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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 4  
6010.58-M  
NOVEMBER 7, 2008**

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

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

**CHANGE TITLE:** CONSOLIDATED CHANGE

**PAGE CHANGE(S):** See pages 2 and 3.

**SUMMARY OF CHANGE(S):** This change brings this Manual up-to-date with published changes to the Aug 2002 TRICARE Reimbursement Manual (TRM), 6010.55-M. Included are Changes 78, 79, 80, 81, 82, and 83. This change also includes minor clarifications/corrections.

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

This change is made in conjunction with Feb 2008 TOM, Change No. 4, Feb 2008 TPM, Change No. 4, and Feb 2008 TSM, Change No. 4.

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

**ATTACHMENT(S):** 94 PAGE(S)  
**DISTRIBUTION:** 6010.58-M

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## Hospital Inpatient Reimbursement In Locations Outside The 50 United States And The District Of Columbia

Issue Date: September 9, 2004

Authority: [32 CFR 199.1\(b\)](#) and [32 CFR 199.14\(m\), \(n\), and \(o\)](#)

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### 1.0 APPLICABILITY

This policy is mandatory for reimbursement of all hospital inpatient services provided in the locations identified in [paragraph 4.2](#). This policy revises, replaces, and supersedes the previously issued policy, effective October 1, 2004, for hospital reimbursement in the Philippines. Puerto Rico follows Continental United States (CONUS) based reimbursement methodologies used for the 50 United States and the District of Columbia.

### 2.0 ISSUE

How are specified inpatient hospital services reimbursed in the locations specified in [paragraph 4.2](#)?

### 3.0 POLICY

The institutional per diem for those specified locations outside the 50 United States and the District of Columbia is the maximum amount TRICARE will authorize to be paid for inpatient services on a per diem basis. The allowable institutional rates for those specified locations outside the 50 United States and the District of Columbia, shall be the lesser of (a) billed charges or; (b) the **amount based on** prospectively determined per diems **which are** adjusted by a country specific index factor.

### 4.0 BACKGROUND

Reimbursement Systems:

#### 4.1 General

**4.1.1** Payment for inpatient hospital stays in specified locations outside the 50 United States and the District of Columbia, are made utilizing the lesser of:

- Billed charges; or
- The prospectively determined per diems adjusted by a country specific index.

**4.1.2** **The** prospectively determined per diem rates for specified locations outside the 50 United States and the District of Columbia, **are** developed into reimbursement groupings by

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utilizing diagnosis codes as contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The per diem rates are the maximum allowable amounts that TRICARE shall reimburse and the amount on which patient cost-shares are calculated. The National U.S. per diem rate is multiplied by a unique country specific index factor which adjusts the National U.S. per diems for the applicable country. The country specific hospital per diem, for those specified locations outside the 50 United States and the District of Columbia is the product of the National U.S. per diem and the country specific index.

## **4.2 Applicability**

**4.2.1** This payment system applies to all hospitals providing services in:

- The Philippines.
- Panama.
- Other as designated by the Government.

**4.2.2** This payment system will be applied by the foreign claims processor. It applies to hospital inpatient services furnished to retirees or their eligible family members or Standard Active Duty Family Members (ADFMs) falling under the claims processing jurisdiction of the foreign claims processor.

**4.2.3** Institutional providers accepting, admitting and treating TRICARE beneficiaries will receive the per diem reimbursement on applicable hospital services included on inpatient claims. This payment system is to be used regardless of the type of hospital inpatient services provided. The prospectively determined per diem rates established under this system are all-inclusive and are intended to include, but not be limited to, a standard amount for nursing and technician services; room, board and meals; drugs including any take home drugs; biologicals; surgical dressings, splints, casts; Durable Medical Equipment (DME) for use in the hospital and is related to the provision of a surgical service, procedure or procedures, equipment related to the provision and performance of surgical procedures; laboratory services and testing; X-ray or other diagnostic procedures directly related to the inpatient Episode Of Care (EOC); special unit operating costs, such as intensive care units; malpractice costs, if applicable, or other administrative costs related to the services furnished to the patients, recordkeeping and the provision of records; housekeeping items and services; and capital costs.

**4.2.4** The per diem rates do not include such items as physicians' fees, irrespective of a physician's employment status with the hospital. The per diem rates do not include other professional providers (e.g., nurse anesthetist) recognized by TRICARE who render directly related inpatient services and bill independently from the hospital for them. A valid primary ICD-9-CM code or narrative description of services must be submitted by the hospital or institutional provider. The medical description provided shall be able to support development of the claim by the overseas claims processor prior to reimbursement.

## **4.3 Country Specific Index**

The country specific index is a factor obtained from the World Bank's International Comparison Program. The index factor, known as Purchasing Power Parity (PPP) conversion factor,

is based on a large array of goods and services or market basket within the specific country which is then standardized and weighted to a U.S. standard and currency. **The World Bank defines PPP conversion factor as: "Number of units of a country's currency required to buy the same amount of goods and services in the domestic market that a U.S. dollar would buy in the U.S."** The use of the country specific index enables a conversion and therefore creates parity between the U.S. and the specific country in the purchasing of the same amount and type of medical services. TRICARE is utilizing the World Bank's International Comparison Program country specific index **as provided in Figure 1.34-1.**

#### **4.4 Institutional Payment Rates**

**4.4.1** The Policy and Statistical Analysis Services contractor shall annually calculate the U.S. National group payment rates and provide them electronically to the **TRICARE Management Activity (TMA), which will be included in Figure 1.34-2.** The provided data will contain the ICD-9-CM range or groups of related diagnosis codes. The first three digits of the principal ICD-9-CM diagnosis code determines placement into a diagnosis group as well as a reimbursement group. The data will also contain a description of the diagnosis ICD-9-CM groups. The rate for each group is the average U.S. allowed amounts per day in short-stay hospitals for all ICD-9-CM diagnoses in the particular group **plus an add-on to reimburse for capital costs. The add-on percentage will be determined by the above contractor using the U.S. data and the amount will be built-in into the per diem rate for each group.** The rate file will also designate the effective date of the per diem rates. **The above contractor shall also communicate the country specific factor to TMA annually or as dictated by the World Bank's International Comparison Program or as determined by TMA. The above contractor shall also provide the country specific adjusted per diem files, electronically to TMA, which will be provided to the overseas claims processor by TMA at least annually, or as specifics dictate. The adjusted per diems will be available at: <http://www.tricare.mil/tma/foreignfee/>.**

**4.4.2** The rate setting methodology was developed as follows:

**4.4.2.1** A rate setting methodology utilizing the first three digits of a primary diagnosis code.

**4.4.2.2** Eighteen diagnosis groupings were defined and designed **based on** the groupings and definitions contained in the ICD-9-CM publication. For example, Group 1 is defined as ICD-9-CM codes 001 to 139, or Infectious and Parasitic Diseases. The first three digits of a primary diagnosis code are utilized for placement into one of the eighteen groups.

**4.4.2.3** The payment rate for each of the 18 diagnostic groups was the average allowed amount per day over all the ICD-9-CM codes in a diagnosis group, based upon the claim's primary diagnosis, **plus an add-on to reimburse for capital costs.**

**4.4.2.4** Group payments were calculated by dividing total allowed charges by total inpatient days for the group.

## **4.5 Payments**

**4.5.1** General. The per diem group payment rate will be based on the first three digits of the primary diagnosis code. The TRICARE allowable charge and amount reimbursed for hospital inpatient care shall be the lesser of:

- Actual billed charges for hospital inpatient care; or
- The TRICARE U.S. National per diem rate multiplied by the country specific index factor is the country specific hospital per diem. This per diem is multiplied by the number of covered days of hospital inpatient care and equals the maximum amount allowed by TRICARE to be paid for the episode on inpatient care.

**4.5.2** Only the primary diagnosis code, on the date of admission, will be taken into consideration when determining the group for a payment rate. Only one payment group can be assigned to each independent episode of inpatient care. Each institutional claim for service reimbursement must contain a valid ICD-9-CM code or narrative description of services, and must be used to represent the primary diagnosis for inpatient admission. If a valid diagnosis code or narrative description is not supplied by the institutional provider it must be developed and supported by the overseas claims processor. Development of an institutional claim should contain the necessary elements to satisfy TRICARE Encounter Data (TED) requirements.

## **4.6 Beneficiary - Change in Eligibility Status**

Since payment is on a per diem basis, the hospital claim for services shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the beneficiary is not TRICARE eligible.

## **4.7 Beneficiary Cost-Shares**

Inpatient cost-shares as contained in [Chapter 2, Section 1](#), for non-Diagnosis Related Group (DRG) facilities shall be applicable to TRICARE's hospital allowable charge.

## **4.8 Updating Payment Rates**

Additions, changes, revisions or deletions to the ICD-9-CM codes or country specific index shall be communicated to the overseas claims processor and be considered as routine updates to this payment system and processed under TRICARE Operations Manual (TOM), [Chapter 1, Section 4, paragraph 2.4](#).

**4.9** The overseas claims processor shall maintain the current year and two immediate past years' iterations of the TRICARE U.S. National per diems and the country specific index factors.

**4.10** There is no TRICARE waiver process applicable to hospitals in specified locations outside the 50 United States and the District of Columbia for institutional inpatient rates.

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**FIGURE 1.34-1 COUNTRY SPECIFIC INDEX FACTORS - 2008**

	COUNTRY SPECIFIC INDEX FACTOR	EFFECTIVE
Philippines	0.52	November 1, 2008
Panama	0.70	February 1, 2008

**FIGURE 1.34-2 INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS - 2008**

GROUP	DESCRIPTION	ICD-9-CM CODE RANGE	NATIONAL INPATIENT PER DIEM
01	Infectious Disease	1 - 139	\$2,463
02	Cancer	140 - 239	\$2,576
03	Endocrine	240 - 289	\$2,457
04	Mental Health	290 - 319	\$851
05	Nervous System	320 - 389	\$2,212
06	Circulatory	390 - 459	\$3,810
07	Respiratory	460 - 519	\$1,972
08	Digestive	520 - 579	\$2,172
09	Genitourinary	580-629	\$2,482
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	\$1,196
11	Musculoskeletal and skin	680 - 739	\$4,304
12	Congenital abnormalities	740 - 759	\$3,570
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	\$717
14	Signs, Symptoms, etc.	780 - 799	\$2,326
15	Injuries	800 - 959	\$2,689
16	Poisoning	960 - 995	\$2,302
17	Complications	996 - 999	\$3,022
18	All other "V" based codes		\$2,080

- END -



## Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia

Issue Date: April 7, 2008

Authority: [32 CFR 199.14\(m\)](#), [\(n\)](#), and [\(o\)](#)

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### 1.0 APPLICABILITY

This policy is mandatory for reimbursement of providers of professional services in specified locations outside the 50 United States and the District of Columbia. This policy revises, replaces, and supersedes the current reimbursement policies for professional reimbursement, effective March 2004, in the Philippines. Puerto Rico follows the reimbursement methodologies used for the 50 United States and the District of Columbia.

### 2.0 ISSUE

How are providers of professional services in locations specified in [paragraph 4.1](#) reimbursed?

### 3.0 POLICY

**3.1** The term "allowable charge" is the maximum amount TRICARE will reimburse for covered health care services:

**3.2** The allowable charge is the lowest of: (a) the actual billed charge or (b) the maximum allowable charge. The maximum allowable charge is developed prospectively and utilizes the U.S. National CHAMPUS Maximum Allowable Charge (CMAC) which incorporates Relative Value Units (RVUs). For any covered service, the National CMAC rate is multiplied by a country specific index factor. This standardizes the National CMAC for that country and thus represents the maximum allowable TRICARE will reimburse in that country for that service.

### 4.0 BACKGROUND

#### 4.1 Reimbursement Systems

**4.1.1** Locations Affected. This payment system applies to covered professional services delivered in all designated locations outside the 50 United States and the District of Columbia. The designated locations are:

- The Philippines
- Panama
- Other as designated by the Government.

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## Chapter 1, Section 35

### Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia

**4.1.2** Applicability. This payment system will be applied by the foreign claims processor. It applies to professional services furnished to retirees or their eligible family members Standard Active Duty Family Members (ADFM) falling under the claims processing jurisdiction of the foreign claims processor.

#### 4.2 General Methodology

**4.2.1** Payment for non-ancillary professional services, in specified locations outside the 50 United States and the District of Columbia, are made utilizing the lesser of (a) billed charges or (b) prospectively determined rates that multiplies the U.S. National CMAC rates by a country specific index factor. The National CMAC rates are comprised of approximately 7,000 Current Procedural Terminology (CPT) codes. Each CPT code associates with an established CMAC rate. There are a limited number of CPT codes that do not have a National CMAC established. If these CPT codes are billed to the TRICARE program, they shall be reimbursed at billed charges. The U.S. National CMAC rates utilized in specified locations outside the 50 United States and the District of Columbia are paid at "the site of service" location of physicians' office without regard of the actual location where the service is delivered. This site of service location (physicians' office) represents the highest reimbursement allowed for all physicians. For example, should a physician, in a specified location outside the 50 United States and the District of Columbia, deliver a service in the emergency room, his payment will be based on the CPT code submitted, and paid at the site of service level of physician office (the highest). Each CPT code rate is multiplied by a specific country index factor and represents the maximum allowed to be paid to professional providers in designated locations outside the 50 United States and the District of Columbia.

