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**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: CLARIFICATION ON DURABLE EQUIPMENT/DURABLE MEDICAL EQUIPMENT,
ORDERING DURABLE EQUIPMENT/DURABLE MEDICAL EQUIPMENT, AND
ASSISTIVE TECHNOLOGY DEVICES**

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PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change conforms DME to that of the statutory language, which identifies "DME" as a subset of "DE" for purposes of the TRICARE Basic Program.

EFFECTIVE DATE: January 30, 2015.

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**This change is made in conjunction with Feb 2008 TOM, Change No. 155 and Feb 2008 TPM,
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**CHANGE 118
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Chapter 1

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Claims for Durable Equipment (DE) and Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Issue Date: December 29, 1982

Authority: 32 CFR 199.4(d)(3)(ii), (d)(3)(iii), (d)(3)(vii), and (d)(3)(viii)

1.0 APPLICABILITY

1.1 This policy is mandatory for durable equipment (DE), such as wheelchairs, iron lungs, and hospital beds.

1.2 This policy is mandatory for reimbursement of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided by either network or non-network providers. Alternative network reimbursement methodologies are also permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

How are claims for DE and DMEPOS to be reimbursed?

3.0 POLICY

3.1 Reimbursement for DE and DMEPOS is established by fee schedules. The fee schedule is referred to, all-inclusively, as the DMEPOS fee schedule. The maximum allowable amount is limited to the lower of the billed charge, the negotiated rate (network providers) or the DMEPOS fee schedule amount.

3.2 The DMEPOS fee schedule is categorized by state. The allowed amount shall be that which is in effect in the specific geographic location at the time covered services and supplies are provided to a beneficiary. For DMEPOS delivered to the beneficiary's home, the home address is the controlling factor in pricing and the home address shall be used to determine the DMEPOS allowed amount.

3.3 Payment for an item of DE/Durable Medical Equipment (DME) may also take into consideration:

3.3.1 The lower of the total rental cost for the period of medical necessity or the reasonable purchase cost; and

3.3.2 Delivery charge, pick-up charge, shipping and handling charges, and taxes.

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Prosthetics, Orthotics, And Supplies (DMEPOS)

3.4 The fee schedule classifies most **items** into one of six categories.

3.4.1 Inexpensive or other routinely purchased **DE/DME**.

3.4.2 Items requiring frequent and substantial servicing.

3.4.3 Customized items.

3.4.4 Other prosthetic and orthotic devices.

3.4.5 Capped rental items.

3.4.6 Oxygen and oxygen equipment.

3.5 Inexpensive or routinely purchased **DE/DME**.

3.5.1 Payment for this type of equipment is for rental or lump sum purchase. The total payment may not exceed the actual charge of the fee for a purchase.

3.5.2 Inexpensive **DE/DME**. This category is defined as equipment whose purchase price does not exceed \$150.

3.5.3 Other routinely purchased **DE/DME**. This category consists of equipment that is purchased at least 75% of the time.

3.5.4 Modifiers used in this category are as follows (not an all-inclusive list):

RR Rental

NU Purchase of new equipment. Only used if new equipment was delivered.

UE Purchase of used equipment. Used equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator).

3.6 Items requiring frequent and substantial servicing.

3.6.1 Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amounts until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing, or for replacement of items in this category.

3.6.2 Supplies and accessories are not allowed separately.

3.6.3 For oxygen and oxygen supplies see [Section 12](#) and the TRICARE Policy Manual (TPM), [Chapter 8, Section 10.1](#).

3.7 Certain customized items.

3.7.1 The beneficiary's physician must prescribe the customized equipment and provide information regarding the patient's physical and medical status to warrant the need for the equipment.

3.7.2 See the TPM, [Chapter 9, Section 15.1](#) for further information regarding customization of DME.

3.8 Capped rental items. Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 15 months or on a purchase option basis not to exceed a period of continuous use of 13 months.

3.9 Upgrade DE/DME (Deluxe, Luxury, or Immaterial Features).

3.9.1 The allowable charge for standard equipment or item of DE/DME may be applied toward any upgraded item, when the beneficiary chooses to upgrade a covered DE/DME, to include additional features that are intended primarily for comfort or convenience, or features beyond those required by the beneficiary's medical condition. Under this arrangement, charges for an upgraded DE/DME are the sole responsibility of the beneficiary. Beneficiary's cost-shares and deductible will apply to the basic DE/DME.

3.9.2 The DE/DME provider is to identify non-payable upgrades to DE/DME using the appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) modifiers.

Example: A beneficiary requests an upgrade DE/DME - the DE/DME provider bills beneficiary for non-payable upgrade, modifier **GA** on first line for item that is provided and modifier **GK** on second line for item that is covered. TRICARE cost-shares medically necessary item only (**GK** line item). The claim line with **GA** modifier will be denied as not medically necessary with the beneficiary responsibility (**PR**) message on the Explanation of Benefits (EOB). The claim line with the **GK** modifier will continue through the usual claims processing.

3.9.3 When the beneficiary upgrades an item of DE/DME, the upgrade charge is not managed by TRICARE, but calculated by the provider or supplier issuing the equipment. As a result, upgraded charges, clerical or calculation errors in connection with the upgraded equipment are not subject to appeal but are subject to administrative review by the contractor upon request from the beneficiary.

Note: The upgrade charge is the difference between the provider's or supplier's charge for the deluxe or upgraded item, and the allowable charge amount for the "covered" (standard) item.

3.9.4 Upgraded items of DE/DME do not count toward the beneficiary's catastrophic cap. However, the beneficiary's responsibility for the standard DE/DME equipment will count towards the catastrophic cap. Charges for deluxe or upgraded items are the beneficiary's responsibility even after the out-of-pocket maximum has been met for covered services.

3.10 Rental fee schedule.

3.10.1 For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10% of the average of allowed purchase prices on claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is limited to 7.5% of the average allowed purchase price. After paying the rental fee schedule amount for 15 months, no further payment may be made except for payment for maintenance and servicing.

3.10.2 Modifiers used in this category are as follows:

RR	Rental
KH	First month rental
KI	Second and third month rental
KJ	Fourth to fifteenth months
BR	Beneficiary elected to rent
BP	Beneficiary elected to purchase
BU	Beneficiary has not informed supplier of decision after 30 days
MS	Maintenance and Servicing
NU	New equipment
UE	Used equipment

3.10.3 Claims Adjudication Determinations.

3.10.3.1 Adjudication of DE/DME claims involves a two-step sequential process involving the following determinations by the contractor:

Step 1: Whether the equipment meets the definition of DE/DME, is medically necessary, and is otherwise covered; and

Step 2: Whether the equipment should be rented or obtained through purchase (including lease/purchase). To arrive at a determination, the following information is required:

- A statement of the patient's prognosis and the estimated length of medical necessity for the equipment.
- The reasonable monthly rental charge.
- The reasonable purchase cost of the equipment.
- The contractor must determine whether, given the estimated period of medical necessity, it would be more economical and appropriate for the equipment to be rented or purchased.

