cap	01/01/2001	AB-01-65			NRS
A7504	Tracheostoma HMES filter	01/01/2001	AB-01-65			NRS
A7505	HMES or trach valve housing	01/01/2001	AB-01-65			NRS
A7506	HMES/trachvalve adhesivedisk	01/01/2001	AB-01-65			NRS
A7507	Integrated filter & holder	01/01/2001	AB-01-65			NRS
A7508	Housing & Integrated Adhesiv	01/01/2001	AB-01-65			NRS
A7509	Heat & moisture exchange sys	01/01/2001	AB-01-65			NRS
A7520	Tracheostomy/larynectomy tube, non-cuffed	01/01/2004	Tr. 8			NRS
A7521	Tracheostomy/larynectomy tube, cuffed	01/01/2004	Tr. 8			NRS
A7522	Tracheostomy/larynectomy tube, stainless steel	01/01/2004	Tr. 8			NRS
A7523	Tracheostomy shower protector, each	01/01/2004	Tr. 8			NRS
A7524	Tracheostomy stent/stud/button, each	01/01/2004	Tr. 8			NRS
A7525 (8)	Tracheostomy mask, each	01/01/2004	Tr. 8	01/01/2004		NRS
A7526 (8)	Tracheostomy tube collar/holder, each	01/01/2004	Tr. 8	01/01/2004		NRS
A7527	Tracheostomy/laryngectomy tube plug/stop, each	01/01/2005	Tr. 340			NRS
G0193	Endoscopic study swallow functn	01/01/2001	AB-01-65			Therapy
G0194	Sensory testing endoscopic stud	01/01/2001	AB-01-65			Therapy
G0195	Clinical eval swallowing funct	01/01/2001	AB-01-65			Therapy
G0196	Eval of swallowing with radio opa	01/01/2001	AB-01-65			Therapy
G0197	Eval of pt for prescip speech devi	01/01/2001	AB-01-65			Therapy

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G0198	Patient adapation & train for spe	01/01/2001	AB-01-65			Therapy
G0199	Reevaluation of patient use spec	01/01/2001	AB-01-65			Therapy
G0200	Eval of patient prescip of voice p	01/01/2001	AB-01-65			Therapy
G0201	Modi for training in use voice pro	01/01/2001	AB-01-65			Therapy
G0279	Excorp shock tx, elbow epi	01/01/2003	AB-02-137			Therapy
G0280	Excorp shock tx other than	01/01/2003	AB-02-137			Therapy
G0281	Elec stim unattend for press	01/01/2003	AB-02-137			Therapy
G0282	Elect stim wound care not pd	01/01/2003	AB-02-137			Therapy
G0283	Elec stim other than wound	01/01/2003	AB-02-137			Therapy
G0329	Electromagntic tx for ulcers	10/01/2004	Tr. 226			Therapy
K0280	Extension drainage tubing	10/01/2000	B-00-50	01/01/2001	A4331	NRS
K0281	Lubricant catheter insertion	10/01/2000	B-00-50	01/01/2001	A4332	NRS
K0407	Urinary cath skin attachment	10/01/2000	B-00-50	01/01/2001	A4333	NRS
K0408	Urinary cath leg strap	10/01/2000	B-00-50	01/01/2001	A4334	NRS
K0409	Sterile H2O irrigation solut	10/01/2000	B-00-50	01/01/2001	A4319	NRS
K0410	Male ext cath w / adh coating	10/01/2000	B-00-50	01/01/2001	A4324	NRS
K0411	Male ext cath w / adh strip	10/01/2000	B-00-50	01/01/2001	A4325	NRS
K0561:	Non-pectin based ostomy paste	10/01/2002	AB-02-092	01/01/2003	A4405	NRS
K0562:	Pectin based ostomy paste	10/01/2002	AB-02-092	01/01/2003	A4406	NRS
K0563:	Ext wear ost skn barr <4sq	10/01/2002	AB-02-092	01/01/2003	A4407	NRS
K0564:	Ext wear ost skn barr >4sq	10/01/2002	AB-02-092	01/01/2003	A4408	NRS
K0565:	Ost skn barr w flng <4sq	10/01/2002	AB-02-092	01/01/2003	A4409	NRS
K0566:	Ost skn barr w flng >4sq	10/01/2002	AB-02-092	01/01/2003	A4410	NRS
K0567:	1 pc drainable ost pouch	10/01/2002	AB-02-092	01/01/2003	A5061	NRS
K0568:	1 pc cnvx drainabl ost pouch	10/01/2002	AB-02-092	01/01/2003	A5061	NRS
K0569:	2 pc drainable ost pouch	10/01/2002	AB-02-092	01/01/2003	A4413	NRS
K0570:	Ostomy skn barr w flng <4sq	10/01/2002	AB-02-092	01/01/2003	A4414	NRS
K0571:	Ostomy skn barr w flng >4sq	10/01/2002	AB-02-092	01/01/2003	A4415	NRS
K0574:	Ostomy pouch filter	10/01/2002	AB-02-092	01/01/2003	A4368	NRS
K0575:	Ost pouch rustle free mat	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0576:	Ostomy pouch comfort panel	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0577:	Ostomy pouch odor barrier	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0578:	Urinary pouch faucet/drain	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0579:	Ost pouch absorbent material	10/01/2002	AB-02-092	01/01/2003	A4422	NRS
K0580:	Ost pouch locking flange	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0581	Ost pch clsd w barrier/fltr	01/01/2003	AB-02-137	01/01/2004	A4416	NRS
K0582	Ost pch w bar/bltinconv/fltr	01/01/2003	AB-02-137	01/01/2004	A4417	NRS
K0583	Ost pch clsd w/o bar w fltr	01/01/2003	AB-02-137	01/01/2004	A4418	NRS
K0584	Ost pch for bar w flange/flt	01/01/2003	AB-02-137	01/01/2004	A4419	NRS
K0585	Ost pch clsd for bar w lk fl	01/01/2003	AB-02-137	01/01/2004	A4420	NRS