**4.2.2** The payment rates are all inclusive. An eligible and a representative procedure code or narrative description must be submitted by the provider or developed by the overseas claims processor.

#### 4.3 Country Specific Index

The country specific index factor is obtained from the World Bank's International Comparison Program. The index factor, known as Purchasing Power Parity (PPP) conversion factor, is based upon a large array of goods and services or market basket within a specific country which is then standardized and weighted to a U.S. standard and currency. The World Bank defines PPP conversion factor as: "Number of units of a country's currency required to buy the same amount of goods and services in the domestic market that a U.S. dollar would buy in the U.S." The use of a country specific index enables a conversion and therefore parity between the U.S. and the specific country in the purchasing of the same amount and type of medical services. TRICARE is utilizing the World Bank's International Comparison Program country specific index as provided in Figure 1.35-1.

#### 4.4 Updating Professional Payment Rates

Annually, the Policy and Statistical Analysis Services contractor shall calculate the National CMAC rates. The data will contain each CPT code, a short description, a U.S. National payment rate, as well as the effective date. On an annual basis, the National CMAC may increase or decrease as determined by TRICARE. This contractor shall separately supply to the TRICARE Management Activity (TMA) the country specific index every year or as dictated by the World Bank's International

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## Chapter 1, Section 35

### Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia

Comparison program or as determined by TRICARE, which will be included in Figure 1.35-1. The above contractor shall also provide the country specific index adjusted CMAC files, and any updates or corrections, electronically to TMA, which will be provided to the overseas claims processor at least annually, or as specifics may dictate. For those codes that contain a technical as well as professional component, each component shall have a separate supplied payment rate. Updates, additions, changes, revisions or deletions to the CPT codes or country specific index or CMACs will be communicated to the overseas claims processor and be considered as routine updates to this payment system and processed under TRICARE Operations Manual (TOM), Chapter 1, Section 4, paragraph 2.4. The adjusted per diems will be available at: <http://www.tricare.mil/tma/foreignfee/>.

#### 4.5 Beneficiary Eligibility - Change in Eligibility Status

Since the payment is on a date of service basis, the professional, and other charges shall be paid for all dates of service that the beneficiary is TRICARE eligible and denied for all dates of services the beneficiary is not TRICARE eligible.

#### 4.6 Beneficiary Cost-Shares

Beneficiary cost-shares are contained in Chapter 2, Section 1, and shall be applicable to TRICARE's applicable professional allowable charges.

4.7 The overseas claims processor and the overseas contractor shall maintain the current year and two immediate past years' iterations of the country specific index adjusted CMAC CPT rates.

#### 4.8 Exception

The payment system does not apply to ancillary services for CPT<sup>1</sup> codes 70000 - 89999. These ancillary services in the Philippines will be reimbursed using the Puerto Rico CMACs and in Panama using the billed charges.

**FIGURE 1.35-1 COUNTRY SPECIFIC INDEX FACTORS - 2008**

	COUNTRY SPECIFIC INDEX FACTOR	EFFECTIVE
Philippines	0.52	November 1, 2008
Panama	0.70	February 1, 2009

- END -

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

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

#### **1.1.6.4 For Certain Reservists**

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

## **1.2 TRICARE Prime**

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

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

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

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

**1.2.4.1** Diagnostic radiology and ultrasound services included in the CPT<sup>1</sup> procedure code range from 70000 - 76999, or any other code for associated contrast media;

**1.2.4.2** Diagnostic nuclear medicine services included in the CPT<sup>1</sup> procedure code range from 78000 - 78999;

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### Chapter 2, Section 1

#### Cost-Shares And Deductibles

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**1.2.4.3** Pathology and laboratory services included in the CPT<sup>2</sup> procedure code range from 80000 - 89399; and

**1.2.4.4** Cardiovascular studies included in the CPT<sup>2</sup> procedure code range from 93000 - 93350.

**1.2.4.5** Venipuncture included in the CPT<sup>2</sup> procedure code range from 36400 - 36416.

**1.2.4.6** Fetal monitoring for CPT<sup>2</sup> procedure codes 59020, 59025, and 59050.

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

### **1.3 Basic Program: TRICARE Standard**

#### **1.3.1 Deductible Amount: Outpatient Care**

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

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

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

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

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

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

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

**1.3.1.4** Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (or \$300.00 if [paragraph 1.3.1.2](#), applies), and no one beneficiary's allowable amounts exceed \$50.00 (or \$150.00 if [paragraph 1.3.1.2](#) applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

**1.3.1.5** In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 USC 310, for services in the Persian Gulf area in connection with Operation Desert

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## Hospital And Other Institutional Reimbursement

Issue Date:  
Authority:

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### 1.0 INTRODUCTION

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

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

#### 2.1 General

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

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

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

### 4.0 BILLED CHARGES/SET RATES

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

#### 4.1 Verification Of Billed Services

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

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

#### **4.2 Use Of Local Or State Regulatory Authority Allowed Charges**

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

#### **4.3 Discounts Or Reductions**

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

#### **4.4 All-Inclusive Rate Providers**

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

### **5.0 REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS (ASCs)**

**5.1** Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA regardless of whether they are provided in a freestanding ASC, in a hospital outpatient clinic, or in a hospital emergency room.

**5.2** TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

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

## Double Coverage Review And Processing Of Claims

Issue Date:

Authority: [32 CFR 199.8](#)

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### 1.0 DEVELOPMENT

All Claims Require Double Coverage Review. All claims, regardless of dollar amount, require review for possible double coverage with the following exceptions:

- Claims for the services of internal resource sharing providers;
- Claims for services provided to **Active Duty Service Members** (ADSMs); and
- Claims for all Supplemental Health Care Program (SHCP) inpatients (TRICARE Operations Manual (TOM), [Chapter 17, Section 3, paragraph 1.2.3](#)).

The contractor must maintain double coverage documentation in its files. Double coverage information must be obtained through any means that will provide a documented record or the claim may be returned with a request for the needed information.

### 2.0 PROCESSING OF CLAIMS

With the exceptions noted in [paragraph 1.0](#), the contractor shall have proof of any double coverage payments prior to adjudication of the claim.

#### 2.1 No Evidence Of Double Coverage

If there is no information to suggest the claim could be covered by another health insurance plan or there is no information on the claim to suggest that the charges have been submitted to or paid by other insurance, the claim shall be processed.

#### 2.2 Double Coverage Is Known

**2.2.1** Whether it is a network or non-network claim, payment must be obtained from the primary insurance coverages or plans. The contractor shall include procedures to ensure this requirement is met in all agreements with its network providers of care. If the provider of care is owned or operated by the contractor or is in a clinic or other facility operated by the contractor as an employee or subcontractor, the **Other Health Insurance (OHI)** shall also be collected by the contractor or its designee. If the claim indicates no OHI coverage, but the **Defense Enrollment Eligibility Reporting System (DEERS)** or contractor's file indicates otherwise, a signed statement or verbal notice from the beneficiary or sponsor furnishing the termination date of the other coverage

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### Chapter 4, Section 2

#### Double Coverage Review And Processing Of Claims

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will be necessary for the contractor to inactivate the positive OHI record. The contractor must have acceptable evidence of processing by the double coverage plan prior to processing the claim. If there is no such evidence submitted with the claim, the contractor may deny the claim and send an Explanation of Benefits (EOB) to the beneficiary and to the provider.

**2.2.2** The contractor shall take appropriate action to ensure that a sample of all Electronic Media Claims (EMC) is audited on a no less than annual basis with verification obtained from the provider to corroborate the submission of a zero OHI payment amount. In addition, no less than annually, the contractor shall audit past EMC submissions to identify all providers who may show a pattern of submissions with OHI payment amounts of zero or of a nominal amount (e.g., \$.01, \$1.00, \$5.00, etc.). All EMC providers who demonstrate a possible pattern of "plugging" nominal OHI payment amounts shall be referred to the contractor's Program Integrity staff for further investigation.

**2.2.3** Except for EMC claims, when Medicare is the primary payer, an Explanation of Medicare Benefits (EOMB) is required. This will enable the contractor to determine whether the provider accepted assignment under Medicare; if the provider accepts assignment, the provider cannot bill for any difference between the billed charge and the Medicare allowed amount. In addition, it will identify cost-share and deductible amounts as well as any allowable charge reductions.

**2.2.4** For double coverage situations which do not involve the routine issuance of an EOB, the following may be accepted in lieu of an EOB:

- Documentation that the beneficiary belongs to the plan;
- Documentation that there is a liability beyond the amounts paid by the primary payor;
- Documentation that the liability is specified in the plan contract; and
- Documentation of total liability on the claim.

**2.2.5** If a contractor becomes aware of the possible existence of OHI through means other than the adjudication of a pending claim (e.g., a provider returns all or a part of TRICARE payment because of payment by OHI), the contractor shall establish an OHI record on DEERS for the patient and request completion of a double coverage questionnaire. Depending upon the circumstances of the individual occurrence, reopening and adjustment of prior claims and/or a Program Integrity referral may also be appropriate. All affected claims must be adjusted appropriately, although adjustment action may be temporarily deferred at the request of Program Integrity staff if such adjustment would compromise their investigation.

### 2.3 DRG-Based System

The contractor must be able to identify OHI payments for all separately-billable components of the inpatient services on a claim. If the OHI EOB does not adequately identify the payments for each separately-billable component, or if claims for their charges are not received, the entire OHI payment is to be applied to the inpatient operating costs. This also applies to claims from higher volume mental health hospitals and units subject to the TRICARE Inpatient Mental Health Per Diem Payment System that are authorized to bill for institution-based professional services.

## Hospital Reimbursement - TRICARE DRG-Based Payment System (General)

Issue Date: October 8, 1987

Authority: [32 CFR 199.14\(a\)\(1\)](#)

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### 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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

How is the TRICARE DRG-based payment system to be used in determining reimbursement for hospitals under TRICARE?

### 3.0 POLICY

#### Statutory Background

**3.1** Department of Defense (DoD) Authorization Act, 1984. The DoD Authorization Act, 1984, amended Title 10, Section 1079(j)(2)(A) and provided TRICARE with the statutory authority to reimburse institutional providers based on DRGs. Specifically, it provides that payments “shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Title XVIII of the Social Security Act”.

**3.2** Consolidated Omnibus Budget Reconciliation Act (COBRA), 1986. On April 7, 1986, the President signed the COBRA which contained a provision requiring hospitals which participate in Medicare also to participate in TRICARE for inpatient services. Because of questions regarding the effect of this provision, it was amended by (Public Law (PL) 99-514, Section 1895(B)(6), which was signed by the President on October 22, 1986. This amendment requires all providers participating in Medicare also to participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

### 4.0 EFFECTIVE DATE

**4.1** Implementation of the TRICARE DRG-based payment system was effective for admissions occurring on or after October 1, 1987. Unless specified differently in sections of this instruction, this is to be considered the effective date for the TRICARE DRG-based payment system.

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Hospital Reimbursement - TRICARE DRG-Based Payment System (General)

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**4.2** Implementation of the TRICARE/CHAMPUS DRG-based payment system modeled on the Medicare Severity DRG shall occur for admissions on or after October 1, 2008.

- END -

## Hospital Reimbursement - TRICARE DRG-Based Payment System (General Description Of System)

Issue Date: October 8, 1987

Authority: [32 CFR 199.14\(a\)\(1\)](#)

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### 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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

How is the TRICARE DRG-based payment system to be used in determining inpatient reimbursement for hospitals?

### 3.0 POLICY

#### 3.1 Scope

The TRICARE DRG-based payment system applies only to hospitals. Under the TRICARE DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively determined rates and applied on a per discharge basis using DRGs. DRG payments will include an allowance for Indirect Medical Education (IDME) costs. Additional payments will be made for capital costs, direct medical education costs and outlier cases. Under the TRICARE DRG-based payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

#### 3.2 Modeled On Medicare's Prospective Payment System (PPS)

The TRICARE DRG-based payment system is modeled on the Medicare PPS. Although many of the procedures in the TRICARE DRG-based payment system are similar or identical to the procedures in the Medicare PPS, the actual payment amounts, DRG weights, and certain procedures are different. This is necessary because of the differences in the two programs, especially in the beneficiary population. While the vast majority of Medicare beneficiaries are over age 65, TRICARE beneficiaries are considerably younger and generally healthier. Moreover, some services, notably obstetric and pediatric services, which are nearly absent from Medicare claims comprise a large part of TRICARE services.

