



DEFENSE
HEALTH AGENCY

MB&RS

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

**CHANGE 116
6010.58-M
AUGUST 31, 2015**

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

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

CHANGE TITLE: REIMBURSEMENT & CODING UPDATES 15-003

CONREQ: 17571

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates the TRICARE Mental Health Reimbursement Systems for FY16, moves the list of Residential Treatment Centers (RTCs) and Psychiatric Partial Hospitalization (PHP) rates from the manuals to the TRICARE reimbursement website, adds notes reflecting ICD-10 implementation, and provides administrative corrections and updates.

EFFECTIVE DATE: October 1, 2015.

IMPLEMENTATION DATE: October 1, 2015.

**FAZZINI.ANN.N
OREEN.119980
2271**

Digitally signed by
FAZZINI.ANN.NOREEN.1199802271
DN: c=US, o=U.S. Government,
ou=DoD, ou=PKI, ou=DHA,
cn=FAZZINI.ANN.NOREEN.1199802271
Date: 2015.08.27 10:47:20 -06'00'

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

**ATTACHMENT(S): 122 PAGE(S)
DISTRIBUTION: 6010.58-M**

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

REMOVE PAGE(S)

CHAPTER 2

Section 1, pages 3 through 6 and 11 through 14

CHAPTER 7

Table of Contents, page 1

Section 1, pages 3 through 7

Section 2, pages 1 through 3

Section 4, pages 1, 2, 5, and 6

Addendum A, pages 1 and 2

Addendum B, page 1

Addendum C, pages 1 through 18

Addendum D (FY 2013), pages 1 through 8

Addendum D (FY 2014), pages 1 through 8

Addendum D (FY 2015), pages 1 through 8

CHAPTER 12

Section 1, pages 1, 2, 7, and 8

Section 4, pages 1 through 35

Section 6, pages 1, 2, and 11 through 44

Addendum G, page 1

Addendum K, page 1

INDEX

pages 1 through 5

INSERT PAGE(S)

Section 1, pages 3 through 6 and 11 through 14

Table of Contents, page 1

Section 1, pages 3 through 7

Section 2, pages 1 through 3

Section 4, pages 1, 2, 5, and 6

Addendum A, pages 1 and 2

Addendum B, pages 1 through 18

★ ★ ★ ★ ★ ★

★ ★ ★ ★ ★ ★

★ ★ ★ ★ ★ ★

★ ★ ★ ★ ★ ★

Section 1, pages 1, 2, 7, and 8

Section 4, pages 1 through 35

Section 6, pages 1, 2, and 11 through 44

Addendum G, page 1

Addendum K, page 1

pages 1 through 4

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CHAMPUS Maximum Allowable Charge (CMAC)). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

1.1.6.3.3 The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2009.

1.1.6.4 For Certain Reservists

The Director, **Defense Health Agency (DHA)**, may waive the individual or family deductible for family members of a Reserve Component (RC) member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a RC member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 United States Code (USC) 101(a)(13). Also, for this purpose a family member is a lawful husband or wife of the member or an eligible child.

1.2 TRICARE Prime

1.2.1 Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, Public Law 106-398, for services provided on or after April 1, 2001, a \$0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and POS charges are not waived by the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2001.

1.2.2 In instances where the CMAC or allowable charge is less than the copayment shown on [Addendum A](#), network providers may only collect the lower of the allowable charge or the applicable copayment.

1.2.3 The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

1.2.4 Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

1.2.4.1 Diagnostic radiology and ultrasound services included in the CPT¹ procedure code range from 70000-76999, or any other code for associated contrast media;

1.2.4.2 Diagnostic nuclear medicine services included in the CPT¹ procedure code range from 78000-78999;

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

1.2.4.3 Pathology and laboratory services included in the CPT² procedure code range from 80000-89399; and

1.2.4.4 Cardiovascular studies included in the CPT² procedure code range from 93000-93350.

1.2.4.5 Venipuncture included in the CPT² procedure code range from 36400-36416.

1.2.4.6 Collection of blood specimens in the CPT² procedure codes 36591 and 36592.

1.2.4.7 Fetal monitoring for CPT² procedure codes 59020, 59025, and 59050.

Note: Multiple discounting will not be applied to the following CPT² procedure codes for venipuncture, fetal monitoring, and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, and 59050.

1.2.5 POS option. See [Section 3](#).

1.3 Basic Program: TRICARE Standard

1.3.1 Deductible Amount: Outpatient Care

1.3.1.1 For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

1.3.1.1.1 Deductible, Individual: Each beneficiary is liable for the first fifty dollars (\$50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

1.3.1.1.2 Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

1.3.1.2 For care rendered on or after April 1, 1991, for all TRICARE beneficiaries except family members of active duty sponsors of pay grade E-4 or below.

1.3.1.2.1 Deductible, Individual: Each beneficiary is liable for the first \$150.00 of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

1.3.1.2.2 Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed \$300.00.

1.3.1.3 TRICARE-Approved Ambulatory Surgery Centers (ASCs), Birthing Centers, or Partial Hospitalization Programs (PHPs). No deductible shall be applied to allowable amounts for services or items rendered to ADFMs or authorized NATO family members.

1.3.1.4 Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (or \$300.00 if [paragraph 1.3.1.2](#), applies), and no one beneficiary's allowable amounts exceed \$50.00 (or \$150.00 if

² CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

[paragraph 1.3.1.2](#) applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

1.3.1.5 In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 USC 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm, the deductible shall be the amount specified in [paragraph 1.3.1.2](#), for care rendered after October 1, 1991.

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

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

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

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

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

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

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

1.3.2 Deductible Amount: Inpatient Care

None.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1 Cost-Shares And Deductibles

1.3.3 Cost-share Amount

1.3.3.1 Outpatient Care

1.3.3.1.1 ADFM or Authorized NATO Beneficiary. The cost-share for outpatient care is 20% of the allowable amount in excess of the annual deductible amount. This includes the professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC or birthing center.

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

1.3.3.2 Inpatient Care

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

FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

PERIOD	DAILY CHARGE
October 1, 2000 - September 30, 2001	\$11.45
April 1, 2001 - Present (for Prime ADFMs only)	\$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	\$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	\$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	\$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	\$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	\$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	\$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	\$15.15
October 1, 2008 - September 30, 2009 (for ADFMs not enrolled in Prime)	\$15.65
October 1, 2009 - September 30, 2010 (for ADFMs not enrolled in Prime)	\$16.30
October 1, 2010 - September 30, 2011 (for ADFMs not enrolled in Prime)	\$16.85
October 1, 2011 - September 30, 2012 (for ADFMs not enrolled in Prime)	\$17.05
October 1, 2012 - September 30, 2013 (for ADFMs not enrolled in Prime)	\$17.35
October 1, 2013 - September 30, 2014 (for ADFMs not enrolled in Prime)	\$17.65
October 1, 2014 - September 30, 2015 (for ADFMs not enrolled in Prime)	\$17.80

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

1.3.3.4.2.2.1.2 Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

1.3.3.4.2.2.2 Under no circumstances can the cost-share exceed the DRG-based amount.

1.3.3.4.2.2.3 Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

1.3.3.4.3 TRICARE Extra

1.3.3.4.3.1 Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

1.3.3.4.3.2 Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is \$250.

1.3.3.4.4 TRICARE Prime

There is no cost-share for ADFMs. For beneficiaries other than ADFMs, the cost-sharing provision is the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of \$11, whichever is greater.

1.3.3.4.5 Maternity Services

See [paragraph 1.3.3.3](#), for the cost-sharing provisions for maternity services.

1.3.3.5 Cost-Shares: Inpatient Mental Health Per Diem Payment System

1.3.3.5.1 General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in [paragraph 1.3.3.2](#) or [1.3.3.4](#) are to be followed.

1.3.3.5.2 Cost-shares for ADFMs. Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any RTC, any Substance Use Disorder Rehabilitation Facility (SUDRF), and any PHP providing mental health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is \$0 per day. See [Addendum A](#) for further information.

1.3.3.5.3 Cost-shares for beneficiaries other than ADFMs.

1.3.3.5.3.1 Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

1.3.3.5.3.2 Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of [paragraph 1.3.3.5.3.2.1](#) or [paragraph 1.3.3.5.3.2.2](#):

1.3.3.5.3.2.1 A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the **Federal Register** along with the per diems published pursuant to [Chapter 7, Section 1](#). This fixed daily amount will also be furnished to contractors by **DHA**. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

- Fiscal Year 2000 - \$144 per day.
- Fiscal Year 2001 - \$149 per day.
- Fiscal Year 2002 - \$154 per day.
- Fiscal Year 2003 - \$159 per day.
- Fiscal Year 2004 - \$164 per day.
- Fiscal Year 2005 - \$169 per day.
- Fiscal Year 2006 - \$175 per day.
- Fiscal Year 2007 - \$181 per day.
- Fiscal Year 2008 - \$187 per day.
- Fiscal Year 2009 - \$193 per day.
- Fiscal Year 2010 - \$197 per day.
- Fiscal Year 2011 - \$202 per day.
- Fiscal Year 2012 - \$208 per day.
- Fiscal Year 2013 - \$213 per day.
- Fiscal Year 2014 - \$218 per day.
- Fiscal Year 2015 - \$224 per day.
- **Fiscal Year 2016 - \$229 per day.**

1.3.3.5.3.2.2 Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

1.3.3.5.4 Claim which spans a period in which two separate per diems exist. A claim subject to the inpatient mental health per diem payment system which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

1.3.3.5.5 Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay.

1.3.3.5.6 Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to be cost-shared as an inpatient claim if the contractor cannot determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service to determine if the care was rendered in the hospital while the beneficiary was an inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

1.3.3.6 Cost-Shares: Partial Hospitalization

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. Effective for care on or after October 1, 1995, the cost-share for ADFMs for inpatient mental health services is \$20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, the cost-share for ADFMs enrolled in Prime for inpatient mental health services is \$0. For retirees and their family members, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs is to be taken from the PHP claim.

1.3.3.7 Cost-Shares: Ambulatory Surgery

1.3.3.7.1 Non-Prime ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share will be \$25 and will be assessed on the facility claim. No cost-share is to be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim is to be cost-shared as ambulatory surgery as required by this section.

1.3.3.7.2 Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to be taken from all ambulatory surgery claims. For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

1.3.3.7.2.1 Twenty-five percent (25%) of the applicable group payment rate (see [Chapter 9, Section 1](#)); or

1.3.3.7.2.2 Twenty-five percent (25%) of the billed charges; or

1.3.3.7.2.3 Twenty-five percent (25%) of the allowed amount as determined by the contractor.

1.3.3.7.2.4 The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share will simply be 25% of the allowed amount.

1.3.3.8 Cost-Shares and Deductible: Former Spouses

1.3.3.8.1 Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars (\$150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the \$150.00 deductible in any fiscal year.

1.3.3.8.2 Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

1.3.3.9 Cost-Share Amount: Under Discounted Rate Agreements

Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

1.3.3.9.1 For non-institutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20% for outpatient care to ADFMs, 25% for care to all others) shall be applied to (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

1.3.3.9.2 For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The single, specific per diem supplied by **DHA** after the application of the agreed upon discount rate; OR,
- Twenty-five percent (25%) of the billed charge.

1.3.3.9.3 For institutional providers subject to the Mental Health Per Diem Payment System (high volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be 25% of the hospital per diem amount after it has been adjusted by the discount.

1.3.3.9.4 For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The fixed daily amount supplied by **DHA** after the application of the agreed upon discount rate; OR,
- Twenty-five percent (25%) of the billed charge.

1.3.3.9.5 For RTCs, the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

Chapter 7

Mental Health

Section/Addendum	Subject/Addendum Title
1	Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System
2	Psychiatric Partial Hospitalization Program (PHP) Reimbursement
3	Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement
4	Residential Treatment Center (RTC) Reimbursement
A	Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume - FY 2014 - FY 2016
B	Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates Figure 7.B-1 TMA Form 771

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 1

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
1,096	October 1, 2015 through September 30, 2016

3.3.3 Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined DHA calculated a hospital-specific per diem which differs by more than five (\$5) dollars from that calculated by the hospital or unit, may apply to the appropriate contractor for a recalculation unless the calculated rate has exceeded the cap amount described in the previous paragraph. The recalculation does not constitute an appeal, as the per diem rates are not appealable. Unless the provider can prove that the contractor calculation is incorrect, the contractor's calculation is final. The burden of proof shall be on the hospital or unit.

3.4 Regional Per Diems for Lower Volume Psychiatric Hospitals and Units

3.4.1 Regional Per Diem. Hospitals and units with a lower volume of TRICARE patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and IDME. Base period regional per diems shall be calculated based upon all TRICARE/lower volume hospitals' and units' claims paid (processed) during the base period. Each regional per diem amount shall be the quotient of all covered charges (without consideration of other health insurance payments) divided by all covered days of care, reported on all TRICARE claims from lower volume hospitals and units in the region paid (processed) during the base period, after having been standardized for IDME costs, and area wage indexes. Direct medical education costs shall be subtracted from the calculation. The regions shall be the same as the federal census regions. See [Addendum A](#), for the regional per diems used for hospitals and units with a lower volume of TRICARE patients.

3.4.2 Adjustments to Regional Per Diem Rates. Two adjustments shall be made to the regional per diem rates when applicable.

3.4.2.1 Wage Portion or Labor-Related Share. The wage portion or labor-related share is adjusted by the DRG-based area wage adjustment. See [Addendum A](#), for area wage adjustment rates. The calculated adjusted regional per diem is not to be rounded up to the next whole dollar.

3.4.2.2 IDME Adjustment. The IDME adjustment factors shall be calculated for teaching hospitals in the same manner as in the DRG-based payment system and applied to the applicable regional per diem rate for each day of the admission. For an exempt psychiatric unit in a teaching hospital, there should be a separate IDME adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

3.4.3 Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, the government shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the DRG-based payment system.

Note: No additional payment is to be made for capital costs. Such costs have been covered in the regional per diem rates which are based on charges.

3.5 Base Period and Update Factors

3.5.1 Hospital-Specific Per Diem Calculated Using Date of Payment. The base period for calculating the hospital-specific and regional per diems, as described above is federal FY 1988. The

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 1

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

base period calculations shall be based on actual claims paid (processed) during the period July 1, 1987 through May 31, 1988, trended forward to September 30, 1988, using a factor of 1.1%.

3.5.2 Hospital-Specific Per Diem Calculated Using Date of Discharge. Upon application by a higher volume hospital or unit to the appropriate contractor, the hospital or unit may have its hospital-specific base period calculations based on TRICARE claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988, if it has generally experienced unusual delays in TRICARE claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00 with the revised per diem not exceeding the cap amount. For this purpose, the unusual delays mean that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations (204 days) longer than the national average (94 days). The burden of proof shall be on the hospital.

3.5.3 Updating Hospital-Specific and Regional Per Diems. Per diems shall be updated by the Medicare update factor. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year by the contractors. New hospitals shall be notified by the contractor at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the **Federal Register** prior to the start of that fiscal year. Initiating FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

FISCAL YEAR	UPDATE FACTOR
2006	3.8%
2007	3.4%
2008	3.4%
2009	3.2%
2010	2.1%
2011	2.6%
2012	3.0%
2013	2.6%
2014	2.5%
2015	2.9%
2016	2.4%

3.6 Higher Volume Hospitals and Units

3.6.1 Higher Volume of TRICARE Mental Health Discharges and Hospital-Specific Per Diem Calculation

3.6.1.1 In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years. All other hospitals and units covered by the TRICARE inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 1

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

3.6.1.2 The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, cannot exceed the cap described in this section. Once a statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

3.6.1.2.1 The TRICARE contractor shall be requested at least annually to submit to the DHA Office of Medical Benefits and Reimbursement Branch (MB&RB) a listing of high volume providers.

3.6.1.2.2 Percent of change and Deflator Factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 2012	235.16%	3.3516
September 30, 2013	243.52%	3.4352
September 30, 2014	258.27%	3.5827

3.6.2 New Hospitals and Units

3.6.2.1 The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

3.6.2.2 By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than three full years. A change in ownership in itself does not constitute a new hospital.

3.6.2.3 Such new hospitals must agree not to bill beneficiaries for any additional cost-share beyond that determined initially based on the regional rate.

3.6.3 Request for a Review of Higher or Lower Volume Classification

Any hospital or unit which DHA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof.

3.7 Payment for Hospital Based Professional Services

3.7.1 Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

3.7.2 Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed separately for hospital based professional services or included those services in the hospital's or unit's charges, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services.

3.8 Leave Days

3.8.1 No Payment. The government shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

3.8.2 Does Not Constitute a Discharge/Do Not Count Toward Day Limit. The government shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital.

3.9 Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System

3.9.1 Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

3.9.2 Services Which Group into Mental Health DRG. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424 prior to October 1, 2008, or services which group into DRG 876 on or after October 1, 2008) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3.9.3 Non-Mental Health Procedures. Admissions for non-mental health procedures that group into non-mental health DRG, in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3.9.4 Sole Community Hospital (SCH). Admission prior to January 1, 2014, (the effective date of the SCH reimbursement methodology described in [Chapter 14, Section 1](#)), any hospital which has

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 1

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

3.9.5 Hospital Outside the 50 States, the District of Columbia, or Puerto Rico. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia, or Puerto Rico.

