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HEALTH AGENCY

MB&RO

CHANGE 110
6010.58-M
JANUARY 12, 2015

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: **CONSOLIDATED CHANGE 14-003**

CONREQ: 16969

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: February 12, 2015.

This change is made in conjunction with Feb 2008 TPM, Change No. 127.

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ATTACHMENT(S): **14 PAGE(S)**
DISTRIBUTION: **6010.58-M**

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

CHANGE 110
6010.58-M
JANUARY 12, 2015

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 2	
Addendum A, pages 1 - 13	Addendum A, pages 1 - 12
CHAPTER 12	
Section 6, pages 43 and 44	Section 6, pages 43 and 44

SUMMARY OF CHANGES

CHAPTER 2

1. Addendum A. This change deletes copayment and associated language for ancillary services (laboratory and x-ray services). Effective Date: 03/26/1998. This change also clarifies the table for readability. Effective Date: 02/15/2015.

CHAPTER 12

2. Section 6. This change removes the requirement found in the TRICARE Reimbursement Manual (TRM) Chapter 12, Section 6 for a quarterly Home Health Agency (HHA) Prospective Payment System (PPS) report. Effective Date: 02/12/2015.

Chapter 2 Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

Beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national Urban Consumer Price Index (CPI-U) medical index (the medical component of the CPI-U). Beneficiary cost-shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.

These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness:

1.0 TRICARE PRIME PROGRAM ANNUAL ENROLLMENT FEES

Does not apply to the TRICARE Extra Program (also see paragraph 5.0, "Point of Service (POS) Option"):

TRICARE PRIME PROGRAM			
EFFECTIVE DATE OF FEES	ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIREES, THEIR FAMILY MEMBERS, ELIGIBLE FORMER SPOUSES, & SURVIVORS
	E1 - E4	E5 & ABOVE	
FY 1996 - FY 2011	None	None	$230 per Retiree or Family Member $460 Maximum per Family
FY 2012	None	None	$260 per Retiree or Family Member $520 Maximum per Family
FY 2013	None	None	$269.28 per Retiree or Family Member $538.56 Maximum per Family
FY 2014	None	None	$273.84 per Retiree or Family Member $547.68 Maximum per Family
FY 2015 - Present	None	None	$277.92 per Retiree or Family Member $555.84 Maximum per Family

EXCEPTIONS:

1. Effective March 26, 1998, the enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare.
2. Effective Fiscal Year (FY) 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime. The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

2.0 TRICARE STANDARD AND EXTRA PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime Program (also see paragraph 5.0, "POS Option"):

TRICARE STANDARD AND EXTRA PROGRAM		
ADFMs		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS
E1 - E4	E5 & ABOVE	
$50 per Individual **$100 Maximum per Family**	**$150 per Individual** **$300 Maximum per Family**	**$150 per Individual** **$300 Maximum per Family**

3.0 OUTPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)				
	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	E1 - E4	E5 & ABOVE			
INDIVIDUAL PROVIDER SERVICES Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit.	**ADFMs:** Cost-share--15% of the fee negotiated by the contractor. **Retirees, their Family Members, & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members, & Survivors:** Cost-share--25% of the allowable charge.
OUTPATIENT HOSPITAL DEPARTMENTS Clinics visits; therapy visits; medical supplies; consultations; treatment room; etc. **Note:** Use other parts of this table for cost-sharing of ASC services, ER services, DME, etc.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit. No separate copayment/cost-share for separately billed professional charges.		
ANCILLARY SERVICES Refer to Section 1 for specific services considered as ancillary services.	$0 copayment per visit.	$0 copayment per visit.	No copayment (see Note 2).		
OTHER RADIOLOGY SERVICES Not considered as ancillary services.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit.		

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)				
	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	E1 - E4	E5 & ABOVE			
ROUTINE PAP SMEARS Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology (see Note 1).	No copayment.	No copayment.	No copayment.	$0 cost-share.	$0 cost-share.
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.		
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.		

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)				
	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	E1 - E4	E5 & ABOVE			
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, pneumoccocal 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.	$0 copayment.	$0 copayment.	$0 copayment.	$0 cost-share.	$0 cost-share.
HOSPICE CARE **Note:** A separate cost-share may be (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.					
WELL CHILD CARE Up to the age of six.	$0 copayment per visit.	$0 copayment per visit.	$0 copayment per visit.		