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Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes

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K0586	Ost pch for bar w lk fl/fltr	01/01/2003	AB-02-137	01/01/2004	A4423	NRS
K0587	Ost pch drain w bar & filter	01/01/2003	AB-02-137	01/01/2004	A4424	NRS
K0588	Ost pch drain for barrier fl	01/01/2003	AB-02-137	01/01/2004	A4425	NRS
K0589	Ost pch drain 2 piece system	01/01/2003	AB-02-137	01/01/2004	A4426	NRS
K0590	Ost pch drain/barr lk flng/f	01/01/2003	AB-02-137	01/01/2004	A4427	NRS
K0591	Urine ost pouch w faucet/tap	01/01/2003	AB-02-137	01/01/2004	A4428	NRS
K0592	Urine ost pouch w bltinconv	01/01/2003	AB-02-137	01/01/2004	A4429	NRS
K0593	Ost urine pch w b/bltin conv	01/01/2003	AB-02-137	01/01/2004	A4430	NRS
K0594	Ost pch urine w barrier/tapv	01/01/2003	AB-02-137	01/01/2004	A4431	NRS
K0595	Os pch urine w bar/fange/tap	01/01/2003	AB-02-137	01/01/2004	A4432	NRS
K0596	Urine ost pch bar w lock fln	01/01/2003	AB-02-137	01/01/2004	A4433	NRS
K0597	Ost pch urine w lock flng/ft	01/01/2003	AB-02-137	01/01/2004	A4434	NRS
K0614	chem/antiseptic solution, 8oz.	10/01/2003	AB-03-096			NRS
K0620	tubular elastic dressing	10/01/2003	AB-03-096			NRS
K0621	gauze, non-impreg pack strip	10/01/2003	AB-03-096	01/01/2004	A6407	NRS

- END -

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Addendum C

Home Health Consolidated Billing Code List - Therapy Codes

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
64550	Apply neurostimulator	01/01/2001	AB-01-65			Therapy
0019T	Extracorp shock wave tx, ms	01/01/2003	AB-02-137			Therapy
0020T	Extracorp shock wave tx, ft	01/01/2003	AB-02-137			Therapy
90901	Biofeedback train, any meth	10/01/2000	B-00-50			Therapy
90911	Biofeedback peri/uro/rectal	10/01/2000	B-00-50			Therapy
92506	Speech/hearing evaluation	10/01/2000	B-00-50			Therapy
92507	Speech/hearing therapy, individual	10/01/2000	B-00-50			Therapy
92508	Speech/hearing therapy, group	10/01/2000	B-00-50			Therapy
92510	Rehab for ear implant	10/01/2000	B-00-50			Therapy
92525	Oral function evaluation	10/01/2000	B-00-50	01/01/2003	92610, 92611	Therapy
92526	Oral function therapy	10/01/2000	B-00-50			Therapy
92597	Oral speech device eval	10/01/2000	B-00-50	01/01/2003	92605, 92606, 92607	Therapy
92598	Modify oral speech device	10/01/2000	B-00-50	01/01/2003	N/A	Therapy
92601	Cochlear implt f/up exam < 7	01/01/2003	AB-02-137			Therapy
92602	Reprogram cochlear implt < 7	01/01/2003	AB-02-137			Therapy
92603	Cochlear implt f/up exam 7 >	01/01/2003	AB-02-137			Therapy
92604	Reprogram cochlear implt 7 >	01/01/2003	AB-02-137			Therapy
92605	Eval for nonspeech device rx	01/01/2003	AB-02-137			Therapy
92606	Non-speech device service	01/01/2003	AB-02-137			Therapy
92607	Ex for speech device rx, 1hr	01/01/2003	AB-02-137			Therapy
92608	Ex for speech device rx addl	01/01/2003	AB-02-137			Therapy
92609	Use of speech device service	01/01/2003	AB-02-137			Therapy
92610	Evaluate swallowing function	01/01/2003	AB-02-137			Therapy
92611	Motion fluoroscopy/swallow	01/01/2003	AB-02-137			Therapy
92612	Endoscopy swallow tst (fees)	01/01/2003	AB-02-137			Therapy
92614	Laryngoscopic sensory test	01/01/2003	AB-02-137			Therapy
92616	Fees w/laryngeal sense test	01/01/2003	AB-02-137			Therapy
95831	Limb muscle testing, manual	01/01/2001	AB-01-65			Therapy
95832	Hand muscle testing, manual	01/01/2001	AB-01-65			Therapy
95833	Body muscle testing, manual	01/01/2001	AB-01-65			Therapy
95834	Body muscle testing, manual	01/01/2001	AB-01-65			Therapy
95851	Range of motion measurements	01/01/2001	AB-01-65			Therapy