3.9.6 Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the DRG-based payment system or the inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates.

- END -

Psychiatric Partial Hospitalization Program (PHP) Reimbursement

Issue Date: July 14, 1993

Authority: [32 CFR 199.14\(a\)\(2\)\(ix\)](#)

1.0 APPLICABILITY

1.1 This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

1.2 Reimbursement of PHPs prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of Outpatient Prospective Payment System (OPPS), and thereafter, freestanding PHPs and other providers who are exempt from the TRICARE OPPS and provider PHP services.

2.0 POLICY

2.1 Per Diem Payment For Psychiatric Partial Hospitalization Services

Psychiatric partial hospitalization services authorized and provided under [32 CFR 199.4\(b\)\(10\)](#) and provided by psychiatric PHPs authorized under [32 CFR 199.4\(b\)\(3\)\(xii\)](#) are reimbursed on the basis of prospectively determined, all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all PHP services provided. The following services and supplies are included in the per diem rate approved for an authorized PHP and are not covered even if separately billed by an individual professional provider. Effective on May 1, 2009 (implementation of OPPS), hospital-based PHP services are reimbursed under the hospital OPPS as described in [Chapter 13, Section 2, paragraph 3.7](#).

2.1.1 Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, etc.

2.1.2 Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the PHP.

2.1.3 Psychological testing and assessment.

2.1.4 Treatment services. All services including routine nursing services, group therapy, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the psychotherapy as indicated in [paragraph 2.2.1](#)). All mental health services must be provided by a authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

2.1.5 Ancillary therapies. Includes art, music, dance, occupational, and other such therapies.

2.1.6 Overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

2.2 Services Which May Be Billed Separately

The following services are not considered as included within the per diem payment amount and may be separately billed when provided by an authorized individual professional provider:

2.2.1 Psychotherapy sessions. Professional services provided by an authorized individual professional provider (who is not employed by or under contract with the PHP) for purposes of providing clinical patient care to a patient in the PHP may be cost-shared when billed by the individual professional provider. Any obligation of a professional provider to provide services through employment or contract in a facility or distinct program of a facility would preclude that professional provider from receiving separate TRICARE reimbursement on a fee-for-service basis to the extent that those services are covered by the employment or contract arrangement. Psychotherapy services provided outside of the employment/contract arrangement can be reimbursed separately from the PHPs per diem. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day not to exceed five sessions in any calendar week in any combination of individual and family therapy. Five sessions per week is an absolute limit, and additional sessions are not covered.

Note: Group therapy is strictly included in the per diem and cannot be paid separately even if billed by an individual professional provider.

2.2.2 Primary/Attending Provider. When a patient is approved for admission to a PHP, the primary or attending provider (if not contracted or employed by the partial program) may provide psychotherapy only when the care is part of the treatment environment which is the therapeutic partial program. That is why the patient is there--because that level of care and that program have been determined as medically necessary. The therapy must be adapted toward the events and interactions outlined in the treatment plan and be part of the overall partial treatment plan. Involvement as the primary or attending is allowed and covered only if he is part of the coherent and specific plan of treatment arranged in the partial setting. The treatment program must be under the general direction of the psychiatrist employed by the program to ensure medication and physical needs of the patients are met and the therapist must be part of the treatment team and

treatment plan. An attending provider must come to the treatment plan meetings and his/her care must be coordinated with the treatment team and as part of the treatment plan. Care given independent of this is not covered.

2.2.3 Non-mental health related medical services. Those services not normally included in the evaluation and assessment of a partial hospitalization patient and not related to care in the PHP. These medical services are those services medically necessary to treat a broken leg, appendicitis, heart attack, etc., which may necessitate emergency transport to a nearby hospital for medical attention. Ambulance services may be cost-shared when billed for by an authorized provider if determined medically necessary for emergency transport.

2.3 Per Diem Rate

For any full-day PHP (minimum of six hours), the maximum per diem payment amount is 40% of the average inpatient per diem amount per case paid to both high and low volume psychiatric hospitals and units established under the mental health per diem reimbursement system. The rates shall be updated to the current year using the same factors as used under the TRICARE mental health per diem reimbursement system. A PHP of less than six hours (with a minimum of three hours) will be paid a per diem rate of 75% of the rate for full-day PHP. TRICARE will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half- or full-day program. See [the DHA web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement](http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement), for the current maximum rate limits which are to be used as is for the full-day and half-day program.

2.4 Other Requirements

No payment is due for leave days, for days in which treatment is not provided, for days in which the patient does not keep an appointment, or for days in which the duration of the program services was less than three hours.

2.5 CAHs

Effective December 1, 2009, PHPs in CAHs shall be reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

- END -

Residential Treatment Center (RTC) Reimbursement

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(b\)\(4\)](#) and [32 CFR 199.14\(f\)](#)

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

2.0 ISSUE

How are Residential Treatment Centers (RTCs) to be reimbursed under TRICARE?

3.0 POLICY

3.1 Rate Structure: Facility Rates and Cap Amount

The rate is the per diem rate authorized for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by an approved RTC, and approved by the contractor.

3.1.1 Individual Facility Rates

For RTCs new to the program, one of the following two alternative methods will be used in determining their individual rates:

3.1.1.1 The all-inclusive per diem rate for RTCs operating or participating in the program during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

- The rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted to include an increase reflecting appropriate annual CPI-U (Consumer Price Index-Urban) update factors up through Fiscal Year (FY) 1997, and Medicare update factors for fiscal years after FY 1997; or
- The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by appropriate annual CPI-U update factors up through FY 1997, and Medicare update factors for fiscal years after FY

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 4

Residential Treatment Center (RTC) Reimbursement

1997; or

- The RTC cap amount.

3.1.1.2 The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the following conditions:

- The per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation adjusted by appropriate annual CPI-U inflation factors up through FY 1997, and Medicare update factors for fiscal years after FY 1997; or
- The RTC cap amount.

Note: A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated. However, no retroactive adjustments will be made if the recalculated rate (based on 12 months of data) is higher than the initial rate (based on less than 12 months of data). The recalculated rate will become effective upon the date both parties sign off on a revised participation agreement. Until such time, the facility will be subject to the provisions and established rate set under the previous agreement.

3.1.2 Cap Amount.

The following methods are used in establishing the maximum cap amount:

3.1.2.1 Prior to April 6, 1995, the cap amount was set at the 75th percentile of all established TRICARE RTC rates nationally and weighted by total TRICARE days provided at each rate during the initial base period (July 1, 1997, through June 30, 1988). The cap amount was adjusted annually (on October 1st of each year) by the CPI-U for medical care up through April 5, 1995.

3.1.2.2 For care on or after April 6, 1995, the cap amount was set at the 70th percentile of all established FY 1994 RTC rates nationally, weighted by total TRICARE days provided at each rate during the first half of FY 1994, and updated to FY 1995.

3.1.2.3 For federal FYs 1996 and 1997, the cap remained frozen at the previous April 6, 1995 cap amount.

3.1.2.4 The cap amount will be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment for fiscal years after FY 1997.

Note: For detailed guidelines on calculation of individual RTC per diem rates and cap amounts, refer to [Addendum B](#).

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 4

Residential Treatment Center (RTC) Reimbursement

3.3.1.2 If the period of time away from the facility is more than 10 days, admission approval is required including an updated treatment plan and progress report.

3.3.2 Authorization for Geographically Distant Family Therapy

3.3.2.1 All geographically distant family therapy must be authorized and approved by the contractor at the time the treatment plan is submitted. The RTC is required to submit a detailed treatment plan for each TRICARE patient within 30 days of admission. The authorization must be on file at the contractor before coverage can be extended. (Refer to the TRICARE Policy Manual (TPM), [Chapter 7, Section 3.14.](#))

3.3.2.2 Cost-Share. Payment for geographically distant family therapy will be cost-shared on an inpatient basis.

3.3.3 Authorization for Coverage of Educational Services

A Public Official's Statement (POS) must be submitted to the contractor demonstrating that the school district in which the TRICARE beneficiary was last enrolled refuses to pay for the educational component of the child's RTC care. The contractor will review the POSs on a case-by-case basis and make a decision on whether they meet the exception for coverage under the program. The authorization for educational services must be on file before coverage can be extended.

3.4 Reimbursement of Therapeutic Absences

Therapeutic leave of absence days may not be reimbursed by TRICARE.

3.5 RTC Participation

3.5.1 In order for the services of an RTC to be authorized, the RTC must sign a participation agreement.

3.5.2 The agreement requires the RTC to accept the TRICARE determined rate as payment in full and collect from the beneficiary or the family of the beneficiary those amounts that represent the beneficiary's liability, as defined by 32 CFR 199, and charges for services and supplies that are not a benefit.

3.5.3 Participation agreements include the specific rate established for each RTC, and the billing number that must be used for claims submission.

3.6 Termination of Participation by RTC

The RTC participation agreement (TPM, [Chapter 11, Addendum G](#)) sets forth the following provisions for termination of participation under the program:

3.6.1 Notice is not required for changes or modifications to the participation agreement resulting from amendments to the 32 CFR 199 through rulemaking procedures.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 4

Residential Treatment Center (RTC) Reimbursement

3.6.2 Changes or modifications resulting from amendments to 32 CFR 199 will become effective on the date the CFR amendment is effective or the date the agreement is amended, whichever date is earlier.

3.6.3 If the RTC does not wish to accept the proposed changes, it may terminate its participation by giving the agency written notice of such intent to terminate at least 60 calendar days in advance of the effective date of termination.

3.6.4 If the RTC's notice of intent to terminate its participation is not given at least 60 days prior to the effective date of the proposed changes/modifications, then the proposed changes/modifications will be incorporated into its agreement for care furnished between the effective date of the changes/modifications and the effective date of the termination of this agreement.

3.7 Payment for RTC care will be made by the contractors only for claims from authorized RTCs.

3.8 Annual Updating of RTC Rates

3.8.1 Once a valid rate is established for each RTC from the base year data it becomes the basis for all future rates. The change in mix of third party payor days thereafter will have no bearing on the TRICARE RTC per diem.

3.8.2 RTC rates will be updated by the Medicare inflation factor for hospitals and units exempt from the Medicare PPS.

3.8.3 Contractors will be provided with the rate updates prior to October 1 of each year (i.e., the start of the new federal fiscal year).

3.8.4 All claims reimbursed under the TRICARE RTC per diem payment system are to be priced for each day of service (using the rate in effect on the day of service) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the day of service. In order to do this, at least three iterations of per diem rates must be maintained on the contractor's on-line system. If the claims filing deadline has been waived and the day of service is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest per diem rate on the contractor's system.

3.8.5 The last three iterations of per diem rates, along with the corresponding cap amounts, will be maintained on the DHA web site at <http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement>. The rates are updated by the Medicare update factor as noted in Section 1, paragraph 3.5.3. The rates are effective on October 1 of each year.

- END -

Chapter 7

Addendum A

Table Of Regional Specific Rates For Psychiatric Hospitals
And Units With Low TRICARE Volume - FY 2014 - FY 2016

UNITED STATES CENSUS REGIONS	FY 2014 REGIONAL RATES 10/01/13 - 09/30/14	FY 2015 REGIONAL RATES 10/01/14 - 09/30/15	FY 2016 REGIONAL RATES 10/01/15 - 09/30/16
NORTHEAST:			
New England (ME, NH, VT, MA, RI, CT)	\$827	\$851	\$871
Mid-Atlantic (NY, NJ, PA)	\$797	\$820	\$840
MIDWEST:			
East North Central (OH, IN, IL, MI, WI)	\$689	\$709	\$726
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$650	\$669	\$685
SOUTH:			
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$820	\$844	\$864
East South Central (KY, TN, AL, MS)	\$877	\$902	\$924
West South Central (AR, LA, TX, OK)	\$747	\$769	\$787
WEST:			
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$746	\$768	\$786
Pacific (WA, OR, CA, AK, HI)	\$882	\$908	\$930
Puerto Rico	\$563	\$579	\$593

Note: This table reflects maximum rates.

For FYs 2014 through 2016: For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 69.6%. The non-labor related share is 30.4%. For wage index values less than or equal to 1.0, the wage portion or labor related share subject to the area wage adjustment is 62%. The non-labor related share is 38%. Utilize the appropriate year DRG wage index file for area wage adjustment calculations.

For FY 2014/Beneficiary Cost-Share: Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$218 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2013.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008
Chapter 7, Addendum A
Table Of Regional Specific Rates For Psychiatric Hospitals And Units
With Low TRICARE Volume - FY 2014 - FY 2016

For FY 2015/Beneficiary Cost-Share: Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$224 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2014.

For FY 2016/Beneficiary Cost-Share: Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$229 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2015.

- END -

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

1.0 DATA COLLECTION FORM

1.1 The TRICARE Management Activity (TMA) Form 771 is designed for the collection of reimbursement data used in the calculation of prospective all-inclusive per diem rates for RTCs seeking certification under the TRICARE RTC program. The form will be sent out as part of the RTC certification package encouraging the facility to conduct a preliminary review of the reimbursement methodology prior to completion of the program certification portion of the application. Refer to attached TMA Form 771.

1.2 The TMA Form 771 is divided into two distinct data collection areas, one dealing with administrative information and the other with reimbursement information.

1.2.1 Administrative Information. Items 1 through 8 of the form identify the facility and establish the base year period over which the reimbursement data was collected. The Employer Identification Number (EIN) is of particular importance since it identifies the RTC for payment.

1.2.2 Reimbursement Information. Items 9 through 11 provide the reimbursement data necessary to calculate an all-inclusive prospective per diem rate for applying RTCs. The data represents those reimbursement levels that the RTC was willing to accept from other third-party payers during its base period. This allows the establishment of a per diem rate which reflects a reasonable amount consistent with rates charged by its peers nationally and with reimbursement it is accepting from other third-party payers.

2.0 ADMINISTRATIVE SUPPORT

2.1 The reviewer will provide the name and telephone number of a contact person that can provide additional help and instruction in filling out the data request form.

2.2 Examples of rate calculations are useful in establishing a conceptual understanding of the per diem methodology and for allowing the RTC to approximate its rates. These examples should include, but not be limited to, the following reimbursement concepts/issues:

- 33-1/3% rule.
- All-inclusive rate.
- Charges allowed outside all-inclusive rate.
- Rate updates.
- Open vs. closed staffing models.

3.0 REVIEW AND ANALYSIS OF SUBMITTED INFORMATION

3.1 Conduct a preliminary review of the information/data submitted on the TMA Form 771 paying particular attention to the opening and data collection start dates. The data collection start date for RTCs which were in operation during the entire base period (July 1, 1987 - June 30, 1988) will be July 1, 1987. The data collection start date should be the same as the opening date for facilities who began operation after June 30, 1988, or began operation before July 1, 1988, but had less than six months of operation by July 1, 1988, since the RTC's base period would be its first 12 months of operation. If the dates are not the same, follow the guidelines below:

3.1.1 Contact the person designated in Item #4 of TMA Form 771 for clarification regarding the discrepancy.

3.1.2 If the discrepancy resulted from a transcription error, correct the error and proceed with the review.

3.1.3 If the discrepancy **did not** result from a transcription error, have the RTC submit revised data encompassing the correct data collection period (i.e., data collected over the first 12 months of operation).

3.2 The reimbursement sections (Items 9 through 10) should be reviewed to make sure the submitted information is complete and correctly formatted. The data contained in these sections will be used to figure the RTC's prospective all-inclusive per diem rate and will be the basis for all future rates. The following are the data element requirements under each of these sections:

3.2.1 Item #9. This section requests information on all third-party payers establishing or affecting an RTC's rates during its specified base period. It includes the following reimbursement information:

3.2.1.1 Name, address and telephone number of each payor for whom a rate was established/accepted. This information is important for verification of rates under Items 9 through 11, especially in the case of state patients where there is often a negotiated contract. If the state rate represents 33-1/3% of total patient days, it might be advisable for the reviewer to request copies of these contracts in order to verify the negotiated rates in effect during the RTCs base period. However, the reviewer will be given discretion in setting its own review parameters for requesting supporting documentation.

3.2.1.2 The rates accepted from each third-party payor during the RTC's designated base period. The accepted rates should not be confused with actual charged amounts. It is not uncommon to bill third-party payers amounts in excess of their allowed charges knowing payment will be less than the charged amounts. The allowed charge represents the amount the facility is willing to accept from a payor for RTC care. A determination will have to be made whether the listed facility rates represent total daily charges (i.e., represent an all-inclusive rate) or only the institutional component of the accepted rate using the following guidelines:

3.2.1.2.1 If there are no additional charges listed under Item #10, the facility rates appearing in Item #9 are to be determined as all-inclusive, and as such, represent payment in full for all mental health services provided within the RTC (both professional and institutional).