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3.10.3.2 If the beneficiary opts to rent/purchase, the contractor must establish a mechanism for making regular monthly payments without requiring the claimant to submit a claim each month. (It is not required or expected that the contractor will automate the automatic payment; the volume of this type claim will be quite low.) In cases of "indefinite needs," medical necessity must be evaluated after the first three months and every six months thereafter. Special care should be taken to avoid payment after termination of TRICARE eligibility or in excess of the total allowable benefit. In making monthly payments, the contractor will report on the TRICARE Encounter Data (TED) only that portion of the billed charge which is applicable to that monthly payment. (See the TRICARE Systems Manual (TSM), [Chapter 2](#).) For example, a wheelchair is being purchased for which the total charge is \$770. The contractor determines that payments will be made over a 10-month period. The allowed charge is \$600. The contractor will show the monthly billed charge as \$77 and \$60 as the allowed.

3.10.4 Notice To Beneficiary. When the contractor makes a determination to rent or purchase, the beneficiary shall be notified of that determination. The beneficiary is not required to follow the contractor's determination. He or she may purchase the equipment even though the contractor has determined that rental is more cost effective. However, payment for the equipment will be based on the contractor's determination. Because of this, the notice should be carefully worded to avoid giving any impression that compliance is mandatory, but should caution the beneficiary concerning the expenses in excess of the allowed amount. Suggested wording is included in [Addendum B](#).

3.11 Oxygen and oxygen equipment. Oxygen and oxygen equipment is to be reimbursed in accordance with [Section 12](#).

3.12 Parenteral/enteral nutrition therapy. Parenteral/enteral pumps can be either rented or purchased.

3.13 Splints and Casts. The reimbursement rates for these items of DMEPOS shall be based on Medicare's pricing.

3.14 Reimbursement Rates.

3.14.1 The DMEPOS pricing information is available at <http://www.health.mil/rates> and the claims processors are required to replace the existing pricing with the updated pricing information within 10 calendar days of publication on the internet.

3.14.2 The pricing for splints and casts is available at <http://www.health.mil/rates> and will be updated annually.

3.14.3 See the TRICARE Operations Manual (TOM), [Chapter 1, Section 4](#) regarding updating and maintaining TRICARE reimbursement systems.

3.15 Inclusion or exclusion of a fee schedule amount for an item or service does not imply any TRICARE coverage.

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3.16 Extensive maintenance which, based on manufacturer recommendations, must be performed by authorized technicians is covered as medically necessary. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the beneficiary. Maintenance may be covered for patient owned-DME when such maintenance must be performed by an authorized technician.

3.17 Replacement and Repair of DMEPOS. The following modifiers are to be used to identify repair and replacement of an item.

3.17.1 RA - Replacement of an item. The RA modifier on claims denotes instances where an item is furnished as a replacement for the same item which has been lost, stolen, or irreparable damaged.

3.17.2 RB - Replacement of a part of DME furnished as part of a repair. The RB modifier indicates replacement parts of an item furnished as part of the service of repairing the item.

4.0 EXCLUSIONS AND LIMITATIONS

4.1 A cost that is non-advantageous to the government shall not be allowed even when the equipment cannot be rented or purchased within a "reasonable distance" of the beneficiary's current address. The charge for delivery and pick up is an allowable part of the cost of an item; consequently, distance does not limit access to equipment.

4.2 Line-item interest and carrying charges for equipment purchase shall not be allowed. A lump-sum payment for purchase of an item of equipment is the limit of the government cost-share liability. Interest and carrying charges result from an arrangement between the beneficiary and the equipment vendor for prorated payments of the beneficiary's cost-share liability over time.

4.3 Routine periodic servicing such as testing, cleaning, regulating, and checking that is generally expected to be done by the owner. Normally, the purchasers are given operating manuals that describe the type of service an owner may perform. Payment is not made for repair, maintenance, and replacement of equipment that requires frequent substantial servicing, oxygen equipment, and capped rental items that the patient has not elected to purchase.

5.0 EFFECTIVE DATES

5.1 September 1, 2005, for the DMEPOS system.

5.2 April 1, 2011, for reimbursement of splints and casts.

- END -

Bonus Payments In Health Professional Shortage Areas (HPSAs)

Issue Date: April 18, 2003
Authority: 32 CFR 199.14(j)(2)

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 bonus payments in medically underserved areas made?

3.0 POLICY

3.1 Background

3.1.1 On April 15, 2002, the Final Rule was published in the **Federal Register** (67 FR 18114), allowing for bonus payments, in addition to the amount normally paid under the allowable charge methodology, to providers in medically underserved areas. Medically underserved areas are the same as those determined by the Secretary of Health and Human Services (HHS) for the Medicare program, designated as Health Professional Shortage Areas (HPSAs) found in all 50 states and Puerto Rico. HPSAs include both primary care and mental health identified HPSAs.

3.1.2 The bonus payments shall be equal to the bonus payments authorized by Medicare, except as necessary to recognize any unique or distinct characteristics or requirements of the TRICARE program, and as described in instructions issued by the Deputy Director, **DHA**.

3.1.3 HPSAs include both primary care and mental health identified HPSAs.

3.1.4 The bonus payment applies to both assigned and non-assigned claims. It also applies to network and non-network physicians.

3.1.5 The bonus payment is based on the zip code of the location where the service is actually performed, which must be in an HPSA, rather than the zip code of the billing office or other location.

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3.1.6 The bonus payment is based solely on the amount paid for professional services. Professional services are those that are paid by the professional CHAMPUS Maximum Allowable Charge (CMAC) file, excluding codes that are clinical laboratory services or that are entirely technical in nature. Claims submitted for the technical component only of a service (i.e., have a **-TC** modifier), if a service can have both professional and technical components, are also ineligible for the HPSA bonus. Thus, all Durable Equipment (**DE**), injectable drugs, vaccines, facility charges, supplies, etc., are not included in the paid amounts used to calculate the HPSA bonus. The professional service CMAC file's documentation describes how codes can be detected which are considered entirely technical or clinical lab. Anesthesia services by physicians paid through the anesthesia Relative Value Unit (RVU) and Conversion Factor (CF) files are also to be included as eligible services for the HPSA bonus calculation. Services that are performed by physicians and are professional services (not supplies, drugs, or other such charges) but do not have CMACs may be included in the HPSA bonus calculation, also, such as unlisted or "not elsewhere specified" CPT¹ codes 27599, 27899, 30999, etc.

3.1.7 Bonus payments apply under Prime, Extra, and Standard for services provided in medically underserved areas.

3.1.8 TRICARE Prime Remote (TPR) and Supplemental Health Care Program (SHCP) shall be included in the bonus payment process.

3.1.9 Under TRICARE For Life (TFL), only those claims where TRICARE is primary would qualify for the bonus payment.

3.1.10 For Other Health Insurance (OHI) claims, the bonus payment would apply, but only on the amount paid by the government.