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Home Health Consolidated Billing Code List - Therapy Codes

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
95852	Range of motion measurements	01/01/2001	AB-01-65			Therapy
96000	Motion analysis, video/3d	01/01/2003	AB-02-137			Therapy
96001	Motion test w/ft press meas	01/01/2003	AB-02-137			Therapy
96002	Dynamic surface emg	01/01/2003	AB-02-137			Therapy
96003	Dynamic fine wire emg	01/01/2003	AB-02-137			Therapy
96105	Assessment of aphasia	10/01/2000	B-00-50			Therapy
97001	Pt evaluation	10/01/2000	B-00-50			Therapy
97002	Pt re-evaluation	10/01/2000	B-00-50			Therapy
97003	Ot evaluation	10/01/2000	B-00-50			Therapy
97004	Ot re-evaluation	10/01/2000	B-00-50			Therapy
97012	Mechanical traction therapy	10/01/2000	B-00-50			Therapy
97014	Electric stimulation therapy	10/01/2000	B-00-50	10/01/2003	N/A	Therapy
97016	Vasopneumatic device therapy	10/01/2000	B-00-50			Therapy
97018	Paraffin bath therapy	10/01/2000	B-00-50			Therapy
97020	Microwave therapy	10/01/2000	B-00-50	01/01/2007	97024	Therapy
97022	Whirlpool therapy	10/01/2000	B-00-50			Therapy
97024	Original definition: Diathermy treatment 01/01/2007 definition: Application of a modality to one or more areas; diathermy (e.g., microwave)	10/01/2000	B-00-50			Therapy
97026	Infrared therapy	10/01/2000	B-00-50			Therapy
97028	Ultraviolet therapy	10/01/2000	B-00-50			Therapy
97032	Electrical stimulation	10/01/2000	B-00-50			Therapy
97033	Electric current therapy	10/01/2000	B-00-50			Therapy
97034	Contrast bath therapy	10/01/2000	B-00-50			Therapy
97035	Ultrasound therapy	10/01/2000	B-00-50			Therapy
97036	Hydrotherapy	10/01/2000	B-00-50			Therapy
97039	Physical therapy treatment	10/01/2000	B-00-50			Therapy
97110	Therapeutic exercises	10/01/2000	B-00-50			Therapy
97112	Neuromuscular reeducation	10/01/2000	B-00-50			Therapy
97113	Aquatic therapy/exercises	10/01/2000	B-00-50			Therapy
97116	Gait training therapy	10/01/2000	B-00-50			Therapy
97122	Manual traction therapy	10/01/2000	B-00-50	01/01/2001	97140	Therapy
97124	Massage therapy	10/01/2000	B-00-50			Therapy
97139	Physical medicine procedure	10/01/2000	B-00-50			Therapy
97140	Manual therapy	01/01/2001	AB-01-65			Therapy
97150	Group therapeutic procedures	10/01/2000	B-00-50			Therapy
97250	Myofascial release	10/01/2000	B-00-50	01/01/2001	97140	Therapy
97260	Regional manipulation	10/01/2000	B-00-50	01/01/2001	97140	Therapy
97261	Supplemental manipulations	10/01/2000	B-00-50	01/01/2001	97140	Therapy

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Home Health Consolidated Billing Code List - Therapy Codes