3.2.1.2.2 If additional charges are listed under Item #10, a determination must be made on whether they apply to all of the third-party payers appearing in Item #9; i.e., whether all of the third-party payers allow payment of additional services above the facility rates listed in Item #9. The reviewer should note that where state or local agencies are involved most of their reimbursement is based on flat per diem rates. The reviewer should contact the RTC if there is any question regarding the applicability of Item #10 charges to any one of the listed third-party payers.

3.2.1.3 The number of patient days provided/paid at each accepted rate. Cumulative patient days will be used in determining the rate high enough to cover at least one-third of the total patient days subject to the cap amount.

3.2.2 Item #10. This section requests information on the payment of any additional services allowed outside the facility rates recorded under Item #9. The sum of these charges will be added to the facility rate in calculating the TRICARE all-inclusive per diem rate. The RTC must provide the methodology (the actual calculations) used in establishing the charge Per Patient Day (PPD) for each of the services listed in this section.

3.2.2.1 Required data elements:

- The service for which additional payment is allowed.
- The frequency of the service.
- The accepted charge/rate per service.
- The accepted charge/rate PPD.

3.2.2.2 The following are examples of services which might be allowed for payment outside the facility rates reflected in Item #9:

- Admission history and physical.
- Medical visits for physical illness or injury.
- Lab drug testing.
- EKG.
- Family therapy.
- Pharmaceuticals.
- Individual and group psychotherapy.

3.2.3 Item #11. This section pertains to the payment of educational services in an RTC. Educational charges are excluded from payment under the prospective per diem system. If the RTC indicates that educational charges are included within the facility rate, they must be removed prior to establishing the TRICARE all-inclusive rate. The educational rate/charge per patient per day reported in Item #11.b will be subtracted from the overall facility rate. Payment of educational services may be paid apart from the facility per diem as long as the services have been authorized by the reviewer. The RTC may provide educational services to its children under the following arrangements:

- The RTC has its own educational program whereby it bills for the entire educational component, incorporating facility and professional costs (i.e., bills for teachers, books, supplies, classroom facilities, etc.).

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

- The RTC has an agreement with its local school district to share in the education of its children. In most cases the local school district agrees to supply the teachers while the RTC provides the classrooms. The RTC only bills for the facilities charges.
- The local school district accepts total responsibility for educating the RTC children. No educational charges are billed since the children attend public school during the day.

3.3 The data collected and used to establish RTC per diem rates will be retained indefinitely.

4.0 BASE YEAR CALCULATIONS

4.1 For RTCs new to the TRICARE program, one of the following two alternative methods will be used in determining their individual rates:

4.1.1 The rates for an RTC which was in operation during the base period (July 1, 1987 through June 30, 1988) will be calculated based on the actual charging practices of the RTC during the 12 months ending July 1, 1988. The individual RTC rate will be the lower of either the TRICARE rate in effect on June 30, 1988, or the rate high enough to cover at least one-third of the total patient days of care provided by the RTC during the 12 months ending July 1, 1988 subject to a maximum cap.

4.1.2 The rates for an RTC which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than six months of operation by July 1, 1988, will be based on the actual charging practices during its first six to 12 consecutive months, with six months being the minimum time in operation for certification under the TRICARE program. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate should be recalculated using the additional reimbursement data. The rates would be calculated the same as in [paragraph 4.1.1](#), except a different base period would be used.

4.2 The following methods are used in establishing the maximum capped per diem amounts:

4.2.1 Prior to April 6, 1995, the capped per diem amount was set at the 75th percentile of all established TRICARE RTC rates nationally and weighted by total TRICARE days provided at each rate during the base period (July 1, 1987, through June 30, 1988). The capped amount was adjusted annually (on October first of each year) by the CPI-U (Consumer Price Index - Urban Wage Earner) for medical care. The following are the capped amounts in effect since December 1, 1988:

RTC CAPPED AMOUNTS

DATES OF SERVICE	CAPPED AMOUNTS
December 1, 1989 - September 30, 1989	\$355
October 1, 1989 - September 30, 1990	373
October 1, 1990 - September 30, 1991	408
October 1, 1991 - September 30, 1992	444
October 1, 1992 - September 30, 1993	477
October 1, 1993 - September 30, 1994	506

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

RTC CAPPED AMOUNTS (CONTINUED)

DATES OF SERVICE		CAPPED AMOUNTS
October 1, 1994	- April 5, 1995	530
April 6, 1995	- September 30, 1997	515
October 1, 1997	- September 30, 1998	515
October 1, 1998	- September 30, 1999	528

4.2.2 The 70th percentile of the day-weighted current (Fiscal Year (FY) 1995) per diems was used in establishing a new cap amount for services rendered on or after April 6, 1995. The following methodology was used in establishing the RTC cap and floor amounts:

4.2.2.1 RTC institutional claims data from the period October 1, 1993 to March 31, 1994 were used (the first half of FY 1994).

4.2.2.2 The FY 1994 per diems were merged onto the claims (from the RTC per diem list in the TRICARE Policy Manual (TPM)) and updated by 1.046 (the CPI-U) to represent FY 1995 per diems.

4.2.2.3 The 30th and 70th percentiles of the day-weighted FY 1995 per diems were calculated as \$429 and \$515. Any RTC per diem above \$515 was cut to \$515 as of April 6, 1995.

5.0 ADJUSTMENT OF BASE YEAR RATE

5.1 The base year rate is adjusted by the following annual inflation factors (CPI-U) for medical care] to bring it forward to the current fiscal year:

UPDATE FACTORS FOR RTC PER DIEM RATES

TIME PERIOD		CPI-U INFLATION FACTORS
July 1, 1988	- November 30, 1988	2.6%
December 1, 1988	- July 30, 1989	4.9
October 1, 1989	- September 30, 1990	9.2
October 1, 1990	- September 30, 1991	8.6
October 1, 1991	- September 30, 1992	7.4
October 1, 1992	- September 30, 1993	6.0
October 1, 1993	- September 30, 1994	4.6
October 1, 1994	- September 30, 1995	4.4
October 1, 1995	- September 30, 1996	3.6

Note: The FY 1997 CPI-U for medical care is 2.6%. This inflation will be used in adjusting FY 1995 RTC rates falling below the 30th percentile of all established FY 1995 rates (\$429.00).

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

UPDATE FACTORS FOR RTC PER DIEM RATES (CONTINUED)

TIME PERIOD		MEDICARE UPDATE FACTOR
October 1, 1997	- September 30, 1998	2.4
October 1, 1998	- September 30, 1999	2.4
October 1, 1999	- September 30, 2000	2.9
October 1, 2000	- September 30, 2001	3.4
October 1, 2001	- September 30, 2002	3.3
October 1, 2002	- September 30, 2003	3.5
October 1, 2003	- September 30, 2004	3.4
October 1, 2004	- September 30, 2005	3.3
October 1, 2005	- September 30, 2006	3.8

Note: The FY 1997 CPI-U for medical care is 2.6%. This inflation will be used in adjusting FY 1995 RTC rates falling below the 30th percentile of all established FY 1995 rates (\$429.00).

5.2 If the RTC's base year falls within the previous year's reporting period, the inflation factor is prorated for the remaining time in that period. The updating process can best be demonstrated through the following example:

Example: RTC E is submitting reimbursement information as a final step in its certification process. The data was collected over the facility's first 12 months of operation (April 1, 1991 - March 31, 1992). Since the RTC's base period extended six months (or 180 days, based on 30-day months and a 360-day year) into the inflation reporting period, the inflation factor for the subsequent update year (October 1 - September 30) was prorated for the remaining time period of May 1, 1992 - September 30, 1992 (six months or 180 days). The following are the calculations used in updating the RTC's all-inclusive base year per diem to FY 1996 (current year per diem amount):

ADJUSTMENT OF BASE YEAR PER DIEM RATE	
Derived rate at 33.33% of total patient days during base period of April 1, 1991 through March 31, 1992.	\$320.00
Plus:	
Consumer Price Indices - Urban Wage Earner for medical care [CPI-U (medical)]:	
For 6-month period ending September 30, 1992 (7.4% x 6/12 = 3.7%)	11.84
Adjusted Rate	\$331.84
For 12-month period ending September 30, 1993 (6.0%)	19.91
Adjusted Rate	\$351.75
For 12-month period ending September 30, 1994 (4.6%)	16.81
Adjusted Rate	\$367.93
For 12-month period ending September 30, 1995 (4.4%)	16.19
Adjusted Rate	\$384.12
TRICARE all-inclusive per diem rate for services on or after October 1, 1995	\$385.00

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

5.3 In a Final Rule published in the **Federal Register** (60 FR 12419) on March 7, 1995, TRICARE imposed a two-year moratorium on the annual updating of RTC per diems rates subject to the following provisions:

5.3.1 TRICARE payments will remain at FY 1995 rates for a two-year period beginning in FY 1996, for any RTC whose 1995 rate was at or above the 30th percentile of all established FY 1995 rates (\$429).

5.3.2 For any RTC whose FY 1995 rate was below that of the 30th percentile, the rate will be adjusted by the lesser of the CPI-U, or the amount that brings the rate up to the 30th percentile level.

5.3.3 For fiscal years after FY 1997, the individual facility rates and cap amount will be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system at the discretion of the Director, **Defense Health Agency (DHA)** or designee.

Note: The above provisions will lead to aggregate expenditures which approximate average facility costs. The 4.4% update factor was used in the RTC rate computation since its FY 1995 rate (\$368) was below the 30th percentile level (\$429).

6.0 CALCULATION OF RTC PER DIEM RATE

6.1 Array the rates accepted by other third-party payers (Item #9) in descending order from lowest to highest in the first column of the Reimbursement Information Work Sheet (see Attachment).

6.2 Place the number of days paid at each of the rates listed above in the second column of the work sheet.

6.2.1 If there is more than one rate with an individual third-party payor during the base period, the RTC must provide the total number of patient days paid by the payor at each rate. Total patient days will be used in determining the most favored rate for the facility. The following is an example of multiple rates paid by an individual payor during the RTC's base period:

Example: RTC F has negotiated three separate rates with a third-party payor over its base period. The three rates were reported as follows:

1. \$295/day from July 1993, through October 31, 1993 - 2,000 patient days;
2. \$315/day from November 1, 1993, through February 29, 1994 - 3,000 patient days;
3. \$330/day from March 1, 1994, through June 30, 1994 - 2,000 patient days.

6.2.2 Each of the above negotiated rates would be reported separately in Item #9 of the TMA Form 771 representing a blending of payments made by a particular payor over a facility's base period.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

6.2.3 Patient days would be combined in those situations where third-party payers were paying the same rate for RTC care. This would represent the cumulative frequency of payments made at each reported reimbursement level in Item #9 of the data collection form.

6.2.4 The following examples represent the methodology used in calculating the TRICARE base year facility rate from data provided under Item #9 of the TMA Form 771:

Example: RTC G provided the following third-party reimbursement data under Item #9 of the TMA Form 771 as part of the certification process:

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
AA	\$253	312
BB	527	207
CC	402	163
DD ***	212	198
EE	454	371
FF	603	118
GG	317	446
HH	489	538
II	552	319
JJ	503	132

*** - State or local government agency.

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
\$212	198	198	7.1%
253	312	510	18.2
317	446	956	34.1
402	163	1,119	39.9
454	371	1,490	53.1
489	538	2,028	72.3
503	132	2,160	77.0
527	207	2,367	84.4
552	319	2,686	95.8
603	118	2,804	100.0
Total	2,804 Patient Days		

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

Step 2: Sum the patient days in column 2, which in this particular example equals **2,804** patient days.

Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

(2,804 patient days x 0.3333 = 934.57 patient days)

Step 4: Go down in the cumulative patient day column (column 3) to where 33-1/3% of the patient days lie (934.57).

Step 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period rate in this example would be **\$317** (refer to table above).

Example: RTC H provided the following third-party reimbursement data under Item #9 of the TMA Form 771 as part of the certification process:

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
AA	\$425	201
BB ***	288	600
CC ***	235	63
DD ***	215	1,040
EE	365	276
FF	515	168
GG ***	288	346
HH	489	538
II	425	319
JJ	450	132

***** - State or local government agency.**

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
\$215	1,040	1,040	28.2%
235	63	1,103	29.9
288	946	2,049	55.6
365	276	2,325	63.1
425	520	2,845	77.2
450	132	2,977	80.8

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
489	538	3,515	95.4
515	168	3,683	100.0
Total	3,683 Patient Days		

Step 2: Sum the patient days in column 2, which in this particular example equals **3,683** patient days.

Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

$$(3,683 \text{ patient days} \times 0.3333 = 1,227.54 \text{ patient days})$$

Step 4: Go down in the cumulative patient day column (column 3) to where 33-1/3% of the patient days lie (1,227.54).

Step 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period rate in this example would be **\$288** (refer to table above).

6.3 The above methodology for deriving the rate at 33-1/3 of the total patient days would only be applicable under the following conditions:

6.3.1 If the rates in Item #9 were all-inclusive for payment of RTC care (i.e., included all payments for institutional and professional services), no additional charges would be added on to the facility rates from Item #10 of the data collection form. The rate established in Step 5 of the above examples would represent the all-inclusive base year rate prior to the inflationary adjustment.

6.3.2 If the charges for additional services listed in Item #10 applied to all of the third-party payers identified in Item #9 (i.e., all of the third-party payers listed in Item #9 allowed payment for additional services outside the facility rate-- rate derived at 33-1/3% of total RTC patient days during the base period-- at the charges PPD established in Item #10), the sum of these charges are added to the facility rate prior to inflationary adjustment.

6.4 In cases where payment of additional services listed in Item #10 do not apply to all of the third-party payers listed in Item #9, or payments vary among the payers for the same services, the sum of the charges PPD for additional services (reported in the last column of Item #10) must be added to the facility rate prior to establishing the rate derived at 33-1/3% of the total patient days. The following example provides the methodology for incorporating these additional charges into the base year rate computations:

Example: RTC I has provided a revised TMA Form 771 indicating that payments for additional services had been overlooked in completing its initial form. The following service charges PPD were provided under Item #10 with the proviso that the additional

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

payments were not allowed by the three state agencies and two private third-party providers. The payers were identified in Item #9 of the form.

ITEM #10 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

PATIENT SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER DAY (PPD)
Individual Therapy	1/week	\$120.00	\$17.14
Group Therapy	2/week	45.00	12.86
Admission History and Physical	1/stay	150.00	1.43
Pharmacy	(\$10,438/2,498 days)		4.18
Psych. Testing	28	650.00	7.29
Total			\$42.90

Note: The RTC's average Length-Of-Stay (LOS) was 105 days during its base period.

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
AA	\$383	114
BB **	165 ***	313
CC **	268	102
DD **	204 ***	485
EE	365	232
FF	471 ***	117
GG **	265 ***	346
HH	489	338
II	425 ***	319
JJ	425	132

**** - State or local government agency.**

***** - Rates represent entire payment for RTC services. Charges for additional services reported in Item #10 not applied to these designated third-party payor rates.**

(1) RATES	(2) ADDITIONAL PAYMENTS	(3) PATIENT DAYS	(4) CUMULATIVE PATIENT DAYS	(5) PERCENT CUMULATIVE PATIENT DAYS
\$165	\$N.A.	313	313	12.5%
204	N.A.	485	798	31.9
265	N.A.	346	1,144	45.8
268	42.90	102	1,246	49.9
365	42.90	232	1,478	59.2
425	N.A.	319	1,797	71.9
383	42.90	114	1,911	76.5
425	42.90	132	2,043	81.8

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

(1) RATES	(2) ADDITIONAL PAYMENTS	(3) PATIENT DAYS	(4) CUMULATIVE PATIENT DAYS	(5) PERCENT CUMULATIVE PATIENT DAYS
471	N.A.	117	2,160	86.5
489	42.90	338	2,498	100.0
		Total	2,498 Patient Days	

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate.

Step 2: Sum the patient days in column 3, which in this particular example equals **2,498** patient days.

Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

$$(2,498 \text{ patient days} \times 0.3333 = 832.58 \text{ patient days})$$

Step 4: Go down in the cumulative patient day column (column 4) to where 33-1/3% of the patient days lie (832.48).

Step 5: Go across to the rates in column 1 and 2 in which 33-1/3 of the accumulative patient days fall. This represents the TRICARE **all-inclusive** base year/period rate. The base year/period rate in this example would be **\$265** (refer to table above).

6.5 If the RTC answers **no** to Item #11.a., the educational rate/charge PPD reported in Item #11.b must be subtracted from the overall facility base year/period rate.

6.6 Personal item charges must also be subtracted from the all-inclusive base year/period prior to inflationary adjustment.

Example: RTC J checked no in Item #11.a. of the TMA Form 771 reporting an educational rate/charge PPD in Item #11.b. The RTC also reported a \$1 PPD charge for personal items.