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)				
	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	E1 - E4	E5 & ABOVE			
FAMILY HEALTH SERVICES Family planning. The exclusions listed in the TPM will apply.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit (see Note 1).	**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.
OUTPATIENT MENTAL HEALTH TO INCLUDE HOME One hour of therapy, no more than two times each week (when medically necessary).	$0 copayment per visit.	$0 copayment per visit.	$25 copayment for individual visits. $17 copayment for group visits.		
AMBULATORY SURGERY (same day) Authorized hospital-based or freestanding Ambulatory Surgical Center (ASC) that is TRICARE certified.	$0 copayment per visit.	$0 copayment per visit.	$25 copayment.	**ADFMs:** Cost-share--$25. for ASC. **Retirees, their Family Members, & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** $25. **Retirees, their Family Members, & Survivors:** Lesser of 25% of group rate or 25% of billed charge.
ALL SURGICAL PROCEDURES REGARDLESS OF WHERE THEY ARE PERFORMED With the exclusion of those surgical procedures referenced Section 1, paragraphs 1.2.4.5 and 1.2.4.7.					
BIRTHING CENTER Prenatal care, outpatient delivery, and postnatal care provided by TRICARE authorized birthing center.					

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)				
	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	E1 - E4	E5 & ABOVE			
IMMUNIZATIONS Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations. **Note**: Immunizations provided in accordance with TPM, Chapter 7, Sections 2.1, 2.2, and 2.5 are also covered as a clinical preventive service (see below).	$0 copayment per visit.	$0 copayment per visit.	N/A	**ADFMs:** $0 cost-share. **Retirees, their Family Members, & Survivors:** N/A	**ADFMs:** $0 cost-share. **Retirees, their Family Members, & Survivors:** N/A
EYE EXAMINATIONS (See Note 4) One routine examination per year for family members of active duty sponsors. **Note**: Routine eye examinations once every two years provided in accordance with TPM, Chapter 7, Section 2.2, are covered as a clinical preventive service (see below) for Prime enrollees.	$0 copayment per visit.	$0 copayment per visit.	N/A		
CLINICAL PREVENTIVE SERVICES Includes those services listed in the TPM, Chapter 7, Sections 2.1, 2.2, and 2.5.	$0 copayment.	$0 copayment.	$0 copayment.	**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 (see Note 1).	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members, & Survivors:** Cost-share--25% of the allowable charge (see Note 1).

4.0 INPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE (SEE NOTE 3)				
TRICARE BENEFITS	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
HOSPITALIZATION Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-ray and other radiology services, necessary medical supplies and appliances, blood and blood products.	$0 copayment per visit.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	**ADFMs:** Per diem charge ($25 minimum charge per admission). No separate cost-share for separately billed professional charges. **Retirees, their Family Members, & Survivors:** $250 per diem copayment or 25% cost-share of total charges (based on the fee schedule negotiated by the contractor), whichever is less, for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	**ADFMs:** Per diem charge ($25 minimum charge per admission). No separate cost-share for separately billed professional charges. **Retirees, their Family Members, & Survivors:** DRG per diem copayment or 25% cost-share of billed charges for institutional services, whichever is less, plus 25% cost-share of allowable for separately billed professional charges.
MATERNITY Hospital and professional services (prenatal, delivery, postnatal).				

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE NOTE 3)				
TRICARE BENEFITS	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
NEWBORN/ADOPTEE CARE (See Note 5) Hospital and professional services.	$0 copayment. No separate copayment/ cost-share for separately billed professional charges.	**Same newborn date of birth and date of admission:** $11 per day ($25 minimum charge) applies to the fourth and subsequent days of the newborn's inpatient stay. **Different newborn date of birth and date of admission:** $11 per day ($25 minimum charge) applies to all days of the newborn's inpatient stay.	**ADFMs:** $0 as newborn is deemed enrolled in Prime for up to 60 days for cost-sharing purposes. No separate cost-share for separately billed professional charges. **Retirees, their Family Members, & Survivors: Same newborn date of birth and date of admission:** Unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three multiplied by $250 OR 25% of TRICARE contractor negotiated charges for institutional services, plus 20% cost-share of separately billed contractor negotiated professional charges.	**ADFMs:** $0 as newborn is deemed enrolled in Prime for up to 60 days for cost-sharing purposes. No separate cost-share for separately billed professional charges. **Retirees, their Family Members, & Survivors:** **DRG Hospital: Same newborn date of birth and date of admission:** Unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three multiplied by DRG per diem copayment OR 25% of billed charges for institutional services, plus 25% cost-share of allowable separately billed professional charges.