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
97265	Joint mobilization	10/01/2000	B-00-50	01/01/2001	97140	Therapy
97504	Orthotic training	10/01/2000	B-00-50	01/01/2007	97760	Therapy
97520	Prosthetic training	10/01/2000	B-00-50	01/01/2007	97761	Therapy
97530	Therapeutic activities	10/01/2000	B-00-50			Therapy
97532	Cognitive skills development	01/01/2001	AB-01-65			Therapy
97533	Sensory integration	01/01/2001	AB-01-65			Therapy
97535	Self care mngment training	10/01/2000	B-00-50			Therapy
97537	Community/work reintegration	10/01/2000	B-00-50			Therapy
97542	Wheelchair mngment training	10/01/2000	B-00-50			Therapy
97545	Work hardening	10/01/2000	B-00-50			Therapy
97546	Work hardening add-on	10/01/2000	B-00-50			Therapy
97597	debridement;surface area less than or equal to 20 square centimeters	01/01/2005	Tr. 340			Therapy
97598	debridement;total wound(s) surface greater than 20 square centimeters	01/01/2005	Tr. 340			Therapy
97601	Wound care selective	01/01/2001	AB-01-65	01/01/2005	97507, 97598	Therapy
97602	Wound care non-selective	01/01/2001	AB-01-65			Therapy
97605	Negative pressure wound therapy (eg vacuum assisted drainage collection); total wound(s) surface area less than or equal to 50 square centimeters	01/01/2005	Tr. 340			Therapy
97606	Negative pressure wound therapy (eg vacuum assisted drainage collection); total wound(s) surface area greater than50 square centimeters	01/01/2005	Tr. 340			Therapy
97703	Prosthetic checkout	10/01/2000	B-00-50	01/01/2007	97762	Therapy
97750	Physical performance test	10/01/2000	B-00-50			Therapy
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes	01/01/2004	Tr. 8			Therapy
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, each 15 minutes	01/01/2007	Tr.1082			Therapy
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	01/01/2007	Tr.1082			Therapy

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	01/01/2007	Tr.1082			Therapy
97770	Cognitive skills development	10/01/2000	B-00-50	01/01/2001	97532, 97533	Therapy
97799	Physical medicine procedure	10/01/2000	B-00-50			Therapy

- END -

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2007

(Final payment amounts per 60-day episodes ending on or after January 1, 2007 and before January 1, 2008 - Continuing calendar year (CY) update.)

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

Section 5201 of the Deficit Reduction Act (DRA) of 2005 (Public Law (PL) No. 109-171) provides that home health payments be updated by the applicable home health payments be updated by the applicable home health market basket percentage increase of CY 2007. For CY 2007, the applicable home health market basket was 3.3%. Section 5201 of the **DRA** also modifies Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to reinstitute a five percent payment increase for home health services furnished in a rural area with respect to episodes and visits beginning on or after January 1, 2007 and before January 1, 2008.

Final 60-Day Episode Payment Amounts for Site of Service in Non-Rural Areas - CY 2007

The following CY 2006 60-day episode payment rate was increased by the home health market basket increase (3.3%) to yield the updated CY 2007 national 60-day episode rate (\$2,339.00) for episodes ending on or after January 1, 2007 and before January 1, 2008:

Total Prospective Payment Amount Per 60-Day Episode for CY 2006	3.3% Update for CY 2007	Total Prospective Payment Amount Per 60-Day Episode For CY 2007
\$2,264.28	x 1.033	\$2,339.00

Following are the national per-visit amounts for Low Utilization Payment Adjustments (LUPAs) (i.e., episodes with four or fewer visits) and outlier calculations updated by the applicable home health market basket for CY 2007 (3.3%) for visits/episodes ending on or after January 1, 2007, and before January 1, 2008):

Home Health Discipline Type	Total Prospective Payment Amount Per 60-Day Episode For CY 2005	3.3% Updated	Total Prospective Payment Amount Per 60-Day Episode For CY 2007
Home Health Aide	\$44.76	x 1.033	\$46.24
Medical Social Services	\$158.45	x 1.033	\$163.68
Occupational Therapy	\$108.81	x 1.033	\$112.40
Physical Therapy	\$108.08	x 1.033	\$111.65
Skilled Nursing	\$98.85	x 1.033	\$102.11
Speech-Language Pathology	\$117.44	x 1.033	\$121.32

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Chapter 12, Addendum L (CY 2007)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2007

Final 60-Day Episode Payment Amounts for Site of Service in Rural Areas - CY 2007

Following is the CY 2006 rural add-on to the 60-day payment for episodes ending on or after January 1, 2006, and before January 1, 2007, for beneficiaries who reside in a rural area before application of case-mix and wage index adjustments while the rural add-on primarily affects those episodes paid on CY 2006 rates, it also affects a number of CY 2007 episodes.