### 3.2.1 DRGs Used

With **some** exceptions, the TRICARE DRG-based payment system uses the same DRGs used in the current Medicare Grouper. Although claims may be grouped into either DRG 469, Principal diagnosis invalid as discharge diagnosis, or DRG 470, Ungroupable, claims in these DRGs must be denied without development. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

- EXCEPTION 1. Beginning with admissions occurring on or after October 1, 1988, the TRICARE system has replaced DRG 435 (Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment Without Complications or Comorbidity) with two age-based DRGs. Any claim which groups into DRG 435 shall be grouped by the contractor into either DRG 900 (where the beneficiary is 21 years old or younger) or DRG 901 (where the beneficiary is over 21 years old). This grouping by the contractor shall be based on the patient's age, as shown on the claim, on the date of admission. Effective for admissions on or after October 1, 2001, DRG 435 has been replaced by DRG 523. Any claim which groups into DRG 523, shall be grouped by the contractor into either DRG 900 or 901 as specified above. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**
- EXCEPTION 2. For admissions occurring on or after April 1, 1989, the TRICARE DRG-based payment system uses Pediatric Modified-DRGs (PM-DRGs) for all neonatal claims except those classified to DRGs 103, 391, 480, 495, 512, and 513. The PM-DRGs are DRGs 600 - 636. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

### 3.2.2 Assignment Of Discharges To DRGs

TMA uses a "Grouper" program to classify specific hospital discharges within DRGs so that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge. The TRICARE Grouper is developed by Health Information Systems, 3M Health Care, and is based on the Centers for Medicare and Medicaid Services (CMS) Grouper, but it also incorporates the PM-DRGs and DRGs 900 and 901.

**3.2.2.1** The Medicare Code Editor (or other similar editor programs) is an integral part of the CMS Grouper and serves two functions. It helps to ensure that the claim discharge data is accurate and complete, so that it can be correctly grouped into a DRG. It also "edits" the claims data to identify cases which may not meet certain coverage requirements or which might involve inappropriate services. Contractors are not required to use any "Editor" program, but it is recommended since the first function will facilitate claims processing, and the second function may be useful in assessing coverage under TRICARE.

**3.2.2.2** The classification of a particular discharge is based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status. (Contractors are required to use the expanded diagnosis and procedure code fields.) For neonatal claims (other than normal newborns), it also is based on the newborn's birth weight, surgery, and the presence of multiple, major and other problems which exist at birth. The birth

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#### Hospital Reimbursement - TRICARE DRG-Based Payment System (General Description Of System)

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weight is to be indicated through use of a fifth digit on the neonatal ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.

**3.2.2.2.1** In situations where the narrative diagnosis on the DRG claim does not correspond to the numerical diagnosis code, the contractor shall give precedence to the narrative and revise the numerical code accordingly. Contractors are not required to make this comparison on every claim. Precedence should be given to the narrative code in those cases where a difference is identified as the result of editing, prepayment review, or other action that would identify a discrepancy. If an adjustment is subsequently necessary because the numerical code was, in fact, correct, the adjustment should be submitted under a Record Processing Mode (RPM) a reason for adjustment code indicating that there was no contractor error.

**3.2.2.2.2** It is the hospital's responsibility to submit the information necessary for the contractor to assign a discharge to a DRG.

**3.2.2.2.3** When the discharge data is inadequate (i.e., the contractor is unable to assign a DRG based on the submitted data), the contractor is to develop the claim for the additional information.

**3.2.2.2.4** In some cases the "admitting diagnosis" may be different from the principal diagnosis. Although the admitting diagnosis is not required to assign a DRG to a claim, it may be needed to determine if a Non-Availability Statement (NAS) is required for mental health admissions (see the TRICARE Policy Manual (TPM), [Chapter 1, Section 6.1](#)).

**3.2.2.2.5** For neonatal claims only (other than normal newborns), the following rules apply.

**3.2.2.2.5.1** If a neonate (patient age 0 - 28 days at admission) is premature, the appropriate prematurity diagnosis code must be used as a principal or secondary diagnosis. The prematurity diagnosis codes are: ICD-9-CM code 764.0 - 764.9, slow fetal growth and fetal malnutrition, and 765.0 - 765.1, disorders relating to short gestation and unspecified low birth weight.

**3.2.2.2.5.2** Where a prematurity diagnosis code is used, a fifth digit value of 1 through 9 must be used in the principal or secondary diagnosis to specify the birth weight. A value of 0 will result in the claim being grouped to the "ungroupable" DRG, and the claim will be denied. If no fifth digit is used, the Grouper will ignore that diagnosis code and the claim will be denied.

**3.2.2.2.5.3** If a neonate is not premature, a prematurity diagnosis code must not be used. The Grouper will automatically assign a birth weight of "> 2,499 grams" and assign the appropriate PM-DRG. If the birth weight is less than 2,500 grams, the birth weight must be provided in the "remarks" section of the CMS 1450 UB-04.

**3.2.2.2.5.4** If there is more than one birth weight on the claim, the Grouper will assign the claim to the "ungroupable" DRG, and the claim will be denied.

**3.2.2.2.5.5** All claims for beneficiaries less than 29 days old upon admission (other than normal newborns) will be assigned to a PM-DRG, except those classified to DRGs 103, 480, 495, 512, and 513. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

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**3.2.2.3** Each discharge will be assigned to only one DRG (related, except as provided in [paragraphs 3.2.2.4](#) and [3.2.2.5](#), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

**3.2.2.4** When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the contractor is to develop the claim to assure that the data are not the result of miscoding by either the contractor or the hospital. Where the procedure and medical condition are supported by the services and the procedure is unrelated to the principal diagnosis, the claim will be assigned to **the** DRG, Unrelated OR Procedure.

**3.2.2.5** When the discharge data submitted by a hospital result in assignment of a DRG which may need to be reviewed for coverage (e.g., abortion without dilation and curettage, which does not meet the TRICARE requirements for coverage), the contractor is to review the claim to determine if other diagnoses or procedures which were rendered concurrently are covered. If other covered services were rendered, the contractor shall change the principal diagnosis to the most logical alternative covered diagnosis, delete the abortion diagnosis and procedure from the claim so that it does not result in a more complex DRG, and regroup the claim.

**Example:** If a claim is grouped into **the** DRG **for an abortion** and the abortion is not covered, but a tubal ligation was performed concurrently, the contractor should change the principal diagnosis to that for the tubal and delete the abortion from the procedures performed. If no covered services were rendered, the claim must be denied, and all related ancillary and professional services which are submitted separately must also be denied.

**3.2.2.5.1** Contractors are not normally required to review all diagnoses and procedures to determine their coverage. Contractors are required to develop for medical necessity only if the principal diagnosis is generally not covered but potentially could be. Deletion of a diagnosis and/or procedure is required only when the principal diagnosis or procedure is not covered.

**3.2.2.5.2** The only exception to the above paragraph is for abortions. Since abortions are statutorily excluded from coverage in most cases, the contractor is to ensure that payment is not affected by a noncovered abortion diagnosis or procedure whether it is principal or secondary. In all cases where payment would be affected, the abortion data is to be deleted from the claim.

### 3.3 Beneficiary Eligibility

#### 3.3.1 Change Of Eligibility Status

**3.3.1.1** Payment when eligibility changes. If a beneficiary is eligible for TRICARE coverage during any part of his/her inpatient confinement, except for the following cases, the claim shall be processed as if the beneficiary was eligible for the entire stay.

**3.3.1.1.1** Claims which qualify for the long-stay or short-stay outlier payment. The long-stay outlier was eliminated for all cases, except neonates and children's hospitals, for admissions occurring on or after October 1, 1997. The long-stay outlier was eliminated for neonates and children's hospitals for admissions occurring on or after October 1, 1998. See [paragraph 3.3.1.3](#).

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**3.3.1.1.2** Claims which qualify for the cost outlier payment after August 1, 2003. See [paragraph 3.3.1.3](#).

**3.3.1.1.3** Claims where a beneficiary gains eligibility after admission. The DRG-based payment is calculated beginning on the first day of TRICARE eligibility.

**3.3.1.1.4** Claims where the loss of TRICARE eligibility results from gaining Medicare eligibility. The claim may still be processed by TRICARE, but it must be submitted to Medicare first and TRICARE payment will be determined under the normal double coverage procedures.

**3.3.1.2** Transfer payments when eligibility status changes. Since payments to a transferring hospital are always based on a per diem amount, if the beneficiary's eligibility status changes while an inpatient in a transferring hospital, payment shall be made only for those days for which the beneficiary was eligible. The procedures below shall be followed in paying outlier amounts in cases involving transfers.

**3.3.1.3** Outlier payments when eligibility status changes. For admissions prior to August 1, 2003, when requested, cost outlier payments are to be made in cases where the beneficiary gains or loses eligibility during an inpatient stay, and the contractor will not be required to determine which costs occurred outside the beneficiary's TRICARE eligibility. Since both long-stay and short-stay outlier payments are made on a per diem basis, no payment is to be made for any days of care which occurred after loss of eligibility and which result from either the long-stay or short-stay outlier. The hospital may bill the beneficiary for any services which would result in long-stay or short-stay outlier payments were it not for the beneficiary's loss of eligibility. For admissions on or after August 1, 2003, when computing the standardized costs for the cost outlier payment, any charges that occur after a beneficiary loses TRICARE eligibility, shall be subtracted from the billed charges prior to multiplying the billed charges by the Cost-to-Charge Ratio (CCR) when calculating the cost outlier payment. The contractor shall request an itemized bill from the hospital to identify these charges.

**Example 1:** The beneficiary loses eligibility on day two where the short-stay outlier cutoff is three days. The beneficiary was discharged on the seventh day. TRICARE reimbursement will be made for two days on a short-stay outlier basis. The beneficiary's cost-share will be based on the two paid days. The hospital may bill the beneficiary for all days of care beyond the second day.

**Example 2:** The beneficiary is discharged on day 10 and lost eligibility on day six. The short-stay outlier cutoff is day 2. TRICARE reimbursement will be based on the normal DRG payment which will apply to the entire Length-Of-Stay (LOS) (nine days). The beneficiary cost-share for a retiree would be based on the total covered days (nine days times the per diem), assuming this is not greater than 25% of the billed charge. An active duty dependent's cost-share would be nine times the current active duty per diem amount. The hospital cannot bill the beneficiary for any costs other than the cost-share.

**Example 3:** The beneficiary gains eligibility after admission. The DRG calculation begins on the first day of TRICARE eligibility. For example, a beneficiary is admitted March 6, 1992 and discharged May 16, 1992, but was only TRICARE eligible starting May 10, 1992. The claim should be treated as if the beneficiary was admitted on May 10, 1992, and the base DRG rate calculated.

**3.3.2 Change Of Sponsor Status From Active Duty To Retired During An Active Duty Family Member's (ADFM's) Inpatient Stay**

An inpatient claim is to be cost-shared as active duty whenever there is evidence that the sponsor was on active duty during any period of the ADFM's inpatient stay.

**3.3.3 Change Of Sponsor Status From Active Duty To Retired During An Active Duty Member's Inpatient Stay**

An inpatient claim is to be cost-shared as retired if an Active Duty Service Member's (ADSM's) status changes to retired during an inpatient stay.

**3.3.4 Professional Claims**

Since payment for related professional services are itemized and billed on a daily basis, the claim shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the patient was not TRICARE eligible.

**3.3.5 Infant Of An Unmarried Family Member**

A child of an unmarried family member is not eligible, therefore, charges for an infant of an unmarried family member are not eligible for reimbursement.

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rate by the geometric mean LOS for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG amount. For neonatal claims, other than normal newborns, payment is graduated by paying twice the per diem amount for the first day of the stay, and 125% of the per diem rate for each subsequent day, up to the full DRG amount.

**3.6.6.2** Special rule for DRGs 209, 210, and 211 for Fiscal Years (FYs) prior to FY 2006. For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in [paragraph 3.6.3](#) and the transfer is assigned to DRGs 209, 210, and 211 is paid as follows:

**3.6.6.2.1** Fifty percent (50%) of the DRG-based payment amount plus one-half of the per diem payment for the DRG for day one (one-half the usual transfer payment of double the per diem for day one).

**3.6.6.2.2** Fifty percent (50%) of the per diem for each subsequent day up to the full DRG payment.

**3.6.6.3** Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2005, a hospital that transfers an inpatient under the circumstances described in [paragraph 3.6.3](#) and the transfer is assigned to DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, and 550 shall be paid under the provisions of [paragraphs 3.6.6.2.1](#) and [3.6.6.2.2](#). For discharges occurring on or after October 1, 2006, those DRGs subject to the special payment rule for transfers are listed in [Addendum C \(FY 2007\)](#). For discharges occurring on or after October 1, 2007, those DRGs subject to the special payment rule for transfers are listed in [Addendum C \(FY 2008\)](#).

**3.6.6.4** Outliers.

- A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers as described in [Section 8, paragraph 3.2.6.1](#). For admissions on or after October 1, 1995, when calculating the cost outlier payment, if the LOS exceeds the geometric mean LOS, the cost outlier threshold shall be limited to the DRG-based payment plus the fixed loss amount. The contractor shall readjudicate claims affected by this change if brought to their attention by any source.
- Refer to <http://www.tricare.mil/drgrates/> for payment details associated with outliers.

