



DEFENSE
HEALTH AGENCY

MB&RO

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066

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SUMMARY OF CHANGE(S): See page 3.

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**Ann N. Fazzini
Team Chief, Medical Benefits &
Reimbursement Office (MB&RO)
Defense Health Agency (DHA)**

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

REMOVE PAGE(S)

CHAPTER 12

Table of Contents, pages 1 through 4
Section 1, pages 7 and 8
Section 2, pages 23, 24, and 27 through 30
Section 3, pages 7 and 8
Section 4, pages 27 through 30
Section 6, pages 19 through 44
Addendum D, pages 1 through 5
Addendum L (FY 2012), pages 1 through 5
★ ★ ★ ★ ★ ★
Addendum M (FY 2012), pages 1 through 17
★ ★ ★ ★ ★ ★

INDEX

pages 1 and 2

INSERT PAGE(S)

Table of Contents, pages 1 through 4
Section 1, pages 7 and 8
Section 2, pages 23, 24, and 27 through 30
Section 3, page 7
Section 4, pages 27 through 30
Section 6, pages 19 through 44
Addendum D, page 1
★ ★ ★ ★ ★ ★
Addendum L (FY 2015), pages 1 through 4
★ ★ ★ ★ ★ ★
Addendum M (FY 2015), page 1

pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 12

1. Section 1. This change removes the Home Health Agency Prospective Payment System (HHA PPS) rate update for Calendar Year 2012 (CY12) and adds the HHA PPS rate update for CY 2015 (CY15). EFFECTIVE DATE: 01/01/2015.
2. Section 2. This change removes TOB 33X. EFFECTIVE DATE: 01/01/2013.
3. Section 3. This change removes outdated language, and inserts updated links for information regarding the OASIS and HAVEN systems. EFFECTIVE DATE: 01/1/2015
4. Section 4. This change deletes references to CY12 and adds references for CY15. EFFECTIVE DATE: 01/01/2015.
5. Section 6. This change removes TOB 33X, and deletes descriptions of HCPCS codes G0151, G0159, G0152, G0160, G0153, G0161, G0154, G0162, G0163, G0164, G0155, and G0156. EFFECTIVE DATE: 01/01/2013.
6. Addendum D. This change removes the title and language for “CMS Form 485 Data Elements” and adds a new title and language for “Home Health Certification and Plan of Care,” reflecting the current CMS policy. EFFECTIVE DATE: 01/01/2015.
7. Addendum L. This change removes the HHA PPS rate update for CY12 and adds the HHA PPS rate update for CY15. EFFECTIVE DATE: 01/01/2015.
8. Addendum M. This change removes the HHA PPS wage index update for CY12 and adds the HHA PPS wage index update for CY15. EFFECTIVE DATE: 01/01/2015.

Chapter 12

Home Health Care (HHC)

Section/Addendum	Subject/Addendum Title
1	Home Health Benefit Coverage And Reimbursement - General Overview
2	Home Health Care (HHC) - Benefits And Conditions For Coverage Figure 12.2-1 Copayments/Cost-Shares For Services Reimbursed Outside The HHA PPS When Receiving Home Health Services Under A POC
3	Home Health Benefit Coverage And Reimbursement - Assessment Process
4	Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology Figure 12.4-1 Calculating Domain Scores From Response Values Figure 12.4-2 Clinical Severity Domain Figure 12.4-3 Functional Status Domain Figure 12.4-4 Service Utilization Domain Figure 12.4-5 HHRG To HIPPS Code Crosswalk Figure 12.4-6 New HIPPS Code Structure Under HH PPS Case-Mix Refinement Figure 12.4-7 Scoring Matrix For Constructing HIPPS Code Figure 12.4-8 Case-Mix Adjustment Variables And Scores For Episodes Ending Before January 1, 2012 Figure 12.4-9 Case-Mix Adjustment Variables And Scores For Episodes Ending On Or After January 1, 2012 Figure 12.4-10 Relative Weights For NRS - Six-Group Approach Figure 12.4-11 NRS Case-Mix Adjustment Variables And Scores Figure 12.4-12 Format For Treatment Authorization Code Figure 12.4-13 Converting Point Values To Letter Codes Figure 12.4-14 Example Of A Treatment Authorization Code Figure 12.4-15 Calculation Of National 60-day Episode Payment Amounts Figure 12.4-16 Standardization For Case-Mix And Wage Index Figure 12.4-17 Per Visit Payment Amounts For Low-Utilization Payment Adjustments
5	Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care
6	Home Health Benefit Coverage And Reimbursement - Claims And Billing Submission Under HHA PPS
7	Home Health Benefit Coverage And Reimbursement - Pricer Requirements And Logic
8	Home Health Benefit Coverage And Reimbursement - Medical Review Requirements
A	Definitions And Acronym Table

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Home Health Care (HHC)

Section/Addendum	Subject/Addendum Title
B	Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes
C	Home Health Consolidated Billing Code List - Therapy Codes
D	Home Health Certification And Plan Of Care (POC)
E	Primary Components Of A Home Care Patient Assessment
F	Outcome And Assessment Information Set (OASIS-B1)
G	Outcome and Assessment Information Set (OASIS) Items Used For Assessments Of 60-Day Episodes
H	Diagnosis Codes For Home Health Resource Group (HHRG) Assignment
I	Home Health Resource Group (HHRG) Worksheet Figure 12.I-1 HHRG For Episodes Beginning On Or After January 1, 2008 Figure 12.I-2 Abbreviated OASIS Questions
J	Health Insurance Prospective Payment System (HIPPS) Tables For Pricer
K	Home Assessment Validation and Entry (HAVEN) Reference Manual
L (CY 2013)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013
	Figure 12.L.2013-1 National 60-Day Episode Payment Rate Updated By The Home Health Market Basket Update For CY 2013, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
	Figure 12.L.2013-2 National Per-Visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2013 HHA PPS Payment Update Percentage, Before Wage Index Adjustment
	Figure 12.L.2013-3 CY 2013 LUPA Add-On Payment Amounts
	Figure 12.L.2013-4 Non-Routine Medical Supply (NRS) Conversion Factor For CY 2013
	Figure 12.L.2013-5 Relative Weights For The Six-Severity NRS System For CY 2013
	Figure 12.L.2013-6 CY 2013 Payment Amounts For Services Provided In A Rural Area, Before Case-Mix Adjustment And Wage Index Adjustment
	Figure 12.L.2013-7 CY 2013 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment
	Figure 12.L.2013-8 CY 2013 LUPA Add-On Payment Amount For Services Provided In A Rural Area
	Figure 12.L.2013-9 CY 2013 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
	Figure 12.L.2013-10 CY 2013 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Home Health Care (HHC)

Section/Addendum	Subject/Addendum Title
L (CY 2014)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2014
	Figure 12.L.2014-1 2013 Estimated Average Payment Per Episode
	Figure 12.L.2014-2 CY 2014 National 60-Day Episode Payment Amounts
	Figure 12.L.2014-3 CY 2014 National Per-Visit Payment Amounts
	Figure 12.L.2014-4 CY 2014 NRS Conversion Factor
	Figure 12.L.2014-5 CY 2014 NRS Payment Amounts
	Figure 12.L.2014-6 CY 2014 Payment Amounts For Services Provided In A Rural Area, Before Case-Mix Adjustment And Wage Index Adjustment
	Figure 12.L.2014-7 CY 2014 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment
	Figure 12.L.2014-8 CY 2014 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
	Figure 12.L.2014-9 CY 2014 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
L (CY 2015)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015
	Figure 12.L.2015-1 CY 2015 National Standardized 60-Day Episode Payment Amounts
	Figure 12.L.2015-2 CY 2015 National Per-Visit Payment Amounts For HHAs
	Figure 12.L.2015-3 CY 2015 NRS Conversion Factor
	Figure 12.L.2015-4 CY 2015 Payment Amounts For 60-Day Episodes For Services Provided In A Rural Area
	Figure 12.L.2015-5 CY 2015 Per-Visit Amounts For Services Provided In A Rural Area
	Figure 12.L.2015-6 CY 2015 NRS Conversion Factor For Services Provided In A Rural Area
	Figure 12.L.2015-7 CY 2015 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
M (CY 2013)	Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2013
M (CY 2014)	Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2014
M (CY 2015)	Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2015
N	Diagnoses Associated With Each Of The Diagnostic Categories Used In Case-Mix Scoring
O	Diagnoses Included In The Diagnostic Categories Used For The Non-Routine Supplies (NRS) Case-Mix Adjustment Model
P	Code Table For Converting Julian Dates To Two Position Alphabetic Values

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Home Health Care (HHC)