Accepted Rate at 1/3 of Patient Day	\$350
Plus:	
Other Service Charges	45
Less:	
Personal Items	1
Education	20
<hr/> All-Inclusive Base Period Rate Prior to Inflationary Adjustment	<hr/> \$374/day

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

6.7 The following is a detailed example of an RTC per diem calculation incorporating all of the data elements reported on the TMA Form 771 including inflationary adjustments:

Example: RTC K submitted the following reimbursement information as part of the certification process:

DATA REVIEW & ANALYSIS

ITEM	DATA REQUESTED	DATA REPORTED
2	EIN	38-1734578
5	Opening Date	June 1, 1990
6	Joint Commission Accreditation	October 31, 1992
7	Data Collection Dates	June 1, 1990 - May 31, 1991

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYORS	RATE ACCEPTED	PATIENT DAYS
AA	\$285	214
BB	453	102
CC	314	371
DD	388	163
EE	502	118
FF	314	246
GG	489	138
HH	402	319

ITEM #10 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

PATIENT SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER DAY (PPD)
Individual Therapy	1/week	\$90.00	\$12.86
Group Therapy	1/week	45.00	6.43
Family Therapy	1/2 weeks	65.00	4.64
Admission History and Physical	1/stay	(\$175/120) <small>(Average Length-of-Stay (ALOS))</small>	1.46
Pharmacy	(\$5,638/1,671 days)		3.38
Psych. Testing	28	650.00	6.28

Total \$35.05

Item #11. EDUCATIONAL CHARGES:

6.7.1 Are educational charges excluded from the daily rate when billing TRICARE?

YES X NO ____

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

6.7.2 What is the educational rate/charge per patient per day in your facility?

\$37.00 PPD

BASE YEAR/PERIOD RATE CALCULATION

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
\$285	214	214	12.8%
314	617	831	49.7
388	163	994	59.5
402	319	1,313	78.6
453	102	1,415	84.7
489	138	1,553	92.9
502	118	1,671	100.0
Total	1,671 Patient Days		

Step 2: Sum the patient days in column 2, which in this particular example equals **1,671** patient days.

Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

$$(1,671 \text{ patient days} \times 0.3333 = 556.94 \text{ patient days})$$

Step 4: Go down in the cumulative day column (column 3) to where 33-1/3% of the patient days lie (556.94).

Step 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period **facility** rate. The base year/period facility rate in this example would be **\$314** (refer to table above).

Step 6: Add the sum of the charges PPD reported in Item #10 of the Form 771 (\$35.05/patient day) to the base year/period facility rate figured in Step 5 since additional payments are allowed for all the listed third party payers in Item #9. The base year/period all-inclusive per diem rate is \$349.05.

Step 7: Subtract any educational and/or personal item charges which are included in the all-inclusive base year/period rate calculated in Step 6. This does not apply in this particular example since there are no personal item and/or educational charges included in the base year/period facility rate.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

INFLATIONARY ADJUSTMENTS

Step 1: Adjust the base year rate by the annual inflation factors [Consumer Price Index - Urban Wage Earner (CPI-U) for medical care] to bring it forward to the current fiscal year as follows:

ADJUSTMENT OF BASE YEAR PER DIEM RATE

Derived rate at 33.33% of total patient days during base period of June 1, 1990 - May 31, 1991. \$349.05

Plus:

Consumer Price Indices - Urban Wage Earner for medical care [CPI-U (medical)]:

For 4-month period ending September 30, 1991 (2.9%) (7.4% x 4/12 - 2.9%) 10.13
Adjusted Rate \$359.18

For 12-month period ending September 30, 1992 (7.4%) 26.58
Adjusted Rate \$385.76

For 12-month period ending September 30, 1993 (6.0%) 23.15
Adjusted Rate \$408.90

For 12-month period ending September 30, 1994 (4.6%) 18.81
Adjusted Rate \$427.71

For 12-month period ending September 30, 1995 (4.4%) 18.82
Adjusted Rate ***\$446.53

TRICARE all-inclusive per diem rate for services on or after October 1, 1995. \$429.00

*** FY 1995 rate below that of the 30th percentile level (\$429) will be adjusted by the lesser of the CPI-U, or the amount that brings the rate up to the 30th percentile level.

ATTACHMENT:

TMA Form 771

FIGURE 7.B-1 TMA FORM 771

INSTRUCTIONS FOR SUBMITTING REIMBURSEMENT INFORMATION FOR PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS	
<p>This reimbursement information will be used to compute a Residential Treatment Center's (RTC) all-inclusive rate under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This rate of reimbursement will reflect a reasonable amount consistent with rates charged by RTCs nationally and with reimbursement already accepted from other third-party payors. All requested information will be subject to on-site verification by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) or its representatives. In accordance with Article 6 of the current CHAMPUS RTC participation agreement, failure to provide all the requested information may result in denial of an application for CHAMPUS certification or termination of a current agreement.</p> <p>Administrative Information:</p> <p>Items 1 through 8 identify the facility and establish the base period parameters for calculating the individual RTC's rate. It is important that the contact person designated in item 2 be familiar with the methodology used in collection of the data. This person may be contacted at a future date if OCHAMPUS should have any questions regarding the submitted information. In items 5 through 7, provide the most recent/current dates for the information requested. Failure to do so may result in a base period that is inconsistent with the operation of your facility.</p> <p>Reimbursement Information:</p> <p>Item 9: For the period July 1, 1987, through June 30, 1988, provide the name, mailing address, and telephone number of all third-party payors for whom a rate was established and what the accepted rate was, and the number of patient days actually provided at that rate. At a minimum, this is to include all federal, state or local government agencies (including CHAMPUS), and other private third-party payors. Also include the rate charged the general public and the number of days actually provided at that rate. Individual private payors do not need to be identified.</p>	<p>The data requirements for RTCs beginning operation after July 1, 1988, or beginning operation <u>before</u> July 1, 1988, but having less than 12 months of operation by July 1, 1988, are identical to the data requirements for those facilities in operation during the entire base period, with the exception of the time frame for which the data is to be provided. The data must be provided for the first 6 to 12 months of operation, with 6 months being the absolute minimum for new facilities. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available the rate shall be recalculated and applied prospectively. If the data only covers a portion of the base period, <u>give the dates</u>. If there is more than one rate with an individual third-party payor during the base period, provide the <u>total</u> number of patient days paid by that payor at each rate during the base period. Total patient days will be used in determining the most favored rate for your facility. The following is an example of how to handle multiple third-party rates over your base period:</p> <p>An RTC had negotiated three separate rates with a third-party payor over its base period. The three rates would be reported as follows:</p> <ol style="list-style-type: none"> (1) \$195/day from July 1, 1987, through October 31, 1987 - 2000 patient days; (2) \$215/day from November 1, 1987, through February 29, 1988 - 3000 patient days; (3) \$230/day from March 1, 1988, through June 30, 1988 - 2000 patient days. <p>In this example the total number of days paid by the third-party payor is 7000.</p> <p>If the RTC was in operation during the base period, provide the requested data for the entire period regardless of change in ownership; for example, if your facility was in operation during the base period (July 1, 1987, through June 30, 1988), but was taken over by a national mental health corporation as of January 1, 1988, provide the requested data from July 1, 1987, through June 30, 1988, along with date of change of ownership. Failure to provide the entire base period data will result in delay in establishing your new rate.</p>

CHAMPUS FORM 771, JUNE 1991

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

FIGURE 7.B-1 TMA FORM 771 (CONTINUED)

REIMBURSEMENT INFORMATION		OMB No: 0704-0295 Expires: 31 January 1994
PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS		
Public reporting bureau for this collection of information is estimated to average 12 hours per response, including the time for reviewing instructions, searching existing data sources, and gathering and maintain the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Washington Headquarters Services, Directorate for information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204 Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0295) Washington, DC 20503.		
1. FACILITY NUMBER:	2. EIN:	
3. FACILITY NAME AND ADDRESS: TELEPHONE NUMBER: ()	4. NAME OF PERSON PREPARING DATA: TITLE:	
5. DATE CURRENT RTC PROGRAM OFFICIALLY OPENED FOR BUSINESS:		
6. DATE OF MOST RECENT JOINT COMMISSION ON ACCREDITATION OF HEALTH ORGANIZATIONS (JCAHO): ACCREDITATION:		
7. DATE OF CURRENT AUTHORIZATION AS A CHAMPUS CERTIFIED RTC:		
8. DATES OVER WHICH DATA WAS COLLECTED _____ TO _____		
9. THIRD PARTY PAYERS ESTABLISHING OR AFFECTING RATES: Data requirements should be carefully reviewed and presented in the following format. (If additional sheets are required, copy the format and attach all completed sheets.)		
NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PAYER	RATE ACCEPTED	PATIENT DAYS PROVIDED AT EACH RATE

CHAMPUS FORM 771, JUNE 1991

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

FIGURE 7.B-1 TMA FORM 771 (CONTINUED)

10. ADDITIONAL SERVICES: Identify each individual service not included in item #9 (If additional sheets are required, copy the format below and attach all completed sheets.)

SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER PATIENT DAY (PPD)

11. EDUCATION CHARGES:

a. Are educational charges excluded from the daily rate when billing CHAMPUS:
 YES _____ NO _____

b. What is the educational rate/charge per patient per day in you facility?
 \$_____ per patient day.

I declare that I have examined the above information and all attachments, and to the best of my knowledge and belief, they are true, correct and complete.

Signature Date

Name (Typed or Printed)

Title

RETURN COMPLETED FORM TO: OCHAMPUS
 PROGRAM INITIATIVES BRANCH
 AURORA, COLORADO 80045-6900

CHAMPUS FORM 771, JUNE 1991

- END -

Home Health Benefit Coverage And Reimbursement - General Overview

Issue Date:

Authority: [32 CFR 199.2](#); [32 CFR 199.4\(e\)\(21\)](#); [32 CFR 199.6\(a\)\(8\)\(i\)\(B\)](#); [32 CFR 199.6\(b\)\(4\)\(xv\)](#); and [32 CFR 199.14\(j\)](#)

1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

2.0 ISSUE

A general overview of the coverage and reimbursement of Home Health Care (HHC).

3.0 POLICY

3.1 Statutory Background

Under 10 United States Code (USC) 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE may, by regulation, be established "to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Similarly, under 10 USC 1079(h), the amount to be paid to health care professionals and other non-institutional health care providers "shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare." Section 701 of the National Defense Authorization Act for Fiscal Year 2007 (NDAA FY 2007) (Public Law (PL) 107-107) (December 28, 2001), added a new Section 10 USC 1074j, establishing a comprehensive, part-time or intermittent HHC benefit to be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (SSA) (42 USC 1395x(m)). Based on these statutory provisions, TRICARE will adopt Medicare's benefit structure and Prospective Payment System (PPS) for reimbursement of Home Health Agencies (HHAs) that is currently in effect for the Medicare program as required by Section 4603 of the Balanced Budget Act (BBA) of 1997 (PL 105-33), as amended by Section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1999, and by Sections 302, 305, and 306 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act (BBRA) of 1999. Section 4603(a) of the BBA provides the authority for development of a Home Health Prospective Payment System (HH PPS) for all Medicare home health services provided under a Plan of Care (POC) that were paid on a reasonable cost basis by adding Section 1895 of the SSA; entitled

“Prospective Payment For Home Health Services.” The above statutory provisions:

- 3.1.1** Include adoption of the comprehensive Outcome and Assessment Information Set (OASIS).
- 3.1.2** Require payment to be made on the basis of a prospective amount.
- 3.1.3** Allow for a new unit of payment.
- 3.1.4** Require the new unit of payment to reflect different patient conditions (case mix) and wage adjustments.
- 3.1.5** Allow for cost outliers (supplemental payment for exceptional high-cost cases).
- 3.1.6** Require proration of the payment when a beneficiary chooses to transfer among HHAs within an episode.
- 3.1.7** Require services to be recorded in 15-minute increments on claims.
- 3.1.8** Require consolidated billing by HHAs for all services and supplies for patients under a home health POC.

3.2 Scope and Conditions of Coverage

3.2.1 Scope of Coverage

The following are items and services that are covered under the home health benefit when furnished by, or under arrangement with, a HHA that participates in the TRICARE program and provides care on a visiting basis in the beneficiary’s home (i.e., a place of residence used as such individual’s home):

- 3.2.1.1** Services that are covered under the prospective payment rates:
 - Part-time or intermittent skilled nursing care provided by or under the supervision of a registered professional nurse;
 - Part-time or intermittent services of a home health aide;
 - Physical, or occupational therapy, or speech-language pathology services;
 - Medical social services under the direction of a physician;
 - Routine and non-routine medical supplies;
 - Medical services provided by an intern or resident-in-training under an approved hospital teaching program, when the HHA is affiliated with or under common control of a hospital; and

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
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 -

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

Issue Date:

Authority: [32 CFR 199.2](#); [32 CFR 199.4\(e\)\(21\)](#); [32 CFR 199.6\(a\)\(8\)\(i\)\(B\)](#); [32 CFR 199.6\(b\)\(4\)\(xv\)](#); and [32 CFR 199.14\(j\)](#)

1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the [Defense Health Agency \(DHA\)](#) and specifically included in the network provider agreement.

2.0 ISSUE

To describe the payment methodology for services rendered to a TRICARE eligible beneficiary under a home health Plan Of Care (POC) established by a physician.

3.0 POLICY

3.1 General Overview

3.1.1 Under the new Prospective Payment System (PPS), TRICARE will reimburse Home Health Agencies (HHAs) a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and Non-Routine (medical) Supplies (NRS) provided under the beneficiary's POC. Durable Medical Equipment (DME) orthotics, prosthetics, certain vaccines, injectable osteoporosis drugs, ambulance services operated by the HHA and other drugs and biologicals administered by other than oral method will be allowed outside the bundled Episode Of Care (EOC) payment rates.

3.1.2 The variation in reimbursement among beneficiaries receiving Home Health Care (HHC) under this newly adopted PPS will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day EOC, with special reimbursement provisions for major intervening events, Significant Changes In Condition (SCIC), and low or high resource utilization. The resource consumption of these beneficiaries will be assessed using Outcome and Assessment Information Set (OASIS) selected data elements. The score values obtained from these selected data elements will be used to classify home health beneficiaries into one of the Home Health Resource Groups (HHRGs) groups, based on their average expected resource costs relative to other HHC patients.

3.1.3 The HHRG classification determines the cost weight; i.e., the appropriate case-mix weight adjustment factor that indicates the relative resources used and costliness of treating different patients. The cost weight for a particular HHRG is then multiplied by a standard average prospective payment amount for a 60-day episode of HHC. The case-mix adjusted standard prospective payment amount is then adjusted to reflect the geographic variation in wages to come up with the final HHA payment amount. Examples of the above calculations will be provided below in order to get a better understanding of the HHA PPS being adopted in this rule, along with the home health benefit structure and applicable reporting requirements.

3.2 Episodes Of Care (EOCs)

3.2.1 The ordinary unit of payment is based on an authorized 60-day EOC. This episode spans a 60-day period which begins with the start of care date (i.e., with the first billable service date) furnished to a beneficiary and ending 60 days later. Payment covers the entire EOC regardless of the number of days of care actually provided during the 60-day period. The only exceptions to this standard payment period are when the following conditions exist: 1) Partial Episode Payment (PEP) adjustment; 2) SCIC adjustment for episodes beginning prior to January 1, 2008; 3) Low Utilization Payment Adjustment (LUPA); 4) additional outlier payment; or 5) medical review determination. There is also downward adjustment in those situations in which the number of therapy services delivered during an episode beginning prior to January 1, 2008, does not meet the anticipated 10 therapy visits threshold. Reduced or additional amounts will be paid under the above situations.

3.2.2 If the beneficiary is still in treatment at the end of the initial 60-day EOC, a decision has to be made regarding recertification for another 60-day EOC; i.e., a physician must certify that the beneficiary is correctly assigned to one of the HHRGs. If the decision is to recertify, a new episode will begin on Day 61 regardless of whether a billable visit is rendered on that day, and ends 60 days later. The HHA will be required to obtain an authorization for the new episode. This pattern would continue (the next episode would start on the 121st day, the next on the 181st day, etc.) as long as the beneficiary was receiving services under a HHA's POC. Extension of the HHA benefit beyond the 60th day will require the HHA to fill out a new assessment (OASIS) in order to assign an appropriate HHRG (case-mix category) for the next 60-day EOC. A revised OASIS, along with the physician's POC and certification, is required before the HHA submits a bill for the next 60-day EOC. The timely submission of this information is essential in determining whether the HHRG rate to be paid is appropriate and accurately reflects the beneficiary's clinical condition. There are currently no limits on the number of medically necessary consecutive 60-day episodes that beneficiaries may receive under the HHA PPS. Allowing multiple episodes is intended to assure continuity of care and payment.

3.2.3 Consecutive authorized episodes will be paid at the full prospective rate as long as there are no intervening events or costs which would affect overall resource utilization under the initially designated case-mix assignment.

3.2.4 More than one episode for a single beneficiary may be authorized for the same or different dates of service. This will occur particularly in situations where there is a transfer to another HHA, or discharge and readmission to the same HHA.

3.2.5 Payment will be prorated when an episode ends before the 60th day in the case of a transfer to another HHA, or in the case of a discharge and readmission within the same 60-day period. Claims for episodes may also be submitted prior to the 60th day if the beneficiary has been

discharged and treatment goals have been met, although payment will not be prorated unless more HHC is subsequently billed in the same 60-day period.