Total Prospective Payment Amount Per 60-Day Episode for CY 2005	Multiplied By Five Percent Rural Increase	Total Prospective Payment Amount Per 60-day Episode For CY 2006 For A Beneficiary Who Resides In A Rural, Non-MSA/Non-CBSA Area
\$2,339.00	1.05	\$2,455.95

The following are rural add-on amounts for visits ending on or after January 1, 2007 and before January 1, 2008, used in the calculation of LUPAs (i.e., episodes with four or fewer visits) and outliers before application of case mix and wage index adjustments:

Home Health Discipline Type	Total prospective payment amount per 60-day episode for CY 2007	Multiplied By Five Percent Rural Increase	Final Standardized Per Visit Payment Amounts Per 60-Day Episode For LUPA
Home Health Aide	\$46.24	1.05	\$48.55
Medical Social Services	\$163.68	1.05	\$171.86
Occupational Therapy	\$112.40	1.05	\$118.02
Physical Therapy	\$111.65	1.05	\$117.23
Skilled Nursing	\$102.11	1.05	\$107.22
Speech-Language Pathology	\$121.32	1.05	\$127.39

Contractor Requirements

- Shall install a new HH PPS Pricer software module effective January 1, 2006.
- Shall apply the CY 2006 HH PPS payment rates for episodes which claim statement "Through" dates on or after January 1, 2007 and before January 1, 2008.
- Shall apply five percent rural add-on HH PPS payment rates for episodes with claim statement "From" dates on or after January 1, 2007 and before January 1, 2008.

- END -

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Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2008

Calculate the Total Prospective Payment Rate:

- Case-mix adjusted and wage-adjusted labor portion of the rate without NRS amount: \$2,023.81
- Case-mix adjusted non-labor portion of the rate without NRS amount: \$763.51
- Calculate the total case-mix and wage-adjusted national standardized 60-day episode payment rate without NRS amount: $\$2,023.81 + \$763.51 = \mathbf{\$2,787.32}$

Calculate the NRS Amount:

- NRS conversion factor: \$52.35
- NRS severity level 4 relative weight: 3.9686
- Calculate the NRS amount: $\$52.35 \times 3.9686 = \mathbf{\$207.76}$
- Calculate the total case-mix and wage-adjusted national standardized 60-day episode payment rate including NRS amount: $\$2,787.32 + \$207.76 = \mathbf{\$2,995.08}$

National Per-Visit Amounts Used to Pay LUPAs and Compute Imputed Costs in Outlier Calculations

Calculation of National Per-Visit Amounts for CY 2008

- CY 2007 national per-visit amounts used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations were increased by the rebased and revised home health market basket (3.0%), and multiplied by 1.05 and 0.95 to account for the estimated percentage of outlier payments.
- The national per-visit amounts were not adjusted (reduced) for increases in case mix since they were not affected by the 4-equation case-mix model.

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Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2008

National per-visit amounts for LUPAs (not including the increase in payment for a beneficiary's only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the home health market basket update for CY 2008, before wage index adjustment based on the site of service for the beneficiary.

Home Health Discipline Type	Final CY 2007 Per-Visit Amounts Per 60-day Episode For LUPAs	Multiply by the Home Health Market Basket (Three Percent)	Adjusted CY 2008 Per-Visit Payment Amount Per Discipline
Home Health Aide	\$46.24	x 1.030 x 1.05 x 0.95	\$47.51
Medical Social Services	\$163.68	x 1.030 x 1.05 x 0.95	\$168.17
Occupational Therapy	\$112.40	x 1.030 x 1.05 x 0.95	\$115.48
Physical Therapy	\$111.65	x 1.030 x 1.05 x 0.95	\$114.71
Skilled Nursing	\$102.11	x 1.030 x 1.05 x 0.95	\$104.91
Speech-Language Pathology	\$121.22	x 1.030 x 1.05 x 0.95	\$124.54

Changes in the Payment of LUPA Episodes for CY 2008

- Payment for LUPA episodes is changed in that for LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode, a revised payment amount of \$87.93 is being added to the LUPA payment before adjusting for wage index.
- This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit.

Example 2. An HHA is providing services to a beneficiary in rural New Hampshire. During the 60-day episode the beneficiary receives only three visits. It is the initial episode during a sequence of adjacent episodes for this beneficiary. The HHA submits all its required quality data.

Number of Visits and Visit Type	Per-Visit Payment Amounts
1 Skilled Nursing Visit	\$104.91
2 Home Health Aide Visits	47.51
Wage Index Value for Rural New Hampshire	1.0863
Increase in LUPA episode payment for only or initial episode in a sequence of adjacent episodes	87.93

Calculate the total wage-adjusted adjustment amount for only or initial episodes in a sequence of adjacent episodes:

Calculate the wage-adjusted portion of the \$87.93 adjustment for only or initial episodes in a sequence of adjacent episodes: $(0.77082 \times \$87.93)$	\$67.78
Apply the wage index factor for rural New Hampshire from Addendum M (CY 2008) : $(1.0863 \times \$67.78)$	\$73.63
Calculate the non-labor portion of the \$87.93 adjustment for only or initial episode in a sequence of adjacent episodes: $(0.22918 \times \$87.93)$	\$20.15
Calculate the total wage-adjusted adjustment amount for only or initial episodes in a sequence of adjacent episodes: $(\$73.63 + \$20.15)$	\$93.78

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Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2008