3.2 Scope Of Benefit

3.2.1 HPSA

3.2.1.1 Effective June 1, 2003, an additional payment shall be made quarterly to physicians who qualify and provide services in medically underserved areas (HPSAs).

3.2.1.2 The bonus payment for HPSA, both primary care and mental health areas, is 10% of the amount actually paid, not 10% of the amount allowed, e.g., CMAC. The HPSA bonus payment only applies to physician's, podiatrist's, oral surgeon's, and optometrist's services rendered in these medically underserved areas. Prior to January 1, 2006, the **QU** and **QB** modifiers were used, but were replaced with the modifier "**AQ**" effective January 1, 2006. As of October 1, 2013, the AQ modifier is no longer required except in those instances where zip codes do not fall entirely within a full county HPSA as noted in [paragraph 3.2.1.11](#).

3.2.1.3 The bonus shall be calculated based on 10% of the amount actually paid a physician during a calendar quarter for services rendered in a medically underserved area.

3.2.1.4 Bonus payments are pass-through payments, non-financially underwritten payments.

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Hospice Reimbursement - Coverage/Benefits

Issue Date: February 6, 1995
Authority: [32 CFR 199.4\(e\)\(19\)](#)

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

Services and supplies reimbursed under hospice benefit.

3.0 POLICY

3.1 TRICARE beneficiaries who are terminally ill (that is, life expectancy of six months or less if the terminal illness runs its normal course) will be eligible for the following services and supplies in addition to regular TRICARE benefits:

3.1.1 Hospice consultation service. Effective January 1, 2005, a beneficiary may receive a hospice consultation service from a physician who is also the medical director or employee of a hospice program if the beneficiary:

- Has not yet elected hospice coverage.
- Has not been seen by the physician on a previous occasion.

3.1.2 The provision of the consult service shall not count towards the hospice cap amount.

3.2 TRICARE beneficiaries who are terminally ill (that is, life expectancy of six months or less if the terminal illness runs its normal course) will be eligible for the following services and supplies in lieu of other TRICARE benefits:

3.2.1 Physician services furnished by hospice employees or under arrangements with the hospice.

Note: Patient care services rendered by an attending physician who is not considered employed by, or under contract with, the hospice are not considered hospice services and are not included in the amount subject to the hospice payment limits as described in [Section 4, paragraph 3.1.5](#) and [3.1.6](#). The attending physician will bill in his/her own right and be subject to the

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appropriate allowable charge methodology (refer to [Section 4, paragraph 3.1.4](#)).

3.2.2 Nursing care provided by or under the supervision of a Registered Nurse (RN).

- The RN must maintain overall nursing management of the patient (e.g., review and evaluation of nursing notes).
- The actual hands-on care may be provided by a licensed practical nurse (LPN) without the RN being physically present.

3.2.3 Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

3.2.4 Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home.

3.2.4.1 Counseling services, including dietary counseling, are provided for the purpose of training the terminally ill patient's family or other caregiver to provide care and to help the patient and those caring for him or her to adjust to the individual's approaching death.

3.2.4.2 Bereavement counseling/therapy, which consists of counseling services provided to the individual's family after the individual's death, is required as part of the overall hospice benefit.

- There must be an organized program for the provision of bereavement services under the supervision of a qualified professional.
- The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery up to one year following the death of the patient.

Note: Although bereavement therapy is an integral part of the hospice concept (i.e., a family-centered, model emphasizing supportive services) and must be made available to the family as a condition for participation it is not reimbursable.

3.2.5 Short-term inpatient care, both respite and general, may be provided in Medicare participating hospice inpatient units, hospitals, or skilled nursing facilities.

3.2.5.1 Inpatient Respite Care.

3.2.5.1.1 Inpatient respite care is provided when necessary to relieve family members or other persons caring for the individual at home.

3.2.5.1.2 Respite care may be provided only on an occasional basis and is limited to no more than five consecutive days at a time.

3.2.5.1.3 The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

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3.2.5.1.4 Respite care is also subject to post-payment medical review by the contractor.

3.2.5.1.5 Inpatient respite care is the only type of hospice care that can be provided in the Medicaid (Title XIX) certified nursing facility.

3.2.5.2 General Inpatient Care.

3.2.5.2.1 Services must conform to the written plan of care.

3.2.5.2.2 Care is required for procedures necessary for pain control or acute or chronic symptom management, which cannot be provided in a home setting.

3.2.6 Medical supplies, including drugs and biologicals.

3.2.6.1 Drugs must be used primarily for the relief of pain and symptom control related to the individual's terminal illness in order to be covered under the hospice program.

3.2.6.2 Medical supplies include those that are part of the written plan of care.

3.2.7 **Durable Equipment (DE) and Durable Medical Equipment (DME)**, as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness and provided for use in the patient's home.

3.2.8 Home health aide services furnished by qualified aides, and homemaker services.

3.2.8.1 Coverage.

3.2.8.1.1 Personal care services.

3.2.8.1.2 Household services to maintain a safe and sanitary environment in areas of the home used by the patient; e.g., changing of beds, **lighthouse** cleaning and/or laundering.

3.2.8.2 Supervision.

3.2.8.2.1 The aide services must be provided under the general supervision of the RN. However, the RN does not have to be physically present while aide services are being rendered.

3.2.8.2.2 Home health aide services must be documented in the nursing notes as well as the treatment plan.

3.2.8.2.3 A RN must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.

3.2.8.2.4 The contractor will assess/evaluate overall RN supervision through the post-payment medical review process.

Note: The contractors will be looking for utilization trends on random samples of claims. A pattern of failure to adequately meet the supervisory requirements for home health aide services (refer to [paragraph 3.2.8](#)) will result in denial or reclassification of the particular rate category.

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3.2.9 Physical therapy, occupational therapy and speech-language pathology services for the purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

3.3 The hospice must ensure that substantially all the following core services are routinely provided directly by hospice employees or provided under an "Authorized use of Arrangements". "Authorized use of Arrangements" the primary hospice may enter into a contract arrangement with another hospice to provide core services under extraordinary, exigent or other non-routine (i.e., high patient load, staffing shortages due to illness) circumstances. The primary hospice may now bill the TRICARE program. However, TRICARE payments for core services remain limited to and reimbursed at one of the four nationally predetermined Medicare rates. Core services consist of:

- Physician services;
- Nursing care;
- Medical social services; and
- Counseling service for individuals and care givers.

Note: Counseling services may be provided by a member of the interdisciplinary group (doctor of medicine or osteopathy, RN, social worker, and pastoral or other counselor) as well as by other qualified professionals as determined by the hospice.

3.4 Although the following non-core services may be provided under arrangement with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings:

- Home health aide services;
- Medical appliances and supplies;
- Physical and occupational therapy;
- Speech-language pathology;
- Short-term inpatient care; and
- Ambulance services.

Note: If contracting is used, the hospice must maintain professional financial, and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified in this policy. The requirements that a hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling be available on a 24-hour basis may be waived if granted by the Centers for Medicare and Medicaid Services (CMS). These waivers are available only to an agency or organization that is located in an area which is not an urbanized area and can demonstrate that it has been unable, despite diligent efforts, to recruit appropriate personnel.