Section/Addendum	Subject/Addendum Title
Q	Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS) Figure 12.Q-1 Request for Anticipated Payment (RAP) - Non-Transfer Situation Figure 12.Q-2 RAP - Non-Transfer Situation With Line Item Service Added Figure 12.Q-3 RAP - Transfer Situation Figure 12.Q-4 RAP - Discharge/Re-Admit Figure 12.Q-5 RAP - Cancellation Figure 12.Q-6 Claim - Non-Transfer Situation Figure 12.Q-7 Claim - Transfer Situation - Beneficiary Transfers To Your HHA Figure 12.Q-8 Claim - Significant Change in Condition (SCIC) Situation Figure 12.Q-9 Claim - No-RAP-Low Utilization Payment Adjustment (LUPA) Claim Figure 12.Q-10 Claim Adjustment Figure 12.Q-11 Claim - Cancellation
R	Input/Output Record Layout
S	Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 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
ADDENDA	
Acronym Table	Addendum A
Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes	Addendum B
Home Health Consolidated Billing Code List - Therapy Codes	Addendum C
CMS Form 485 - Home Health Certification And Plan Of Care Data Elements	Addendum D
Primary Components of Home Health Assessment	Addendum E
Outcome and Assessment Information Set (OASIS-B1)	Addendum F
OASIS Items Used for Assessments Of 60-Day Episodes	Addendum G
ICD-9-CM Diagnosis Codes for Home Health Resource Group (HHRG) Assignment	Addendum H
Home Health Resource Group (HHRG) Worksheet	Addendum I
HIPPS Tables for Pricer	Addendum J
Home Assessment Validation and Entry (HAVEN) Reference Manual	Addendum K
Annual HHA PPS Rate Updates	
Calendar Year 2013	Addendum L (CY 2013)
Calendar Year 2014	Addendum L (CY 2014)
Calendar Year 2015	Addendum L (CY 2015)
Annual HHA PPS Wage Index Updates	
Calendar Year 2013	Addendum M (CY 2013)
Calendar Year 2014	Addendum M (CY 2014)
Calendar Year 2015	Addendum M (CY 2015)
Diagnoses Associated with Diagnostic Categories Used in Case-Mix Scoring	Addendum N

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 1
Home Health Benefit Coverage And Reimbursement - General Overview

IMPLEMENTING INSTRUCTIONS (CONTINUED)

Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model	Addendum O
Code Table for Converting Julian Dates to Two Position Alphabetic Values	Addendum P
Examples of Claims Submissions Under Home Health Agency Prospective Payment System (HHA PPS)	Addendum Q
Input/Output Record Layout	Addendum R
Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008	Addendum S

- END -

3.3.1.1 Consequently, billing for all such items and services is to be made to a single HHA overseeing that plan, and this HHA is known as the primary agency or HHA for HHA PPS billing purposes.

3.3.1.2 Payment will be made to the primary HHA without regard to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or whether any other contracting or consulting arrangements exist with the primary agency, or "otherwise". Payment for all items is included in the HHA PPS episode payment the primary HHA receives.

3.3.1.2.1 Types of services that are subject to the home health CB provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated with or under common control of that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

3.3.1.2.2 Contractors will deny any claims from other than the primary HHA that contain billing for the services and items above when billed for dates of service that have not been authorized by the contractor.

3.3.1.2.3 Lists of procedures are incorporated as addenda to this policy in order to facilitate adherence to the home health CB requirements. Procedure codes on these lists will be denied if billed by other than the HHA creating the episode (i.e., the primary provider designated under the contractors' preauthorization process for providing HHC to TRICARE eligible beneficiaries). The following lists of procedures will be issued annually in conjunction with the release of the yearly Health Care Financing Administration Common Procedure Coding System (HCPCS) update:

- [Addendum B](#) - list of **NRS** codes.
- [Addendum C](#) - list of therapy codes.

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

3.3.1.3.1 DME

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

3.3.1.3.1.2 DME will be paid in accordance with the reimbursement guidelines set forth in [Chapter 1, Section 11](#), less an appropriate cost-share/copayment and deductible (refer to [Figure](#)

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 2

Home Health Care (HHC) - Benefits And Conditions For Coverage

12.2-1, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

3.3.1.3.1.3 DME may be billed by a supplier to a contractor on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form or billed by a HHA on a CMS 1450 UB-04 using **Type Of Bills (TOBs)** 032X, 033X, and 034X as appropriate. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.** While the contractors' systems will allow either party to submit these claims, the following requirements will be initiated in order to prevent duplicative billing:

- HHA providers required to submit line item dates on DME items.
- Providers instructed to bill each month's DME rental as a separate line item.
- HHAs allowed to bill DME not under a POC on the TOB 034X.

3.3.1.3.1.4 Crossover edits will be developed to prevent duplicate billing of DME.

- Since CB does not apply to DME, claims for equipment not authorized by the contractor will be denied. Appropriate appeal rights will apply.
- DME can be billed by other than the Primary HHA under HHA PPS system when authorized by the contractor (i.e., by supplier/vendor or other HHA).
- System must be able to identify duplicative billing based on dates of services.

3.3.1.3.2 Osteoporosis Drugs

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

3.3.1.3.2.2 Osteoporosis injections as a HHA benefit.

- Cover U.S. Food and Drug Administration (FDA) approved injectable drugs for osteoporosis for female beneficiaries.
- Only injectable drugs that meet the requirement have the generic name of calcitonin-salmon or calcitonin-human.

3.3.1.3.2.3 Payment is established from a schedule of allowable charges based on the Average Wholesale Price (AWP), less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#), for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

- The drug is billed on a CMS 1450 UB-04 under TOB 034X with revenue code 0636 and HCPCS code J0630.
- The cost of administering the drug is included in the charge for the visit billed under TOB 032X or 033X, as appropriate. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.**

3.3.1.3.4.2 Payment.

3.3.1.3.4.2.1 The reasonable cost of the cancer drugs furnished by a provider (i.e., the **AWP** determined from a **schedule of allowable charges based on the AWP**), less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

3.3.1.3.4.2.2 Bill on CMS 1450 UB-04, TOB 034X.

- Enter revenue code 0636 in Form Locator (FL) 42, the name and HCPCS of the oral drug in FLs 43 and 44, and the name of the tablets or capsules in FL 46 of the CMS 1450 UB-04.
- An exception is made for 50mg/ORAL of cyclophosphamide (J8530), which is shown as two units.
- Complete the remaining items in accordance with regular billing instructions.
- A cancer diagnosis must be entered in FLs 67 A - Q of the CMS 1450 UB-04 for coverage of an oral cancer drug.

3.3.1.3.5 **Antiemetic Drugs**

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

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

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

3.3.1.3.5.1.3 Payment.

3.3.1.3.5.1.3.1 The reasonable cost of the self-administered antiemetic drugs furnished by a provider (i.e., the **AWP** determined from a **schedule of allowable charges based on the AWP**) less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

3.3.1.3.5.1.3.2 Bill on CMS 1450 UB-04, TOB 034X.

3.3.1.3.5.1.3.2.1 Enter revenue code 0636 in FL42.

3.3.1.3.5.1.3.2.2 Enter one of the following HCPCS codes in FL 44, as appropriate:

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 2

Home Health Care (HHC) - Benefits And Conditions For Coverage

- K0416 - Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified.
- Enter the name of the self-administered drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit.
- Complete the remaining items in accordance with regular billing instructions.
- TRICARE does not pay for a visit solely for administration of self-administered antiemetic drugs in conjunction with oral anticancer drugs.

3.3.1.3.6 Orthotics and Prosthetics

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

3.3.1.3.6.1 Orthotics and prosthetics may be billed by a supplier to a contractor on a CMS 1500 Claim Form or billed by a HHA on a CMS 1450 UB-04 using TOBs 032X, 033X and 034X as appropriate. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.**

3.3.1.3.6.2 Payment will be paid in accordance with the reimbursement guidelines set forth in [Chapter 1, Section 11](#), less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

3.3.1.3.7 Enteral and Parenteral Nutritional Therapy

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

3.3.1.3.7.2 Payment is based on the reasonable purchase cost less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

3.3.1.3.7.3 Enteral and Parenteral supplies and equipment may be billed by a supplier to a contractor on a CMS 1500 Claim Form, or billed by a HHA on a CMS 1450 UB-04 using TOBs 032X, 033X, and 034X as appropriate. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.**

3.3.1.3.8 Drugs and Biologicals Administered By Other Than Oral Method

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

- Prescribed by a physician or practitioner;

- Approved by the FDA; and
- Reasonable and necessary for the individual patient.

3.3.1.3.8.2 Billing Methods.

- The HHA may bill for the drugs/biologicals on a CMS 1450 UB-04 under TOB 034X with revenue codes 025X or 063X and HCPCS National Level II Medicare “J” codes; or
- The home infusion company and/or pharmacy delivering the medication for home administration may bill the contractor directly using the CMS 1500 Claim Form with appropriate National Drug Code (NDC) or HCPCS coding.
- The contractors’ systems will allow either party to submit these claims, but will not allow duplicative billing.

3.3.1.3.8.3 Payment.

- The reasonable cost of the drugs/biologicals furnished by a provider (refer to [Chapter 1, Section 15, paragraph 3.3.1](#) for the pricing of home infusion drugs furnished through a covered item of DME) less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).
- The cost of administering the drug is included in the charge for the visit billed under TOB 032X or 033X, as appropriate. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.**

3.3.1.3.9 **Ambulance Transfers**

3.3.1.3.9.1 Payment will be allowed outside the 60-day episode amount for ambulance services furnished directly by a HHA or provided under arrangement between a HHA and ambulance company (see [Chapter 1, Section 14](#)).

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

3.3.1.3.9.3 For ambulance services provided prior to October 1, 2013:

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 2

Home Health Care (HHC) - Benefits And Conditions For Coverage

3.3.1.3.9.3.2 Payment of HHA ambulance services will be based on statewide prevailing rate (both for service and mileage) less an appropriate cost-share/copayment and deductible (refer to [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

3.3.1.3.9.4 For ambulance services provided on and after October 1, 2013, TRICARE adopts Medicare’s Ambulance Fee Schedule (AFS) as the TRICARE CMAC for ambulance services (see [Chapter 1, Section 14](#)).

3.3.1.4 Cost-Sharing/Copayments

The following table provides the applicable cost-shares/copayments for services exempt from home health CB (i.e., services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of treatment). Refer to [Chapter 2, Addendum A, paragraph 2.0 and 3.0](#), for TRICARE Extra and Standard annual fiscal year deductibles.

