



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 79  
6010.58-M  
APRIL 4, 2013**

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

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

**CHANGE TITLE:** REIMBURSEMENT AND CODING UPDATES 13-001

**CONREQ:** 16411

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

**SUMMARY OF CHANGE(S):** See pages 4 and 5.

**EFFECTIVE DATE:** As indicated, otherwise upon direction of the Contracting Officer.

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

**This change is made in conjunction with Feb 2008 TPM, Change No. 87 and Feb 2008 TSM,  
Change No. 47.**

**CORN.GLENN  
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**Ann N. Fazzini  
Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S): 161 PAGE(S)  
DISTRIBUTION: 6010.58-M**

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

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**CHAPTER 6**

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## **SUMMARY OF CHANGES**

### **CHAPTER 6**

1. Section 4. This change mirrors the language in TNEC that was omitted in error when the T3 TRM, Chapter 6, Section 4 change was published.
2. Section 8. This change corrects the TRICARE outlier amount.

### **CHAPTER 7**

3. Section 1. This change provides the mental health Deflator Factor (DF), updates Residential Treatment Center (RTC) information, and updates the Home Health Agency Prospective Payment System (HHA PPS) for Calendar Year (CY) 2013.
4. Addendums D (FY 2012) and D (FY 2013). This change provides the mental health DF, updates RTC information, and updates the HHA PPS for CY 2013.

### **CHAPTER 9**

5. Section 1. This change provides the Ambulatory Surgical Center (ASC) reimbursement update for FY 2013.

### **CHAPTER 11**

6. Addendum A (FY 2013). This change corrects a typo for the Hospice Cap amount.

### **CHAPTER 12**

7. Sections 1, 6, and 7. This change provides the mental health DF, updates RTC information, and updates the HHA PPS for CY 2013.
8. Section 4. Updated cross-references to Addendum L (CY 2013) and Addendum M (CY 2013), removed Addendum L (CY 2010) and Addendum M (CY 2010).
9. Addendums B, H, L (CY 2012), L (CY 2013), M (CY 2013), N, O, and S. This change provides the mental health DF, updates RTC information, and updates the HHA PPS for CY 2013.

### **CHAPTER 13**

10. Section 3. This change updates the qualifying criteria for TRICARE Transitional Outpatient Payments (TTOPs).

**SUMMARY OF CHANGES (Continued)**

**CHAPTER 15**

11. Section 1. This change provides the annual Critical Access Hospital (CAH) Cost-To-Charge Ratio (CCR) caps.

**APPENDIX A**

12. Updated the appendix with new acronyms.



## 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** All services related to solid organ acquisition, including the costs of the donor's inpatient stay for TRICARE covered transplants by TRICARE authorized transplantation centers. Acquisition costs related to solid organ 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.

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

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

**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 the DRGs for such transplants.

**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:

**3.3.10.1** For services provided prior to International Classification of Diseases, 10th Revision (ICD-10) implementation, 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 International Classification of Diseases, 9th Revision, Clinical Modification (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
286.7	Acquired Coagulation Factor Deficiency

**3.3.10.2** For services provided on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**, 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 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes is listed on the claim:

D66	Hereditary Factor VIII Deficiency
D67	Hereditary Factor IX Deficiency
D68.0	Von Willebrand's Disease
D68.1	Hereditary Factor XI Deficiency
D68.2	Hereditary Deficiency of Other Clotting Factors
D68.31	Hemorrhagic Disorder Due to Intrinsic Circulating Anticoagulants
D68.4	Acquired Coagulation Factor Deficiency

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**3.3.10.3** 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.

**3.3.10.4** 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.

**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.

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**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.

### **3.8 Critical Access Hospitals (CAHs)**

Prior to December 1, 2009, CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to [Chapter 15, Section 1](#).

- END -



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rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

- Short-stay outliers will be reimbursed at 200% of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for IDME. Cost outlier payments shall be paid on short stay outlier cases that qualify as a cost outlier.
- Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

**3.2.6.4 Cost Outliers**

**3.2.6.4.1** Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

**3.2.6.4.1.1** For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the CCR and adjusting this amount for IDME costs by dividing the amount by one plus the hospital's IDME adjustment factor. For admissions occurring on or after October 1, 1997, the costs for IDME are no longer standardized.

**3.2.6.4.1.2** Cost outliers will be reimbursed the DRG-based amount plus 80% effective October 1, 1994 of the standardized costs exceeding the threshold.