**3.6.6.5** Transfer assigned to DRG 601. If a transfer is classified into DRG 601 (Neonate, transferred < 5 days old), the transferring hospital is paid in full. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

### 3.7 Leave Of Absence Days

**3.7.1** General. Normally, a patient will leave a hospital which is subject to the DRG-based payment system only as a result of a discharge or a transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled

immediately, a specific surgical team was not available, bilateral surgery was planned, further treatment is indicated following diagnostic tests but cannot begin immediately, a change in the patient's condition requires that scheduled surgery be delayed for a short time, or test results to confirm the need for surgery are delayed.

**3.7.2** Billing for leave of absence days. In billing for inpatient stays which include a leave of absence, hospitals are to use the actual admission and discharge dates and are to identify all leave of absence days by using revenue code 18X for such days. Contractors are to disallow all leave of absence days. Neither the Program nor the beneficiary may be billed for days of leave.

**3.7.3** DRG-based payments for stays including leave of absence days. Placing a patient on a leave of absence will not result in two DRG-based payments, nor can any payment be made for leave of absence days. Only one claim is to be submitted when the patient is formally discharged (as opposed to being placed on leave of absence), and only one DRG-based payment is to be made. The contractor should ensure that the leave of absence does not result in long-stay outlier days being paid and that it does not increase the beneficiary's cost-share.

**3.7.4** Services received while on leave of absence. The technical component of laboratory tests obtained while on a leave of absence would be included in the DRG-based payment to the hospital. The professional component is to be cost-shared as inpatient. Tests performed in a physician's office or independent laboratory are also included in the DRG-based payment.

**3.7.5** Patient dies while on leave of absence. If patient should die while on leave of absence, the date the patient left the hospital shall be treated as the date of discharge.

### **3.8 Area Wage Indexes**

The labor-related portion of the ASA will be adjusted to account for the differences in wages among geographic areas and will correspond to the labor market areas used in the Medicare PPS, and the actual indexes used will be those used in the Medicare PPS. The wage index used is to be the one for the hospital's actual address--not for the hospital's billing address.

### **3.9 Redesignation Of Certain Hospitals To Other Wage Index Areas**

TRICARE is simply following this statutory requirement for the Medicare Prospective Payment System (PPS), and the Centers for Medicare and Medicaid Services (CMS) determines the areas affected and wage indexes used.

**3.9.1** Admissions occurring on or after October 1, 1988. A hospital located in a rural county adjacent to one or more urban areas shall be treated as being located in the urban area to which the greatest number of workers commute. The area wage index for the urban area shall be used for the rural county.

**3.9.2** Admissions occurring on or after April 1, 1990. In order to correct inequities resulting from application of the rules in [paragraph 3.9.1](#), CMS modified the rules for those rural hospitals deemed to be urban. TRICARE has also adopted these changes. Some of these hospitals continue to use the urban area wage index, others use a wage index computed specifically for the rural county, and others use the statewide rural wage index.

## Hospital Reimbursement - TRICARE DRG-Based Payment System (Applicability Of The DRG System)

Issue Date: October 8, 1987

Authority: [32 CFR 199.14\(a\)\(1\)](#)

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### 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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

What providers and services are to be reimbursed under the TRICARE Diagnosis Related Groups (DRG)-based payment system?

### 3.0 POLICY

#### 3.1 Areas Affected

The TRICARE DRG-based payment system shall apply to hospital services in the 50 United States, the District of Columbia, and Puerto Rico. The DRG-based payment system shall not be used with regard to services rendered outside the 50 United States, the District of Columbia, or Puerto Rico.

**3.1.1** State waivers. Any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs may be exempt from the TRICARE DRG-based payment system under the following circumstances:

**3.1.1.1** The following requirements must be met in order for a state to be exempt.

- The state must be exempt from the Medicare Prospective Payment System (PPS);
- The state must request, in writing to TMA, that it be exempt from the TRICARE DRG-based payment system; and
- Payments in the state must continue to be at a level to maintain savings comparable to those which would be achieved under the TRICARE DRG-based payment system. TMA will monitor reimbursement levels in any exempted state to ensure that payment levels there do not exceed those under the TRICARE DRG-based payment

system. If they do exceed that level, TMA will work with the state to resolve the problem. However, if a satisfactory solution cannot be found, TMA will terminate the exemption after due notice has been given to the state.

**3.1.1.2** The only state which is exempt is Maryland.

### **3.2 Services Subject To The DRG-Based Payment System**

Unless exempt, all normally covered inpatient hospital services furnished to TRICARE beneficiaries are subject to the TRICARE DRG-based payment system.

### **3.3 Services Exempt From The DRG-Based Payment System**

The following hospital services, even when provided in a hospital subject to the TRICARE DRG-based payment system, are exempt from the TRICARE DRG-based payment system and shall be reimbursed under the appropriate procedures.

**3.3.1** Services provided by hospitals exempt from the DRG-based payment system as defined in [paragraph 3.6](#).

**3.3.2** All services related to TRICARE covered solid organ transplants for which there is no DRG assignment.

**3.3.3** Acquisition costs related to transplants shall be paid on a reasonable cost basis and are not included in the DRG.

**3.3.4** All services provided by hospital-based professionals (physicians, psychologists, etc.) which, under normal TRICARE requirements, would be billed by the hospital. This does not include any therapy services (physical, speech, etc.), since these are included in the DRG-based payment. For radiology and pathology services provided by hospital-based physicians, any related non-professional (i.e., technical) component of these services is included in the DRG-based payment and cannot be billed separately. The services of hospital-based professionals which are employed by, or under contract to, a hospital must still be billed by the hospital and must be billed on a participating basis.

**3.3.5** Anesthesia services provided by nurse anesthetists. This may be separately billed only when the nurse anesthetist is the primary anesthetist for the case.

**Note:** As a general rule, TRICARE will only pay for one anesthesia claim per case. When an anesthesiologist is paid for anesthesia services, a nurse anesthetist is not authorized to bill for those same services. Services which support the anesthesiologist in the operating room fall within the DRG allowed amount and are considered to be already included in the facility fee, even if the support services are provided by a nurse anesthetist. Charging for such services is considered an inappropriate billing practice.

**3.3.6** All outpatient services related to inpatient stays.

**Note:** Payment for trauma services (e.g., revenue code 068X), is included in the TRICARE DRG-based payment system.

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#### Hospital Reimbursement - TRICARE DRG-Based Payment System (Applicability Of The DRG System)

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**3.3.7** All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 481.

**3.3.8** All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV (Human Immunodeficiency Virus) seropositive.

**3.3.9** All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis.

**3.3.10** For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE patient who is a hemophiliac. Payment will be made for blood clotting factor when one of the following hemophilia ICD-9-CM diagnosis codes is listed on the claim:

286.0	Congenital Factor VIII Disorder;
286.1	Congenital Factor IX Disorder;
286.2	Congenital Factor XI Deficiency;
286.3	Congenital Deficiency of Other Clotting Factors;
286.4	Von Willebrand's Disease;
286.5	Hemorrhagic Disorder Due to Circulating Anticoagulants; and
286.7	Acquired Coagulation Factor Deficiency.

**3.3.10.1** Each unit billed on the hospital claim represents 100 payment units except Q0187, Factor VIIa. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be \$1,600 (paid at \$0.64/unit - Factor VIII). For HCPCS Q0187, one billing unit represents 1.2mg.

**Note:** Since the costs of blood clotting factor are reimbursed separately, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.

**3.3.10.2** Contractors shall make payment for blood clotting factor using Average Sale Price (ASP) plus 6%, using the Medicare Part B Drug Pricing file. The price allows for payment of a furnishing fee and is included in the ASP per unit.

### **3.4 Hospitals Subject To The TRICARE DRG-Based Payment System**

All hospitals within the 50 United States, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

### **3.5 Substance Use Disorder Rehabilitation Facilities (SUDRFs)**

With admissions on or after July 1, 1995, SUDRFs are subject to the DRG-based system.

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**3.6** The following types of hospitals or units which are exempt from the Medicare PPS, are exempt from the TRICARE DRG-based payment system. In order for hospitals and units which do not participate in Medicare to be exempt from the TRICARE DRG-based payment system, they must meet the same criteria (as determined by the TMA, or designee) as required for exemption from the Medicare PPS as contained in Section 412 of Title 42 CFR.

**3.6.1** Hospitals within hospitals.

**3.6.2** Psychiatric hospitals.

**3.6.3** Rehabilitation hospitals.

**3.6.4** Psychiatric and rehabilitation units (distinct parts).

**3.6.5** Long-term hospitals.

**3.6.6** Sole Community Hospitals (SCHs). Any hospital which has qualified for special treatment under the Medicare PPS as a SCH and has not given up that classification is exempt from the TRICARE DRG-based payment system. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

**3.6.7** Christian Science sanitariums.

**3.6.8** Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare PPS is exempt from the TRICARE DRG-based payment system.

**3.6.9** Hospitals outside the 50 United States, the District of Columbia, and Puerto Rico.

**3.6.10** Satellite facilities.

### **3.7 Hospitals Which Do Not Participate In Medicare**

It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE provider. However, any hospital which is subject to the TRICARE DRG-based payment system and which otherwise meets TRICARE requirements but which is not a Medicare-participating provider (having completed a CMS 1561, Health Insurance Benefit Agreement, and a CMS 1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement ([Addendum A](#)) with TMA. By completing the participation agreement, the hospital agrees to participate on all inpatient claims and to accept the TRICARE-determined allowable amount as payment in full for its services. Any hospital which does not participate in Medicare and does not complete a participation agreement with TMA will not be authorized to provide services to program beneficiaries.

## Hospital Reimbursement - TRICARE DRG-Based Payment System (DRG Weighting Factors)

Issue Date: October 6, 1987

Authority: [32 CFR 199.14\(a\)\(1\)](#)

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### 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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

What is the purpose of DRG weighting factors under the TRICARE DRG-based payment system, and how will they be calculated, used, and updated?

### 3.0 POLICY

**3.1** DRG Weighting Factors. The DRG weights reflect the relative resource consumption associated with each DRG. That is, the weight reflects the average resources required by all hospitals to treat a case classified as a specific DRG relative to the resources required to treat cases in each of the other DRGs. All weights are standardized to a theoretical average weight of 1.0 which is the average weight of all TRICARE claims in the data base. (This is the relative weight of the national average charge per discharge.)

**3.2** Calculation of DRG weights. The TRICARE weights are derived from charges. They will not reflect standardization for capital or direct medical education expenses, but the charges on which they are based are standardized for Indirect Medical Education (IDME) differences. The TRICARE DRG weights will be discharge-weighted. Specifically, the denominator used to calculate each weight represents the national average charge per discharge for the average patient. In order to calculate the DRG relative weights the following procedures will be followed.

**3.2.1** Grouping of charges. All discharge records in the database will be grouped by DRG using the current Medicare grouper program.

**3.2.2** Remove DRGs that represent discharges with invalid data or diagnoses insufficient for DRG assignment purposes. Therefore, these records are removed from the database.

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**3.2.3** IDME standardization. To standardize the charges for the cost effects of IDME factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.04 \times \left[ \left( 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

- For admissions occurring during Fiscal Year (FY) 2006, the above formula applies.
- For admissions occurring during FY 2007, the same formula shall be used except the first number shall be 1.00.
- For admissions occurring during FY 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.

**3.2.4** Calculation of DRG average charges. After the standardization for IDME, an average charge for each DRG category will be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

**3.2.5** Calculation of national average charge per discharge. A national average charge per discharge will be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

**3.2.6** DRG relative weights. DRG relative weights will be calculated for each DRG category by dividing each DRG average charge by the national average charge.

**3.3** Empty and low-volume DRGs. For any DRG with less than 10 occurrences in the TRICARE database, the Director, TMA, or designee, has the authority to consider alternative methods for estimating TRICARE weights in these low-volume DRG categories.

**3.4** Updating DRG weights. Medicare is required to adjust the DRG relative weights under the Prospective Payment System annually to ensure that the weights reflect the use of new technologies and other practice pattern changes that affect the relative use of hospital resources among DRG categories. Likewise, every year during the annual DRG update TMA will recalculate all DRG weights using TRICARE charge data and the methodology described above.

- END -

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**3.2.6.4.1.3** For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

$$\text{Standard Cost} = (\text{Billed Charges} \times \text{CCR})$$

$$\text{Outlier Payment} = 80\% \text{ of } (\text{Standard Cost} - \text{Threshold})$$

$$\text{Total Payments} = \text{Outlier Payments} + (\text{DRG Base Rate} \times (1 + (\text{IDME})))$$

**Note:** Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the CCR.

**3.2.6.4.1.4** The CCR for admissions occurring on or after October 1, 2005, is 0.4130. The CCR for admissions occurring on or after October 1, 2006, is 0.3967. The CCR for admissions occurring on or after October 1, 2007, is 0.3888

**3.2.6.4.1.5** The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2006 is 0.923, for FY 2007 is 0.925, and for FY 2008 is 0.925.