Calculate the wage-adjusted LUPA payment amount for the skilled nursing and home health aid portion of the payment:

Calculate the labor portion of the per visit payment amount for one skilled nursing visit: (0.77082 x \$104.91)	\$80.87
Apply the wage index factor for rural New Hampshire from Addendum M (CY 2008) : (1.0863 x \$80.87)	\$87.85
Calculate the non-labor portion of the per-visit payment amount for one skilled nursing visit: (0.22918 x 104.91)	\$24.04
Calculate the wage-adjusted LUPA payment amount for one skilled nursing visit: (\$87.85 + \$24.04)	\$111.89
Calculate the labor portion of the per-visit payment amount for two home health aid visits: (0.77082 x (\$47.51 + \$47.51))	\$73.24
Apply the wage index factor for rural New Hampshire from Addendum M (CY 2008) : (1.0863 x \$73.24)	\$79.56
Calculate the non-labor portion of the per-visit payment amount for two home health aide visits (0.22918 x (\$47.51 + \$47.51))	\$21.78
Calculate the wage-adjusted LUPA payment amount for two home health aide visits: (\$79.56 + \$21.78)	\$101.34
Calculate the LUPA amount for one skilled nursing/two home health aide episodes, before applying any increase for the only episode or initial episode in a sequence of adjacent episodes: (\$111.89 + \$101.34)	\$213.23

Calculate total LUPA payment:

Calculate the Total LUPA payment (with proposed increase for an only episode or initial episode in a sequence of adjacent episodes): (\$213.23 + \$93.78)	\$307.01
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Outlier Payment Calculations. Outlier payments are determined and calculated using the same methodology that has been used since the implementation of the HH PPS. The following example details the calculation of an outlier payment.

Example 2: Calculation of an Outlier Payment

The outlier payment amount is the product of the imputed amount in excess of the outlier threshold absorbed by the HHA and the loss sharing ratio. The outlier payment is added to the sum of the wage and case-mix adjusted 60-day episode amount. The steps to calculate the total episode payment, including an outlier payment, are given below.

For this example, assume that a beneficiary lives in Greenville, SC and that the episode in question began and ended in CY 2008. The episode has a case-mix severity = C3F3S5, and is a second episode with 63 visits (30 skilled nursing, 20 home health aide visits, and 13 physical therapy visits). The beneficiary had 105 NRS points, for an NRS severity level = 6). Therefore, the NRS payment amount = \$551.00, the case-mix weight = 1.9413, the wage index = 0.9860.

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Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2008

Step 1: Calculate case-mix and wage-adjusted 60-day episode payment, including NRS.

National standardized 60-day episode payment amount for episodes beginning and ending in CY 2008:	\$2,270.32
Calculate the case-mix adjusted episode payment:	
Multiply the national standardized 60-day episode payment by the applicable case mix-weight: ($\$2,270.32 \times 1.9413$)	\$4,407.37
Divide the case-mix adjusted episode payment into the labor and non-labor portions:	
Labor portion: ($0.77082 \times \$4,407.37$)	\$3,397.29
Non-labor portion: ($0.22918 \times \$4,407.37$)	\$1,010.08
Wage-adjust the labor portion by multiplying it by the wage index factor for Greenville, SC: ($0.9860 \times \$3,397.73$)	\$3,349.73
Add wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted 60-day episode payment before NRS added: ($\$3,349.73 + \$1,010.08$)	\$4,359.81
Add NRS amount to get the total case-mix and wage 60-day episode payment including NRS: ($\$551.00 + \$4,359.81$)	\$4,910.81

Step 2: Calculate wage-adjusted outlier threshold.

Fixed dollar loss amount = national standardized 60-day episode payment multiplied by 0.89 FDL ratio: ($\$2,270.32 \times 0.89$)	\$2,050.58
Divide fixed dollar loss amount into labor and non-labor portions:	
Labor portion: ($0.77082 \times \$2,020.58$)	\$1,557.50
Non-labor portion: ($0.22918 \times \$2,020.58$)	\$463.08
Wage adjust the labor portion by multiplying the labor portion of the fixed dollar loss amount by the wage index: ($\$1,557.50 \times 0.9860$)	\$1,535.70
Calculate the wage-adjusted fixed dollar loss amount without NRS by adding the wage-adjusted portion of the fixed dollar loss amount to the non-labor portion of the fixed dollar loss amount: ($\$1,535.70 + \463.08)	\$1,998.78
Calculate the fixed dollar amount of NRS:	
Multiply the NRS payment amount by the FDL ratio: ($\$551.00 \times 0.89$)	\$490.39
Divide the NRS fixed dollar loss amount into labor and non-labor portions:	
Labor portion: ($0.77082 \times \$490.39$)	\$378.00
Non-labor portion: ($0.22918 \times \$490.39$)	\$112.39
Wage-adjust the labor portion by multiplying the labor portion of the NRS fixed loss amount by the wage index: ($\$378.00 \times 0.9860$)	\$372.71
Add the wage-adjusted labor portion to the non-labor portion for the total NRS amount: ($\$372.71 + \112.39)	\$485.10
Calculate the total wage-adjusted fixed dollar loss amount including NRS by adding the wage-adjusted fixed dollar loss amount of NRS to the wage-adjusted fixed dollar loss amount without NRS: ($\$485.10 + \$1,998.78$)	\$2,483.88
Add the case-mix and wage-adjusted 60-day episode amount including NRS and the wage-adjusted fixed dollar loss amount including NRS to get the wage-adjusted outlier threshold: ($\$4,910.81 + \$2,483.88$)	\$7,394.69