FIGURE 12.2-1 COPAYMENTS/COST-SHARES FOR SERVICES REIMBURSED OUTSIDE THE HHA PPS WHEN RECEIVING HOME HEALTH SERVICES UNDER A POC

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

- END -

Medicaid OASIS files have been delayed, transmission of TRICARE locked files will not be required at this time. HHAs will, however, still be responsible for the collection and encoding of OASIS data. This information will provide a mechanism for objectively measuring facility performance and quality. It will also be used to support the HHA PPS (i.e., generate the HIPPS code and claim-OASIS matching key output required on the CMS 1450 UB-04 claim form for pricing).

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

3.2.3.6 Please see [Addendum G](#) for information regarding the OASIS. The HHA can access the web site and download the required OASIS data set for each data collection time point; i.e., start of care, resumption of care following an inpatient facility stay, follow-up, discharge (not to an inpatient facility), transfer to inpatient facility (with or without agency discharge), and death at home. See [Addendum K](#) for information regarding the HAVEN system.

3.2.4 Case Management Responsibilities

It is recognized that while an abbreviated OASIS assessment may facilitate payment under the HHA PPS, it does not adequately reflect the management oversight required to ensure quality of care for beneficiaries under the age of 18 and obstetrical patients. As a result, the contractors will have to continue to case manage these beneficiary categories through the use of appropriate evaluation criteria as required under the specific terms of their contract to ensure the quality and appropriateness of home health services (e.g., the use of Interqual criteria for managing the appropriateness of home health services). Contractor involvement will even be more critical in cases where home health services are provided in non-Medicare HHAs (i.e., those HHAs for which Medicare certification is not available due to the beneficiary categories they serve). Refer to [Section 4, paragraph 3.6](#) for the hierarchical placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of 18 or receiving maternity care.

3.2.5 Transition

As of the first day of health care delivery of the new contract, all HHAs should be conducting comprehensive assessments and updates at the required time points, and incorporating the OASIS data set, with the exception of those beneficiaries receiving maternity care, beneficiaries under the age of 18 and beneficiaries receiving only housekeeping/chore services. Medicare-certified HHAs are required to conduct abbreviated assessments for TRICARE beneficiaries who are under the age of 18 or receiving maternity care for payment under the HHA PPS. Assessments are not required for TRICARE beneficiaries who are under the age of 18 or receiving maternity care in a HHA eligible for provider status under the corporate services provider classification (i.e., those HHAs for which Medicare certification is not available due to the special beneficiary categories they serve). Refer to [Section 4, paragraph 3.6](#) for the hierarchical placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of 18 or receiving maternity care.

- END -

3.8.1.3 The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in [Figure 12.4-16](#) for case-mix, budget neutrality and outliers in the establishment of a final standardized and budget neutral payment amount per 60-day episode for FY 2001.

FIGURE 12.4-16 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX

NON-STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS	STANDARDIZATION FACTOR FOR WAGE INDEX AND CASE-MIX	BUDGET NEUTRALITY FACTOR	OUTLIER ADJUSTMENT FACTOR	STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS
\$2,416.01	0.96184	0.88423	1.05	\$2,115.30

3.8.1.3.1 The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in [Addendums L \(CY 2013\)](#), [L \(CY 2014\)](#), and [L \(CY 2015\)](#).

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

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

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

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

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

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

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

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

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

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

3.8.1.4 Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts has not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in [Addendums L \(CY 2013\)](#), [L \(CY 2014\)](#), [L \(CY 2015\)](#), [M \(CY 2013\)](#), [M \(CY 2014\)](#), and [M \(CY 2015\)](#).

3.8.1.5 Annual Updating of HHA PPS Rates and Wage Indexes.

3.8.1.5.1 In subsequent fiscal years, HHA PPS rates (i.e., both the national 60-day episode amount and per-visit rates) will be increased by the applicable home health market basket index change.

3.8.1.5.2 Three iterations of these rates will be maintained in [Addendums L \(CY 2013\)](#), [L \(CY 2014\)](#), and [L \(CY 2015\)](#). These rate adjustments are also integral data elements used in updating the Pricer.

3.8.1.5.3 Three iterations of wage indexes will also be maintained in [Addendums M \(CY 2013\)](#), [M \(CY 2014\)](#), and [M \(CY 2015\)](#), for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

3.8.2 Calculation of Reduced Payments

Under certain circumstances, payment will be less than the full 60-day episode rate to accommodate changes of events during the beneficiary's care. The start and end dates of each event will be used in the apportionment of the full-episode rate. These reduced payment amounts are referred to as: 1) PEP adjustments; 2) SCIC adjustments; 3) LUPAs; and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

Note: Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) has not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in [Addendums L \(CY 2013\)](#), [L \(CY 2014\)](#), [L \(CY 2015\)](#), [M \(CY 2013\)](#), [M \(CY 2014\)](#), and [M \(CY 2015\)](#).

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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

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 12.4-17](#).

FIGURE 12.4-17 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

* 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.

FIGURE 12.4-17 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS (CONTINUED)

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			
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 \(CY 2013\)](#), [L \(CY 2014\)](#), [L \(CY 2015\)](#), [M \(CY 2013\)](#), [M \(CY 2014\)](#), and [M \(CY 2015\)](#).

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

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

3.1.2.19.28.2 For episodes in which the beneficiary's site of service changes from one MSA or CBSA to another within the episode period, HHAs should submit the MSA or CBSA code corresponding to the site of service at the end of the episode on the claim.

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

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

3.1.2.19.29 FL 42 and 43 Revenue Code and Revenue Description Required. Claims must report a 023 revenue code line matching the one submitted on the RAP for the episode. If this matching 023 revenue code line is not found on the claim, TRICARE claims systems will reject the claim.

3.1.2.19.29.1 If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), report one or more additional 023 revenue code lines to reflect each change. SCICs are determined by an additional OASIS assessment of the beneficiary, which changes the HIPPS code that applies to the episode and requires a change order from the physician to the POC. Each additional 023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised POC in FL 45 and zero changes in FL 47. In the rare instance when a beneficiary is assessed more than once in one day, report one 023 line for that date, indicating the HIPPS code derived from the assessment that occurred latest in the day.

3.1.2.19.29.2 Claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 42X, 43X, 44X, 55X, 56X, and 57X) must be reported as a separate line. Any of the following revenue codes may be used:

3.1.2.19.29.2.1 27X - Medical/Surgical Supplies (also see 62X, an extension of 27X). Code indicates the charges for supply items required for patient care.

- Rationale - Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PRSTH/ORTH DEV
5 - Pace Maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 - Oxygen-Take Home	O2/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

- Required detail: With the exception of revenue code 274, only service units and a charge must be reported with this revenue code. If also reporting revenue code 623 to separately identify wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for the 623 revenue code line and other supply revenue codes are mutually exclusive. Report only non-routine supply items in this revenue code or in 623. Revenue code 274 requires a HCPCS code, the date of service, service units and a charge amount.

3.1.2.19.29.2.2 42X - Physical Therapy - Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

- Rationale - Permits identification of particular services.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

- Required detail: HCPCS code G0151, HCPCS code G0159, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.3 43X - Occupational Therapy (OT) - Services provided by a qualified OT practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining;

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other OT (may include restorative therapy)	OTHER OCCUP THER

- Required detail: HCPCS code G0152, HCPCS code G0160, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.4 44X - Speech-Language Pathology - Charges for services provided to persons with impaired communications skills.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PATH

- Required detail: HCPCS code G0153, HCPCS code G0161, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.5 55X - Skilled Nursing - Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

- Required detail: HCPCS code G0154, HCPCS code G0162, HCPCS code G0163, HCPCS code G0164, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

amount.

3.1.2.19.29.2.6 56X - Medical Social Services - Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

- Rationale: Necessary for TRICARE home health billing requirements. May be used at other times as required by hospital.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED SOCIAL SVS
1 - Visit charge	MED SOC SERV/VISIT
2 - Hourly charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Service	MED SOC SERV/OTHER

- Required detail: HCPCS code G0155, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.7 57X - Home Health Aide (Home Health) - Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

- Rationale: Necessary for TRICARE home health billing requirements.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

- Required detail: HCPCS code G0156, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

Note: Revenue codes 58X and 59X may no longer be reported as covered on TRICARE home health claims under HHA PPS. If reporting these codes, report all charges as non-covered. Revenue code 624, IDEs, may no longer be reported on TRICARE home health claims under HHA PPS.

3.1.2.19.29.2.8 Optional: Revenue codes for optional billing of DME: Billing DME provided in the episode is not required on the HHA PPS claim. HHAs retain the option to bill these services to their contractor or to have the service provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HHA PPS claims must use the revenue codes below.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.19.29.2.8.1 29X - DME (Other Than Rental) - Code indicates the charges for medical equipment that can withstand repeated use (excluding rental equipment).

- Rationale: TRICARE requires a separate revenue center for billing.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of New DME	MED EQUIP/NEW
3 - Purchase of Used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

- Required detail: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and for service units of one.

3.1.2.19.29.2.8.2 60X - Oxygen (Home Health) - Code indicates charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment. If a beneficiary has purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply.

- Rationale: TRICARE required detailed revenue coding.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	02/HOME HEALTH
1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
2 - Oxygen - State/Equip/Suppl Under LPM	02/STATE EQUIP//UNDER 1 LPM
3 - Oxygen - State/Equip/Over 4 LPM	02/STATE EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	02/STATE EQUIP/PORT ADD-ON

- Required detail: The applicable HCPCS code for the item, a date of service, number of service units, and charge amount.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.19.29.2.9 Revenue code for optional reporting of wound care supplies:

3.1.2.19.29.2.9.1 62X - Medical/Surgical Supplies - Extension of 27X - Code indicates charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed.