**3.2.6.4.2** For FY 2006, a fixed loss cost-outlier threshold is set of \$21,783. Effective October 1, 2005, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,783 (also wage-adjusted).

**3.2.6.4.3** For FY 2007, a fixed loss cost-outlier threshold is set of \$22,649. Effective October 1, 2006, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,649 (also wage-adjusted).

**3.2.6.4.4** For FY 2008, a fixed loss cost-outlier threshold is set of \$22,649. Effective October 1, 2007, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,649 (also wage-adjusted).

The cost-outlier threshold shall be calculated as follows:

$$\{[\text{Fixed Loss Threshold} \times ((\text{Labor-Related Share} \times \text{Applicable wage index}) + \text{Non-labor-related share}) \times \text{NOSCASTC}] + (\text{DRG Base Payment (wage-adjusted)} \times (1 + \text{IDME}))\}$$

**Example:** Using FY 1999 figures  $\{[10,129 \times ((0.7110 \times \text{Applicable wage index}) + 0.2890) \times 0.913] + (\text{DRG Based Payment (wage-adjusted)} \times (1 + \text{IDME}))\}$

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**3.2.6.5 Burn Outliers**

**3.2.6.5.1** Burn outliers generally will be subject to the same outlier policies applicable to the TRICARE DRG-based payment system except as indicated below. For admissions prior to October 1, 1998, there are six DRGs related to burn cases. They are:

- 456 - Burns, transferred to another acute care facility
- 457 - Extensive burns w/o O.R. procedure
- 458 - Non-extensive burns with skin graft
- 459 - Non-extensive burns with wound debridement or other O.R. procedure
- 460 - Non-extensive burns w/o O.R. procedure
- 472 - Extensive burns with O.R. procedure

**3.2.6.5.2** Effective for admissions on or after October 1, 1998, the above listed DRGs are no longer valid.

**3.2.6.5.3** For admissions on or after October 1, 1998, there are eight DRGs related to burn cases. They are:

- 504 - Extensive 3rd degree burn w skin graft
- 505 - Extensive 3rd degree burn w/o skin graft
- 506 - Full thick burn w sk graft or inhal inj w cc or sig tr
- 507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
- 508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
- 509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
- 510 - Non-extensive burns w cc or significant trauma
- 511 - Non-extensive burns w/o cc or significant trauma

**3.2.6.5.3.1** Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.

**3.2.6.5.3.2** For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60%.

**3.2.6.5.3.3** Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

**3.2.6.5.3.4** Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90%.

**3.2.6.5.3.5** For a burn outlier in a children's hospital, the appropriate children's hospital outlier threshold is to be used (see below), but the marginal cost factor is to be either 60% or 90% according to the criteria above.

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**3.2.6.6 Children's Hospital Outliers**

The following special provisions apply to cost outliers.

**3.2.6.6.1** The threshold shall be the same as that applied to other hospitals.

**3.2.6.6.2** Effective October 1, 2005, the standardized costs are calculated using a CCR of 0.4468. Effective October 1, 2006, the standardized costs are calculated using a CCR of 0.4282. Effective October 1, 2007, the CCR was 0.4198. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

**3.2.6.6.3** The marginal cost factor shall be 80%.

**3.2.6.6.4** For admissions occurring during FY 2006, the marginal cost factor shall be adjusted by 1.21. For admissions occurring during FY 2007, the marginal cost factor shall be adjusted by 1.27. For admissions occurring during FY 2008, the marginal cost factor shall be adjusted by 1.26.

**3.2.6.6.5** The NOSCASTC for calculating the cost-outlier threshold for FY 2006, the NOSCASTC is 0.923, for FY 2007 the NOSCASTC is 0.925, and for FY 2008, the NOSCASTC is 0.925.

The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

**Step 1:** Computation of Standardized Costs:

Billed Charges x CCR

(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)

**Step 2:** Determination of Cost-Outlier Threshold:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]}

**Step 3:** Determination of Cost Outlier Payment

{[(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor] x Adjustment Factor}

**Step 4:** Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

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**3.2.6.7 Neonatal Outliers**

Neonatal outliers in hospitals subject to the TRICARE DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the CCR of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the CCR used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same CCR used for all other acute care hospitals.

**3.2.7 IDME adjustment**

**3.2.7.1 General**

The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.04 \times \left[ \left( 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

- For admissions occurring during FY 2006, the above formula shall be used.
- For admissions occurring during FY 2007, the same formula shall be used except the first number shall be 1.00.
- For admissions occurring during FY 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.

**3.2.7.2 Number of Interns and Residents**

TRICARE will use the number of interns and residents from CMS most recently available Provider Specific File.

**3.2.7.3 Number of Beds**

TRICARE will use the number of beds from CMS's most recently available Provider Specific File.

**3.2.7.4 Updates of IDME Factors**

**3.2.7.4.1** TRICARE will use the ration of interns and residents to beds from CMS' most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual

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DRG update. The updated factors provided with the annual DR update shall be applied to claims with a date of discharge on or after October 1 of each year.

**3.2.7.4.2** Other updates of IDME factors. It is the contractor's responsibility to update the IDME factor if a hospital provides information (for the same base periods) which indicates that the IDME factor provided by TRICARE with the DRG update is incorrect or needs to be updated. An IDME factor is updated based on the hospital submitting CMS Worksheet showing the number of interns, residents, and beds. The effective date of these other updates shall be the date payment is made to the hospital (check issued) for its CAP/DME costs, but in no case can it be later than 30 days after the hospital submits the appropriate worksheet or information. The contractor shall notify TMA of such IDME updates.

**3.2.7.4.3** This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

**3.2.7.5 Adjustment for Children's Hospitals**

An IDME adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

**3.2.7.5.1** Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated information on its number of interns, residents and beds since the previous October 1 and advise them to provide the updated information by October 1 of that same year.

**3.2.7.5.2** The contractors shall send the number of interns, residents, and beds and the updated ratios for children's hospitals to TMA, MB&RS, or designee, by April 1 of each year to be used in TMA's annual DRG update calculations. These updated amounts will be included in the files for the October DRG update.

**3.2.7.6 TRICARE for Life (TFL)**

No adjustment for IDME costs is to be made on any TFL claim on which Medicare has made any payment. If TRICARE is the primary payer (e.g., claims for stays beyond 150 days) payments are to be adjusted for IDME in accordance with the provisions of this section.

### **3.2.8 Present On Admission (POA) Indicators and Hospital Acquired Conditions (HACs)**

**3.2.8.1** Effective for admissions on or after October 1, 2009, those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for every diagnosis on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

**3.2.8.2** There are five POA indicator reporting options, as defined by the ICD-9-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was present on admission.
- W = Affirms that the provider has determined based on data and clinical judgement that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not present on admission.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

**3.2.8.3** HACs. TRICARE shall adopt those HACs adopted by CMS. On or about September 2009, the HACs, and their respective diagnosis codes will be posted at <http://www.tricare.mil/drgates>.

**3.2.8.4** Provider responsibilities and reporting requirements. For non-exempt providers, issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

**3.2.8.5** The TRICARE/CHAMPUS contractor shall accept, validate, retain, pass, and store the POA indicator.

**3.2.8.6** Exempt Providers.

**3.2.8.6.1** The following hospitals are exempt from POA reports for TRICARE:

- Critical Access Hospitals (CAHs)
- Long-Term Care (LTC) Hospitals
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Hospitals

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- Inpatient Rehabilitation Hospitals
- Psychiatric Hospitals
- Sole Community Hospitals (SCHs)
- Veterans Administration (VA) Hospitals

**3.2.8.6.2** Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

**3.2.8.7** The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complications or charges because the DRG was demoted to a lesser-severity level.

**3.2.8.8** Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

- END -



## Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

Issue Date: November 28, 1988

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

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### 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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

How is the TRICARE inpatient mental health per diem payment system to be used in determining reimbursement for psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the Diagnostic Related Groups (DRG)-based payment system?

### 3.0 POLICY

#### 3.1 Inpatient Mental Health Per Diem Payment System

The inpatient mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the DRG-based payment system. The system uses two sets of per diems. One set of per diems applies to psychiatric hospitals and psychiatric units of general acute hospitals that have a relatively high number (25 or more per federal fiscal year) of TRICARE mental health discharges. For higher volume hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to psychiatric hospitals and units with a relatively low number (less than 25 per federal fiscal year) of TRICARE mental health discharges. For higher volume providers, the contractors are to maintain files which will identify when a provider becomes a high volume provider; the federal fiscal year when the provider had 25 or more TRICARE mental health discharges; the calculation of each provider's high volume rate; and the current high volume rate for the provider. For lower volume hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and Indirect Medical Education (IDME) costs and additional pass-through payments for direct medical education costs.

#### 3.2 Applicability of the Inpatient Mental Health Per Diem Payment System

**3.2.1** Facilities. The inpatient mental health per diem payment system applies to services covered that are provided in a Medicare DRG-exempt psychiatric hospitals and a Medicare DRG-

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exempt unit of a hospital. In addition, any psychiatric hospital that does not participate in Medicare, or any hospital that has a psychiatric unit that has not been so designated for exemption from Medicare DRG because the hospital does not participate in Medicare, must be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the inpatient mental health per diem payment system upon demonstrating that it meets the same Medicare criteria. The contractor is responsible for requesting from a hospital that does not participate in Medicare sufficient information from that hospital which will allow it to make a determination as to whether the hospital meets the Medicare criteria in order to designate it as a DRG-exempt hospital or unit. The inpatient mental health per diem payment system does not apply to mental health services provided in non-psychiatric hospitals or non-psychiatric units. Substance use disorder rehabilitation facilities are not reimbursed under the inpatient mental health per diem payment system (see [Section 3](#)).

**3.2.2** DRGs. All psychiatric hospitals' and psychiatric units' covered inpatient claims which are classified into a mental health DRG of 425 - 432 or a substance use disorder DRG of 433, DRGs 521 - 523, and DRGs 900 and 901 shall be subject to the TRICARE inpatient mental health per diem payment system. **Effective October 1, 2008, all psychiatric hospitals and psychiatric units covered claims which are classified into a mental health DRG of 880 - 887 or a substance use disorder DRG of 894, 895, 898, and 899 shall be subject to the TRICARE inpatient mental health per diem system.**

**3.2.3** State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers, i.e., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

### 3.3 Hospital-Specific Per Diems for Higher Volume Psychiatric Hospitals and Units

**3.3.1** Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by the government in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE claims paid (processed) during the base period. The base period amount, however, may not exceed the cap.

**3.3.2** Cap Amount. The cap amount is established at the 70th percentile.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
832	October 1, 2005 through September 30, 2006
860	October 1, 2006 through September 30, 2007
889	October 1, 2007 through September 30, 2008

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

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

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

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

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

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

- END -



## Chapter 12

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J1	Health Insurance Prospective Payment System (HIPPS) Table For Pricer For Episodes Beginning Prior To January 1, 2008
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L (CY 2006)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2006
L (CY 2007)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2007
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become the single adjusted or finalized claim for an episode in claims history -- claims will be able to be adjusted by HHAs after submission.

**3.2.3.4.7** There will not be late charge bills (TOB 0325 or 0335) under HHA PPS -- services can only be added through adjustment of the claim (TOB 0327 or 0337).

**3.2.3.4.8** New codes will appear on standard formats under HHA PPS.

**3.2.3.4.9** The TOB frequency code of "9" has been created specifically for HHA PPS billing.

**3.2.3.4.10** A 0023 revenue code will appear on both RAPs and claims, with new HIPPS codes for HHRGs in the Healthcare Common Procedure Codes (HCPCs) field of a line item.

**3.2.3.4.11** Source of Admission codes "B" (transfer from another HHA) and "C" (discharge and readmission to the same HHA) have been created for HHA PPS billing.

**3.2.3.5** The wage indexes used for the HHA PPS are the same as those used in calculation of acute inpatient hospital DRG amounts, except they lag behind by one full year.

**3.2.3.6** CMS 1450 UB-04 line itemization will have to be expanded to 450 lines for the reporting of services and supplies rendered during the extended 60-day episode period.

**3.2.3.7** HHA PPS claims will be exempt from commercial claim auditing software.

### **3.2.4 Reimbursement**

The adoption of the Medicare HHA PPS will replace the retrospective physician-oriented fee-for-service model currently used for payment of home health services under TRICARE. Under the PPS, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's POC. Other health services including, but not limited to, DME and osteoporosis drugs may receive reimbursement outside of the PPS. A fixed case-mix and wage adjusted 60-day episode payment will also be paid to Medicare-certified HHAs providing home health services to beneficiaries who are under the age of 18 and/or receiving maternity care. However, this payment amount will be determined through the manual completion and scoring of an abbreviated assessment form. The 23 items in this assessment will provide the minimal amount of data necessary for generating a HIPPS code for payment under the HHA PPS (see [Section 4, paragraph 3.6](#) for more details regarding this abbreviated assessment process). HHAs for which there is no Medicare-certification due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of beneficiaries under the age of 18 or receiving maternity care) will be reimbursed in accordance with payment provisions established under the corporate services provider class (see the TRICARE Policy Manual (TPM), [Chapter 11, Section 12.1](#) for payment provisions that apply to HHAs qualifying for coverage under this class of provider).