Note: Physical therapy, occupational therapy and speech-language pathology services are included as part of the treatment plan of the interdisciplinary group (a member of which is a doctor of medicine or osteopathy). Medical review of these services will occur as part of the post-payment medical review process.

3.5 The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be available on a 24-hour

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basis to the extent necessary to meet the needs of individuals for are that is reasonable and necessary for the palliation and management of the terminal illness and related condition.

3.6 Hospice services must be provided in a manner consistent with accepted standards of practice.

3.7 Twenty-four (24) hour nursing and home health aide services may be provided only during periods of crisis and then only as necessary to maintain the terminally ill individual at home.

Note: A period of crisis is defined as the time a patient requires continuous care to achieve palliation or management of acute medical symptoms.

3.8 The hospice benefit is exempt from those limitations on custodial care and personal comfort items applicable to the Basic Program.

3.9 All services, medical appliances, and supplies associated with the palliative care of the terminal patient **are** included within the hospice rate with the exception of hands-on physician services (both hospice based and independent attending physicians).

3.9.1 The hospice will be responsible for providing medical appliances -- which includes covered **DE** (e.g., **DME**, hospital bed, wheelchair, etc.) as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness -- for use in the patient's home while he or she is under hospice care. The use of this equipment is included in the daily hospice rate.

3.9.2 Parental and enteral nutrition therapies would be covered under the daily hospice rate if determined to be essential for the **palliative care** of the terminal patient; however, these types of therapies will be relatively rare in a hospice setting since they are considered life sustaining treatment modalities.

3.10 Any other item or service which is specified in the treatment plan and for which payment may otherwise be made is a covered service under the hospice benefit.

Example: A hospice determines that a patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the treatment plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

3.11 If a hospice furnishes, at the request of a beneficiary, items or services in addition to those that are covered under the hospice benefit, the hospice may charge the beneficiary for these items or services.

- END -

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Issue Date: February 6, 1995
Authority: [32 CFR 199.14\(g\)](#)

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

To establish procedural guidelines for reimbursement of hospice care.

3.0 POLICY

3.1 Hospice Program Reimbursement

Hospice care will be reimbursed at one of four predetermined national Medicare rates (refer to the tables in Addendums B (urban) and C (rural) based on the type and intensity of services furnished to the beneficiary. The labor-related portions of each of these rates are adjusted by the wage index applicable to the hospice program providing the care (refer to [paragraph 3.1.2](#), for further explanation). A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period.

3.1.1 Levels Of Reimbursement

TRICARE will use the national Medicare hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with an approved hospice program:

3.1.1.1 Routine Home Care

The hospice will be paid for routine home care for each day the patient is at home, under the care of the hospice, and not receiving continuous care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. Payment for routine home care (i.e., revenue code 651) will be based on the geographic location at which the service is furnished as opposed to the location of the hospice.

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Example: TRICARE reimbursement for 30 days of routine home care from January 1, 1995, through January 30, 1995 in Chicago, Illinois.

Wage Component Subject to Index	x	Index for Chicago	=	Adjusted Wage Component				
\$62.19	x	1.2196	=	\$75.85				
Adjusted Wage Component	+	Nonwage Component	=	Adjusted Rate	x	30 days Home Care	=	Routine Rate
\$75.85	+	\$28.32	=	\$104.17	x	30	=	\$3,125.10

3.1.1.2 Continuous Home Care

The hospice will be paid the continuous home care rate when continuous home care is provided. Payment for continuous care (i.e., revenue code 652) will be based on the geographic location at which the service is furnished as opposed of the location of the hospice. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. The following provisions are used for payment of this level of care:

3.1.1.2.1 A minimum of eight hours of care must be provided within a 24-hour period, starting and ending at midnight. If less than eight hours of care are provided within a 24-hour period, the care will be paid at the lower routine home care rate.

3.1.1.2.2 More than half of the continuous home care must be provided by either a registered nurse (RN) or licensed practical nurse (LPN); i.e., a RN or LPN must provide more than one-half of the total hours being billed for each 24-hour period.

3.1.1.2.3 Homemaker and home health aide services may be provided to supplement the nursing care to enable the beneficiary to remain at home.

3.1.1.2.4 For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours per day. A part of an hour will be rounded to a whole hour for each hour of continuous care during a 24-hour period.

Example: TRICARE reimbursement for 10 hours of continuous home care provided on December 15, 2006, in Denver, Colorado:

National Rate		Wage Component Subject to Index	x	Index for Denver	=	Adjusted Wage Component
\$528.30		\$362.99	x	1.2141	=	\$440.71
Adjusted Wage Component	+	Nonwage/ 24 Hour Component	x	Hours of Care	=	Hospice Rate
		(\$440.71 + \$165.31)	x	10	=	\$252.50
		24 hr				

The continuous home care rate of \$252.50 was figured by dividing the adjusted rate (i.e., the adjusted wage component plus nonwage component) by 24 hours and multiplying that amount by the actual number of hours rendered.

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beginning November 1 and ending October 31, regardless of when payment is actually made.

- Payments are measured in terms of **all** payments made to hospices on behalf of **all** TRICARE beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap (i.e., all TRICARE beneficiaries within a particular hospice program).
- Payments made to a hospice for an individual electing hospice care on October 5, 1994, pertaining to services rendered in the cap year beginning November 1, 1994, and ending October 31, 1995, would be counted as payments made during that cap year (November 1, 1994 - October 31, 1995), even though the individual would not be counted in the calculation of the cap for that year. The individual would, however, be counted in the cap calculation for the following year, because the election occurred after September 27.

3.1.5.1.4 The hospice will be responsible for reporting the number of TRICARE beneficiaries electing hospice care during the “cap period” to the contractor. This must be done within 30 days after the end of the “cap period”.

3.1.5.1.5 The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

3.1.5.1.6 The adjusted cap amount will be obtained by **DHA** from the CMS prior to the end of each cap period and provided to the contractors.

3.1.5.1.7 Payments in excess of the cap amount must be refunded by the hospice program.

3.1.5.2 Determining Number of Elections

The following rules must be adhered to by the hospice in determining the number of TRICARE beneficiaries who have elected hospice care during the period:

3.1.5.2.1 The beneficiary must not have been counted previously in either another hospice’s cap or another reporting year.

3.1.5.2.2 The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing TRICARE beneficiary during the current cap year.

3.1.5.2.3 Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

3.1.5.2.4 There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different TRICARE-certified hospices. A calculation must be made to determine the percentage of the patient’s Length Of Stay (LOS) in each hospice relative to the total length of hospice stay.

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3.1.5.2.4.1 The contractor having jurisdiction over the hospice program in which the beneficiary dies or exhausts the hospice benefit will be responsible for determining the proportionate LOS for all preceding hospices.