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE NOTE 3)				
TRICARE BENEFITS	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
NEWBORN/ADOPTEE CARE (See Note 5) (Continued)			**Different newborn date of birth and date of admission:** Unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of hospital days for the newborn multiplied by $250 or 25% of TRICARE contractor negotiated charges for institutional services, plus 20% cost-share of separately billed contractor negotiated professional charges.	**Different newborn date of birth and date of admission:** Unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of hospital days for the newborn multiplied by DRG per diem copayment OR 25% of billed charges for institutional services, plus 25% cost-share of allowable separately billed professional charges. **DRG Exempt Hospital:** Unless the newborn is deemed enrolled in Prime, the cost-share will be 25% of allowed charges for institutional services, plus 25% cost-share of allowable separately billed professional charges.

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE NOTE 3)				
TRICARE BENEFITS	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
SKILLED NURSING FACILITY (SNF) CARE Same benefit as Medicare except that there is no limitation to the number of days of coverage. Benefit includes semiprivate room, regular nursing services, meals including special diets, physical, occupational and speech therapy, drugs furnished by the facility, necessary medical supplies, and appliances.	$0 copayment per visit.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	**ADFMs:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members, & Survivors:** $250 per diem copayment or 20% cost-share of total charges (based on the fee schedule negotiated by the contractor), whichever is less, for institutional services, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	**ADFMs:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members, & Survivors:** 25% cost-share of allowed charges for institutional services, plus 25% cost-share of allowable for separately billed professional charges.

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE NOTE 3)				
TRICARE BENEFITS	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
FOR MENTAL ILLNESS With authorization, up to 30 days per fiscal year for adults (age 19+), up to 45 days per fiscal year for children under age 19; up to 150 days residential treatment for children and adolescents.	$0 copayment per visit.	$40 per diem charge. No separate copayment/cost-share for separately billed professional charges.	**ADFMs:** $20 per diem charge ($25 minimum charge per admission). **Retirees, their Family Members, & Survivors:** Cost-share--20% of total charges (based on the fee schedule negotiated by the contractor) for institutional services, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	**ADFMs:** $20 per diem charge ($25 minimum charge per admission). **Retirees, their Family Members, & Survivors:** Inpatient High Volume Hospital: Cost-share--25% hospital specific per diem. **Inpatient Low Volume Hospital:** Lower of fixed daily amount or 25% hospital billed charges. **RTC:** Cost-share--25% of the TRICARE allowed amount. **Partial Hospitalization:** Cost-share--25% of the TRICARE allowed amount. Plus, 25% cost-share of allowable charges for separately billed professional charges.
SUBSTANCE USE TREATMENT (Inpatient, partial) With authorization, seven days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.				
PARTIAL HOSPITALIZATION-MENTAL HEALTH With authorization, up to 60 days per fiscal year (minimumhours/day of therapeutic services).				

5.0 POINT OF SERVICE (POS)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
A Prime enrollee may receive services under the Point of Service option by self-referring for non-emergency care. Refer to Section 3, for policy on the POS option.	**Outpatient Deductible:** $300.00 individual $600.00 family. **Inpatient and Outpatient Cost-Share:** 50% of the allowed charges (see Note 6).	Outpatient Deductible: $300.00 individual $600.00 family. **Inpatient and Outpatient Cost-Share:** 50% of the allowed charges (see Note 6).	POS option does NOT apply to TRICARE Extra beneficiaries.	POS option does NOT apply to TRICARE Standard beneficiaries.

Refer to Section 2 for information on catastrophic loss protection.

Note 1: As indicated in TPM, Chapter 7, Section 2.2, there are no copayments associated with covered preventive services for TRICARE Prime beneficiaries. Effective for dates of service on or after October 14, 2008, cost-shares are waived for certain preventive services for TRICARE Standard and Extra beneficiaries, as described in Section 1, paragraphs 1.3.3.10 and 1.4.3.