### **3.2.5 Authorized Providers**

**3.2.5.1** Bachelor of Science (BS) medical social workers (MSWs), social worker assistants, and home health aides that are not otherwise authorized providers under the Basic Program may

provide home health services to TRICARE beneficiaries that are under a home health POC authorized by a physician. The services are part of a package of services for which there is a fixed case-mix and wage-adjusted 60-day episode payment.

**3.2.5.2** HHAs must be Medicare certified and meet all Medicare conditions of participation [Sections 1861(o) and 1891 of the Social Security Act and Part 484 of the Medicare regulation (42 CFR 484)] in order to receive payment under the HHA PPS for home health services under the TRICARE program.

**Note:** The HHA will be responsible for assuring that all individuals rendering home health services meet the qualification standards specified in [Section 2](#). The contractor will not be responsible for certification of individuals employed by or contracted with a HHA.

**3.2.5.3** HHAs for which Medicare-certification is not available due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of TRICARE eligible beneficiaries that are under the age of 18 or receiving maternity care) must meet the qualifying conditions for corporate services provider status as specified in the TPM, [Chapter 11, Section 12.1](#). Those specialized HHAs qualifying for corporate services provider status will be reimbursed in accordance with the provisions outlined in [Section 4, paragraph 3.6.3.2](#).

### **3.2.6 Transition to HHA PPS**

**3.2.6.1** As of the first day of health care delivery of the new contract, all HHAs must bill all services delivered to homebound TRICARE beneficiaries under a home health POC under HHA PPS. The HHA PPS applies to claims billed on a CMS 1450 UB-04, with Form Locator (FL) 4 TOB 032X or 033X. HHAs will still occasionally bill TRICARE using TOB 034X, but these claims will not be subject to PPS payment. If an HHA has beneficiaries already under an established POC prior to this date, the open claims for services on or before (TBD) must be closed and submitted for payment under the standard TRICARE fee-for-service allowable charge methodology. Claims for services on or after (TBD) will be processed and paid under the HHA PPS. Under no circumstances should a HHA claim span payment systems. Claims for services dates spanning payment systems will be returned to the provider for splitting.

**3.2.6.2** The Managed Care Support Contractors (MCSCs) will identify all beneficiaries receiving HHC services 60 days prior to implementation of the HHA PPS and notify them and the HHA of any change in their benefit (i.e., changes in coverage of services or reimbursement), with the exception of beneficiaries that were under the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) on or before December 28, 2001, and those grandfathered under the HHC Demonstration. The MCSCs will be expected to work with the HHAs and beneficiaries toward a smooth transition to the new HHA PPS.

**3.2.6.3** The HHA PPS will apply in all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and Guam.

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

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

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

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

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

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

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

- The first position is no longer a fixed value. The refined HH PPS uses a four equation case-mix model which assigns differing scores in the clinical, functional and services domains based on whether an episode is an early or later episode in a sequence of adjacent episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores.
- The second, third, and fourth positions of the code remain a one-to-one crosswalk to the three domains of the HHRG coding system. The second through fourth positions of the HH PPS HIPPS code will only allow alphabetical characters.
- The fifth position indicates a severity group for NRS. The HH PPS grouper software will assign each episode into one of six NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number of one through six before submitting the claim.
- **The first four positions of the HIPPS code submitted on the final claim must match what was on the Request for Anticipated Payment (RAP). The fifth digit may vary (i.e., where the HHA initially anticipated the use of NRS during the episode only to subsequently find out that they were not required - the supply indicator may need to be changed if no supplies were provided).**

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

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

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

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

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

**3.5.1.4** The new HIPPS coding structure has resulted in 153 case-mix groups represented by the first four positions of the code. Each of these case-mix groups can be combined with a NRS severity level, resulting in 918 HIPPS codes in all (i.e., 153 case-mix times six NRS severity levels). With two values representing supply levels (1-6 in cases where NRS's are not associated with the first four positions of the HIPPS code and S-X where they are), there are actually 1836 new HIPPS codes. Refer to [Addendum J3](#) (for episodes beginning on or after January 1, 2008) for a complete listing of HH PPS case-mix refined HIPPS codes (all five positions) with associated weights.

positions, from OASIS item M0030), the date the assessment was completed (eight-positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The claims-OASIS matching key is reported in FL 44 of the CMS 1450 UB-04.

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

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

**3.6.2.2** The second, third, and fourth positions of the HIPPS code (alphabetical characters) will be assigned based on the scoring of the 23 OASIS items reflected in the HHRG Worksheet for episodes beginning on or after January 1, 2008 in [Addendum I](#). The OASIS items for use in this abbreviated assessment scoring will be available on the CMS web site (<http://www.cms.hhs.gov/HomeHealthQualityInits/>) as indicated in [Addendum G2](#). However, since Clinical Severity Domain category "C0", Function Status Domain category "F0", and Service Utilization Domain category "S0" are no longer recognized as part of the refined HIPPS coding structure they will default to "C1", "F1", and "S1", respectively, in establishing reimbursement under the abbreviated assessment for TRICARE beneficiaries who are under the age of 18 or receiving maternity care.

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

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

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

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

needs of patients under the age of 18), the contractor will authorize care in, and designate primary provider status to, the Medicare HHA.

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

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

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

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

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

### **3.7 Split Payments (Initial and Final Payments)**

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

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

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

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

**3.8 Calculation of Prospective Payment Amounts**

**3.8.1 National 60-Day Episode Payment Amounts**

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

**3.8.1.2** Figure 12.4-14 provides the calculations involved in the establishment of the non-standardized prospective payment amount per 60-day episode in FY 2001, along with adjustments for NRS, Part B therapies and OASIS implementation and ongoing costs.

**FIGURE 12.4-14 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS**

<b>DISCIPLINES</b>	<b>TOTAL COSTS</b>	<b>TOTAL VISITS</b>	<b>AVERAGE COST PER VISIT</b>	<b>AVER. # VISITS PER 60-DAYS</b>	<b>HOME HEALTH PROSPECTIVE PAYMENT RATE</b>
Home Health Aide Services	\$5,915,395,602	141,682,907	\$41.75	13.40	\$559.45
Medical Social Services	458,571,353	2,985,588	153.59	0.32	49.15
Occupational Therapy	444,691,130	4,244,901	104.76	0.53	55.52
Physical Therapy	2,456,109,303	23,605,011	104.05	3.05	317.35
Skilled Nursing Services	12,108,884,714	127,515,950	94.96	14.08	1,337.04
Speech Pathology Service	223,173,331	1,970,399	113.26	0.18	20.39
Total Non-Standardized Prospective Payment Amount Per 60-day Episode for FY 2001:					<b>\$2,338.90</b>
<b>ADJUSTMENTS:</b>					
1. Average cost per episode for NRS included in the home health benefit and reported as costs on the cost report					<b>\$43.54</b>
2. Average payment per episode for NRS possibly unbundled and billed separately for Part B					<b>\$6.08</b>
3. Average payment per episode for Part B therapies					<b>\$17.76</b>
4. Average payment per episode for OASIS one time adjustment for form changes					<b>\$5.50</b>
5. Average payment per episode for ongoing OASIS adjustment costs					<b>\$4.32</b>
Total Non-Standardized Prospective Payment Amount for 60-day Episode for FY 2001 Plus Medical Supplies, Part B Therapies and OASIS					<b>\$2,416.01</b>

**3.8.1.3** The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in Figure 12.4-15 for case-mix, budget neutrality and outliers in the

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establishment of a final standardized and budget neutral payment amount per 60-day episode for FY 2001.

**FIGURE 12.4-15 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX**

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

**3.8.1.3.1** The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in [Addendums L \(CY 2006\)](#), [L \(CY 2007\)](#), and [L \(CY 2008\)](#).

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

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

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

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

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

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

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

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

**Step 1:** Add the wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted episode payment.

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

**3.8.1.4** Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts have not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in [Addendums L \(CY 2006\)](#), [L \(CY 2007\)](#), [L \(CY 2008\)](#), [M \(CY 2006\)](#), [M \(CY 2007\)](#), and [M \(CY 2008\)](#).

### 3.8.1.5 Annual Updating of HHA PPS Rates and Wage Indexes.

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

**3.8.1.5.2** Three iterations of these rates will be maintained in [Addendums L \(CY 2006\)](#), [L \(CY 2007\)](#), and [L \(CY 2008\)](#). These rate adjustments are also integral data elements used in updating the Pricer.

**3.8.1.5.3** Three iterations of wage indexes will also be maintained in [Addendums M \(CY 2006\)](#), [M \(CY 2007\)](#), and [M \(CY 2008\)](#), for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

### 3.8.2 Calculation of Reduced Payments

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

**Note:** Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) have not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in [Addendums L \(CY 2006\)](#), [L \(CY 2007\)](#), and [L \(CY 2008\)](#), [M \(CY 2006\)](#), [M \(CY 2007\)](#), and [M \(CY 2008\)](#).

#### 3.8.2.1 PEP Adjustment

The PEP adjustment is used to accommodate payment for EOCs less than 60 days resulting from one of the following intervening events: 1) beneficiary elected a transfer prior to the end of the 60-day EOC; or 2) beneficiary discharged after meeting all treatment goals in the original POC and subsequently readmitted to the same HHA before the end of the 60-day EOC. The PEP adjustment is based on the span of days over which the beneficiary received treatment prior to the intervening event; i.e., the days, including the start-of-care date/first billable service date through and including the last billable service date, before the intervening event. The original POC must be terminated with no anticipated need for additional home health services. A new 60-day EOC would have to be initiated upon return to a HHA, requiring a physician's recertification of the POC, a new OASIS assessment, and authorization by the contractor. The PEP adjustment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary was receiving care prior to the intervening event by the beneficiary's assigned 60-day episode payment. The PEP adjustment is only applicable for beneficiaries having more than four billable home health visits. Transfers of beneficiaries between HHAs of common ownership are only applicable when the agencies are located in different metropolitan statistical areas. Also, PEP adjustments do not apply in situations where a patient dies during a 60-day EOC. Full episode payments are made in these particular cases. For example, a beneficiary assigned to HHRG C2F1S2 and receiving care in Denver, CO was discharged from a HHA on Day 28 of a 60-day EOC and subsequently returned to the same

HHA on Day 40. However, the first billable visit (i.e., a physician ordered visit under a new POC) did not occur until Day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original POC were accomplished and there was no anticipated need for home care during the balance of the 60-day episode. Since the last visit was furnished on Day 28 of the initial 60-day episode, the PEP adjustment would be equal to the assigned 60-day episode payment times 28/60, representing the proportion of the 60 days that the patient was in treatment. Day 42 of the original episode becomes Day 1 of the new certified 60-day episode. The following steps are used in calculating the PEP adjustment:

**Step 1:** Calculate the proportion of the 60 days that the beneficiary was under treatment.

$$(28/60) = 0.4667$$

**Step 2:** Multiply the beneficiary assigned 60-day episode payment amount by the proportion of days that the beneficiary was under treatment.

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

### 3.8.2.2 SCIC Payment Adjustment

#### 3.8.2.2.1 For Episodes Beginning Prior To January 1, 2008

The full episode payment amount is adjusted if the beneficiary experiences a SCIC during a 60-day episode that was not envisioned in the initial treatment plan. It reflects a proportional payment adjustment for both the time prior to and after the SCIC and results in the assignment of a new HHRG. The new HHRG is assigned based on the HHA's revised OASIS assessment, accompanied by appropriate changes in the physician's POC. The apportionment of payment is a two-part process. The first part involves determining the proportion of the 60-day episode prior to the SCIC and multiplying it by the original episode payment amount. The second part entails the multiplying of the remaining proportion of the 60-day episode after the SCIC by the new episode payment level initiated through the certification and assessment process. For example, a Denver, CO HHA assigns a beneficiary to HHRG C2F1S2 that equals \$3,970.20. The beneficiary's first billable day is Day 1. The beneficiary experiences a SCIC on Day 16. The last billable service day prior to the SCIC was Day 18. The HHA completes a new OASIS assessment and obtains the necessary physician orders to change the case-mix assignment to HHRG C3F2S3, which equals \$5,592.96. The HHA starts rendering services under the revised POC and at the new case-mix level on Day 22. Days 1 through 18 are used in calculating the first part of the SCIC adjustment, while Days 22 through 60 are used in calculating the second part of the SCIC adjustment. The following steps are used in calculating SCIC payment adjustment:

**Step 1:** Multiply the proportion of the 60-day episode before the SCIC by the original episode payment amount.

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

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

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

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

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

**3.8.2.2.2 For Episodes Beginning On Or After January 1, 2008**

The refined HH PPS no longer contains a policy to allow for adjustments reflecting SCICs. Episodes paid under the refined HH PPS will be paid based on a single HIPPS code. Claims submitted with additional HIPPS codes reflecting SCICs will be returned to the provider; i.e., claims for episodes beginning on or after January 1, 2008, that contain more than one revenue code 0023 line.