3.1.5.2.4.2 The contractor will also be responsible for disseminating this information to any other contractors having jurisdiction for hospices in which the beneficiary was previously enrolled.

Note: While it is assumed that crossing of contractor jurisdictional areas (care in hospices located in different jurisdictional areas) will be relatively rare, there is no question that it will occasionally happen. Care in another jurisdictional area can only be detected if it is reported in the admission notice or detected upon retrospective (post payment) medical review; e.g., in the case of a change in election, the second (receiving) hospice will use Item 38 (CMS 1450 UB-04) of the admission notice to indicate the transferring hospice's complete name, address, and provider number. The method of reporting will be left up to the individual contractor. The information should be shared with the other contractors as soon as possible after the demise of the beneficiary so that the other contractors have ample time to adjust the elections used in calculating the hospice's cap amount. The contractor will have to maintain this information for end of the year reconciliation (figuring of cap amounts).

3.1.5.2.4.3 Each contractor will then adjust the number of beneficiaries reported by these hospices based on the latest information at the time the cap is applied.

Example: John Smith, a TRICARE beneficiary, initially elects hospice care from Hospice A on September 2, 1994. Mr. Smith stays in Hospice A until October 2, 1994 (30 days) at which time he changes his election and enters Hospice B. Mr. Smith stays in Hospice B for 70 days until his death on December 11, 1994. The contractor having jurisdiction over Hospice B will be responsible for determining the proportionate number of TRICARE beneficiaries to be reported by each hospice that delivered hospice services to Mr. Smith. This contractor determines that the total length of hospice stay for Mr. Smith is 100 days (30 days in Hospice A and 70 days in Hospice B). Since Mr. Smith was in Hospice A for 30 days, Hospice A should count 0.3 of a TRICARE beneficiary for Mr. Smith in its hospice cap calculation (30 days divided by 100 days). Hospice B should count 0.7 of a TRICARE beneficiary in its cap calculation (70 days divided by 100 days). The contractor servicing Hospice B will make these determinations and notify the contractor servicing Hospice A of its determination. These contractors will then be responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

3.1.5.3 Readjustment of Cap Amount

Readjustment may be required if information previously unavailable to the contractor at the time the hospice cap is applied subsequently becomes available.

Example: Using the previous example, if the contractor servicing Hospice A had calculated and applied the hospice cap on November 30, 1994, information would not have been available at that time to adjust the number of beneficiaries reported by Hospice A, since Mr. Smith did not die until December 11, 1994. The contractor servicing Hospice A would have to recalculate and reapply the hospice cap to Hospice A based on the information it later received from the contractor servicing Hospice B. The cap for

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Example: Serenity Hospice of Seattle, Washington, provided the following information/data on its annual report form (received by contractor on December 1, 1993):

Number of TRICARE beneficiaries electing hospice care during the period from September 28, 1993 through September 27, 1994.	29
Total payment received and receivable for the cap period from November 1, 1993 through October 31, 1994 for services furnished to TRICARE beneficiaries during the cap period.	\$202,161.55
Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to TRICARE beneficiaries for the period from November 1, 1993 through October 31, 1994.	\$91,354.75
Aggregate number of TRICARE inpatient days for both general inpatient and inpatient respite care for the period of November 1, 1993 through October 31, 1994.	292
Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from November 1, 1993 through October 31, 1994.	1,237

Inpatient Limitation

Step 1: Maximum allowable inpatient days (MAIDs) are calculated by multiplying the total number of days of TRICARE hospice care by 0.2.

Total TRICARE Hospice Days	x	Percent Inpatient Limitation	=	Maximum Allowable Number of Inpatient
1,237 days	x	0.2	=	247.44

Step 2: Since the total number of days (292 days) of inpatient care exceed the maximum allowable number of inpatient days (rounded to 247 days) the limitation will be determined by:

Step 2a: Calculating the ratio of the maximum allowable days to the number of actual days of inpatient care and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement that was made).

<u>Maximum Allowable Inpatient Days</u> Actual Days of Inpatient Care	x	Total Inpatient Reimbursement	=	Amount (a)
247 days <hr/> 292 days	x	\$91,854.70	=	\$77,699.05

Step 2b: Multiply excess inpatient days by the routine home care rate.

Excess Inpatient Care Days (Actual Days - MAIDs)	x	Routine Home Care Rate for Seattle	=	Amount (b)
(292 days - 245 days) = 45 days	x	\$94.02	=	\$4,230.90

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Step 2c: Add together amounts from Steps 2a and 2b.

Amount (a)	+	Amount (b)	=	Amount (c)
\$77,699.05	+	\$4,230.90	=	\$81,929.95

Step 2d: Compare amount from Step 2c with total TRICARE payments received and receivable for the cap period from November 1, 1993 through October 31, 1994.

Actual TRICARE Payments	-	Amount (c) Above of Inpatient	=	Payments in Excess Limitation
\$91,354.75	-	\$81,929.95	=	\$9,424.80

3.1.7 Notification and Recoupment

The contractors will be responsible for notifying those hospice programs which have been paid in excess of the aggregate cap amount and/or inpatient limitation.

3.1.7.1 The contractors will calculate the cap and inpatient amounts for each TRICARE hospice program and request a refund for those exceeding the calculated amounts.

Note: The contractor will be given discretion in developing its own letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed under [paragraph 3.1.10](#).

3.1.7.2 All refund checks will be sent to the **DHA** Contract Resource Management (CRM) Directorate.

3.1.7.2.1 If the hospice fails to submit the refund, the contractor will issue two additional demand letters which will be sent out at appropriate intervals as required by the TRICARE Operations Manual (TOM).

3.1.7.2.2 Copies of the demand letters will not be sent to the beneficiary, and providers will not be placed on offset to collect overpayments.

3.1.7.2.3 If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, recoupment cases will be transferred to **DHA** in compliance with the TOM.

3.1.8 Hospice Reporting Responsibilities

The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

3.1.8.1 Data requirements.

3.1.8.1.1 Total number of TRICARE beneficiaries electing hospice care during the period beginning September 28 of the previous cap year through September 27 of the current cap year.

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- 3.1.8.1.2** Total number of TRICARE hospice days (both inpatient and home care).

- 3.1.8.1.3** Total reimbursement received and receivable for cap period for services furnished to TRICARE beneficiaries, including employed physician's services not of an administrative and/or general supervisory nature.

- 3.1.8.1.4** Total reimbursement received and receivable for general inpatient and respite care during cap period.

- 3.1.8.1.5** Aggregate number of TRICARE inpatient days for both general inpatient care and inpatient respite care during cap period.

- 3.1.8.1.6** Aggregate number of TRICARE routine days during cap period.

- 3.1.8.1.7** Aggregate total number of days of hospice care provided to all TRICARE beneficiaries during the cap period.