3.3 Case-Mix Adjustment

3.3.1 Elements of the Case-Mix Model

The variation in reimbursement among beneficiaries receiving HHC under this newly adopted PPS will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day EOC with special reimbursement provisions for major intervening events, SCICs, and low or high resource utilization. A case-mix system has been developed to measure the severity and projected resource utilization of beneficiaries receiving home health services using selected data elements off of the OASIS assessment instrument (i.e., the assessment document submitted by HHAs for reimbursement) and an additional element measuring receipt of at least 10 visits for therapy services. These key data elements are organized and assigned a score value in order to measure the impact of clinical, functional and services utilization dimensions on total resource use. The resulting summed scores are used to assign a beneficiary to a particular severity level within each of the following domains:

3.3.1.1 Clinical Severity Domain

The clinical severity domain captures significant indicators of clinical need for several OASIS items. These include patient history, sensory, integument, respiratory, elimination, and neuro/emotional/behavioral status. It includes OASIS items pertaining to the following clinical conditions and risk factors: diagnoses involving orthopedic, neurological, or diabetic conditions; therapies used at home (i.e., intravenous therapy or infusion therapy, parenteral and enteral nutrition); vision; pain frequency; pressure ulcers, stasis ulcers, burns, trauma and surgical wounds; dyspnea; urinary and bowel incontinence; bowel ostomy; and cognitive/behavioral problems, such as impaired decision making and hallucinations. The clinical severity domain has four severity levels (0-3) and takes into account the beneficiary's primary diagnosis and prevalent medical conditions.

3.3.1.2 Functional Dimension

The functional status domain is comprised of six Activities of Daily Living (ADLs) from the ADL sections of the OASIS assessment instrument. These include upper and lower body dressing, bathing, toileting, transferring, and locomotion, and consists of five severity levels (0-4).

3.3.1.3 Services Utilization Domain

The services utilization dimension has four severity levels (0-3) and includes two types of data elements. First is the patient's use of inpatient services (both inpatient and Skilled Nursing Facility (SNF)/rehabilitation stays) in the 14 days preceding admission to home care. This information is obtained from the patient history section of the OASIS. The second data element in the service utilization dimension measures home health therapy hours (physical, occupational, or speech/language) totaling eight hours (approximately 10 therapy visits) or more during the 60-day EOC. The threshold of eight hours targets additional payments for home health therapy to patients with a clear need for therapy.

3.3.1.4 Other Variables Affecting Case-Mix Adjustment

3.3.1.4.1 Diagnosis. Since home health diagnosis is generally used informally to characterize home health patients and the types of services they require, it is an important variable in the case-mix adjustment process. Since OASIS completion rules require submission of only the first three digits of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code, the analysis used these categories. Since individual analysis of the 900+ codes was not practical, the diagnosis codes were grouped into Diagnostic Groups (DGs). These were based on the Quality Indicator Groups (QUIGs) that had been developed for use in monitoring HHC and outcomes with OASIS. Three of the DGs were found to be statistically significant predictors of home health resource use - Orthopedic, Neurologic, and Diabetic. A fourth category, Burn/Trauma, is not based on the QUIGs, but was subsequently added to the model to capture patients with high needs for wound care who are not otherwise captured by existing OASIS items. A listing of the **diagnoses** included in each DG as a primary or secondary diagnosis is presented in [Addendum H](#). **For services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, use diagnosis codes as contained in the ICD-9-CM. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-10-CM.**

3.3.1.4.2 Secondary Diagnoses. The first secondary diagnosis is considered in some cases when the diagnosis of interest for case-mix purposes is a code representing manifestation of an underlying condition which is entered as the primary diagnosis.

3.3.1.4.3 Availability of Caregiver. The availability of a caregiver was excluded from the case-mix adjustment model since it was found to add little predictive insight given the variables that were already included.

3.3.1.4.4 Service Utilization Variables. It was found that patients who had a rehab or SNF discharge, as well as a hospital discharge, in the 14 days before home health admission generally had lower resource use than patients who had been in a rehab or SNF only. It was felt that those who could move from a hospital to rehab/SNF to home care in 14 days were making good progress, while those who come to home care from a longer rehab or SNF stay likely had more chronic problems, or were progressing more slowly. Thus, lack of a recent hospital discharge (blank item M0175, line 1 on the OASIS) would be a definite predictor of resource utilization.

3.3.2 Response Values, Scores and Severity Levels

3.3.2.1 OASIS Item Response Values

The OASIS contains 90 data items. OASIS items responses involve unique statements that require an objective assessment, and the number of possible responses varies by item.

3.3.2.1.1 Each of the possible responses have point values assigned to them that reflect their relationship to home health resource utilization.

3.3.2.1.2 In most of the items, several responses are grouped and assigned one value. For example, for item M0670 (Bathing), response options 2, 3, 4, or 5 (ranging from "able to bathe in shower or tub with assistance of another person" to "totally bathed by another person") are all

given a point value of 8. If the patient had been rated as independent in bathing, however, with response 0, no value is added to the score.

3.3.2.2 Point Scoring

The point values for the OASIS items within each of the three domains are summed to determine a patient's point score in each domain (clinical, functional and service utilization.) For example, if the response for each of the items listed in the Functional Domain is a 2, then the score for the domain would be calculated as follows in [Figure 12.4-1](#).

FIGURE 12.4-1 CALCULATING DOMAIN SCORES FROM RESPONSE VALUES

M0650 / M0660	Dressing	Response 2 has a value of 4, so 4 is added to the score.
M0670	Bathing	Response 2 has a value of 8, so 8 is added to the score.
M0680	Toileting	Response 2 has a value of 3, so 3 is added to the score.
M0690	Transferring	Response 2 has a value of 6, so 6 is added to the score.
M0700	Locomotion	Response 2 has a value of 6, so 6 is added to the score.
Summing the values for the items produces a score of 27 for the function domain.		

3.3.2.3 Severity Levels.

Within each domain, the total score is assigned to a severity level. For example, a summed score of 27 in the Functional Domain, as shown above, would place a patient in the "high" (F3) functional severity level. There are four clinical severity levels, five functional severity levels, and four service utilization severity levels. The range of scoring differs for each domain, so that a score of 25 in the Clinical Domain would correspond to a moderate (C2) clinical severity level, but a score of 25 in the Functional Domain would place the patient in the high functional severity level. A patient with a score of 43 for the Clinical Domain would be placed in the high clinical (C3) severity level, while a patient with a total score of six in the Service Domain would be placed in the moderate (S2) severity level for that domain.

3.3.2.4 Grid System of OASIS Items, Values and Scoring

The following figures ([Figure 12.4-2](#) - [Figure 12.4-4](#)) list the OASIS items used in the case-mix model, along with corresponding descriptions, values and scoring:

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-2 CLINICAL SEVERITY DOMAIN

OASIS+ ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0230 / M0240	Primary home care diagnosis (plus first secondary Dx ONLY for selected manifestation codes)	-credit only the single highest value: If Orthopedic DG, add 11 to score If Diabetes DG, add 17 to score If Neurological DG, add 20 to score	Min (C)= 0-7
M0250	IV/Infusion/Parenteral/Enteral Therapies	-credit only the single highest value: If box 1, add 14 to score If box 2, add 20 to score If box 3, add 24 to score	
M0390	Vision	If box 1 or 2, add 6 to score	High (C3)= 41+
M0420	Pain	If box 2 or 3, add 5 to score	
M0440	Wound/Lesion	If box 1 and M0230 is Burn/Trauma DG, add 21 to score	
M0450	Multiple pressure ulcers	If 2 or more stage 3 or 4 pressure ulcers, add 17 to score	Min (C) = 0-7
M0460	Most problematic pressure ulcer stage	If box 2, add 14 to score If box 3, add 22 to score	
M0488	Surgical wound status	If box 2, add 7 to score If box 3, add 15 to score	Low (C1) = 8-19
M0490	Dyspnea	If box 2, 3 or 4, add 5 to score	Mod (C2) = 20-40
M0530	Urinary incontinence	If box 1 or 2, add 6 to score	High (C3) = 41+
M0540	Bowel incontinence	If box 2-5, add 9 to score	
M0550	Bowel ostomy	If box 1 or 2, add 10 to score	
M0610	Behavioral problems	If box 1-6, add 3 to score	

FIGURE 12.4-3 FUNCTIONAL STATUS DOMAIN

OASIS+ ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0650 (current) M0660 (current)	Dressing	If M0650 = box 1, 2, or 3 / or M0660 = box 1, 2, or 3/} -> add 4 to score	Min (F0) = 0-2
M0670 (current)	Bathing	If box 2, 3, 4, or 5, add 8 to score	Low (F1) = 3-15
M0680 (current)	Toileting	If box 2-4, add 3 to score	Mod (F2) = 16-23
M0690 (current)	Transferring	If box 1, add 3 to score If box 2-5, add 6 to score	High (F3) = 24-29
M0700 (current)	Locomotion	If box 1 or 2, add 6 to score If box 3-5, add 9 to score	Max (F4) = 30

FIGURE 12.4-4 SERVICE UTILIZATION DOMAIN

OASIS+ ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0175 B line 1	No hospital discharge past 14 days	If box 1 is BLANK, add 1 to score	Min (S0) = 0-2
M0175 B line 2 or 3	Inpatient rehab/SNF discharge past 14 days	If box 2 or 3, add 2 to score	Low (S1) = 3
M0825	Therapy threshold (10 or more therapy [PT, OT, SLP] visits during episode)	If box 1, add 4 to score	Mod (S2) = 4-6 High (S3) = 7

3.3.3 Case-Mix Grouper

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

3.3.4 Therapy Hours Verification

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

3.3.5 HHRG Updating

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

3.3.6 HHRG Reporting on Claim

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

3.3.6.1 Composition of HIPPS Codes for HHA PPS

3.3.6.1.1 The HIPPS Code is a distinct five position, alphanumeric code.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

3.3.6.1.1.1 The first position is a fixed letter “H” to designate home health, and does not correspond to any part of HHRG coding.

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

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

3.3.6.1.1.4 The HHRG to HIPPS code crosswalk is summarized in [Figure 12.4-5](#):

FIGURE 12.4-5 HHRG TO HIPPS CODE CROSSWALK

(CLINICAL) POSITION #2	(FUNCTIONAL) POSITION #3	(SERVICE) POSITION #4	POSITION #5	DOMAIN LEVEL
A (HHRG: C0)	E (HHRG: F0)	J (HHRG: S0)	1 = Second, third, and fourth positions computed	= Min
B (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	2 = Second position derived	= Low
C (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	3 = Third position derived	= Mod
D (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	4 = Fourth position derived	= High
	I (HHRG: F4)		5 = Second and third positions derived	= Max
			6 = Third and fourth positions derived	
			7 = Second and fourth positions derived	
			8 = Second, third, and fourth positions derived	
		N through Z	9, 0 (expansion values for future use)	

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

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

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

3.3.6.5 Examples of HIPPS Codes:

- HAEJ1 would indicate a patient whose HHRG code is minimal clinical severity, minimal functional severity, and minimal service severity. All items in all domains had valid data, so all the codes were computed.
- HCFM5 would indicate a patient whose HHRG code is moderate clinical severity, low functional severity, and high service severity, and the codes for the functional and service domains were derived because some of the items in each of those domains

had responses which were invalid.

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

3.4 Grouper Linkage of Assessment with Payment

3.4.1 HHAs are required to assess potential patients, and re-assess existing patients, using the OASIS tool.

3.4.2 Grouper software determines the appropriate HHRG for payment of a HHA PPS 60-day episode from the results of an OASIS submission for a beneficiary as input, or "grouped" in this software. Grouper outputs HHRGs as HIPPS coding.

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

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

3.5 Refined Case-Mix Model for Home Health Episodes Beginning On or After January 1, 2008

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

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

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

- The first position is no longer a fixed value. The refined HH PPS uses a four equation case-mix model which assigns differing scores in the clinical, functional and services domains based on whether an episode is an early or later episode in a sequence of adjacent episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores.
- The second, third, and fourth positions of the code remain a one-to-one crosswalk to the three domains of the HHRG coding system. The second through fourth positions of the HH PPS HIPPS code will only allow alphabetical characters.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

- The fifth position indicates a severity group for NRS. The HH PPS grouper software will assign each episode into one of six NRS severity levels and create the fifth position of the HIPPS code with the values **S** through **X**. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number of one through six before submitting the claim.
- The first four positions of the HIPPS code submitted on the final claim must match what was on the Request for Anticipated Payment (RAP). The fifth digit may vary (i.e., where the HHA initially anticipated the use of NRS during the episode only to subsequently find out that they were not required - the supply indicator may need to be changed if no supplies were provided).

FIGURE 12.4-6 NEW HIPPS CODE STRUCTURE UNDER HH PPS CASE-MIX REFINEMENT

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

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

- First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level = HIPPS code 1AFKS.
- Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity level 3 = HIPPS code 4CHMV.
- Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score is high and supply severity level 4, but supplies were not provided due to a special circumstance = HIPPS code 5BHN4.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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

3.5.1.4 The new HIPPS coding structure has resulted in 153 case-mix groups represented by the first four positions of the code. Each of these case-mix groups can be combined with a NRS severity level, resulting in 918 HIPPS codes in all (i.e., 153 case-mix times six NRS severity levels). With two values representing supply levels (1-6 in cases where NRS's are not associated with the first four positions of the HIPPS code and **S-X** where they are), there are actually 1836 new HIPPS codes. Refer to the **DHA** web site (<http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement>) for a complete listing of HH PPS case-mix refined HIPPS codes (all five positions) with associated weights.

3.5.2 Constructing of HIPPS Codes from Grouping Step and Point Scores

The following scoring matrix (Figure 12.4-7) will be used in construction of the HIPPS code for payment under HH PPS:

FIGURE 12.4-7 SCORING MATRIX FOR CONSTRUCTING HIPPS CODE

	LEVEL	FIRST & SECOND EPISODES		THIRD + EPISODES		ALL EPISODES	HIPPS CODE		
		0-13 THERAPY VISITS	14-19 THERAPY VISITS	0-13 THERAPY VISITS	14-19 THERAPY VISITS	20+ THERAPY VISITS	LEVEL	HIPPS VALUES	HIPPS POSITION
Grouping Step:		1	2	3	4	5	Step:	1-5	1
Clinical Severity Level: (by point scores- Figure 12.4-8)	C1	0 to 4	0 to 6	0 to 2	0 to 8	0 to 7	C1	A	2
	C2	5 to 8	7 to 14	3 to 5	9 to 16	8 to 14	C2	B	
	C3	9+	15+	6+	17+	15+	C3	C	
Functional Severity Level: (by point scores- Figure 12.4-8)	F1	0 to 5	0 to 6	0 to 8	0 to 7	0 to 6	F1	F	3
	F2	6	7	9	8	7	F2	G	
	F3	7+	8+	10+	9+	8+	F3	H	
Services Utilization Level: (by number of therapy visits)	S1	0 to 5	14 to 15	0 to 5	14 to 15	20+ (1 Group)	S1	K	4
	S2	6	16 to 17	6	16 to 17		S2	L	
	S3	7 to 9	18 to 19	7 to 9	18 to 19		S3	M	
	S4	10		10			S4	N	
	S5	11 to 13		11 to 13			S5	P	
NRS - Supplies Severity Level: (by NRS point scores- Figure 12.4-10)	NRS-1	0					NRS-1	S	5
	NRS-2	1 to 14					NRS-2	T	
	NRS-3	15 to 27					NRS-3	U	
	NRS-4	28 to 48					NRS-4	V	
	NRS-5	49 to 98					NRS-5	W	
	NRS-6	99+					NRS-6	X	

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

3.5.2.1 Case-mix adjustment variables and scores used in constructing HIPPS codes (i.e., point scoring used in [Figure 12.4-6](#) for determining the appropriate HIPPS code for payment).

3.5.2.1.1 The point scores for clinical and functional severity levels (second and third positions of HIPPS code) are derived from [Figure 12.4-8](#) which gives a description of each diagnosis group followed by four columns representing the four legs of the four-equation model. The diagnoses associated with each of the diagnostic categories in [Figure 12.4-8](#) can be found in [Addendum N](#).