SUBCATEGORY	STANDARD ABBREVIATION
3 - Surgical Dressings	SURG DRESSING

- Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 27x to identify non-routine supplies other than those used for wound care, ensure that the change amounts for the two revenue code lines are mutually exclusive.
- HHA may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 623. Notwithstanding the standard abbreviation "surg dressing", use this item to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.
- Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist TRICARE's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.
- You may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. TRICARE claims systems will assure this amount reflects charges associated with all revenue code lines, excluding any 023.

3.1.2.19.30 FL 44. HCPCS/Rates Required. On the earliest dated 023 revenue code line, report the HIPPS code which was reported on the RAP. On claims reflecting a SCIC, report on each additional 023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment.

- For revenue code lines other than 023, which detail all services within the episode period, report HCPCS codes as appropriate to that revenue code.
- Coding detail for each revenue code under HHA PPS is defined above under FL 43.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

3.1.2.19.31 FL 45. Service Date Required. On each 023 revenue code line, report the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, report services dates as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43.

3.1.2.19.32 FL 46. Units of Service Required. Do not report units of service on 023 revenue code lines (the field may be zero or blank). For line items detailing all services within the episode period, report units of service as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), report as units of service the number of 15-minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit, and time spent updating medical records in the home as part of such a visit, may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15-minute increment.

3.1.2.19.33 FL 47. Total Charges Required. Zero charges must be reported on the 023 revenue line. TRICARE claims systems will place the reimbursement amount for the RAP in this field on the electronic claim record.

- For other line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43.
- Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). TRICARE claims systems will not make any payment determinations based upon submitted charge amounts.

3.1.2.19.34 FL 48. Non-Covered Charges Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here. Report all non-covered charges, including no-payment claims.

- Claims with Both Covered and Non-Covered Charges - Report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. On the CMS 1450 UB-04 flat file, use record type 61, Field No. 10 (total charges) and Field No. 11 (non-covered charges).
- Claims with ALL Non-Covered Charges - Submit claims when all of the charges on the claim are non-covered (no-payment claim). Complete all items on a no-payment claim in accordance with instructions for completing payment claims, with the exception that all charges are reported as non-covered.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.19.35 Examples of Completed FLs 42 through 48 - The following provides examples of revenue code lines as HHAs should complete them, based on the reporting requirements above.

FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
Report the multiple 023 lines in a SCIC situation as follows:					
023	HAEJ1	100101		0.00	
023	HAFM1	100101		0.00	
Report additional revenue code lines as follows:					
270			8	84.73	
291	K0006	100101	1	120.00	
420	G0151	100501	3	155.00	
430	G0152	100701	4	160.00	
440	G0153	100901	4	175.00	
550	G0154	100201	1	140.00	
560	G0155	101401	8	200.00	
570	G0156	101601	3	65.00	
580		101801	3	0.00	75.00
623			5	47.75	

3.1.2.19.36 2FL 49. (Untitled) Not Required.

3.1.2.19.37 FLs 50A, B, and C. Payer Identification Required. If TRICARE is the primary payer, the HHA enters "TRICARE" on line A. When TRICARE is entered on line 50A, this indicates that the HHA has developed for other insurance coverage and has determined that TRICARE is the primary payer. All additional entries across the line (FLs 51-55) supply information needed by the payer named in FL 50A. If TRICARE is the secondary or tertiary payer, HHAs identify the primary payer on line A and enter TRICARE information on line B or C as appropriate. Conditional and other payments for TRICARE Secondary Payer (MSP) situations will be made based on the HHA PPS claim.

3.1.2.19.38 FL 51. TRICARE Provider Number Required. Enter the 9-18 position tax identification number assigned by TRICARE. It must be entered on the same line as "TRICARE" in FL 50.

- If the TRICARE provider number changes within a 60-day episode, reflect this by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number.
- In this case, report the original provider number in this field.

3.1.2.19.39 FLs 52A, B, and C. Release of Information Certification Indicator Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

3.1.2.19.40 FLs 53A, B, and C. Assignment of Benefits Certification Indicator Not Required.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.19.41 FLs 54A, B, and C. Prior Payments Not Required.

3.1.2.19.42 FLs 55A, B, and C. Estimated Amount Due Not Required.

3.1.2.19.43 FL 56. (Untitled) Not Required.

3.1.2.19.44 FL 57. (Untitled) Not Required.

3.1.2.19.45 FLs 58A, B, and C. Insured's Name Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information is shown in FLs 50-54, enter the patient's name as shown on his HI card or other TRICARE notice. Enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than TRICARE and you are requesting payment because:

3.1.2.19.45.1 Another payer paid some of the charges and TRICARE is secondarily liable for the remainder;

3.1.2.19.45.2 Another payer denied the claim; or

3.1.2.19.45.3 You are requesting conditional payment. If that person is the patient, enter "Patient." Payers of higher priority than TRICARE include:

- Employer Group Health Plans (EGHPs) for employed beneficiaries and their spouses;
- EGHPs for beneficiaries entitled to benefits solely on the basis of End Stage Renal Disease (ESRD) during a TRICARE Coordination Period;
- An auto-medical, no-fault, or liability insurer;
- Lisps for disabled beneficiaries; or
- Worker's Compensation (WC) including Black Lung (BL).

3.1.2.19.46 FLs 59A, B, and C. Patient's Relationship to Insured Required. If claiming payment under any of the circumstances described under FLs 58A, B, or C, enter the code indicating the relationship of the patient to the identified insured.

CODE STRUCTURE:		
CODE	TITLE	DEFINITION
01	Patient is the Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured Financial Responsibility	Self-explanatory
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

CODE STRUCTURE:		
CODE	TITLE	DEFINITION
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.

3.1.2.19.47 FLs 60A, B, and C. Certificate/SSN/HI Claim/Identification Number Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information was shown on FLs 39-41, and 50-54, enter the patient's TRICARE HICN; i.e., if TRICARE is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of TRICARE Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office. If claiming a conditional payment under any of the circumstances described under FLs 58A, B, or C, enter the involved claim number for that coverage on the appropriate line.

3.1.2.19.48 FLs 61A, B, and C. Group Name Required. Where you are claiming a payment under the circumstances described in FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the name of the group or plan through which that insurance is provided.

3.1.2.19.49 FLs 62A, B, and C. Insurance Group Number Required. Where you are claiming a payment under the circumstance described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter identification number, control number or code assigned by such HI carrier to identify the group under which the insured individual is covered.

3.1.2.19.50 FL 63. Treatment Authorization Code Required. Enter the claims-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an 18-position code, containing the start of care date (eight positions, from OASIS Item M0030), the date the assessment was completed (eight positions, from OASIS Item M0090), and the reason for assessment (two positions, from OASIS Item M0100). Copy these OASIS items exactly as they appear on the OASIS assessment, matching the date formats used on the assessment.

- In most cases, the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.
- The IDE revenue code, 624, is not allowed on HHA PPS RAPs. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

3.1.2.19.51 FL 64. Employment Status Code Required. Where you are claiming payment under the circumstances described in the second paragraphs of FLs 58A, B, or C, and there is involvement

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

of WC or an EGHP, enter the code which defines the employment status of the individual identified, if the information is readily available.

CODE STRUCTURE:		
CODE	TITLE	DEFINITION
1	Employed Full Time	Individual claimed full time employment.
2	Employed Part Time	Individual claimed part time employment.
3	Not Employed	Individual states that he or she is not employed full time or part time.
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for national assignment.
9	Unknown	Individual's employment status is unknown

3.1.2.19.52 FL 65. Employer Name Required. Where you are claiming a payment under the circumstance described under FLs 58A, B, or C, and there is involvement of WC or EGHP, enter the name of the employer that provides health care coverage for the individual.

3.1.2.19.53 FL 66. Employer Location Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual. A specific location is the city, plant, etc., in which the employer is located.

3.1.2.19.54 FL 67. Principal Diagnosis Code Required. Enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, do not fill with zeros.

- The ICD-9-CM codes and principal diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS from Item M0230 (Primary Diagnosis), and on the CMS Form 485, from Item 11 (ICD-9-CM/Principle Diagnosis).
- In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principle diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

3.1.2.19.55 FLs 68-75. Other Diagnoses Codes Required. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the POC. Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

- For other diagnoses, the diagnoses and ICD-9-CM codes reported in FLs 67 A-Q must match the additional diagnoses reported on the OASIS, from Item M0240 (Other Diagnoses), and on the CMS Form 485, from Item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the POC was established. In listing the diagnoses, place them

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields from M0240 on the OASIS, or on the CMS Form 485, from Item 13, may be reported in FLs 67 A-Q on the claim if they are reported in the narrative from Item 21 of the CMS Form 485.

- In most cases, the other diagnoses codes on the claim will match those submitted on the RAP. In SCIC cases, however, the other diagnoses codes reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

3.1.2.19.56 FL 69. Admitting Diagnosis Not Required.

3.1.2.19.57 FL 72. E-Code Not Required.

3.1.2.19.58 FL 73. (Untitled) Not Required.

3.1.2.19.59 FL 74. Principal Procedure Code and Date Not Required.

3.1.2.19.60 FL 74 a-e. Other Procedure Codes and Dates Not Required.

3.1.2.19.61 FL 76. Attending/Requesting Physician ID Required. Enter the UPIN and name of the attending physician who has signed the POC.