- 3.1.8.2** Contractors will be given discretion in designing their own report forms taking into consideration the above data requirements. The following is an example of an acceptable report form:

CAP PERIOD ENDED - October 31, ____

Hospice _____

Provider Number: _____

- 1.** Number of TRICARE beneficiaries electing hospice care during the period from 09/28/____ through 09/27/____. _____

- 2.** Total payment received and receivable for the cap period from 11/01/____ through 10/31/____ for services furnished to TRICARE beneficiaries during the cap period, including employed physician's services not of an administrative and/or general supervisory nature. _____

- 3.** Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to TRICARE beneficiaries for the period from 11/01/____ through 10/31/____. _____

- 4.** Aggregate number of TRICARE inpatient days for both general inpatient care and inpatient respite care for the period from 11/01/____ through 10/31/____. _____
 - a.** Aggregate number of TRICARE routine days for the period from 11/01/____ through 10/31/____. _____

 - b.** Aggregate number of TRICARE continuous home care hours for the period 11/01/____ through 10/31/____. _____

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5. Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from 11/01/____ through 10/31/____.

SIGNATURE

DATE

TITLE

3.1.9 End of the Year Reconciliation

The contractor will be responsible for calculation of the cap amount and inpatient limitation for each TRICARE approved hospice program within its jurisdictional area.

3.1.9.1 The information/data for calculation of the cap amount and inpatient limitation will come directly off of the data report form which must be submitted to the contractor within 30 days after the end of the cap period (i.e., by December 1st of each year).

3.1.9.1.1 The contractors will not be responsible for validation of this information unless there is a request for reconsideration by one of the hospice programs.

3.1.9.1.2 Adjustments to these end of the year calculations should be minimal since the hospice will be reporting total payments **received** and **receivable** for the cap period.

3.1.9.1.3 Payments for hospital based physicians (billed by the hospice program on the CMS 1450 UB-04) will be subject to the cap amount; i.e., it will be figured into hospice payments made during the cap period.

3.1.9.1.4 Independent attending physician or NP services are not considered a part of the hospice benefit and are not figured into the cap amount calculations. The provider will bill for the services on a CMS 1500 Claim Form using appropriate Current Procedural Terminology (CPT) codes.

3.1.9.2 The contractor will have 30 days (until January 1st of each year) in which to calculate and apply the cap and inpatient amounts to each TRICARE approved hospice within its jurisdictional area. The contractor will request a refund from those hospice programs found to exceed the calculated amounts.

3.1.9.2.1 The contractor will be given discretion in developing its own recoupment letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed under [paragraph 3.1.10](#).

3.1.9.2.2 Refund checks will be sent to the **DHA** CRM Directorate. If the hospice fails to submit the refund, the contractor will issue two additional demand letters which will be sent out at appropriate intervals as required by the TOM. Copies of the demand letters will not be sent to the beneficiary, and providers will not be placed on offset to collect overpayments. If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, recoupment cases will be transferred to **DHA** in compliance with the TOM.

Note: Medical review will be the responsibility of those contractors processing the claims. The contractor will only be looking for utilization trends on random samples. A pattern of failure to adequately meet the medical review criteria specified in [paragraph 3.3](#), will result in denial or reclassification of the particular rate category. The notice of denial or reclassification of the hospice care will be retrospective (post payment) and result in a claim adjustment (recoupment action). A duplicate claim adjustment (EOB) would be sent to both the provider and the beneficiary. The beneficiary will be held harmless for those services for which the provider would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements (refer to [Addendum D](#), Article 3.4, of the Participation Agreement for Hospice Program Services TRICARE Beneficiaries). The contractor will be given discretion in determining at what point care will be denied for lack of supporting medical documentation.

3.3.3 Reclassification of Level of Care

The contractor may reclassify care from one rate category to another as a result of their review. The contractor will be responsible for adjusting the reimbursement on the previously processed claims to the appropriate level of care.

Example: If continuous home care was provided to a patient whose condition did not require the level of care described in [paragraph 3.1.1.2](#), payment will be made at the appropriate level (in this case, the routine home care rate.)

3.3.4 Related Services

All services and/or supplies associated with the palliative care of the terminal patient **are** included within the hospice rate with the exception of hands on physician services (both hospice based and independent attending physicians).

3.3.4.1 The hospice will be responsible for providing medical appliances (which includes covered **Durable Equipment (DE) and Durable Medical Equipment (DME)** (e.g., hospital bed, wheelchair, etc.) as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness) for use in the patient's home while he or she is under hospice care. The use of this equipment is included in the daily hospice rate.

3.3.4.2 Parental and enteral nutrition therapies would be covered under the daily hospice rate if determined to be essential for the **palliative care** of the terminal patient; however, representatives from Medicare have informed us that these types of therapies would be relatively rare in a hospice setting since they are considered life sustaining treatment modalities.

3.3.4.3 Ambulance services would be covered under the daily hospice rate if determined necessary for management of the patient's terminal illness (e.g., ambulance transport from the patient's residence to a hospice inpatient facility).

- END -

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

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

The benefits and conditions for coverage under Home Health Care (HHC).

3.0 POLICY

3.1 Conditions for Coverage of Home Health Services

Home Health Agency (HHA) services are covered by TRICARE when the following criteria are met:

3.1.1 The person to whom the services are provided is an eligible TRICARE beneficiary.

3.1.2 The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the TRICARE program.

3.1.3 The beneficiary qualifies for coverage of home health services.

3.1.4 To qualify for TRICARE coverage of any home health services, the patient must meet each of the criteria specified below:

3.1.4.1 Patient Confined to the Home

As defined in [32 CFR 199.2](#), a patient is considered homebound when a beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment -- including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care

program that is licensed or certified by a state, or accredited to furnish adult day-care services in the state -- shall not disqualify an individual from being considered to be confined to his/her home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for nonmedical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. **An exception is made to the above homebound definitional criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories is written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.**

3.1.4.1.1 HHAs are responsible for demonstrating that the adult daycare center is licensed or certified/accredited as part of determining whether the patient is homebound for purposes of TRICARE eligibility. Examples of information that could demonstrate licensure or certification/accreditation include: the license/certificate of accreditation number of the adult day care center; the effective date of the license/certificate of accreditation; and the name of the authority responsible for the license/certificate of accreditation of the adult day care center.

3.1.4.1.2 Patients will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if leaving home is medically contraindicated.

3.1.4.1.3 Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists:

3.1.4.1.3.1 Patients paralyzed from a stroke who are confined to a wheelchair or require the aid of crutches in order to walk;

3.1.4.1.3.2 Patients who are blind or senile and require the assistance of another person in leaving their place of residence;

3.1.4.1.3.3 Patients who have lost the use of their upper extremities and, therefore, are unable to open doors, use handrails or stairways, etc., and require the assistance of another individual to leave their place of residence;

3.1.4.1.3.4 Patients who have just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, their actions are restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.;

3.1.4.1.3.5 Patients with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity; and

3.2.3.3.5 Examples of supplies that can be considered non-routine include, but are not limited to:

- Dressings/Wound Care
- Sterile dressings
- Sterile gauze and toppers
- Kling and Kerlix rolls
- Telfa pads
- Eye pads
- Sterile solutions, ointments
- Sterile applicators
- Sterile gloves
- IV supplies
- Ostomy supplies
- Catheter and catheter supplies
 - Foley catheters
 - Drainage bags, irrigation trays
- Enemas and douches
- Syringes and needles
- Home testing
 - Blood glucose monitoring strips
 - Urine monitoring strips

3.2.3.4 Other Items

Consider other items that are often used by persons who are not ill or injured to be medical supplies only where:

3.2.3.4.1 The item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation, and

3.2.3.4.2 The item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury.

3.2.3.4.3 Items that generally serve a routine hygienic purpose (e.g., soaps and shampoos) and items that generally serve as skin conditioners (e.g., baby lotion, baby oil, skin softeners, powders, lotions) are not considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician's prescribed treatment of the patient's existing skin (scalp) disease or injury.