FIGURE 12.4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012 (CONTINUED)

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
17	Primary or Other Diagnosis = Neuro 3 - Stroke AND M0700 (Ambulation) = 3 or more	1	5		
18	Primary or Other Diagnosis = Neuro 4 - Multiple Sclerosis AND AT LEAST ONE OF THE FOLLOWING: M0670 (bathing) = 2 or more OR M0680 (Toileting) = 2 or more OR M0690 (Transferring) = 2 or more OR M0700 (Ambulation) = 3 or more	3	3	12	18
19	Primary or Other Diagnosis = Ortho 1 - Leg Disorders or Gait Disorders AND M0460 (most problematic pressure ulcer stage) = 1, 2, 3 or 4	2			
20	Primary or Other Diagnosis = Ortho 1 - Leg OR Ortho 2 - Other orthopedic disorders AND M0250 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	5	5		
21	Primary or Other Diagnosis = Psych 1 – Affective and other psychoses, depression	3	5	2	5
22	Primary or Other Diagnosis = Psych 2 - Degenerative and other organic psychiatric disorders	1	2		2
23	Primary or Other Diagnosis = Pulmonary disorders	1	5	1	5
24	Primary or Other Diagnosis = Pulmonary disorders AND M0700 (Ambulation) = 1 or more	1			
25	Primary Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications	10	20	8	20
26	Other Diagnosis = Skin 1 - Traumatic wounds, burns, post-operative complications	6	6	4	4
27	Primary or Other Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications OR Skin 2 – Ulcers and other skin conditions AND M0250 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	2		2	
28	Primary or Other Diagnosis = Skin 2 - Ulcers and other skin conditions	6	12	5	12
29	Primary or Other Diagnosis = Tracheostomy	4	4	4	
30	Primary or Other Diagnosis = Urostomy/Cystostomy	6	23	4	23
31	M0250 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	8	15	5	12
32	M0250 (Therapy at home) = 3 (Enteral)	4	12		12
33	M0390 (Vision) = 1 or more	1			1
34	M0420 (Pain) = 2 or 3	1			
35	M0450 = Two or more pressure ulcers at stage 3 or 4	3	3	5	5

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012 (CONTINUED)

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
36	M0460 (Most problematic pressure ulcer stage) = 1 or 2	5	11	5	11
37	M0460 (Most problematic pressure ulcer stage) = 3 or 4	16	26	12	23
38	M0476 (Stasis ulcer status) = 2	8	8	8	8
39	M0476 (Stasis ulcer status) = 3	11	11	11	11
40	M0488 (Surgical wound status) = 2		2	3	
41	M0488 (Surgical wound status) = 3	4	4	4	4
42	M0490 (Dyspnea) = 2, 3, or 4	2	2		
43	M0540 (Bowel Incontinence) = 2 to 5	1	2	1	
44	M0550 (Ostomy) = 1 or 2	5	9	3	9
45	M0800 (Injectable Drug Use) = 0, 1, or 2	1	1	2	4
FUNCTIONAL DIMENSION					
46	M0650 or M0660 (Dressing upper or lower body) = 1, 2, or 3	2	4	2	2
47	M0670 (Bathing) = 2 or more	3	3	6	6
48	M0680 (Toileting) = 2 or more	2	3	2	
49	M0690 (Transferring) = 2 or more		2		
50	M0700 (Ambulation) = 1 or 2	1		1	
51	M0700 (Ambulation) = 3 or more	3	4	4	5

Notes: The data for the regression equations come from a 20% random sample of episodes from CY 2005. The sample excludes LUPA episodes, outlier episodes, and episodes with SCIC or PEP adjustments.

Points are additive; however, points may not be given for the same line item in the table more than once.

Please see Medicare Home Health Diagnosis Coding guidance at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp for definitions of primary and secondary diagnoses.

FIGURE 12.4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012

Note: 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
CLINICAL DIMENSION					
1	Primary or Other Diagnosis = Blindness/Low Vision	3	3	3	3
2	Primary or Other Diagnosis = Blood disorders	2	5		
3	Primary or Other Diagnosis = Cancer, selected benign neoplasms	3	8	3	10
4	Primary Diagnosis = Diabetes	5	13	1	8
5	Other Diagnosis = Diabetes	3	5	1	5
6	Primary or Other Diagnosis = Dysphagia AND Primary or Other Diagnosis = Neuro 3 - Stroke	2	6		6

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012 (CONTINUED)

Note: 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
7	Primary or Other Diagnosis = Dysphagia AND M1030 (Therapy at home) = 3 (Enteral)		6		
8	Primary or Other Diagnosis = Gastrointestinal disorders	2	6	1	5
9	Primary or Other Diagnosis = Gastrointestinal disorders AND M1630 (ostomy) = 1 or 2	2			
10	Primary or Other Diagnosis = Gastrointestinal disorders AND Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis, OR Neuro 2 - Peripheral neurological disorders, OR Neuro 3 - Stroke, OR Neuro 4 - Multiple Sclerosis			2	
11	Primary or Other Diagnosis = Heart Disease OR Hypertension	3	6	1	7
12	Primary Diagnosis = Neuro 1 - Brain disorders and paralysis	3	8	5	8
13	Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis AND M1840 (Toileting) = 2 or more	3	10	3	10
14	Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis OR Neuro 2 - Peripheral neurological disorders AND M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	1	4	1	2
15	Primary or Other Diagnosis = Neuro 3 - Stroke		2		
16	Primary or Other Diagnosis = Neuro 3 - Stroke AND M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	1	3	2	8
17	Primary or Other Diagnosis = Neuro 3 - Stroke AND M1860 (Ambulation) = 4 or more	1	5		
18	Primary or Other Diagnosis = Neuro 4 - Multiple Sclerosis AND AT LEAST ONE OF THE FOLLOWING: M1830 (bathing) = 2 or more OR M1840 (Toileting) = 2 or more OR M1850 (Transferring) = 2 or more OR M1860 (Ambulation) = 4 or more	3	3	12	18
19	Primary or Other Diagnosis = Ortho 1 - Leg Disorders or Gait Disorders AND M1324 (most problematic pressure ulcer stage) = 1, 2, 3, or 4	2			

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012 (CONTINUED)

Note: 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

	Episode number within sequence of adjacent episodes	1 or 2	1 or 2	3+	3+
	Therapy visits	0-13	14+	0-13	14+
	EQUATION:	1	2	3	4
20	Primary or Other Diagnosis = Ortho 1 - Leg OR Ortho 2 - Other orthopedic disorders AND M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	5	5		
21	Primary or Other Diagnosis = Psych 1 - Affective and other psychoses, depression	4	6	2	6
22	Primary or Other Diagnosis = Psych 2 - Degenerative and other organic psychiatric disorders	1	3		3
23	Primary or Other Diagnosis = Pulmonary disorders	1	5	1	5
24	Primary or Other Diagnosis = Pulmonary disorders AND M1860 (Ambulation) = 1 or more	1			
25	Primary Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications	10	20	8	20
26	Other Diagnosis = Skin 1 - Traumatic wounds, burns, post-operative complications	6	6	4	4
27	Primary or Other Diagnosis = Skin 1 -Traumatic wounds, burns, and post-operative complications OR Skin 2 - Ulcers and other skin conditions AND M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	2		2	
28	Primary or Other Diagnosis = Skin 2 - Ulcers and other skin conditions	6	12	5	12
29	Primary or Other Diagnosis = Tracheostomy	4	4	4	
30	Primary or Other Diagnosis = Urostomy/Cystostomy	6	22	4	22
31	M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	8	15	5	11
32	M1030 (Therapy at home) = 3 (Enteral)	4	11		11
33	M1200 (Vision) = 1 or more	1			2
34	M1242 (Pain) = 3 or 4	1			
35	M1308 = Two or more pressure ulcers at stage 3 or 4	3	3	5	5
36	M1324 (Most problematic pressure ulcer stage) = 1 or 2	5	11	5	11
37	M1324 (Most problematic pressure ulcer stage) = 3 or 4	16	26	12	22
38	M1334 (Stasis ulcer status) = 2	7	7	7	7
39	M1334 (Stasis ulcer status) = 3	11	11	11	11
40	M1342 (Surgical wound status) = 2		2	3	
41	M1342 (Surgical wound status) = 3	4	4	4	4
42	M1400 (Dyspnea) = 2, 3, or 4	2	2		
43	M1620 (Bowel Incontinence) = 2 to 5	1	2	1	
44	M1630 (Ostomy) = 1 or 2	5	9	3	9
45	M2030 (Injectable Drug Use) = 0, 1, 2, or 3	0	1	2	3

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-9 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING ON OR AFTER JANUARY 1, 2012 (CONTINUED)

Note: 4-Equation Model was Estimated on Episodes from 2005 where 401.1 and 401.9 were not counted in the Hypertension Diagnosis Group.

Episode number within sequence of adjacent episodes		1 or 2	1 or 2	3+	3+
Therapy visits		0-13	14+	0-13	14+
EQUATION:		1	2	3	4
FUNCTIONAL DIMENSION					
46	M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	2	4	2	2
47	M1830 (Bathing) = 2 or more	3	3	6	6
48	M1840 (Toileting) = 2 or more	2	3	2	
49	M1850 (Transferring) = 2 or more		1		
50	M1860 (Ambulation) = 1, 2, or 3	1		1	
51	M1860 (Ambulation) = 4 or more	3	3	4	5

Notes: The data for the regression equations come from a 20% random sample of episodes from CY 2005. The sample excludes LUPA episodes, outlier episodes, and episodes with SCIC or PEP adjustments.

Points are additive; however, points may not be given for the same line item in the table more than once.

Please see Medicare Home Health Diagnosis Coding guidance at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp for definitions of primary and secondary diagnoses.

3.5.2.2 The point scores for service utilization levels (fourth position of the HIPPS code) are determined by the number of therapy visits (see [Figure 12.4-7](#) for range of visits within each service utilization level and associated episode).

3.5.2.3 The point scores for NRS levels (fifth position of the HIPPS code) are derived from the six severity groups in [Figure 12.4-10](#). These severity levels more accurately reflect the large variation in NRS used across all patient types.

FIGURE 12.4-10 RELATIVE WEIGHTS FOR NRS - SIX-GROUP APPROACH

SEVERITY LEVEL	POINTS (SCORING)	RELATIVE WEIGHT	PAYMENT AMOUNT
1	0	0.2698	\$ 14.12
2	1 to 14	0.9742	51.00
3	15 to 27	2.6712	139.84
4	28 to 48	3.9686	207.76
5	49 to 98	6.1198	320.37
6	99+	10.5254	551.00

Note: NRS conversion factor = \$52.35.

3.5.2.3.1 [Figure 12.4-11](#) provides the case-mix variables (i.e., selected skin conditions and other clinical factors) and scores used in assigning a NRS to one of the six severity levels in [Figure](#)

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

12.4-10.

FIGURE 12.4-11 NRS CASE-MIX ADJUSTMENT VARIABLES AND SCORES

ITEM	DESCRIPTION	SCORE
SELECTED SKIN CONDITIONS:		
1	Primary diagnosis = Anal fissure, fistula and abscess	15
2	Other diagnosis = Anal fissure, fistula and abscess	13
3	Primary diagnosis = Cellulitis and abscess	14
4	Other diagnosis = Cellulitis and abscess	8
5	Primary diagnosis = Diabetic ulcers	20
6	Primary diagnosis = Gangrene	11
7	Other diagnosis = Gangrene	8
8	Primary diagnosis = Malignant neoplasms of skin	15
9	Other diagnosis = Malignant neoplasms of skin	4
10	Primary or Other diagnosis = Non-pressure and non-stasis ulcers	13
11	Primary diagnosis = Other infections of skin and subcutaneous tissue	16
12	Other diagnosis = Other infections of skin and subcutaneous tissue	7
13	Primary diagnosis = Post-operative Complications	23
14	Other diagnosis = Post-operative Complications	15
15	Primary diagnosis = Traumatic Wounds and Burns	19
16	Other diagnosis = Traumatic Wounds and Burns	8
17	Primary or other diagnosis = V code, Cystostomy care	16
18	Primary or other diagnosis = V code, Tracheostomy care	23
19	Primary or other diagnosis = V code, Urostomy care	24
20	OASIS M0450 = 1 or 2 pressure ulcers, stage 1	4
21	OASIS M0450 = 3+ pressure ulcers, stage 1	6
22	OASIS M0450 = 1 pressure ulcer, stage 2	14
23	OASIS M0450 = 2 pressure ulcers, stage 2	22
24	OASIS M0450 = 3 pressure ulcers, stage 2	29
25	OASIS M0450 = 4+ pressure ulcers, stage 2	35
26	OASIS M0450 = 1 pressure ulcer, stage 3	29
27	OASIS M0450 = 2 pressure ulcers, stage 3	41
28	OASIS M0450 = 3 pressure ulcers, stage 3	46
29	OASIS M0450 = 4+ pressure ulcers, stage 3	58
30	OASIS M0450 = 1 pressure ulcer, stage 4	48
31	OASIS M0450 = 2 pressure ulcers, stage 4	67
32	OASIS M0450 = 3+ pressure ulcers, stage 4	75
33	OASIS M0450e = 1 (unobserved pressure ulcer(s))	17
34	OASIS M0470 = 2 (2 stasis ulcers)	6
35	OASIS M0470 = 3 (3 stasis ulcers)	12
36	OASIS M0470 = 4 (4+ stasis ulcers)	21
37	OASIS M0474 = 1 (unobservable stasis ulcers)	9

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-11 NRS CASE-MIX ADJUSTMENT VARIABLES AND SCORES (CONTINUED)

ITEM	DESCRIPTION	SCORE
38	OASIS M0476 = 1 (status of most problematic stasis ulcer: fully granulating)	6
39	OASIS M0476 = 2 (status of most problematic stasis ulcer: early/partial granulation)	25
40	OASIS M0476 = 3 (status of most problematic stasis ulcer: not healing)	36
41	OASIS M0488 = 2 (status of most problematic surgical wound: early/partial granulation)	4
42	OASIS M0488 = 3 (status of most problematic surgical wound: not healing)	14
OTHER CLINICAL FACTORS:		
43	OASIS M0550 = 1 (ostomy not related to inpt stay/no regimen change)	27
44	OASIS M0550 = 2 (ostomy related to inpt stay/regimen change)	45
45	Any `Selected Skin Conditions` (rows 1-42 above) AND M0550 = 1 (ostomy not related to inpt stay/no regimen change)	14
46	Any `Selected Skin Conditions` (rows 1-42 above) AND M0550 = 2 (ostomy related to inpt stay/ regimen change)	11
47	OASIS M0250 (Therapy at home) = 1 (IV/Infusion)	5
48	OASIS M0520 = 2 (patient requires urinary catheter)	9
49	OASIS M0540 = 4 or 5 (bowel incontinence, daily or > daily)	10

Note: Points are additive; however, points may not be given for the same line item in the table more than once. Points are not assigned for a secondary diagnosis if points are already assigned for a primary diagnosis from the same diagnosis /condition group.

Please see Medicare Home Health Diagnosis Coding guidance at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp for definitions of primary and secondary diagnoses.

3.5.2.3.2 The supply payment amounts derived from the above severity level matrix (Figure 12.4-10) will be included in the total payment returned by the HH Pricer. It will not be reflected separately on the claim. Supply amounts will not be calculated on LUPA claims.

3.5.2.3.3 Refer to Addendum O for the diagnoses included in the diagnostic categories for the NRS case-mix adjustment model (Figure 12.4-11).

3.5.2.3.4 NRS provided during an EOC are subject to consolidated billing. If the date of service for NRS falls within the dates of an EOC, payment for the NRS is denied. However, NRS claims may be submitted by suppliers on the professional claim format, which has both "from" and "to" dates on each item. Medicare has instructed suppliers to report the delivery date as the "from" date, and the date by which the supplies will be used in the "to" date. When this causes the "to" date on a supply line item subject to consolidated billing to overlap on EOC, the service may be denied incorrectly. Contractors shall ensure proper payment of NRS provided prior to the beginning of an EOC ("from" date prior to the beginning of an EOC), even if the "to" date overlaps the EOC.

3.5.3 Adjustment of HIPPS Code for Incorrect Episode Designation

The contractors' claims processing systems will perform re-coding of claims where the HIPPS code does not reflect the correct episode using the 18-position treatment authorization code (formally known as the claim-OASIS matching key code) reported in Form Locator (FL) 63 of the UB-04 (CMS Form 1450).

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

3.5.3.1 Following is the new format of the treatment authorization code for episodes beginning on or after January 1, 2008:

FIGURE 12.4-12 FORMAT FOR TREATMENT AUTHORIZATION CODE

POSITION	DEFINITION	FORMAT
1-2	M0030 (Start-of-care date) - 2 digit year	99
3-4	M0030 (Start-of-care date) - alpha code for Julian date	XX
5-6	M0090 (Date assessment completed) - 2 digit year	99
7-8	M0090 (Date assessment completed) - alpha code for Julian Date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) - Early=1, Late=2	9
11	Alpha code for Clinical severity points - under Equation 1	X
12	Alpha code for Functional severity points - under Equation 1	X
13	Alpha code for Clinical severity points - under Equation 2	X
14	Alpha code for Functional severity points - under Equation 2	X
15	Alpha code for Clinical severity points - under Equation 3	X
16	Alpha code for Functional severity points - under Equation 3	X
17	Alpha code for Clinical severity points - under Equation 4	X
18	Alpha code for Functional severity points - under Equation 4	X

3.5.3.1.1 The Julian dates in positions 3-4 and 7-8 are converted from three position numeric values to two position alphabetic values using the code system in [Addendum P](#).

3.5.3.1.2 The two position numeric scores in positions 11-18 are converted to a single alphabetic code using values in [Figure 12.4-13](#).

FIGURE 12.4-13 CONVERTING POINT VALUES TO LETTER CODES

POINTS	LETTER CODE						
0 or 1	A	8	H	15	O	22	V
2	B	9	I	16	P	23	W
3	C	10	J	17	Q	24	X
4	D	11	K	18	R	25	Y
5	E	12	L	19	S	26	Z
6	F	13	M	20	T		
7	G	14	N	21	U		

3.5.3.2 [Figure 12.4-14](#) provides an example of a treatment authorization code that is created by the grouper software using the format outlined in [Figure 12.4-13](#).