Note: Medicare requires HHAs to enter the UPIN and name of the attending physician who has established the POC in FL 76 of the CMS 1450 UB-04. The UPIN information will be allowed on the RAP and claims but not stored until required.

3.1.2.19.62 FL 77. Other Physician ID Not Required.

3.1.2.19.63 FL 80. Remarks Not Required.

3.1.2.19.64 FL 86. Date Not Required. See FL 45, line 23.

3.1.2.20 Examples of Claims Submission Under the HHA PPS. The following types of claims submissions can be viewed in [Addendum J](#):

- RAP - non-transfer situation
- RAP - non-transfer situation with line item service added
- RAP - transfer situation
- RAP - discharge/re-admit
- RAP - cancellation
- Claim - non-transfer situation
- Claim - transfer situation
- Claim - SCIC
- Claim - no-RAP-LUPA claim
- Claim - adjustment

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

- Claim - cancellation

3.1.2.21 Claims Adjustments and Cancellations.

3.1.2.21.1 Both RAPs and claims may be canceled by HHAs if a mistake is made in billing (TOB 328); episodes will be canceled in the system, as well.

3.1.2.21.2 Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment.

3.1.2.21.3 RAPs can only be canceled, and then re-billed, not adjusted.

3.1.2.21.4 HHRGs can be changed mid-episode if there is a significant change in the patient's condition (SCIC adjustment).

3.1.2.21.5 PEP Adjustments. Episodes can be truncated and given PEP adjustment if the beneficiaries choose to transfer among HHAs or if a patient is discharged and subsequently readmitted during the same 60-day period.

3.1.2.21.5.1 In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called PEPs. When either the agency the beneficiary is transferring from is preparing the claim for the episode, or an agency that has discharged a patient knows when preparing the claim that the same patient will be readmitted in the same 60 days, the claim should contain patient status code 06 in FL 17 (Patient Status) of the CMS 1450 UB-04.

3.1.2.21.5.2 Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service, to and including the day of the last billable service.

3.1.2.21.5.3 Transfers. Transfer describes when a single beneficiary chooses to change HHAs during the same 60-day period. By law under the HHA PPS system, beneficiaries must be able to transfer among HHAs, and episode payments must be pro-rated to reflect these changes.

- To accommodate this requirement, HHAs will be allowed to submit a RAP with a transfer indicator in FL 15 (Source of Admission) of CMS 1450 UB-04 even when an episode may already be open for the same beneficiary at another HHA.
- In such cases, the previously open episode will be automatically closed in TRICARE systems as of the date services began at the HHA the beneficiary transferred to, and the new episode for the "transfer to" agency will begin on that same date.
- Payment will be pro-rated for the shortened episode of the "transferred from" agency, adjusted to a period less than 60 days, whether according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency. The HHAs may not submit RAPs opening episodes when anticipating

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

a transfer if actual services have yet to be delivered.

3.1.2.21.5.4 Discharge and Readmission Situation Under HHA PPS. HHAs may discharge beneficiaries before the 60-day episode has closed if all treatment goals of the POC have been met, or if the beneficiary ends care by transferring to another HHA. Cases may occur in which an HHA has discharged a beneficiary during a 60-day episode, but the beneficiary is readmitted to the same agency in the same 60 days.

3.1.2.21.5.4.1 Since no portion of the 60-day episode can be paid twice, the payment for the first episode must be pro-rated to reflect the shortened period: 60 days less the number of days after the date of delivery of the last billable service until what would have been the 60th day.

3.1.2.21.5.4.2 The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock").

3.1.2.21.5.4.3 As with transfers, FL 15 (Source of Admission) of CMS 1450 UB-04 can be used to send "a transfer to same HHA" indicator on a RAP, so that the new episode can be opened by the HHA.

3.1.2.21.5.4.4 Beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, SNFs), but HHAs may choose to discharge in such cases.

- When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same 60-day period.
- Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA.

3.1.2.21.5.5 Payment When Death Occurs During an HHA PPS Episode. If a beneficiary's death occurs during an episode, the full payment due for the episode will be made.

- This means that PEP adjustments will not apply to the claim, but all other payment adjustments apply.
- The "Through" date on the claim (FL 6) of CMS 1450 UB-04, closing the episode in which the beneficiary died, should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

3.1.2.21.5.6 LUPA. If an HHA provides 4 visits or less, it will be reimbursed on a standardized per-visit payment instead of an episode payment for a 60-day period. Such payment adjustments, and the episodes themselves, are called LUPAs.

- On LUPA claims, non-routine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 6

Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

- Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on RAs and claims history.
- If the claim for the LUPA is later adjusted such that the number of visits becomes five or more, payments will be adjusted to an episode basis, rather than a visit basis.

3.1.2.21.5.7 Special Submission Case: "No-RAP" LUPAs. There are also reducing adjustments in payments when the number of visits provided during the episode fall below a certain threshold LUPAs.

- Normally, there will be two percentage payments (initial and final) paid for an HHA PPS episode - the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which an HHA knows that an episode will be four visits or less even before the episode begins, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment.
- In such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage that otherwise would likely have been largely recouped automatically against other payments.
- However, HHAs may submit both a RAP and claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in recoupment of funds when the claim is submitted. HHAs should also be aware that receipt of the RAP or a "No-RAP LUPA" claim causes the creation of an episode record in the system and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk for that period of not being established as the primary HHA.
- Physician orders must be signed when these claims are submitted.
- If an HHA later needs to add visits to the claim, so that the claim will have more than 4 visits and no longer be a LUPA, the HHA should submit an adjustment claim so the intermediary may issue full payment based on the HIPPS code.

3.1.2.21.5.8 Therapy Threshold Adjustment. There are downward adjustments in HHRs if the number of therapy services delivered during an episode does not meet anticipated thresholds - therapy threshold.

3.1.2.21.5.8.1 The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

3.1.2.21.5.8.2 The number of therapy hours projected on the OASIS assessment at the start of the episode, will be confirmed by the visit information submitted in line item detail on the claim for the episode.

3.1.2.21.5.8.3 Because the advent of 15-minute increment reporting on home health claims only recently preceded HHA PPS, therapy hours will be proxied from visits at the start of HHA PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent 8 hours of therapy.

3.1.2.21.5.8.4 Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational or speech therapy combined).

3.1.2.21.5.8.5 Logic is inherent in HIPPS coding so that there are essentially two HIPPS representing the same payment group:

- One if a beneficiary does not receive the therapy hours projected, and
- Another if he or she does meet the “therapy threshold”.
- Therefore, when the therapy threshold is not met, there is an automatic “fall back” HIPPS code, and TRICARE systems will correct payment without access to the full OASIS data set.
- If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case-mix for the episode with a new HIPPS code and pay the episode on the basis of the new code.
- HHAs will receive the difference between the full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code.
- The electronic RA will show both the HIPPS code submitted on the claim and the HIPPS that was used for payment, so such cases can be clearly identified.
- If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangements which were not billed timely to the primary agency, TRICARE systems will re-price the claim and pay the full episode payment based on the original HIPPS.
- A HIPPS code may also be changed based on medical review of claims.

3.1.2.21.5.9 SCIC. While HHA PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes a change in patient condition will occur that is significant enough to require the patient to be re-assessed during the 60-day episode period and to require new physician’s orders.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

3.1.2.21.5.9.1 In such cases, the HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode, even in the rare case of two different HIPPS codes applying to services on the same day.

3.1.2.21.5.9.2 Since a line item date is required in every case, Pricer will then be able to calculate the number of days of service provided under each HIPPS code, and pay proportional amounts under each HIPPS based on the number of days of service provided under each payment group (count of days under each HIPPS from and including the first billable service, to and including the last billable service).

3.1.2.21.5.9.3 The total of these amounts will be the full payment for the episode, and such adjustments are referred to as SCIC adjustments.

3.1.2.21.5.9.4 The electronic RA, including a claim for a SCIC-adjusted episode, will show the total claim reimbursement and separate segments showing the reimbursement for each HIPPS code.

3.1.2.21.5.9.5 There is no limit on the number of SCIC adjustments that can occur in a single episode. All HIPPS codes related to a single SCIC-adjusted episode should appear on the same claim at the end of that episode, with two exceptions:

- One - If the patient is re-assessed and there is no change in the HIPPS code, the same HIPPS does not have to be submitted twice, and no SCIC adjustment will apply.
- Two - If the HIPPS code weight increased but the proration of days in the SCIC adjustment would result in a financial disadvantage to the HHA, the SCIC is not required to be reported.

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

3.1.2.21.5.9.7 Payment will be made based on six HIPPS, and will be determined by contractor medical review staff, if more than six HIPPS are billed.

3.1.2.21.6 Outlier Payments. There are cost outliers, in addition to episode payments.

3.1.2.21.6.1 HHA PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in a 60-day period, TRICARE systems will provide extra, or "outlier", payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

3.1.2.21.6.2 Outlier determinations will be made comparing the summed wage-adjusted imputed costs for each discipline (i.e., the summed products of each wage-adjusted per-visit rate for each discipline multiplied by the number of visits of each discipline on the claim) with the sum of: the case-mix adjusted episode payment plus a wage-adjusted fixed loss threshold amount.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

3.1.2.21.6.3 If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific HRG payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment, in addition to the episode payment.

3.1.2.21.6.4 Outlier payment amounts are wage index adjusted to reflect the MSA or CBSA in which the beneficiary was served.

3.1.2.21.6.5 Outlier payment is a payment for an entire episode, and therefore only carried at the claim level in paid claim history, not allocated to specific lines of the claim.