3.2.3.5 Supplies Left at Home

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the patient or other caregiver. These items must be part of the POC in which the home health staff are actively involved. For example, the patient is dependent on insulin injections but the nurse visits once a day to change wound dressings. The wound dressings/irrigation solution may be left in the home between visits. Do not leave supplies such as needles, syringes, and catheters that require administration by a nurse in the home between visits.

3.2.4 Durable Equipment (DE)

DE covered under the home health benefit subject to the beneficiary's applicable deductible and copayment/cost-share (refer to [Chapter 2, Addendum A](#) and [Figure 12.2-1](#) for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA Prospective Payment System (PPS) amount).

3.2.5 Services of Interns and Residents

Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program if the services are ordered by the physician who is responsible for the POC and the HHA is affiliated with or is under common control of a hospital furnishing the medical services. Approved means:

- Approved by the Accreditation Council for Graduate Medical Education;
- In the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;
- In the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association (ADA); or
- In the case of an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Education of the American Podiatric Association.

3.2.6 Outpatient Services

Outpatient services include any of the items described above which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and:

- Which require equipment which cannot readily be made available at the patient's place of residence, or
- Which are furnished while he/she is at the facility to receive the services described above.
- The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must be a qualified provider of services. However, there are special provisions for the use of the facilities of rehabilitation centers.
- The cost of transporting an individual to a facility cannot be reimbursed as home health services.

3.3 Consolidated Billing (CB) Requirements Under HHA PPS

3.3.1 The Balanced Budget Act (BBA) of 1997 required CB of all home health services while a beneficiary is under a home health POC authorized by a physician.

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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

This policy describes the methods used in designating the primary provider of home health services and for tracking the Episodes Of Care (EOCs) for payment under the Home Health Agency Prospective Payment System (HHA PPS).

3.0 POLICY

3.1 Background

3.1.1 With the advent of the HHA PPS and home health Consolidated Billing (CB), Medicare had to establish a means of identifying a "primary" HHA for payment purposes (i.e., a HHA that would receive payment for all services during a designated EOC). Medicare addressed this problem through the establishment of an administratively complex on-line inquiry transaction system [i.e., a Health Insurance Query for Health Agencies (HIQH)] whereby other home health providers could determine whether or not the beneficiary was currently in a home health EOC. This on-line query system required the establishment of a HHA PPS episode auxiliary file which is continually updated as Requests for Anticipated Payments (RAPs) and claims are processed through the Regional Home Health Intermediary's (RHHI) claims processing systems. The HIQH system must be able to immediately return the following information to providers querying the system: 1) contractor and provider numbers; 2) episode start and end dates; 3) period status indicator; 4) HHA benefit periods; 5) secondary payer information; 6) hospice periods; and 7) HIQH header information. The HIQH transaction system must also be able to access 36 episode iterations displayed two at a time.

3.1.2 The implementation and maintenance of such an on-line transactional query system would be administratively burdensome and costly for the program. It would have to be maintained by one of the claims processing subcontractors since it is a national system requiring continual on-line updating. Determining "primary" provider status from the query system (i.e., the first RAP or,

under special circumstances, the first claim submitted and processed by the RHHI) would circumvent the contractors' utilization management responsibilities/requirements under their existing Managed Care Support (MCS) contracts. In other words, the contractors would no longer be able to assess and direct Home Health Care (HHC) within their region(s). Designation of primary HHA status (i.e., the only HHA allowed to receive payment for services rendered during an EOC) would be dependent on the first RAP or claim submitted and processed for a particular EOC. The determination of where and by whom the services are provided would be dependent on the provider instead of the Managed Care Support Contractor (MCSC).

3.1.3 An alternative approach is being adopted that will meet the primary goals of ensuring Medicare PPS payment rates and benefit coverage while retaining utilization management. Under this alternative approach, the preauthorization process will determine "primary status" of the HHA. Authorization screens (part of the automated authorization file) will be used to house pertinent episode data. This alternative will necessitate contractor preauthorization for all HHC (i.e., HHC delivered under both Prime and Standard). Expansion of the existing authorization requirements is a viable option given the fact that one of the MCSCs is already authorizing HHC for standard beneficiaries under its contract. The alternative authorization process is preferable to the development and maintenance of a national on-line transactional query system, given its enormous implementing and maintenance costs. Adoption of the above alternative will preclude implementation of Medicare's on-line transactional system and maintenance of complex auxiliary episode files. However, adoption of this alternative process does not preclude the prescribed conventions currently in place for establishing EOCs; e.g., transfers, discharges and readmissions to the same facility within 60-day episodes, Significant Changes In Condition (SCICs), Low Utilization Payment Adjustments (LUPAs), and continuous EOCs will all be monitored and authorized as part of the authorization process. Contractors will maintain and update episode data on expanded authorization screens.

3.2 Designation of Primary Provider

3.2.1 Preauthorization Process

The preauthorization process is critical to establishment of primary provider status under the HHA PPS; i.e., designating that HHA which may receive payment under the CB provisions for home health services provided under a Plan of Care (POC).

3.2.1.1 The contractor is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries (both Prime and Standard) seeking HHC. In other words, HHC can only be accessed by TRICARE beneficiaries upon referral by the PCM, or attending physician, and with preauthorization by the contractor. The contractor shall establish and maintain these functions to facilitate referrals of beneficiaries to HHAs. For example, a beneficiary in need of home health services will request preauthorization and placement by the MCSC or other contractor designee. The MCSC will search its network for a HHA which will meet the needs of the requesting beneficiary. The beneficiary will be granted preauthorization approval for home health services provided by the selected HHA. The selected HHA will in turn be notified of its primary provider status under TRICARE (i.e., the selected HHA will be notified that it will be the only HHA authorized for payment for services provided to the referred TRICARE beneficiary) and must submit a request for anticipated payment after the first service has been rendered. The RAP will initiate the EOC under the preauthorization process.

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3.4.3 When the patient status of a claim is 06, indicating transfer, the episode period end date will be adjusted to reflect the through date of that claim, and payment is also adjusted.

3.4.4 The system will permit a "transfer from" and a "transfer to" agency to bill for the same day when it is the date of transfer and a separate RAP/claim is received overlapping that 60-day period containing either a transfer or a discharge-readmit indicator.