**3.8.2.3 LUPA**

**3.8.2.3.1 For Episodes Beginning Prior To January 1, 2008**

**3.8.2.3.1.1** The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in [Figure 12.4-1](#) plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in [Figure 12.4-16](#).

**FIGURE 12.4-16 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS**

HOME HEALTH DISCIPLINE TYPE	AVERAGE COST PER VISIT				STANDARDIZATION FACTOR FOR WAGE INDEX	OUTLIER ADJUSTMENT FACTOR	PER VISIT PAYMENT AMOUNTS PER 60-DAY EPISODE FOR FY 2001
	FROM THE PPS AUDIT SAMPLE	FOR NON-ROUTINE MEDICAL SUPPLIES*	FOR ONGOING OASIS ADJUSTMENT COSTS	FOR ONE-TIME OASIS SCHEDULING CHANGE			
Home Health Aide	\$41.75	\$1.94	\$0.12	\$0.21	0.96674	1.05	\$43.37
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

\* Combined average cost per-visit amounts for NRS reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.

**3.8.2.3.1.2** The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits.

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

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

**Step 1:** Multiple the per-visit rate per discipline by the number of visits and add them together to get the total unadjusted low-utilization payment amount.

Skilled nursing visits	1 x \$95.79	=	\$ 95.79
Physical therapy visits	1 x \$104.74	=	\$104.74
Home health aide visits	2 x \$43.37	=	\$ 86.74
Total unadjusted payment amount			\$287.27

**Step 2:** Multiply the unadjusted payment amount by its labor and non-labor related percentages to get the labor and non-labor portion of the payment amount.

Labor Portion	=	(\$287.27 x 0.77668)	=	\$223.12
Non-Labor Portion	=	(\$287.27 x 0.22332)	=	\$64.15

**Step 3:** Multiply the labor portion of the payment amount by the wage index for Denver, CO.

$$(\$223.12 \times 1.0190) = \$227.36$$

**Step 4:** Add the labor and non-labor portions together to arrive at the LUPA.

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

#### 3.8.2.3.2 For Episodes Beginning On Or After January 1, 2008

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

#### 3.8.2.4 Therapy Threshold Adjustment

##### 3.8.2.4.1 For Episodes Beginning Prior To January 1, 2008

There is a downward adjustment in the 60-day episode payment amount if the number of therapy services delivered during an episode does not meet the threshold. The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours

provided over the course of the episode. The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, is confirmed by the visit information submitted in line-item detail on the claim for the episode. If therapy use is below the utilization threshold (i.e., the projected range of hours for physical, occupational or speech therapy combined), there is an automatic downward adjustment in the 60-day episode payment amount.

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

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

**3.8.2.4.2.2** Due to this increased complexity of the payment system regarding therapies, the Pricer software in the claims processing system will re-code all claims based on the actual number of therapy services provided. The re-coding will be performed without regard to whether the number of therapies delivered increased or decreased compared to the number of expected therapies reported on the OASIS assessment and used to base RAP payment. As in the original HH PPS, the remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

### **3.8.3 Calculation of Outlier Payments**

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

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

received 54 skilled nursing visits, 48 home health aide visits, and six physical therapy visits. The following steps are used in calculating the outlier payment:

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

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

$$(1.9532 \times \$2,115.30) = \$4,131.61$$

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

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

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

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

$$(0.9086 \times \$3,208.94) = \$2,915.64$$

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

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

### 3.8.3.2.2 Calculation of the Wage-Adjusted Outlier Threshold

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

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

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

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

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

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

$$(0.9086 \times \$1,856.49) = \$1,686.80$$

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

$$(\$1,686.80 + \$533.80) = \$2,220.60$$

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

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

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

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

Skilled Nursing Visits	(54 x \$95.79)	=	\$5,172.66
Home Health Aide Visits	(48 x \$43.37)	=	\$2,081.76
Physical Therapy Visits	(6 x \$104.74)	=	\$628.44

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

**1. Skilled Nursing Visits**

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

Labor Portion	=	(.77668 x \$5,172.66)	=	\$4,017.50
Non-Labor Portion	=	(.22332 x \$5,172.66)	=	\$1,155.16

- Wage-adjusted labor portion of imputed costs.

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

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

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

**2. Home Health Aide Visits**

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

Labor Portion	=	(.77668 x \$2,081.76)	=	\$1,616.86
Non-Labor Portion	=	(.22332 x \$2,081.76)	=	\$464.90

- Wage-adjusted labor portion of imputed costs.

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

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

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

**3. Physical Therapy Visits**

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

$$\text{Labor Portion} = (.77668 \times \$628.44) = \$488.10$$

$$\text{Non-Labor Portion} = (.22332 \times \$628.44) = \$140.34$$

- Wage-adjusted labor portion of imputed costs.  
 $(\$488.10 \times 0.9086) = \$443.49$
- Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

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

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

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

**3.8.3.2.4 Calculation of Outlier Payment**

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

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

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

$$(\$1,264.35 \times 0.80) = \mathbf{\$1,018.68}$$

**3.8.3.2.5 Calculation of Total Payment to HHA**

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

$$(\$3,838.32 + \$1,018.68) = \mathbf{\$4,857.00}$$

**3.9 Other Health Insurance (OHI) Under HHA PPS**

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

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liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

- END -



Home Health Resource Group (HHRG) Worksheet

**FIGURE 12.I-1 HHRG FOR EPISODES BEGINNING PRIOR TO JANUARY 1, 2008**

CLINICAL SEVERITY DOMAIN				
OASIS ITEM	DESCRIPTION	ITEM RESPONSE	I. SCORING RULES	ITEM SCORE
M0230(a)/ M0240(b)	Primary home care diagnosis/ First secondary diagnosis		If Orthopedic DG, add 11 to score If Neurological DG, add 20 to score If Diabetes DG, add 17 to score If Burn/Trauma DG, see under M0440	(max is 20)
M0250	IV/Infusion/Parenteral/Enteral Therapies		If box 1, add 14 to score If box 2, add 20 to score If box 3, add 24 to score	(max is 24)
M0390	Vision		If box 1 or 2, add 6 to score	
M0420	Pain		If box 2 or 3, add 5 to score	
M0440	Wound/Lesion		If box 1 and M0230/240 is Burn/Trauma DG, add 21 to score	
M0450	Multiple pressure ulcers		If 2 or more stage 3 or 4 pressure ulcers, add 17 to score	
M0460	Current stage, most problematic pressure ulcer		If box 1 or 2, add 15 to score If box 3 or 4, add 36 to score	(max is 36)
M0476	Stasis ulcer		If box 2, add 14 to score If box 3, add 22 to score	
M0488	Surgical wound		If box 2, add 7 to score If box 3, add 15 to score	
M0490	Dyspnea		If box 2, 3, or 4, add 5 to score	
M0530	Urinary incontinence		If box 1 or 2, add 6 to score	
M0540	Bowel incontinence		If box 2, 3, 4, or 5, add 9 to score	
M0550	Bowel ostomy		If box 1 or 2, add 10 to score	
M0610	Behavioral Problems		If box 2, 3, 4, 5, or 6, add 3 to score	(max is 3)
TOTAL SCORE:				
Categories: [0-7 = C0] [8-19 = C1] [20-40 = C2] [41+ = C3] CATEGORY: <input type="text" value="C"/>				
FUNCTIONAL STATUS DOMAIN				
OASIS ITEM	DESCRIPTION	ITEM RESPONSE	SCORING RULES	ITEM SCORE
M0650 (current)	Dressing upper body		If M0650 = box 1, 2, or 3, Or	
M0660 (current)	Dressing lower body		If M0660 = box 1, 2, or 3, add 4 to score	(max is 4)
M0670 (current)	Bathing		If box 2, 3, 4, or 5, add 8 to score	
M0680 (current)	Toileting		If box 2, 3, or 4, add 3 to score	
M0690 (current)	Transferring		If box 1, add 3 to score If box 2, 3, 4, or 5, add 6 to score	
M0700 (current)	Locomotion		If box 1 or 2, add 6 to score If box 3, 4, 5, or 6, add 9 to score	
TOTAL SCORE:				
Categories: [0-2 = F0] [3-15 = F1] [16-23 = F2] [24-29 = F3] [30 = F4] CATEGORY: <input type="text" value="F"/>				
SERVICE UTILIZATION DOMAIN				
OASIS ITEM	DESCRIPTION	ITEM RESPONSE	SCORING RULES	ITEM SCORE
M0175 line 1	Hospital disch. past 14 days		If box 1 IS BLANK, add 1 to score	
M0175 line 2	Rehab dischg. past 14 days		If box 2 or 3, add 2 to score	
M0175 line 3	SNF dischg. past 14 days			(max is 2)
M0825	10 or more therapy (PT, SLP, OT) visits planned/recd. in 60 days		If yes, add 4 to score	
TOTAL SCORE:				
Categories: [02 = S0] [3 = S1] [4-6 = S2] [7 = S3] CATEGORY: <input type="text" value="S"/>				

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Chapter 12, Addendum I

Home Health Resource Group (HHRG) Worksheet

**FIGURE 12.I-2 HHRG FOR EPISODES BEGINNING ON OR AFTER JANUARY 1, 2008**

CLINICAL SEVERITY DOMAIN				
OASIS ITEM	DESCRIPTION	ITEM RESPONSE	I. SCORING RULES	ITEM SCORE
M0230(a)/ M0240(b)	Primary home care diagnosis/ Secondary diagnoses		If Orthopedic DG, add 11 to score If Neurological DG, add 20 to score If Diabetes DG, add 17 to score <i>If Burn/Trauma DG, see under M0440</i>	(max is 20)
M0250	IV/Infusion/ Parenteral/ Enteral Therapies		If box 1, add 14 to score If box 2, add 20 to score If box 3, add 24 to score	(max is 24)
M0390	Vision		If box 1 or 2, add 6 to score	
M0420	Pain		If box 2 or 3, add 5 to score	
M0440	Wound/Lesion		If box 1 and M0230/240 is Burn/Trauma DG, add 21 to score	
M0450	Multiple pressure ulcers		If 2 or more stage 3 or 4 pressure ulcers, add 17 to score	
M0460	Current stage, most problematic pressure ulcer		If box 1 or 2, add 15 to score If box 3 or 4, add 36 to score	(max is 36)
M0476	Stasis ulcer		If box 2, add 14 to score If box 3, add 22 to score	
M0488	Surgical wound		If box 2, add 7 to score If box 3, add 15 to score	
M0490	Dyspnea		If box 2, 3, or 4, add 5 to score	
M0520	Urinary incontinence		If box 1 or 2, add 6 to score	
M0540	Bowel incontinence		If box 2, 3, 4, or 5, add 9 to score	
M0550	Bowel ostomy		If box 1 or 2, add 10 to score	
M0610	Behavioral Problems		If box 2, 3, 4, 5, or 6, add 3 to score	(max is 3)
TOTAL SCORE:				
Categories:	[0-19 = C1]	[20-40 = C2]	[41+ = C3]	CATEGORY: <b>C</b>

FUNCTIONAL STATUS DOMAIN				
OASIS ITEM	DESCRIPTION	ITEM RESPONSE	SCORING RULES	ITEM SCORE
M0650 (current)	Dressing upper body		If M0650 = box 1, 2, or 3, Or	
M0660 (current)	Dressing lower body		If M0660 = box 1, 2, or 3, add 4 to score	(max is 4)
M0670 (current)	Bathing		If box 2, 3, 4, or 5, add 8 to score	
M0680 (current)	Toileting		If box 2, 3, or 4, add 3 to score	
M0690 (current)	Transferring		If box 1, add 3 to score If box 2, 3, 4, or 5, add 6 to score	
M0700 (current)	Locomotion		If box 1 or 2, add 6 to score If box 3, 4, or 5, add 9 to score	
M0800	Management of Injections		If box 1, add 1 to score If box 2, add 2 to score	
TOTAL SCORE:				
Categories:	[0-15 = F1]	[16-23 = F2]	[24-29 = F3]	[30 = F4] CATEGORY: <b>F</b>

SERVICE UTILIZATION DOMAIN				
OASIS ITEM	DESCRIPTION	ITEM RESPONSE	SCORING RULES	ITEM SCORE
M0175 line 1	Hospital discharge past 14 days		If box 1 IS BLANK, add 1 to score	
M0175 line 2	Rehab dischg. past 14 days		If box 2 or 3, add 2 to score	
M0175 line 3	SNF dischg. past 14 days			(max is 2)
M0826	Total number of therapy (PT, SLP, OT) visits recd. in 60 days		Actual number of visits NA No therapy visits	
TOTAL SCORE:				
Categories:	[0-3 = S1]	[4-6 = S2]	[7 = S3]	CATEGORY: <b>S</b>

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Chapter 12, Addendum I

Home Health Resource Group (HHRG) Worksheet

**FIGURE 12.I-3 ABBREVIATED OASIS QUESTIONS**

(To be used in conjunction with Home Health Resource Group (HHRG) Worksheet for scoring and payment of home health episodes beginning on or after January 1, 2008 for children and maternity cases.)