3.1.2.21.6.6 Separate outliers will not be calculated for different HIPPS codes in a SCIC situation, but rather the outlier calculation will be done for the entire claim.

3.1.2.21.6.7 Outlier payments will be made on remittances for specific episode claims. HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total reimbursement for the episode claim on a remittance, but it will be identified separately on the claim in history with a value code 17 in CMS 1450 UB-04 FLs 39-41, with an attached amount, and in condition code 61 in CMS 1450 UB-04 FLs 18-28. Outlier payments will also appear on the electronic RA in a separate segment.

3.1.2.22 Exclusivity and Multiplicity of Adjustments.

3.1.2.22.1 Episode payment adjustments only apply to claims, not RAPs.

3.1.2.22.2 Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold, PEP or SCIC adjustment, and also will not receive outlier payments.

3.1.2.22.3 For other HHA PPS claims, multiple adjustments may apply on the same claim, although some combinations of adjustments are unlikely (i.e., a SCIC and therapy threshold adjustment in a shortened episode (PEP adjustment)).

3.1.2.22.4 All claims except LUPA claims will be considered for outlier payment.

3.1.2.22.5 Payment adjustments are calculated in Pricer software.

3.1.2.22.6 Payments are case-mix and wage adjusted employing Pricer software (a module that will be attached to existing TRICARE claims processing systems) at the contractor processing TRICARE home health claims.

3.1.2.22.7 The MCSC must designate the primary provider of home health services through its established authorization process. Only one HHA - the primary or the one establishing the beneficiary's POC - can bill for home health services other than DME under the home health benefit. If multiple agencies are providing services simultaneously, they must take payment under arrangement with the primary agency.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.22.8 Payment for services remains specific to the individual beneficiary who is homebound and under a physician's POC.

3.1.2.23 Chart Representation of Billing Procedures.

3.1.2.23.1 One 60-day Episode, No Continuous Care (Patient Discharged):

RAP	CLAIM
Contains one HIPPS Code and OASIS Matching Key output from Grouper software linked to OASIS	Submitted with Patient Status Code 01 and contains same HIPPS Code as RAP
Does not give any line item detail for TRICARE but can include line item charges for other carrier	Gives all line item detail for the entire home health episode
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date of Discharge or Day 60
Creates home health episode in automated authorization system (authorization screen)	Closes home health episode automated authorization system (authorization screen)
Triggers initial percentage payment for 60-day home health episode	Triggers final percentage payment

3.1.2.23.2 Initial Episode in Period of Continuous Care:

FIRST EPISODE		NEXT EPISODE(S)
RAP	CLAIM	RAP(S) & CLAIM(S)
First Episode		Next Episode(s)
RAP	Claim	RAP(s) & Claim(s)
Contains one HIPPS code and Claim-OASIS Matching Key output from Grouper software linked to OASIS.	Contains same HIPPS Code as RAP with Patient Status Code 30	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPs and claims throughout the period of continuous care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. Claims submitted at the end of each 60 day period.
Does not give any other line item detail for TRICARE use.	Gives all line item detail for entire home health episode.	
From and Through Dates match first service delivered.	From Date same as RAP, Through Date, Day 60 of home health episode.	The RAP and claim From and Through Dates in a period of continuous care are first day of home health episode, w/ or w/o service (i.e., Day 61, 121, 181, etc.).
Creates home health episode in authorization system.	Closes home health episode in authorization system.	
Triggers initial percentage payment.	Triggers final percentage payment for 60-day home health episode.	Creates or closes home health episode.

3.1.2.23.2.1 The above scenarios are expected to encompass most episode billings.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.23.2.2 For RAPs, Source of Admission Code “B” is used to receive transfers from other agencies; “C”, if readmission to same agency after discharge.

3.1.2.23.2.3 There is no number limit on medically necessary episodes in continuous care periods.

3.1.2.23.3 A Single LUPA Episode:

RAP	CLAIM
Contains one HIPPS Code and Claims-OASIS Matching Key output from Grouper software linked to OASIS. Does not give any other line item detail for TRICARE use	Submitted after discharge or 60 days with Patient Status Code 01. Contains same HIPPS Code as RAP, gives all line item detail for the entire home health episode - line item detail will not show more than 4 visits for entire episode.
From and Through Dates match date of first service delivered.	From Date same as RAP, Through Date Discharge or Day 60.
Creates home health episode in authorization system.	Closes home health episode in authorization system.
Triggers initial percentage payment.	Triggers final percentage payment for 60-day home health episode.

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

3.1.2.23.3.2 While also less likely, a LUPA, though never prorated, can also be part of a shortened episode or an episode in which the patient condition changes.

3.1.2.23.4 “No-RAP” LUPA Episode. When a HHA knows from the outset that an episode will be 4 visits or less, the agency may choose to bill only a claim for the episode. Claims characteristics are the same as the LUPA final claim on the previous page.

PROs	CONS
Will not get large episode percentage payment up-front for LUPA that will be reimbursed on a visit basis (overpayment concern, but new payment system will recoup such “overpayments” automatically against future payments) and less paperwork.	No payment until claim is processed

3.1.2.23.5 Episode with a PEP Adjustment - Transfer to Another Agency or Discharge-Known Readmission to Same Agency:

RAP	CLAIM
Contains one HIPPS Code and Claim-OASIS Matching Key output from Grouper software linked to OASIS.	Submitted after discharge with Patient Status Code of 06.
Does not contain other line item detail for TRICARE use.	Contains same HIPPS Code as RAP, and gives all line item detail for entire home health episode.
From and Through Dates match date of first service delivered.	From Date same as RAP, Through Date is discharge.
Creates home health episode in authorization system.	Closes home health episode in authorization system at date of discharge, not 60 days.
Triggers initial percentage payment.	Triggers final percentage payment, and total payment for the episode will be cut back proportionately (x/60), “x” being the number of days of the shortened home health episode.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.23.5.1 Known Readmission: agency has found after discharge the patient will be re-admitted in the same 60-day episode ("transfer to self" - new episode) before final claim submitted.

3.1.2.23.5.2 A PEP can also occur in a period of otherwise continuous care.

3.1.2.23.5.3 A PEP episode can contain a change in patient condition.

3.1.2.23.6 Episode with a PEP Adjustment - Discharge and "Unknown" Re-Admit, Continuous Care:

FIRST EPISODE (RAP)	CLAIM	START OF NEXT EPISODE (RAP)
Contains one HIPPS and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Submitted after discharge or 60 days with Patient Status 01 - agency submitted claim before the patient was re-admitted in the same 60-day episode.	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPS and claims throughout the period of continuous care.
Does not contain other line item detail for TRICARE use	Contains same HIPPS Code as RAP, and gives all line item detail for the entire episode.	Contains Source of Admission Code "C" to indicate patient re-admitted in same 60 days that would have been in previous episode, but now new Episode will begin and previous episode automatically shortened.
Creates home health episode in authorization system	Closes home health episode in authorization system 60 days initially, and then revised to less than 60 days after next RAP received.	
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60 of home health episode.	From and Through Dates, equal first episode day with service or Day 60 of home health episode without service (i.e., Day 61, 121, 181).
Triggers initial percentage payment	Triggers final payment, may be total payment for home health episode at first, will be cut back proportionately (x/60) to the number of the shortened episode when next billing received.	Opens next Episode in authorization system. Triggers initial payment for new home health episode.

3.1.2.23.7 Episode with a SCIC Adjustment:

RAP	CLAIM
Contains one HIPPS Code and Claim-OASIS Matching Key output from Grouper	Submitted after discharge with Patient Status Code software linked to OASIS as appropriate (01, 30, etc.). Carries Matching Key and diagnoses consistent with last OASIS assessment.
Does not contain other line item for TRICARE use	Contains same HIPPS Code as RAP, additional HIPPS output every time patient reassessed because of change in condition, and gives all line item detail for the entire home health episode.
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60.
Creates home health episode in authorization system	Closes home health episode in authorization system.
Triggers initial percentage payment	Triggers final percentage payment.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
 Chapter 12, Section 6
 Home Health Benefit Coverage And Reimbursement - Claims And Billing
 Submission Under HHA PPS

3.1.2.23.8 General Guidance on Line Item Billing Under HHA PPS - Quick Reference on Billing
 Most line items on HHA PPS RAPs and Claims:

TYPE OF LINE ITEM	EPISODE	SERVICES/VISITS	OUTLIER
Claim Coding	New 023 revenue code with new HIPPS on HCPCS of same line.	Current revenue codes 42X, 43X,44X, 55X, 56X, 57X w/Gxxxx HCPCS for increment reporting (Note: Revenue codes 58X and 59X not permitted for HHA PPS).	Determined by Pricer - Not billed by HHAs.
TOB	Billed on 32X only (have 485, patient homebound).	Billed on 32X only if POC; 34X* if no 485.	Appears on remittance only for HHA PPS (via Pricer)
Payment Bases	PPS episode rate: (1) full episode w/ or w/out SCIC adjustment, (2) less than full episode w/PEP adjustment, (3) LUPA paid on visit basis, (4) therapy threshold adjustment.	When LUPA on 32X, visits paid on adjusted national standardized per visit rates; paid as part of Outpatient PPS for 34X*.	Addition to PPS episode rate payment only, not LUPA, paid on claim basis, not line item.
PPS Claim?	Yes , RAPs and Claims	Yes , Claims only [34X*; no 485/ non-PPS]	Yes , Claims only

Note: For HHA PPS, HHA submitted IC TOB must be 322 - may be adjusted by 328; Claim TOB must be 329-may be adjusted by 327, or 328.