3.4.5 When the status of the claim is 01, no change is made in the episode length or claim payment unless a separate RAP/Claim is received overlapping that 60-day period and containing either a transfer or a discharge-readmit indicator.

3.4.6 The system will also act on source of admission codes on RAPs; for example, "B" (indicating transfer) and "C" (indicating readmission after discharge by the same agency in the same 60-day period) will open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone will not trigger creation of a new episode.

3.4.7 Claims for institutional inpatient services [i.e., inpatient hospital and skilled nursing facility (SNF) services] will continue to have priority over claims for home health services under HHA PPS. Beneficiaries cannot be institutionalized and receive homebound care simultaneously. Therefore, if an HHA PPS claim is received, and the system finds dates of service on the HH claims that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the system will reject the HH claim.

3.4.8 A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment is likely to apply. Occurrence span code 74, previously used in such situations, should not be employed on HHA PPS claims.

3.4.9 If an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, there would be one shortened HHA PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall. The agency should cancel the PEP claim and the readmission RAP in these cases and re-bill a continuous EOC.

3.4.10 The system will edit to prevent duplicate billing of **Durable Equipment (DE)** and Durable Medical Equipment (DME). Consequently, the system must edit to ensure that all DME items billed by HHAs have a line-item date of service and Healthcare Common Procedure Coding System (HCPCS) coding, though home health CB does not apply to DME by law.

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3.5 Chart Summarizing the Effects of RAP/Claim Actions on the HHA PPS Episode

TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
Initial RAP (Percentage Payments 0-60)	Open an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next episode.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Initial RAP with Transfer Source Code of B	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day.	<ul style="list-style-type: none"> • The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of the transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs.
RAP Cancellation by Provider or Contractor	The episode record is deleted from system.	<ul style="list-style-type: none"> • No episode exists to prevent RAP submission or No-RAP LUPA claim submission.
RAP Cancellation by System	The episode record remains open on system	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present. • To correct information on this RAP, the original RAP must be replaced, canceled by the HHA and then re-submitted once more with the correct information.
Claim (full)	60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Claim (discharge with goals met prior to Day 60)	Episode record complete; episode "through" date remains at the 60th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	<ul style="list-style-type: none"> • A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date.

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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 Equipment (DE), 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.

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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.

Note: Any **Durable Equipment (DE)**, Durable Medical Equipment (DME), orthotics, and prosthetic devices for which transitional pass-through payment does not apply will be paid under the DMEPOS fee schedule when the hospital is acting as the supplier (paid outside the PPS).

3.2.5.3 Pass-Through Payment Criteria for Devices

Pass-through payments will be made for new or innovative medical devices that meet the following requirements:

3.2.5.3.1 They were not recognized for payment as a hospital outpatient service prior to 1997 (i.e., payment was not being made as of December 31, 1996). However, the medical device shall be treated as meeting the time constraint (i.e., payment was not being made for the device as of December 31, 1996) if either:

3.2.5.3.1.1 The device is described by one of the initial categories established and in effect, or

3.2.5.3.1.2 The device is described by one of the additional categories established and in effect, and

- An application under the Federal Food, Drug, and Cosmetic Act has been approved; or
- The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or
- The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of the Act.

3.2.5.3.2 They have been approved/cleared for use by the U.S. Food and Drug Administration (FDA).

3.2.5.3.3 They are determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

3.2.5.3.4 They are an integral and subordinate part of the procedure performed, are used for one patient only, are surgically implanted or inserted via a natural or surgically created orifice on incision, and remain with that patient after the patient is released from the HOPD.

3.2.5.3.4.1 Reprocessed single-use devices that are otherwise eligible for pass-through payment will be considered for payment if they meet FDA's most recent regulatory criteria on single-use devices.

3.2.5.3.4.2 It is expected that hospital charges on claims submitted for pass-through payment for reprocessed single-use devices will reflect the lower cost of these devices.

Note: The FDA published guidance for the processing of single-use devices on August 14, 2000 - "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals".

3.2.5.3.5 They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets.

3.2.5.3.6 They are not materials and supplies such as sutures, clips, or customized surgical kits furnished incidental to a service or procedure.

3.2.5.3.7 They are not material such as biologicals or synthetics that may be used to replace human skin.

3.2.5.3.8 No existing or previously existing device category is appropriate for the device.

3.2.5.3.9 The associated cost is not insignificant in relation to the APC payment for the service in which the innovative medical equipment is packaged.

3.2.5.3.10 The new device category must demonstrate that utilization of its devices provide substantial clinical improvement for beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories.

3.2.5.4 Duration of Transitional Pass-Through Payments

3.2.5.4.1 The duration of transitional pass-through payments for devices is for at least two, but not more than three years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category.

3.2.5.4.2 The costs of devices no longer eligible for pass-through payments will be packaged into the costs of the procedures with which they are normally billed.

3.2.6 General Coding and Billing Instructions and Explanations

3.2.6.1 Devices implanted, removed, and implanted again, not associated with failure (applies to transitional pass-through devices only):

- In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices - the device that resulted in fracture and the one that was implanted into the patient.
- It is realized that there may be instances where an implant is tried but later removed due to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (e.g., physician implants an anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve a desirable result). In such instances, separate reimbursement will be provided for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

Note: This applies to transitional pass-through devices only and not to devices packaged into an APC.

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Appendix A

Acronyms And Abbreviations

ANCC	American Nurses Credentialing Center
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Adenomatous Polyposis Coli Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ARB	Angiotensin Receptor Blocker
ARCIS	Archives and Records Centers Information System
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ASRM	American Society for Reproductive Medicine
AT	Assistive Technology
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BAA	Business Associate Agreement
BACB	Behavior Analyst Certification Board
BART	BRAC Analysis Large Rearrangement Test

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Appendix A

Acronyms And Abbreviations

BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birthing Center
BCaBA	Board Certified Assistant Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst - Doctoral
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BE&SD	Beneficiary Education and Support Division
BH	Behavioral Health
BI	Background Investigation
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPPV	Benign Paroxysmal Positional Vertigo
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BT	Behavior Technician
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs

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Appendix A

Acronyms And Abbreviations

CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CARC	Claim Adjustment Reason Code
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBL	Commercial Bill of Lading
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
CCD	Corporate Credit or Debit
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEA	Carotid Endarterectomy

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Appendix A

Acronyms And Abbreviations

CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CF	Conversion Factor Cystic Fibrosis
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf
CIF	Central Issuing Facility Common Intermediate Format
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMR	Cardiovascular Magnetic Resonance
CMS	Centers for Medicare and Medicaid Services

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Appendix A

Acronyms And Abbreviations

CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRP	Canalith Repositioning Procedure
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)

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Appendix A

Acronyms And Abbreviations

CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Composite Tissue Allotransplantation Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTLN1	Citrullinemia Type 1
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
CUI	Controlled Unclassified Information
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigative Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDD	Degenerative Disc Disease
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix

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