Data Elements Used In Determination Of Outlier Payments

Outlier payments are payments made in addition to regular 60-day case-mix and wage-adjusted episode payments for episodes that incur unusually large costs due to home health care needs. Outlier payments are made for episodes for which the estimated costs exceed a threshold amount. The outlier threshold for each case-mixed group, Partial Episode Payment (PEP) adjustment, or total Significant Change In Condition (SCIC) adjustment is defined as the 60-day episode payment amount, PEP adjustment or total SCIC adjustment for that group plus a Fixed Dollar Loss (FDL) amount. The FDL amount is computed by multiplying the wage-adjusted 60-day episode payment amount by the FDL ratio. The outlier threshold is then subtracted from the total wage-adjusted imputed per visit cost 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 the loss-sharing ratio to obtain the outlier payment. Following are the FDL ratios and loss-sharing ratios for the last three years:

UPDATE YEAR	FDL RATIO	LOSS-SHARING RATIO
CY 2006	0.65	0.80
CY 2007	0.67	0.80
CY 2008	0.89	0.80

- END -

Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

On input records with Type of Bill (TOB) 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H, 321, 331, 32J, 33J, 32K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or contractor initiated adjustments), Pricer will perform the following calculations in the numbered order.

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PAYMENT-INDICATOR." If the value is 0 or 2, use the full standard episode rate in subsequent calculations. If the value is 1 or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

Note: Since TRICARE is not following Medicare's requirement for a 2% reduction in the standard episode rate due to the failure of the provider to report required quality data, all four values (0, 1, 2, or 3) appearing in "INIT-PAYMENT-INDICATOR" will result in full payment of standard episode rate.

1. Low Utilization Payment Adjustment (LUPA) calculation.

- a. If the "REVENUE-SUM1-6-QTY-ALL" (the total of the six revenue code quantities, representing the total number of visits on the claim) is less than five, read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated "REVENUE-COST" field.

If the following conditions are met, calculate an additional LUPA add-on payment:

- the dates in the "SER-FROM-DATE" AND "ADMIT-DATE" fields match;
- the first position of the Health Insurance Prospective Payment System (HIPPS) code is a 1 or a 2; AND
- the value in "LUPA-SRC-ADM" is not a B or C.

Wage index adjust the current LUPA add-on amount and return this amount in the "LUPA-ADD-PAYMENT" field.

Return the sum of all "REVENUE-COST" amounts in the "TOTAL-PAYMENT" field. If the LUPA payment includes LUPA add-on amount, return 14 in the "PAY-RTC" field. Otherwise, return 06 in the "PAY-RTC" field. These distinct return codes assist the contractors' systems in apportioning visit payments to claim lines. No further calculations are required.

- b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the re-coding process in Step 2.

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Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

2. Re-coding of claims based on episode sequence and therapy thresholds.

- a. Read the "RECODE-IND." If the value is 0, proceed to Step c.

If the value in "RECODE-IND" is 1, find the number of therapy services reported in "REVENUE-SUM 1-3-QTY-THR." If the number of therapy services is in the range 0-13, re-code the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, re-code the first position of the HIPPS code to 2.

If the value in "RECODE-IND" is 3, find the number of therapy services reported in "REVENUE-SUM 1-3-QTY-THR." If the number of therapy services is in the range 0-13, re-code the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, re-code the first position of the HIPPS code to 4.

- b. Read the alphabetic values in the "CLINICAL-SEV-EQ" field and "FUNCTION-SEV-EQ" field for which the number at the end of the field names corresponds to the recorded first position of the HIPPS code determined in Step a. Translate the alphabetic value from a hexavigesimal code to its corresponding numeric value. These are the severity scores in the clinical and functional domains of the case mix model under the payment equation that applies to the claim.