* 34X claims for home health visit/services on this chart will not be paid separately if a home health episode for same beneficiary is open on the system (exceptions noted on chart below).

TYPE OF LINE ITEM	DME** (NON-IMPLANTABLE, OTHER THAN OXYGEN & P/O)	OXYGEN & P/O (NON-IMPLANTABLE P/O)	NON-ROUTINE*** MEDICAL SUPPLIES	OSTEOPOROSIS DRUGS	VACCINE	OTHER OUTPUT ITEMS (ANTIGENS, SPLINTS & CASTS)
Claim Coding	Current revenue codes 29X, 294 for drugs/supplies for effective DME use w/HCPCS.	Current revenue codes 60X (Oxygen) and 274 (P/O) w/HCPCS.	Current revenue code 27X, and voluntary use of 623 for wound care supplies.	Current revenue code 636 & HCPCS.	Current revenue codes 636 (drug) and HCPCS, 771 (administration).	Current revenue code 550 & HCPCS.
TOB	Billed to Contractor on 32X if 485; 34X*, if no 485.	Billed to Contractor on 32X if 485; 34X*, if no 485.	Billed on 32X if 485; or 34X*, if no 485.	Billed on 34X* only.	Billed on 34X* only.	Billed on 34X* only.

Note: For HHA PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).

* 34X claims for home health services, except as noted for specific items above, will not be paid separately if a home health episode for the same beneficiary is open on the system.

** Other than DME treated as routine supplies according to TRICARE.

*** Routine supplies are not separately billable or payable under TRICARE Home Health Care (HHC). When billing on TOB 32X, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 6

Home Health Benefit Coverage And Reimbursement - Claims And Billing

Submission Under HHA PPS

TYPE OF LINE ITEM	DME** (NON-IMPLANTABLE, OTHER THAN OXYGEN & P/O)	OXYGEN & P/O (NON-IMPLANTABLE P/O)	NON-ROUTINE*** MEDICAL SUPPLIES	OSTEOPOROSIS DRUGS	VACCINE	OTHER OUTPUT ITEMS (ANTIGENS, SPLINTS & CASTS)
Payment Basis	Lower of total rental cost or reasonable purchase cost.	Allowable charge methodology. Oxygen concentrator - rental or purchase.	Bundled into PPS payment if 32X (even LUPA); paid in cost report settlement for 34X*.	Average wholesale cost, and paid separately with or without open HHA PPS episode.	Average wholesale cost, and paid separately with or without open HHA PPS episode.	
PPS Claims?	Yes , Claim only [34X*, no 485/non-PPS]	Yes , Claim only [34X*, if no 485/non-PPS]	Yes , Claim only [34X*, if no POC/non-PPS]	No (34X*; claims only)	No (34X*; claims only)	No (34X*; claims only)

Note: For HHA PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).
 * 34X claims for home health services, except as noted for specific items above, will not be paid separately if a home health episode for the same beneficiary is open on the system.
 ** Other than DME treated as routine supplies according to TRICARE.
 *** Routine supplies are not separately billable or payable under TRICARE Home Health Care (HHC). When billing on TOB 32X, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270.

3.1.2.24 Other Billing Considerations.

3.1.2.24.1 Billing for Nonvisit Charges. Under HHA PPS, all services under a POC must be billed as a HHA PPS episode. All services within an episode of care must be billed on one claim for the entire episode.

- TOB 329 and 339 are not accepted without any visit charges. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.**
- Nonvisit charges incurred after termination of the POC are payable under medical and other health services on TOB 34X.

3.1.2.24.2 Billing for Use of Multiple Providers. When a physician deems it necessary to use two participating HHAs, the physician designates the agency which furnishes the major services and assumes the major responsibility for the patient's care.

- The primary agency bills for all services furnished by both agencies and keeps all records pertaining to the care. The primary agency's status as primary is established through the submission of a RAP.
- The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies.
- Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the system indicates an episode of care is open for a beneficiary, deny the RAP on any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 6

Home Health Benefit Coverage And Reimbursement - Claims And Billing Submission Under HHA PPS

3.1.2.24.3 Home Health Services Are Suspended or Terminated and Then Reinstated. A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health service. When the suspension is temporary (does not extend beyond the end of the 60-day episode) and the physician later determines that the services must be resumed, the resumed services are paid as part of the same episode and under the same POC as before. The episode from date and the admission date remain the same as on the RAP. No special indication need be made on the episode claim for the period of suspended services. Explanation of the suspension need only be indicated in the medical record.

- If, when services are resumed after a temporary suspension (one that does not extend beyond the end date of the 60-day episode), the HHA believes the beneficiary's condition is changed sufficiently to merit a SCIC adjustment, a new OASIS assessment may be performed, and change orders acquired from the physician. The episode may then be billed as a SCIC adjustment, with an additional 023 revenue code line reflecting the HIPPS code generated by the new OASIS assessment.
- If the suspension extends beyond the end of the current 60-day episode, HHAs must submit a discharge claim for the episode. Full payment will be due for the episode. If the beneficiary resumes care, the HHA must establish a new POC and submit a RAP for a new episode. The admission date would match the episode from date, as the admission is under a new POC and care was not continuous.

3.1.2.24.4 Preparation of a Home Health Billing Form in No-Payment Situations. HHAs must report all non-covered charges on the CMS 1450 UB-04, including no-payment claims as described below. HHAs must report these non-covered charges for all home health services, including both Part A (TOB 0339) and Part B (TOB 0329 or 034X) service. Non-covered charges must be reported only on HHA PPS claims. RAPs do not require the reporting of non-covered charges. HHA no-payment bills submitted with types of bill 0329 or 0339 will update any current home health benefit period on the system. **Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.**

3.1.2.24.5 HHA Claims With Both Covered and Non-Covered Charges. HHAs must report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. (Provider should not report the non-payment codes outlined below). On the CMS 1450 UB-04 flat file, HHAs must use record type 61, Field No. 10 (outpatient total charges) and Field No. 11 (outpatient non-covered charges) to report these charges. Providers utilizing the hard copy CMS 1450 UB-04 report these charges in FL 47. "Total Charges," and in FL 48 "Non-Covered Charges." You must be able to accept these charges in your system and pass them on to other payers.

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

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 Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 12, Section 6
Home Health Benefit Coverage And Reimbursement - Claims And Billing
Submission Under HHA PPS

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 -

Home Health Certification And Plan Of Care (POC)

Home health care services provided under this chapter must be provided under a Plan Of Care (POC) established and approved by a physician, and the care must be certified by a physician. Please see the Medicare Benefit Policy Manual, Chapter 7, Sections 30.2 and 30.5 for the documentation requirements for the POC and physician certification. This manual is available here: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf>.

- END -

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

(Final payment amounts per 60-day episodes ending on or after January 1, 2015, and before January 1, 2016 - Continuing Calendar Year (CY) update.)

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

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for Calendar Year (CY) 2015 that the standard prospective payment amount be increased by a factor equal to the applicable Home Health (HH) market basket update for HHAs.

Rebasing of 60-Day Episode Payment Amount, National Per-Visit Rates, and the Non-Routine Medical Supplies (NRS) Conversion Factor

For CY 2014, as required by section 3131(a)(1) of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS), in their Final Rule published December 2, 2013, rebased the national, standardized 60-day episode payment amount, the national per-visit rates, and the NRS conversion factor. The rebasing adjustments will occur over the next four years. For CY 2015 the rebasing adjustment is \$80.95.

National 60-Day Episode Payment Amounts - CY 2015

In order to calculate the CY 2015 national standardized 60-day episode, the CY 2014 estimated average payment per 60-day episode of \$2,869.27 is adjusted by the wage index standardization factor, a case-mix budget neutrality factor, the rebasing adjustment, and the home health market basket update, as reflected in [Figure 12.L.2015-1](#).

FIGURE 12.L.2015-1 CY 2015 NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNTS

CY 2014 National Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2015 National, Standardized 60-Day Episode Payment
\$2,869.27	x 1.0024	x 1.0366	- \$80.95	x 1.021	= \$2,961.38

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2015

To calculate the CY 2015 national per-visit rates, the 2014 national per-visit rates are adjusted by a wage index budget neutrality factor, and are then increased by the maximum rebasing adjustments described in the December 2, 2013, CMS Final Rule. Finally, the rates are updated by the CY 2015 HH market basket update. National per-visit rates are not subjected to the nominal increase in case-mix. The final updated CY 2015 national per-visit rates per discipline are reflected in [Figure 12.L.2015-2](#):

FIGURE 12.L.2015-2 CY 2015 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS

HH Discipline Type	CY 2014 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2015 Per-Visit Payment
HH Aide	\$54.84	x 1.0012	+ \$1.79	x 1.021	\$57.89
Medical Social Services (MSS)	194.12	x 1.0012	+ 6.34	x 1.021	204.91
Occupational Therapy (OT)	133.30	x 1.0012	+ 4.35	x 1.021	140.70
Physical Therapy (PT)	132.40	x 1.0012	+ 4.32	x 1.021	139.75
Skilled Nursing (SN)	121.10	x 1.0012	+ 3.96	x 1.021	127.83
Speech-Language Pathology (SLP)	143.88	x 1.0012	+ 4.70	x 1.021	151.88

Payment of LUPA Episodes

For CY 2014 and years following, as described in the December 2, 2013, CMS Final Rule, the per-visit payment amount for the first SN, PT, and SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes is multiplied by the LUPA add-on factors, which are: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP.

NRS Conversion Factor Update

Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2015, the 2014 NRS conversion factor was adjusted using the 2.82 rebasing adjustment factor, as described in the December 2, 2013, CMS Final Rule, and then updated by the CY 2015 HH market basket. See [Figure 12.L.2015-3](#).