Note 2: For dates of service on or after March 26, 1998, under TRICARE Prime, services defined as "ancillary services" in Section 1 require no copayment.

Note 3: An eligible former spouse is responsible for payment of copayment/cost-sharing amounts identical to those required for beneficiaries other than family members of active duty members.

Note 4: Eye examinations are covered under the TRICARE Prime Program's "clinical preventive services". See the TPM, Chapter 7, Section 2.2.

Note 5: The TRICARE Regional Director (RD) and Director of each TRICARE Area Office (TAO) shall be granted the authority to extend the deemed period up to 120 days, on a case-by-case or regional basis.

Note 6: TRICARE Reimbursement will be limited to 50% of the billed/allowed charges.

- END -

1450 UB-04 report these charges in FL 47. "Total Charges," and in FL 48 "Non-Covered Charges." You must be able to accept these charges in your system and pass them on to other payers.

3.1.2.24.6 HHA Claims With All Non-Covered Charges. HHAs must submit claims when all of the charges on the claim are non-covered (no-payment claim). HHAs must complete all items on a no-payment claim in accordance with instructions for completing payment bills, with the exception that all charges are reported as non-covered. You must provide a complete system record for these claims. Total the charges on the system under revenue code 0001 (total and non-covered). Non-payment codes are required in the system records where no payment is made for the entire claim. Utilize non-payment codes in §3624. These codes alert TRICARE to bypass edits in the systems processing that are not appropriate in non-payment cases. Enter the appropriate code in the "Non-Payment Code" field of the system record if the nonpayment situation applies to all services covered by the bill. When payment is made in full by an insurer primary to TRICARE, enter the appropriate "Cost Avoidance" codes for MSP cost avoided claims. When you identify such situations in your development or processing of the claim, adjust the claim data the provider submitted, and prepare an appropriate system record.

3.1.2.24.7 No-Payment Billing and Receipt of Denial Notices Under HHA PPS. HHAs may seek denials for entire claims from TRICARE in cases where a provider knows all services will not be covered by TRICARE. Such denials are usually sought because of the requirements of other payers (e.g., Medicaid) for providers to obtain TRICARE denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

3.1.2.24.7.1 Submission and Processing. In order to submit a no-payment bill to TRICARE under HHA PPS, providers must:

3.1.2.24.7.2 Use TOB 03x0 in FL 4 and condition code 21 in FL 18-28 of the CMS 1450 UB-04 claim form.

3.1.2.24.7.3 The statement dates on the claim, FL 6, should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported.

3.1.2.24.7.4 Providers must also key in the charge for each line item on the claim as a non-covered charge in FL 48 of each line.

3.1.2.24.7.5 In order for these claims to process through the subsequent HHA PPS edits in the system, providers are instructed to submit a 023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (HAEJ1) as a proxy, an 18-digit string of the number 1, "111111111111111111", for the OASIS Claim-Matching Key in FL 63, and meet other minimum TRICARE requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching Key output should be used.

3.1.2.24.7.6 TRICARE standard systems will bypass the edit that required a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems must also ensure that a matching RAP has not been paid for that billing period.

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

3.1.2.24.8 Simultaneous Covered and Non-Covered Services. In some cases, providers may need to obtain a TRICARE denial notice for non-covered services delivered in the same period as covered services that are a part of an HHA PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, and submit the appropriate HHA PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. TRICARE claims processing systems and automated authorization files will allow such duplicate claims to process when all services on the claim are non-covered.

3.2 Reporting Requirements

Effective for home health services rendered on or after the first day of health care delivery of the new contract, reimbursement will follow Medicare's HHA PPS methodology. With the implementation of HHA PPS, revenue code 023 must be present on all HHA PPS TEDs in addition to all other revenue code information pertinent to the treatment. See the TRICARE Systems Manual (TSM), Chapter 2, Addendum H for a list of valid revenue codes. In addition, under HHA PPS all HHA TEDs must be coded with special rate code "V" Medicare Reimbursement Rate or Special Rate Code "D" for a Discount Rate Agreement.

- END -