If the recorded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE-SUM 1-3-QTY-THR" field to re-code the **second**, **third**, and **fourth** positions of the HIPPS code according to the table below:

CLINICAL-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 2nd position value	FUNCTION-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 3rd position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-4	A	0-3	F	0-5	K
5-9	B	4-5	G	6	L
10+	C	6+	H	7-9	M
				10	N
				11-13	P

If the re-coded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE-SUM 1-3-QTY-THR" field to re-code the **second**, **third**, and **fourth** positions of the HIPPS code according to the table below:

CLINICAL-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 2nd position value	FUNCTION-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 3rd position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-4	A	0-5	F	14-15	K
5-12	B	6-8	G	16-17	L
13+	C	9+	H	18-19	M

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Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

If the recorded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE-SUM 1-3-QTY-THR" field to re-code the **second, third, and fourth** positions of the HIPPS code according to the table below:

CLINICAL-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 2nd position value	FUNCTION-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 3rd position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-2	A	0-9	F	0-5	K
3-4	B	9-10	G	6	L
5+	C	11+	H	7-9	M
				10	N
				11-13	P

If the recorded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE-SUM 1-3-QTY-THR" field to re-code the **second, third, and fourth** positions of the HIPPS code according to the table below:

CLINICAL-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 2nd position value	FUNCTION-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 3rd position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-4	A	0-9	F	14-15	K
5-12	B	9-10	G	16-17	L
13+	C	11+	H	18-19	M

Move the resulting re-coded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to Health Resource Group (HRG) payment calculations. Use the weights associated with the code in the "HRG-OUTPUT-CODE" field for all further calculations.

- c. If the first position of the HIPPS code submitted in "HRG-INPUT-CODE" is a 5 and the number of therapy services in "REVENUE-SUM 1-3-QTY-THR" is less than 20, read the value in the "EPISODE-TIMING" field.

If the value in the "EPISODE-TIMING" field is a 1 and the number of therapy services is in the range 0-13, re-code the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, re-code the first position of the HIPPS code to 2.

If the value in the "EPISODE-TIMING" field is a 2, and the number of therapy services in the range 0-13, re-code the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, re-code the first position of the HIPPS code to 4.

Return to Step b. and re-code the remaining positions of the HIPPS code as described above.

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Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

- d. In all other cases, read only the "REVENUE-SUM 1-3-QTY-THR" field and re-code the 4th positions of the HIPPS code according to the table below, if necessary:

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 or 4	
REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-5	K	14-15	K
6	L	16-17	L
7-9	M	18-19	M
10	N		
11-13	P		

Move the resulting rec-oded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculation. Use the weights associated with the code in the "HRG-OUTPUT-CODE" field for all further calculations.

3. HRG payment calculations.

- a. If the "PEP-INDICATOR" is an N:

Find the weight for the first four positions of the "HRG-OUTPUT-CODE" from the weight table for the calendar year in which the "SEV-THRU-DATE" falls. Multiply the weight times the standard episode rate for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. Multiply the case-mix rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1." Multiply the case-mix adjusted rate by the current nonlabor-related percentage to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Find the non-routine supply weight corresponding to the fifth positions of the "HRG-OUTPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. The result is the case-mix adjusted payment for non-routine supplies.

Sum the payment results for both portions of the "HRG-OUTPUT-CODE" and proceed to the outlier calculation (see Step 4).

- b. If the "PEP-INDICATOR" is a Y:

Perform the calculations of the case-mix and wage index adjusted payment for the HRG and supply amounts, Determine the proportion to be used to calculate this Partial Episode Payment (PEP) by dividing the "PEP-DAYS" amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (Step 4).

4. Outlier calculation:

- a. Wage index adjust the outlier fixed loss amount for the year in which the "SERV-THRU-DATE" falls, using the Metropolitan Statistical Area (MSA) code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

Acronyms And Abbreviations

3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Devices
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACS	American Cancer Society
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADFM	Active Duty Family Member
ADL	Activities of Daily Living
ADP	Automated Data Processing

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Appendix A

Acronyms And Abbreviations

ADSM	Active Duty Service Member
AFOSI	Air Force Office of Special Investigations
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance

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Appendix A

Acronyms And Abbreviations

ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone M arrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C/S	Client/Server
CA	Care Authorization

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Appendix A

Acronyms And Abbreviations

CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Craft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs

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CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease

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COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTEP	Cancer Therapy Evaluation Program
CTCL	Cutaneous T-Cell Lymphoma
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service

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DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid

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DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnostic Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc

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DWR	DSO Web Request
Dx	Diagnosis
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing

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EMG	Electromyograma
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization

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FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy

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HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolypsis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with

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IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular
IND	Investigational New Drugs
INR	Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient

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IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
DLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment

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LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RS	Medical Benefits and Reimbursement Systems
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index

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MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial

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NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk

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OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PCMBN	PCM By Name
PCMRS	PCM Reassignment System
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application)
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider

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PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

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POA	Power of Attorney
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prospective Payment System Ports, Protocols and Services
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue

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QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier

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Acronyms And Abbreviations

SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact

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SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life

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TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits

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TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan

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USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veteran Affairs (hospital) Veteran Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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