FIGURE 12.L.2015-3 CY 2015 NRS CONVERSION FACTOR

CY 2014 NRS Conversion Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2015 NRS Conversion Factor
\$53.65	x 0.9718	x 1.021	= \$53.23

The payment amounts, using the above computed CY 2014 NRS conversion factor (\$53.65), for the various severity levels based on the updated conversion factor are calculated in [Figure 12.L.2015-5](#).

Labor And Non-Labor Percentages

For CY 2015, the labor percent is 78.535%, and the non-labor percent is 21.465%.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

Outlier Payments

Under the HHA PPS, outlier payments are made for episodes for which the estimated cost exceeds a threshold amount. The wage adjusted Fixed Dollar Loss (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. The FDL ratio, which is used in calculating the FDL amount, for CY 2015 is 0.45.

Outcome and Assessment Information Set (OASIS)

HHAs must collect OASIS data in order to participate in the TRICARE program. See [Addendum G](#) for the OASIS.

Temporary 3% Rural Add-On for the HHA PPS

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, enacted on December 8, 2003, and as amended by Section 3131(c) of the Affordable Care Act) provides an increase of 3% of the payment amount otherwise made under Section 1895 of the Social Security Act for HH services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act), for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The 3% rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor when HH services are provided in rural (non-Core Based Statistical Area (CBSA)) areas. The applicable case-mix and wage index adjustments are subsequently applied. Episodes that qualify for the 3% rural add-on will be identified by a CBSA code that begins with '999'.

National 60-Day Episode Payment Amounts for Rural, Non-CBSA Areas

In order to calculate the national standardized 60-day episode payment for beneficiaries residing in a rural area, the CY 2015 national standardized 60-day episode payment of \$2,961.38 was increased by 3%. See [Figure 12.L.2015-4](#).

FIGURE 12.L.2015-4 CY 2015 PAYMENT AMOUNTS FOR 60-DAY EPISODES FOR SERVICES PROVIDED IN A RURAL AREA

CY 2015 National, Standardized 60-Day Episode Payment Rate	Multiplied by the 3% Rural Add-On	CY 2015 Rural National, Standardized 60-Day Episode Payment Rate
\$2,961.38	x 1.03	\$3,050.22

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment

The CY 2015 national per-visit amounts were increased by 3% for beneficiaries who reside in rural areas. See [Figure 12.L.2015-5](#).

FIGURE 12.L.2015-5 CY 2015 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

HH Discipline Type	CY 2014 Per-Visit Rate	Multiplied by the 3% Rural Add-On	CY 2014 Rural Per-Visit Rate
HH Aide	\$57.89	x 1.03	\$59.63
MSS	204.91	x 1.03	211.06
OT	140.70	x 1.03	144.92
PT	139.75	x 1.03	143.94
SN	127.83	x 1.03	131.66
SLP	151.88	x 1.03	156.44

Payment for NRS

The NRS conversion factor for CY 2015 payments was increased by 3% for beneficiaries who reside in rural areas. See [Figure 12.L.2015-6](#) and [Figure 12.L.2015-7](#).

FIGURE 12.L.2015-6 CY 2015 NRS CONVERSION FACTOR FOR SERVICES PROVIDED IN A RURAL AREA

CY 2015 NRS Conversion Factor	Multiplied by the 3% Rural Add-On	CY 2015 NRS Conversion Factor
\$53.23	x 1.03	\$54.83

FIGURE 12.L.2015-7 CY 2015 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR BENEFICIARIES RESIDING IN A RURAL AREA

Severity Level	Points (Scoring)	Relative Weight	Total NRS Payment Amount For Rural Areas
1	0	0.2698	\$14.79
2	1 to 14	0.9742	53.42
3	15 to 27	2.6712	146.46
4	28 to 48	3.9686	217.60
5	49 to 98	6.1198	335.55
6	99+	10.5254	577.11

- END -

Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2015

In 2013 the Office of Management and Budget (OMB) issued changes in the delineation of Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Combined Statistical Areas. Centers for Medicare and Medicaid Services (CMS) finalized changes to the wage index based on the revised Core Based Statistical Area (CBSA) delineations for the Calendar Year (CY) 2015 HH PPS wage index. These changes are made to the wage index using a blended wage index for a one-year transition. For each county, a blended wage index is calculated as 50% of the CY 2015 wage index using the current OMB delineations and 50% of the CY 2015 wage index using the revised OMB delineations. Beginning January 1, 2016, the wage index for all HH PPS payments will be fully based on the new OMB delineations.

The CY 2015 transitional wage index is available for download at <http://www.tricare.mil/tma/HHPPS>.

- END -

Index

A	Chap	Sec/Add
Accommodation Of Discounts Under Provider Reimbursement Methods	1	2
Acronyms And Abbreviations		Appendix A
Adjusted Standardized Amounts (ASAs)		
DRG-Based Payment System	6	7
FY 2013	6	B (FY2013)
FY 2014	6	B (FY2014)
FY 2015	6	B (FY2015)
Allowable Charges		
CHAMPUS Maximum Allowable Charges (CMAC)	5	3
Providers	5	1
Ambulance Services	1	14
Skilled Nursing Facility (SNF)	8	C
Ambulatory Surgical Center (ASC) Reimbursement	9	1
Anesthesia	1	9
Assistant Surgeons	1	17

B	Chap	Sec/Add
Benefits And Beneficiary Payments Under The TRICARE Program	2	A
Birthing Center		
Rate Non-Professional Component	10	A
Reimbursement	10	1
Birthing Room	1	32
Bonus Payments In Health Professional Shortage Areas (HPSAs)	1	33

C	Chap	Sec/Add
Catastrophic Loss Protection	2	2
Certified Psychiatric Nurse Specialists	1	6
CHAMPUS Maximum Allowable Charges (CMAC)	5	3
Charges For Provider Administrative Expenses		19
Claims Auditing Software	1	3
Consolidated Billing	8	2
Skilled Nursing Facility (SNF)	8	C
Coordination Of Benefits (COB)	4	3
Cost-Shares And Deductibles	2	1
Cost-Shares for Pharmacy Benefits Program	2	B
Critical Access Hospitals (CAHs)	15	1

D	Chap	Sec/Add
Discounts	3	3
Double Coverage		
Actions	4	4
Coordination Of Benefits (COB)	4	3
Review And Processing Of Claims	4	2
Double Coverage	4	1
DRG-Based Payment System		
Adjusted Standardized Amounts (ASAs)	6	7
FY 2013	6	B (FY2013)
FY 2014	6	B (FY2014)
FY 2015	6	B (FY2015)
Applicability Of The DRG System	6	4
Basis Of Payment	6	3
Charges To Beneficiaries	6	10
Determination Of Payment Amounts	6	5
DRG Weighting Factors	6	6
DRGs, DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds		
FY 2013	6	C (FY2013)
FY 2014	6	C (FY2014)
FY 2015	6	C (FY2015)
General Description Of System	6	2
General	6	1
Health Benefit Program Agreement	6	A
Information Provided By TMA	6	9
Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS) Claims	1	11

E	Chap	Sec/Add
Economic Interest In Connection With Mental Health Admissions	1	8
Emergency Inpatient Admissions To Unauthorized Facilities	1	29

F	Chap	Sec/Add
Figures	1	B
Forensic Examinations Following Sexual Assault or Domestic Violence	1	36
Freestanding Ambulatory Surgical Center (ASC) Reimbursement	9	1
Freestanding Birthing Center Reimbursement	10	1

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Index

F (CONTINUED)	Chap	Sec/Add	H (CONTINUED)	Chap	Sec/Add
Freestanding Partial Hospitalization Program (PHP)			Home Health Care (HHC) (Continued)		
Maximum Rates for FY 2013 - FY 2015	7	B	Examples Of Claims Submission Under HHA PPS	12	Q
Reimbursement	7	2	HAVEN Reference Manual	12	K
			Health Insurance Prospective Payment System (HIPPS) Tables For Pricer	12	J
			HHRG Worksheet	12	I
			Home Health Consolidated Billing Code List		
			Non-Routine Supply (NRS) Codes	12	B
			Therapy Codes	12	C
			Input/Output Record Layout	12	R
			OASIS Items Used For Assessments Of 60-Day Episodes Beginning On Or After January 1, 2008 Or On Or After January 1, 2010	12	G
			Primary Components Of A Home Care Patient Assessment	12	E
			Home Infusion Claims		
			Before January 30, 2012	3	6
			On Or After January 30, 2012	3	7
			Hospice		
			Participation Agreement	11	D
			Rate Information		
			Care Rates		
			FY 2013	11	A (FY2013)
			FY 2014	11	A (FY2014)
			FY 2015	11	A (FY2015)
			Wage Indexes for Rural Areas		
			FY 2013	11	C (FY2013)
			FY 2014	11	C (FY2014)
			FY 2015	11	C (FY2015)
			Wage Indexes for Urban Areas		
			FY 2013	11	B (FY2013)
			FY 2014	11	B (FY2014)
			FY 2015	11	B (FY2015)
			Reimbursement		
			Conditions For Coverage	11	3
			Coverage/Benefits	11	2
			General Overview	11	1
			Guidelines For Payment Of Designated Levels Of Care	11	4
			Hospital Reimbursement	3	2
			Billed Charges Set Rates	1	21
			DRG-Based Payment System		
			Adjusted Standardized Amounts	6	7
			Adjustments To Payment Amounts	6	8
			Applicability Of The DRG System	6	4
			Basis Of Payment	6	3