FIGURE 12.4-14 EXAMPLE OF A TREATMENT AUTHORIZATION CODE

POSITION	DEFINITION	ACTUAL VALUE	RESULTING CODE
1-2	M0030 (Start-of-care date) - two digit year	2007	07
3-4	M0030 (Start-of-care date) - alpha code for Julian date	Julian date 245	JK

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-14 EXAMPLE OF A TREATMENT AUTHORIZATION CODE (CONTINUED)

POSITION	DEFINITION	ACTUAL VALUE	RESULTING CODE
5-6	M0090 (Date assessment completed) - two digit year	2008	08
7-8	M0090 (Date assessment completed) - alpha code for Julian date	Julian date 001	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing) - Early = 1, Late = 2	01	1
11	Clinical severity points - under Equation 1	7	G
12	Functional severity points - under Equation 1	2	B
13	Clinical severity points - under Equation 2	13	M
14	Functional severity points - under Equation 2	4	D
15	Clinical severity points - under Equation 3	3	C
16	Functional severity points - under Equation 3	4	D
17	Clinical severity points - under Equation 4	12	L
18	Functional severity points - under Equation 4	7	G

The treatment authorization code that would appear on the claim would be, in this example: **07JK08AA41GBMDCDLG**

3.5.3.3 Episode adjustment process using authorization code.

3.5.3.3.1 Contractor claims processing systems will validate the treatment authorization code except where condition code 21 is present on the claim. If the code is validated, the contractors will return claims to the provider if the treatment authorization code fails any of the following validation edits:

- The first, second, fifth, sixth, and ninth positions of the treatment authorization codes must be numeric;
- The third, fourth, seventh, and eighth positions of the code must be alphabetic;
- The tenth position of the code must contain a value of one or two; and
- The eleventh through 18th positions of the code must be alphabetic.

3.5.3.3.2 The system shall read the home health episode history when a new episode is received and identify any HIPPS codes that represent an incorrect position in the sequence. The sequence of episodes are determined without regard to changes in the HHA. The calculated 60-day episode end date will be used to measure breaks between episodes in all cases except for episodes subject to PEP adjustments. In the case of PEP episodes, the date of latest billing will be used.

3.5.3.3.3 If the contractors' system identifies a HIPPS code that represents an incorrect position in the sequence of episodes it will be re-coded and adjusted using the last nine positions of the treatment authorization code and the following re-coding logic:

3.5.3.3.3.1 The last eight positions of the treatment authorization will contain codes representing the points for the clinical domain and the functional domain as calculated under each of the four equations of the refined HH PPS case mix system. The treatment authorization code,

including these domain codes, will be calculated by the HH PPS Grouper software, so that providers can transfer this 18 position code to their claims.

3.5.3.3.3.2 The input/output record for the HH Pricer will be modified to convert existing filler fields into new fields to facilitate recording. A new nine position field will be created to carry the clinical and functional severity point information. The last nine positions of the treatment authorization code will be extracted and placed into this new field in the input/output record. This will enable the HH Pricer to record claims using the point information.

3.5.3.3.3.3 On incoming original RAPs and claims, the HH Pricer will disregard the code in this nine position field, since the submitted HIPPS code is being priced at face value. The code in this nine position field will be used in recording claims identified as misrepresenting the episode sequence. To enable the Pricer to distinguish these two cases, an additional one position numeric field will be added to the input/output record.

3.5.3.3.3.4 On the original RAPs and claims, the system will populate the new one position field with a zero.

- If a claim is submitted by the provider as a first or second episode and the claim is actually a third or later episode, the system will populate the new field with a 3 to indicate this.
- If a claim is submitted by the provider as a third or later episode and the claim is actually a first or second episode, the system will populate the new field with a 1 to indicate this.

3.5.3.3.3.5 When the new one position field is populated with a 1 or a 3, the HH Pricer will record the claim using the following steps:

- Step 1:** The HH Pricer will determine, from the new episode sequence and the number of therapy visits on the claim, which equation of the HH PPS case-mix model applies to the claim.
- Step 2:** The HH Pricer will find the two positions in the new nine position field that correspond to the equation identified in Step 1.
- Step 3:** The HH Pricer will convert the alphabetic codes in these positions to numeric point values.
- Step 4:** The HH Pricer will read the appropriate column on the case-mix scoring table to find the new clinical and functional severity levels that correspond to that point value (Figure 12.4-8).
- Step 5:** Using the severity levels identified in Step 4 and the HIPPS code structure shown in the above table, the HH Pricer will determine the new HIPPS code that applies to the claim.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

3.5.3.3.3.6 The HH Pricer will use the new HIPPS code resulting from these steps to re-price the claim and will return the new code to the existing output HIPPS code field in the input/output record.

3.5.3.3.3.7 When the first position of the HIPPS code is a five and the number of therapy services on the claim are less than 20, the HH Pricer will use the first position of the new nine position field to record the first position of the HIPPS code and complete the steps described above.

3.5.3.4 Adjustment of previously paid episodes.

3.5.3.4.1 The contractor claims processing systems will initiate automatic adjustments for previously paid episodes when the receipt of earlier dated episodes change their position in a sequence of episodes. The system will re-code and re-price the automatic adjustments.

3.5.3.4.2 The system will calculate a supply adjustment amount and add it to the otherwise re-priced episode amount.

3.5.3.5 Determining the gap between episodes (i.e., if the episodes are adjacent/contiguous.

3.5.3.5.1 The 60-day period to determine a gap that will begin a new sequence of episodes will be counted in most instances from the calculated 60-day end date of the episode. The exception to this is for episodes that were subject to PEP adjustment.

3.5.3.5.2 In PEP cases, the system will count 60 days from the date of the last billable home health visit provided in the PEP episode.

3.5.3.5.3 Intervening stays in inpatient facilities will not create any special consideration in counting the 60-day gap.

- If an inpatient stay occurred within an episode, it would not be a part of the gap, as counting would not begin at Day 60, which in this case could be later than the inpatient discharge date.
- If an inpatient stay occurred within the period after the end of all HH episode and before the beginning of the next one, those days would be counted as part of the gap just as any other days would.

3.5.3.5.4 If episodes are received after a particular claim is paid that change the sequence initially assigned to the paid episode (for example, by service dates falling earlier than those of the paid episode, or by falling within a gap between paid episodes), the system will initiate automatic adjustments to correct the payment of any necessary episodes as described above.

3.5.3.6 Refer to [Addendums R](#) and [S](#) for changes in input/output record layout and Pricer logic for 60-day episodes beginning on or after January 1, 2008.

3.6 Abbreviated Assessments for Establishment of Payments Under HHA PPS

3.6.1 Medicare-certified HHAs will be required to conduct abbreviated assessments for TRICARE beneficiaries who are under the age of 18 or receiving maternity care for payment under

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

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

3.6.2.1 The first position of the HIPPS code - which assigns differing scores in the clinical, functional and services domains based on whether an episode is an early or later episode in a sequence of adjacent episodes and the number of visits incurred during that episode - will be reported by the HHA in accordance with the HIPPS coding structure outlined in [Figure 12.4-6](#) (i.e., numerical values 1 through 5 based on the EOC and number of visits).

3.6.2.2 The second, third, and fourth positions of the HIPPS code (alphabetical characters) will be assigned based on the scoring of the 23 OASIS items reflected in the HHRG Worksheet for episodes beginning on or after January 1, 2008 in [Addendum I](#). The OASIS items for use in this abbreviated assessment scoring will be available on the CMS web site (<http://www.cms.hhs.gov/HomeHealthQualityInits/>) as indicated in [Addendum G](#). However, since Clinical Severity Domain category "C0", Function Status Domain category "F0", and Service Utilization Domain category "S0" are no longer recognized as part of the refined HIPPS coding structure they will default to "C1", "F1", and "S1", respectively, in establishing reimbursement under the abbreviated assessment for TRICARE beneficiaries who are under the age of 18 or receiving maternity care.

3.6.2.3 The fifth position of the HIPPS code will be reported by the HHA using the HIPPS coding structure outlined in [Figure 12.4-6](#) based on the EOC and number of visits, along with whether or not supplies were actually provided during the episode of HHC; i.e., 1-6 in cases where NRSs are not associated with the first four positions of the HIPPS code and S-X where they are.

3.6.2.4 A treatment authorization code will not be required for the processing and payment of home health episodes under the abbreviated assessment process. As a result, the contractors will not have the responsibility of recoding claims and/or validating the 18-position treatment authorization code that is normally required for the processing and payment of home health claims subject to the full-blown OASIS assessment.

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

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

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

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

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

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

3.6.3.2.4 There are also regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems as long as they do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies.

3.7 Split Payments (Initial and Final Payments)

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

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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

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

3.8 Calculation of Prospective Payment Amounts

3.8.1 National 60-Day Episode Payment Amounts

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

3.8.1.2 [Figure 12.4-15](#) provides the calculations involved in the establishment of the non-standardized prospective payment amount per 60-day episode in FY 2001, along with adjustments for NRS, Part B therapies and OASIS implementation and ongoing costs.

FIGURE 12.4-15 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS

DISCIPLINES	TOTAL COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	AVER. # VISITS PER 60-DAYS	HOME HEALTH PROSPECTIVE PAYMENT RATE
Home Health Aide Services	\$5,915,395,602	141,682,907	\$41.75	13.40	\$559.45
Medical Social Services	458,571,353	2,985,588	153.59	0.32	49.15
Occupational Therapy	444,691,130	4,244,901	104.76	0.53	55.52
Physical Therapy	2,456,109,303	23,605,011	104.05	3.05	317.35
Skilled Nursing Services	12,108,884,714	127,515,950	94.96	14.08	1,337.04
Speech Pathology Service	223,173,331	1,970,399	113.26	0.18	20.39

Total Non-Standardized Prospective Payment Amount Per 60-day Episode for FY 2001: **\$2,338.90**

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-15 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS

ADJUSTMENTS:	
1. Average cost per episode for NRS included in the home health benefit and reported as costs on the cost report	\$43.54
2. Average payment per episode for NRS possibly unbundled and billed separately for Part B	\$6.08
3. Average payment per episode for Part B therapies	\$17.76
4. Average payment per episode for OASIS one time adjustment for form changes	\$5.50
5. Average payment per episode for ongoing OASIS adjustment costs	\$4.32
Total Non-Standardized Prospective Payment Amount for 60-day Episode for FY 2001 Plus Medical Supplies, Part B Therapies and OASIS	\$2,416.01

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.

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

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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 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
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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.

$$\text{Labor Portion} = (\$287.27 \times 0.77668) = \$223.12$$

$$\text{Non-Labor Portion} = (\$287.27 \times 0.22332) = \$64.15$$

Step 3: Multiply the labor portion of the payment amount by the wage index for Denver, CO.
 $(\$223.12 \times 1.0190) = \227.36

Step 4: Add the labor and non-labor portions together to arrive at the LUPA.
 $(\$227.36 + \$64.15) = \mathbf{\$291.51}$

3.8.2.3.2 For Episodes Beginning On Or After January 1, 2008

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

3.8.2.4 Therapy Threshold Adjustment

3.8.2.4.1 For Episodes Beginning Prior To January 1, 2008

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

3.8.2.4.2 For Episodes Beginning On Or After January 1, 2008

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

3.8.2.4.2.2 Due to this increased complexity of the payment system regarding therapies, the Pricer software in the claims processing system will re-code all claims based on the actual number of therapy services provided. The re-coding will be performed without regard to whether the number of therapies delivered increased or decreased compared to the number of expected therapies reported on the OASIS assessment and used to base RAP payment. As in the original HH

PPS, the remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

3.8.3 Calculation of Outlier Payments

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

3.8.3.2 The outlier payment amount is a proportion of the wage-adjusted estimated imputed costs beyond the wage-adjusted threshold. The loss-sharing ratio is the proportion of additional costs paid as an outlier payment. The loss-sharing ratio, along with the FDL amount, is used to constrain outlier costs to five percent of total episode payments. The estimated imputed costs are derived from those home health visits actually ordered and received during the 60-day episode. The total visits per discipline are multiplied by their national average per-visit amounts (refer to [Figure 12.4-4](#) for the calculation of national average per-visit amounts) and are wage-adjusted. The wage-adjusted imputed costs for each discipline are summed to get the total estimated wage-adjusted imputed costs for the 60-day EOCs. The outlier threshold is then subtracted from the total wage-adjusted imputed per visit costs for the 60-day episode to come up with the imputed costs in excess of the outlier threshold. The amount in excess of the outlier threshold is multiplied by 80% (i.e., the loss share ratio) to obtain the outlier payment. The HHA receives both the 60-day episode and outlier payment. For example, a beneficiary assigned to HHRG C2L2S2 [case-mix weight of 1.9532 and receiving HHA care in Missoula, MT (wage index of 0.9086)], has physician orders for and received 54 skilled nursing visits, 48 home health aide visits, and six physical therapy visits. The following steps are used in calculating the outlier payment:

3.8.3.2.1 Calculation of Case-Mix and Wage-Adjusted Episode Payment

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

$$(1.9532 \times \$2,115.30) = \$4,131.60$$

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

$$\text{Labor Portion} = (0.77668 \times \$4,131.60) = \$3,208.93$$

$$\text{Non-Labor Portion} = (0.22332 \times \$4,131.60) = \$922.67$$

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

$$(0.9086 \times \$3,208.93) = \$2,915.63$$

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

$$(\$2,915.63 + \$922.67) = \mathbf{\$3,838.30}$$

3.8.3.2.2 Calculation of the Wage-Adjusted Outlier Threshold

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

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

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

$$\text{Labor Portion} = (0.77668 \times \$2,390.29) = \$1,856.49$$

$$\text{Non-Labor Portion} = (0.22332 \times \$2,390.29) = \$533.80$$

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

$$(0.9086 \times \$1,856.49) = \$1,686.81$$

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

$$(\$1,686.81 + \$533.80) = \$2,220.61$$

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

$$(\$3,838.30 + \$2,220.61) = \mathbf{\$6,058.91}$$

3.8.3.2.3 Calculation of Wage-Adjusted Imputed Cost of 60-Day Episode

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

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

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

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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

1. Skilled Nursing Visits

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

$$\text{Labor Portion} = (0.77668 \times \$5,172.66) = \$4,017.50$$

$$\text{Non-Labor Portion} = (0.22332 \times \$5,172.66) = \$1,155.16$$

- Wage-adjusted labor portion of imputed costs.

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

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

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

2. Home Health Aide Visits

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

$$\text{Labor Portion} = (0.77668 \times \$2,081.76) = \$1,616.86$$

$$\text{Non-Labor Portion} = (0.22332 \times \$2,081.76) = \$464.90$$

- Wage-adjusted labor portion of imputed costs.

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

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

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

3. Physical Therapy Visits

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

$$\text{Labor Portion} = (0.77668 \times \$628.44) = \$488.10$$

$$\text{Non-Labor Portion} = (0.22332 \times \$628.44) = \$140.34$$

- Wage-adjusted labor portion of imputed costs.

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

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

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

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

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

3.8.3.2.4 Calculation of Outlier Payment

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

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

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

$$(\$1,264.35 \times 0.80) = \mathbf{\$1,011.48}$$

3.8.3.2.5 Calculation of Total Payment to HHA

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

$$(\$3,838.30 + \$1,011.48) = \mathbf{\$4,849.78}$$

3.9 Other Health Insurance (OHI) Under HHA PPS

Payment under the HHA PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see [Section 6](#)). However, if the beneficiary has OHI which has processed the claim as primary payer, it is likely that the information necessary to determine the TRICARE PPS payment amount will not be available. Therefore, special procedures have been established for processing HHA claims involving OHI. These claims will not be processed as PPS claims. Such claims will be allowed as billed unless there is a provider discount agreement. The only exception to this is cases when there is evidence on the face of the claim that the beneficiary's liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

- END -

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

Issue Date:

Authority: [32 CFR 199.2](#); [32 CFR 199.4\(e\)\(21\)](#); [32 CFR 199.6\(a\)\(8\)\(i\)\(B\)](#); [32 CFR 199.6\(b\)\(4\)\(xv\)](#); and [32 CFR 199.14\(j\)](#)

1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the [Defense Health Agency \(DHA\)](#) and specifically included in the network provider agreement.

2.0 ISSUE

To describe the procedures involved in submitting Requests for Anticipated Payments (RAPs) and claims for 60-day episodes of care under the Home Health Agency Prospective Payment System (HHA PPS).

3.0 POLICY

3.1 Episode Payment

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

3.1.1 RAPs

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

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

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

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

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

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

3.1.1.5 RAPs are submitted on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 billing under Type of Bill (TOB) [Form Locator (FL) 4] 0322.