- |   |  |   |  |
|---|--|---|--|
| 1. MO230(a) Primary home care diagnosis |  | 15.MO610 Behaviors                              | <input type="checkbox"/> 1 Memory deficits                               |
| 2. MO240(b) First secondary diagnosis   |  |   | <input type="checkbox"/> 2 Impaired decisions                            |
| 3. MO250 Therapies                      | <input type="checkbox"/> 1 IV Infusion<br><input type="checkbox"/> 2 Parenteral<br><input type="checkbox"/> 3 Enteral Therapies  |   | <input type="checkbox"/> 3 Verbal disruptions                            |
| 4. MO390 Vision                         | <input type="checkbox"/> 0 Normal vision<br><input type="checkbox"/> 1 Partially impaired: cannot see medication labels or newsprint<br><input type="checkbox"/> 2 Severe impairment: cannot locate objects  | 16 MO650/660 Dress Upper & Lower Body           | <input type="checkbox"/> 4 Physical aggression                           |
| 5. MO420 Frequency of pain              | <input type="checkbox"/> 0 No pain<br><input type="checkbox"/> 1 Less often than daily<br><input type="checkbox"/> 2 Daily, but not constant<br><input type="checkbox"/> 3 All of the time   |   | <input type="checkbox"/> 5 Disruptive                                    |
| 6. MO440 Wound Lesion                   | <input type="checkbox"/> 0 No<br><input type="checkbox"/> 1 Yes  | 17.MO670 Bathing                                | <input type="checkbox"/> 6 Delusional                                    |
| 7. MO450 Pressure ulcers                |  |   | <input type="checkbox"/> 7 None of above                                 |
| 8. MO460 Current stage                  | <input type="checkbox"/> 1 Stage 1<br><input type="checkbox"/> 2 Stage 2<br><input type="checkbox"/> 3 Stage 3<br><input type="checkbox"/> 4 Stage 4<br><input type="checkbox"/> NA No observable stasis ulcer   |   | <input type="checkbox"/> 0 Able to dress self                            |
| 9. MO476 Stasis ulcer                   | <input type="checkbox"/> 1 Fully granulating<br><input type="checkbox"/> 2 Early/partial granulation<br><input type="checkbox"/> 3 Not healing<br><input type="checkbox"/> NA No observable stasis ulcer   | 18 MO680 Toileting                              | <input type="checkbox"/> 1 Clothes laid out                              |
| 10.MO488 Surgical wound                 | <input type="checkbox"/> 1 Fully granulating<br><input type="checkbox"/> 2 Early/partial granulation<br><input type="checkbox"/> 3 Not healing<br><input type="checkbox"/> NA No observable surgical wound   |   | <input type="checkbox"/> 2 Need help                                     |
| 11.MO490 Respiratory                    | <input type="checkbox"/> 1 Fully granulating<br><input type="checkbox"/> 2 Walking 20 ft, climbing stairs<br><input type="checkbox"/> 3 Moderate exertion-dressing, using bedpan, walking < 20 ft<br><input type="checkbox"/> 4 Minimal exertion - eating talking, agitation<br><input type="checkbox"/> NA No observable surgical wound                                 | 19.MO690 Transferring                           | <input type="checkbox"/> 3 Entirely dependent                            |
| 12.MO520 Urinary Incontinence           | <input type="checkbox"/> 0 Timed-voiding defers<br><input type="checkbox"/> 1 During night only<br><input type="checkbox"/> 2 During night & day   |   | <input type="checkbox"/> UK Unknown                                      |
| 13.MO540 Bowel Incontinence             | <input type="checkbox"/> 0 Very rarely/never<br><input type="checkbox"/> 1 Less than once weekly<br><input type="checkbox"/> 2 One to three/week<br><input type="checkbox"/> 3 Four to six/week<br><input type="checkbox"/> 4 Daily<br><input type="checkbox"/> 5 More often than daily<br><input type="checkbox"/> NA Has ostomy<br><input type="checkbox"/> UK Unknown | 20.MO700 Ambulation                             | <input type="checkbox"/> 0 Able to bathe self                            |
| 14.MO550 Ostomy for Bowel               | <input type="checkbox"/> 0 No ostomy<br><input type="checkbox"/> 1 Ostomy not related to IP stay & no change necessary<br><input type="checkbox"/> 2 Ostomy needs change/treatment   |   | <input type="checkbox"/> 1 Use devices                                   |
|   |  | 21.MO800 Management of Injections               | <input type="checkbox"/> 2 Assistance to bathe                           |
|   |  |   | <input type="checkbox"/> 3 Participates                                  |
|   |  | 22.MO826 Total number of therapy visits _____ # | <input type="checkbox"/> 4 Unable to use shower or tub                   |
|   |  |   | <input type="checkbox"/> 5 Totally dependent                             |
|   |  |   | <input type="checkbox"/> UK Unknown                                      |
|   |  | 23.MO175 Discharge                              | <input type="checkbox"/> 0 Independent w/ or w/o device                  |
|   |  |   | <input type="checkbox"/> 1 When reminded, assisted, supervised           |
|   |  |   | <input type="checkbox"/> 2 Unable get to toilet, use commode             |
|   |  |   | <input type="checkbox"/> 3 Use bedpan/urinal                             |
|   |  |   | <input type="checkbox"/> 4 Totally dependent                             |
|   |  |   | <input type="checkbox"/> UK Unknown                                      |
|   |  |   | <input type="checkbox"/> 0 Independent                                   |
|   |  |   | <input type="checkbox"/> 1 Use device                                    |
|   |  |   | <input type="checkbox"/> 2 Walk w/supervision                            |
|   |  |   | <input type="checkbox"/> 3 Chairfast, able to wheel self                 |
|   |  |   | <input type="checkbox"/> 4 Chairfast, unable to wheel self               |
|   |  |   | <input type="checkbox"/> 5 Bedfast                                       |
|   |  |   | <input type="checkbox"/> UK Unknown                                      |
|   |  |   | <input type="checkbox"/> 0 Independent                                   |
|   |  |   | <input type="checkbox"/> 1 Minimal assistance/device                     |
|   |  |   | <input type="checkbox"/> 2 Assist w/ weight-bearing & pivoting           |
|   |  |   | <input type="checkbox"/> 3 Transfer w/o wt-bearing & pivoting            |
|   |  |   | <input type="checkbox"/> 4 Bedfast, able to turn                         |
|   |  |   | <input type="checkbox"/> 5 Bedfast, unable to turn                       |
|   |  |   | <input type="checkbox"/> UK Unknown                                      |
|   |  |   | <input type="checkbox"/> 0 Independent                                   |
|   |  |   | <input type="checkbox"/> 1 Able to inject w/prepared syringes, reminders |
|   |  |   | <input type="checkbox"/> 2 Administered by another                       |
|   |  |   | <input type="checkbox"/> NA No injectables                               |
|   |  |   | <input type="checkbox"/> UK Unknown                                      |
|   |  |   | <input type="checkbox"/> 1 Hospital                                      |
|   |  |   | <input type="checkbox"/> 2 Rehab facility                                |
|   |  |   | <input type="checkbox"/> 3 SNF   |
|   |  |   | <input type="checkbox"/> 4 Other nursing facility                        |
|   |  |   | <input type="checkbox"/> 5 Other Specify _____                           |
|   |  |   | <input type="checkbox"/> NA Patient was not discharged                   |

- END -



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Chapter 12, Addendum S

Input/Output Record Layout

FILE POSITION	FORMAT	TITLE	DESCRIPTION		
<b>FOR EPISODES BEGINNING PRIOR TO JANUARY 1, 2008</b>					
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.		
			<b>Payment return codes:</b>		
			00	Final payment where no outlier applies	
			01	Final payment where outlier applies	
			03	Initial percentage payment, 0%	
			04	Initial percentage payment, 50%	
			05	Initial percentage payment, 60%	
			06	LUPA payment only	
			07	Final payment, Significant Change In Condition (SCIC)	
			08	Final payment, SCIC with outlier	
			09	Final payment, PEP	
			11	Final payment, PEP with outlier	
			12	Final payment, SCIC within PEP	
			13	Final payment, SCIC with PEP with outlier	
			<b>Error return codes:</b>		
			10	Invalid TOB	
			15	Invalid PEP days	
			16	Invalid HRG days, > 60	
			20	PEP indicator invalid	
			25	Med review indicator invalid	
			30	Invalid Metropolitan Statistical Area (MSA)/CBSA code	
			35	Invalid Initial Payment Indicator	
			40	Dates < October 1, 2000 or invalid	
70	Invalid HRG code				
75	No HRG present in 1st occurrence				
80	Invalid revenue code				
85	No revenue code present on 3x9 or adjustment TOB				
403-407	9(5)	REVENUE-SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.		
408-412	9(5)	REVENUE- SUM 1-6- QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.		
413-421	9(7)V9(2)	OUTLIER- PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.		

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Chapter 12, Addendum S

Input/Output Record Layout

FILE POSITION	FORMAT	TITLE	DESCRIPTION
<b>FOR EPISODES BEGINNING ON OR AFTER JANUARY 1, 2008</b>			
431-435	9(3)V9(2)	LUPA-ADD-ON PAYMENT	Output item: The add-on amount to be paid for LUPA claims that are the first episode in a sequence.
436	X	LUPA-SRC-ADM	Input item: The source of admission code on the RAP or claim.
437	X	RECODE-IND	Input item: A recoding indicator set by the contractors' claims processing systems in response to the identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0=default value 1=HIPPS code shows later episode, should be early episode 3=HIPPS code shows early episode, should be later episode
438	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Contractors' systems copy this code from the 10th position of the treatment authorization code. Valid values: 1=early episode 2=late episode
439	X	CLINICAL-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Contractors' systems copy this code from the 11th position of the treatment authorization code.
440	X	FUNCTION-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Contractors' systems copy this code from the 12th position of the treatment authorization code.
441	X	CLINICAL-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Contractors' systems copy this code from the 13th position of the treatment authorization code.
442	X	FUNCTION-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Contractors' systems copy this code from the 14th position of the treatment authorization code.
443	X	CLINICAL-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Contractors' systems copy this code from the 15th position of the treatment authorization code.
444	X	FUNCTION-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Contractors' systems copy this code from the 16th position of the treatment authorization code.
445	X	CLINICAL-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Contractors' systems copy this code from the 17th position of the treatment authorization code.
446	X	FUNCTION-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Contractors' systems copy this code from the 18th position of the treatment authorization code.
447-450	X	FILLER	

## Acronyms And Abbreviations

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

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## Appendix A

### Acronyms And Abbreviations

---

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

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

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
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone Marrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service

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## Appendix A

### Acronyms And Abbreviations

---

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

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## Appendix A

### Acronyms And Abbreviations

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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
<b>CIF</b>	<b>Central Issuing Facility</b>
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer

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## Appendix A

### Acronyms And Abbreviations

---

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

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

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

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## Appendix A

### Acronyms And Abbreviations

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DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
<b>DOS</b>	<b>Date Of Service</b>
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
<b>DRG</b>	<b>Diagnosis</b> Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility

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### Acronyms And Abbreviations

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DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
<b>DXA</b>	<b>Dual Energy X-Ray Absorptiometry</b>
<b>ECAS</b>	<b>European Cardiac Arrhythmia Society</b>
<b>EHRA</b>	<b>European Heart Rhythm Association</b>
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support

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EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim
	Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin
	Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank

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FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV <sub>1</sub>	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
<b>FOBT</b>	<b>Fecal Occult Blood Testing</b>
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center <b>Hospital Acquired Condition</b>
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program

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HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolypoid Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
<b>HRS</b>	<b>Heart Rhythm Society</b>
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy

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HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
<b>HUD</b>	<b>Humanitarian Use Device</b>
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular

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IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization

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LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover

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#### Acronyms And Abbreviations

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MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
<b>MI</b>	<b>Myocardial Infarction</b>
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit

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NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School

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NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass

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PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
<b>PAT</b>	<b>Performance Assessment Tracking</b>
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
<b>PCI</b>	<b>Percutaneous Coronary Intervention</b>
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information

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PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney <b>Present On Admission</b>
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	<b>Purchasing Power Parity</b>
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue

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PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director

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RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)

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SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) <b>Special Indicator (code)</b> Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services

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## Appendix A

### Acronyms And Abbreviations

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STSF	Specialized Treatment Service Facility
<b>SUBID</b>	<b>Sub-Identifier</b>
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora

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TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration

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### Acronyms And Abbreviations

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TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration

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### Acronyms And Abbreviations

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VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
<b>WII</b>	<b>Wounded, Ill, and Injured</b>
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
<b>WTU</b>	<b>Warrior Transition Unit</b>
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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