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

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

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

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

3.1.1.10 If care continues at the same provider for a second episode of care, HHAs may submit the RAP for the second episode even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, use the current mechanism of generating a debit and deducting it on the HHA's next remittance advice (RA) to recoup the overpaid 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

code, containing the start of care date (eight positions, from OASIS Item M0030), the date the assessment was completed (eight positions, from OASIS Item M0090), and the reason for assessment (two positions, from OASIS Item M0100). Verify that 18 numeric values are reported in this field.

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

3.1.1.11.50 FL 64. Employment Status Code Not Required.

3.1.1.11.51 FL 65. Employer Name Not Required.

3.1.1.11.52 FL 66. Employer Location Not Required.

3.1.1.11.53 FL 67. Principal Diagnosis Code Required. HHAs must enter the International Classification of Diseases, 9th Revision, Clinical Modification (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 principle diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS from Item M0230 (Primary Diagnosis), and on the CMS Form 485, from Item 11 (ICD-9-CM/Principle Diagnosis).

Note: For services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, use diagnosis codes as contained in the ICD-9-CM. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-10-CM.

3.1.1.11.54 FLs 68-75. Other Diagnoses Codes Required. HHAs must enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the POC. These codes must 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-P must match the additional diagnoses reported on the OASIS, from Item M0240 (Other Diagnoses), and on the CMS Form 485, from Item 13 (ICD-9-CM/Other Pertinent Diagnoses).
- Other pertinent diagnoses are all conditions that co-existed at the time the POC was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services

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

provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the CMS Form 485, from Item 13, may be reported in FLs 67 A - Q on the RAP if they are reported in the narrative from Item 21 of the CMS Form 485.

3.1.1.11.55 FL 69. Admitting Diagnosis Not Required.

Note: For services provided before the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-9-CM. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-10-CM.

3.1.1.11.56 FL 72. E-Code Not Required.

3.1.1.11.57 FL 73. (Untitled) Not Required.

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

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

3.1.1.11.60 FL 76. Attending/Requesting Physician ID Required. HHAs must enter the UPIN and name of the attending physician who has established the POC with verbal orders. Deny the RAP if the UPIN indicated in this field is on the sanctioned provider list.

Note: Medicare requires HHAs to enter the UPIN and name of the attending physician who has established the 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.

3.1.1.11.61 FL 78. Other Physician ID Not Required.

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

3.1.1.11.63 FL 86. Date Not Required See FL 45 Level 23.

3.1.2 Claims Submission and Processing

HHAs are required to submit the following claims detail for final payment under the HHA PPS:

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

3.1.2.2 HHAs may not submit this claim until after all services provided in the episode are reflected on the claim and the POC and any subsequent verbal order have been signed by the

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

physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

3.1.2.3 Home health claims must be submitted with a new TOB 329.

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

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

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

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

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

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

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

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

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

3.1.2.13 Claim will be paid as a Low Utilization Payment Adjustment (LUPA) if there are four or less visits total in an episode, regardless of changes in HIPPS code.

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

3.1.2.15 The claim will be processed as a debit/credit adjustment against the record created by the RAP.

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

3.1.2.16 The related RA will show the RAP payment was recouped in full and a 100% payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

3.1.2.17 Claims for episodes may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100% payment is made in the next calendar or fiscal year, at that year's rates. Claim payment rates are determined using the statement "through" date on the claim.

3.1.2.18 HHAs should be aware that HHA PPS claims will be processed in the TRICARE claims system as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims. As the claim is processed, the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the RA so the net reimbursement on the claim can be easily understood.

3.1.2.19 Coding required for a HHA PPS claim is as follows:

3.1.2.19.1 FL 1. (Untitled) Provider Name, Address, and Telephone Number Required. The minimum entry is the agency's name, city, state, and zip code. The post office number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine digit zip codes are acceptable. Use this information in connection with the TRICARE provider number (FL 51) to verify provider identity.

3.1.2.19.2 FL 2. (Untitled) Not Required.

3.1.2.19.3 FL 3. Patient Control Number Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

3.1.2.19.4 FL 4. TOB Required. This three digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bills accepted for HHA PPS RAPs are any combination of the codes listed below:

3.1.2.19.4.1 Code Structure (only codes used to bill TRICARE are shown).

3.1.2.19.4.2 First Digit: Type of Facility

3 - Home Health

3.1.2.19.4.3 Second Digit: Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient

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

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

3.1.2.19.4.4 Third Digit: Frequency.

- **7** - Replacement of Prior Claim - Used to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims may be submitted at any point within the timely filing period after the payment of the original claim.
- **8** - Void/Cancel of a Prior Claim - Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP and claim must be submitted for the episode to be paid.
- **9** - Final Claim for a HHA PPS Episode - This code indicates the home health bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7 or 8.
- HHA PPS claims are submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." Late charge bills, submitted with frequency "5," are not accepted under HHA PPS. To add services within the period of a paid home health claim, an adjustment must be submitted.

3.1.2.19.5 FL 5. Federal Tax Number Required.

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

3.1.2.19.7 FL 7. Covered Days Not Required.

3.1.2.19.8 FL 8. Non-covered Days Not Required.

3.1.2.19.9 FL 9. Coinsurance Days Not Required.

3.1.2.19.10 FL 10. Lifetime Reserve Days Not Required.

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

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

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

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

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

3.1.2.19.15 FL 16. Patient's Marital Status Not Required.

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

3.1.2.19.17 FL 18. Admission Hour Not Required.

3.1.2.19.18 FL 19. Type of Admission Not Required.

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

3.1.2.19.20 FL 21. Discharge Hour Not Required.

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

CODE STRUCTURE	
CODE	DEFINITION
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of another organized home health service organization, or discharged and readmitted to the same HHA within a 60-day episode period
07	Left against medical advice or discontinued care
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility, such a hospital, SNF, ICF or freestanding hospice (hospice claims only)
42	Expired - place unknown (hospice claims only)
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharged/transferred with this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge POC

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	DEFINITION
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge POC.

3.1.2.19.21.1 Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a PEP adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original POC met and has been readmitted within the 60-day episode. Situations may occur in which a HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, TRICARE claims systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claim record to 06.

3.1.2.19.21.2 In cases where an HHA is changing the contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "From" dates before the provider's termination date must be submitted to the contractor the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods - the "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new intermediary.

3.1.2.19.22 FL 23. Medical Record Number Optional. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

3.1.2.19.23 FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes When Applicable. Enter any NUBC approved code to describe conditions and apply to the claim.

3.1.2.19.23.1 Required. If adjusting a HHA PPS claim (TOB 3x7), report one of the following:

CODE	DEFINITION
D0	Change to Service Dates
D1	Change to Charges
D2	Change to Revenue Codes/HCPSC
D7	Change to Make TRICARE the Secondary Payer
D8	Change to Make TRICARE the Primary Payer
D9	Any other Change
E0	Change in Patient Status

3.1.2.19.23.2 If adjusting the claim to correct a HIPPS code, report condition code D9. Enter "Remarks" in FL 84 indicating the reason for the HIPPS code change.

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

3.1.2.19.23.3 Required. If canceling the claim (TOB 3x8), report one of the following:

CODE	DEFINITION
D5	Cancel to Correct HICH
D6	Cancel Only to Repay a Duplicate or OIG Overpayment. Use when D5 is not appropriate

3.1.2.19.23.4 Enter "Remarks" in FL 84 indicating the reason for cancellation of the claim.

3.1.2.19.24 FLs 32, 33, 34, and 35. Occurrence Codes and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27 is not required on HHA PPS RAPs.

3.1.2.19.24.1 Fields 32A-35A must be completed before fields 32B-35B.

3.1.2.19.24.2 Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

3.1.2.19.24.3 When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

3.1.2.19.24.4 Other codes may be required by other payers, and while they are not used by TRICARE, they may be entered on the bill if convenient.

3.1.2.19.25 FL 36. Occurrence Span Code and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the claim.

3.1.2.19.25.1 Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY.

3.1.2.19.25.2 Reporting of occurrence span code 74 to show the date of an inpatient admission within an episode is not required.

3.1.2.19.26 FL 37. ICN/DCN Required. If submitting an adjustment (TOB 3x7) to a previously paid HHA PPS claim, enter the control assigned to the original HHA PPS claim here. Insert the ICN/DCN of the claim to be adjusted here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payers B and C on lines B and C, respectively, in FL 37.

3.1.2.19.26.1 Since HHA PPS claims are processed as adjustments to the RAP, TRICARE claims systems will match all HHA PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically.

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

3.1.2.19.26.2 Providers do not need to submit an ICN/DCN on all HHA PPS claims, only on adjustments to paid claims.

3.1.2.19.27 FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than TRICARE as defined in FP 58, the address of the other payer may be shown here or in 84 (Remarks).

3.1.2.19.28 FLs 39-41. Value Codes and Amounts Required. Home health episode payments must be based upon the site at which the beneficiary is served. Claims will not be processed with the following value code:

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.

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 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.

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

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
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; 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.

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

3.1.2.19.29.2.5 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 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

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

- 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.

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

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
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.

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.

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

3.1.2.19.30 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.

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).

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

- 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.

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 FL 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

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

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.

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

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
03	Natural Child/Insured Financial Responsibility	Self-explanatory
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
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.

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

3.1.2.19.51 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 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.

Note: For services provided before the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-9-CM. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-10-CM.

- 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.

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

3.1.2.19.55 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.

Note: For services provided before the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-9-CM. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-10-CM.

- 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 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.

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

3.1.2.20 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
- 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.

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

3.1.2.21.5.3 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 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.

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

3.1.2.21.5.5 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.
- 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"

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 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.

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.

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

- 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.

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

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

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.

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.

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

3.1.2.22.2 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.

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)

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

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.

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.

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

3.1.2.23.4 “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.

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.

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

FIRST EPISODE (RAP)	CLAIM	START OF NEXT EPISODE (RAP)
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.

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)

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).

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	EPISODE	SERVICES/VISITS	OUTLIER
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*** (NON-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/HPCPs.	Current revenue codes 60X (Oxygen) and 274 (P/O) w/HPCPs.	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.
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.

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 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.

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

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

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 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.

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

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

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

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

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

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

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

3.2 Reporting Requirements

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

- END -

Outcome and Assessment Information Set (OASIS) Items Used For Assessments Of 60-Day Episodes

Refer to the Centers for Medicare and Medicaid Services (CMS) web site (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html>) for Outcome and Assessment Information Set (OASIS) items (e.g., OASIS data set and user manual) used in the assessment of 60-day episodes beginning on or after January 1, 2008 or on or after January 1, 2010.

- END -

Home Assessment Validation and Entry (HAVEN) Reference Manual

Refer to the Centers of Medicare and Medicaid Services (CMS) web site (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/HAVEN.html>) for the Outcome and Assessment Information Set (OASIS) HAVEN Systems Reference Manual.

- 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) Reimbursement	7	2	Home Health Care (HHC) (Continued)		
			HHRG Worksheet	12	I
			Home Health Certification And Plan Of Care (POC)	12	D
			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
			Charges To Beneficiaries	6	10
			Determination Of Payment Amounts	6	5
			DRG Weighting Factors	6	6

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Index

H (CONTINUED)	Chap	Sec/Add	O (CONTINUED)	Chap	Sec/Add
Hospital Reimbursement (Continued)			Outpatient Prospective Payment System (OPPS)-Ambulatory Payment Classification (APC)		
DRG-Based Payment System (Continued)			Billing And Coding Of Services Under APC Groups	13	2
General Description Of System	6	2	Claims Submission And Processing Requirements	13	4
General	6	1	Development Schedule For TRICARE OCE/APC Quarterly Update	13	A
Information Provided By TMA	6	9	General	13	1
Inpatient Mental Health Per Diem Payment System	7	1	Medical Review And Allowable Charge Review Under the OPPS	13	5
Locations Outside The 50 United States And The District Of Columbia	1	34	Outpatient Code Editor (OCE)		
Other Than Billed Charges	1	22	No Government Pay List (NGPL) Quarterly Update Process	13	C
Outpatient Services	1	24	Notification Process For Quarterly Updates	13	B
Payment When Only SNF Level Of Care Is Required	1	23	Prospective Payment Methodology	13	3
Hospital-Based			Oxygen And Related Supplies	1	12
Birthing Center Reimbursement	10	1			
Birthing Room	1	32			
I	Chap	Sec/Add	P	Chap	Sec/Add
Individual Consideration Cases	5	4	Partial Hospitalization Program (PHP) Reimbursement	7	2
Inpatient Mental Health Per Diem Payment System	7	1	Participation Agreement For Hospice Program Services For TRICARE Beneficiaries	11	D
Insulin	1	15	Payment For Professional/Technical Components Of Diagnostic Services	5	5
			Payment Reduction	3	4
			Pharmacy Benefits Program - Cost-Shares	2	B
			Physician Assistants	1	6
			Point Of Service (POS) Option	2	3
			Postoperative Pain Management-Epidural Analgesia	1	10
			Preferred Provider Organization (PPO) Reimbursement	1	25
			Prior to Implementation Of The Reasonable Cost Method for CAHs and Implementation of the OPPS, And Thereafter, For Services Not Otherwise Reimbursed Under Hospital OPPS		
			Ambulatory Surgical Center (ASC) Outpatient Services	9	1
			Psychiatric Freestanding Partial Hospitalization Program (PHP)	7	2
			Psychiatric Partial Hospitalization Program (PHP)	7	2
			Processing And Payment Of Home Infusion Claims		
			Before January 30, 2012	3	6
			On Or After January 30, 2012	3	7
L	Chap	Sec/Add			
Laboratory Services	1	13			
Legal Obligation To Pay	1	27			
Legend Drugs	1	15			
Locality-Based Reimbursement Rate Waiver	5	2			
M	Chap	Sec/Add			
Medical Errors	1	37			
N	Chap	Sec/Add			
National Health Service Corps Physicians Of The Public Health Service	1	5			
Network Provider Reimbursement	1	1			
Newborn Charges	1	31			
Non-OPPS Facilities Reimbursement	9	1			
Nurse Practitioners	1	6			
O	Chap	Sec/Add			
OASIS-B1	12	F			
Obstetrical Care	1	18			
Orthotics	1	11			

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Index

P (CONTINUED)			R (CONTINUED)		
	Chap	Sec/Add		Chap	Sec/Add
Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia	1	35	Residential Treatment Center (RTC) Guidelines For The Calculation Of Individual RTC Per Diem Rates	7	B
Professional Services-Obstetrical Care	1	18	Reimbursement	7	4
Prosthetics	1	11			
Psychiatric Hospitals And Units Regional Specific Rates (FY 2014 - FY 2016)	7	A			
R			S		
	Chap	Sec/Add		Chap	Sec/Add
Reduction Of Payment For Noncompliance With Utilization Review Requirements	1	28	Skilled Nursing Facility (SNF) Case-Mix Adjusted Federal Rates		
Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume (FY 2014 - FY 2016)	7	A	FY 2013	8	D (FY2013)
Reimbursement			FY 2014	8	D (FY2014)
Administration	3	5	FY 2015	8	D (FY2015)
Ambulatory Surgical Center (ASC)	9	1	Example Of Computation of Adjusted PPS Rates And SNF Payment		
Birthing Center (Freestanding and Hospital-Based)	10	1	FY 2013	8	B (FY2013)
Covered Services Provided By Individual Health Care Professionals And Other Non-Institutional Health Care Providers	1	7	FY 2014	8	B (FY2014)
Emergency Inpatient Admissions To Unauthorized Facilities	1	29	FY 2015	8	B (FY2015)
Freestanding Ambulatory Surgical Center (ASC)	9	1	Fact Sheet Regarding Consolidated Billing and Ambulance Services	8	C
Freestanding Psychiatric Partial Hospitalization Program (PHP)	7	2	Letter To SNF Regarding Participation Agreement	8	G
Hospital	3	2	Prospective Payment System (PPS) Reimbursement	8	2
In Teaching Setting	1	4	Resource Utilization Group-III (RUG-III)	8	A
Individual Health Care Professionals	3	1	Wage Indexes		
Institutional Health Care Provider	3	2	Rural Areas (Based On CBSA Labor Market Areas)		
Network Provider	1	1	FY 2013	8	F (FY2013)
Non-Institutional Health Care Providers	3	1	FY 2014	8	F (FY2014)
Non-OPPS Facilities	9	1	FY 2015	8	F (FY2015)
Outpatient Services	1	24	Urban Areas (Based On CBSA Labor Market Areas)		
Physician Assistants, Nurse Practitioners, And Certified Psychiatric Nurse Specialists	1	6	FY 2013	8	E (FY2013)
Preferred Provider Organization (PPO)	1	25	FY 2014	8	E (FY2014)
Psychiatric Partial Hospitalization Program (PHP)	7	2	FY 2015	8	E (FY2015)
Residential Treatment Center (RTC)	7	4	Sole Community Hospitals (SCHs)	14	1
Skilled Nursing Facility (SNF)	8	1	Specific Double Coverage Actions	4	4
Substance Use Disorder Rehabilitation Facilities (SUDRFs)	7	3	State Agency Billing	1	20
Travel Expenses For Specialty Care	1	30	Sample Agreement	1	A
			Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement	7	3
			Supplemental Insurance	1	26
			Surgery	1	16

- END -