**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, 2010, is 0.3664. The CCR for admissions occurring on or after October 1, 2011, is 0.3460. **The CCR for admissions occurring on or after October 1, 2012, is 0.2979.**

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**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 2011 is 0.920, for FY 2012 is 0.919, and for FY 2013 is 0.920.

**3.2.6.4.2** For FY 2011, a TRICARE fixed loss cost-outlier threshold is set at \$21,229. Effective October 1, 2010, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,229 (also wage-adjusted).

**3.2.6.4.3** For FY 2012, a TRICARE fixed loss cost-outlier threshold is set at \$21,482. Effective October 1, 2011, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,482 (also wage-adjusted).

**3.2.6.4.4** For FY 2013, a TRICARE fixed loss cost-outlier threshold is set at \$20,075. Effective October 1, 2012, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$20,075 (also wage-adjusted).

**3.2.6.4.5** 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  $\{[10,129 \times ((0.7110 \times \text{Applicable wage index}) + 0.2890) \times 0.913] + (\text{DRG Based Payment (wage-adjusted)} \times (1 + \text{IDME}))\}$

#### **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.

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which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

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

**3.6.1.2.2** Percent of change and Deflator Factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1991	63.18%	1.6318
September 30, 1992	85.81%	1.8581
September 30, 1993	94.48%	1.9448
September 30, 1994	106.94%	2.0694
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383
September 30, 1997	126.20%	2.2620
September 30, 1998	116.93%	2.1693
September 30, 1999	129.19%	2.2919
September 30, 2000	128.82%	2.2882
September 30, 2001	131.83%	2.3183
September 30, 2002	141.57%	2.4157
September 30, 2003	159.90%	2.5990
September 30, 2004	171.39%	2.7139
September 30, 2005	185.93%	2.8593
September 30, 2006	200.58%	2.9724
September 30, 2007	205.85%	2.9785
September 30, 2008	233.63%	3.3363
September 30, 2009	246.31%	3.4631
September 30, 2010	234.40%	3.3440
September 30, 2011	250.77%	3.5077
September 30, 2012	287.75%	3.8775

### 3.6.2 New Hospitals and Units

**3.6.2.1** The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives

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the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

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

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

#### **3.6.3 Request for a Review of Higher or Lower Volume Classification**

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

#### **3.7 Payment for Hospital Based Professional Services**

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

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

#### **3.8 Leave Days**

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

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

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

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

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

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

**3.9.4** Sole Community Hospital (SCH). 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 -



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 Chapter 7, Addendum D (FY 2012)  
 TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2012

<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	801.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	773.00
<b>IDAHO</b>	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	363.00
Kootenai Medical Center 2003 Lincoln Way Coeur d'Alene, ID 83814 EIN: 82-0231746	461.00
<b>INDIANA</b>	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	452.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	478.00
<b>KANSAS</b>	
KVC Hospitals, Inc Prairie Ridge Psychiatric Hospital 4300 Brenner Drive Kansas City, KS 66104 EIN: 27-1672159	479.00
<b>KENTUCKY</b>	
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	677.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	720.00
<b>MARYLAND</b>	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	416.00
<b>MISSOURI</b>	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	345.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	422.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	431.00
<b>MONTANA</b>	
Acadia Montana 55 Basin Creek Road Butte, MT 59701 EIN: 62-1681724	463.00
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	461.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	801.00

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 TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2012

<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	338.00
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 56-1317433	491.00
<b>OHIO</b>	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	423.00
<b>PENNSYLVANIA</b>	
KidsPeace National Centers 5300 KidsPeace Drive Orefield, PA 18069 EIN: 23-2654908	561.00
<b>SOUTH CAROLINA</b>	
ABS LINC'S SC, Inc dba Palmetto Pines Behavioral Health 225 Midland Parkway Summerville, SC 29485 EIN: 57-0840074	634.00
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	460.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	768.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	476.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>TEXAS</b>	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	736.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	801.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	668.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	751.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	690.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	474.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	474.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	595.00
<b>VIRGINIA</b>	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	785.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	796.00
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 EIN: 54-1465094	668.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	470.00
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 EIN: 20-1215130	504.00
The Pines Residential Treatment Center - Kempsville, The 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	668.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	771.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	523.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	664.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	822.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	794.00
<b>IDAHO</b>	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	373.00
<b>INDIANA</b>	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	464.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	491.00
<b>KANSAS</b>	
KVC Hospitals, Inc Prairie Ridge Psychiatric Hospital 4300 Brenner Drive Kansas City, KS 66104 EIN: 27-1672159	492.00
<b>KENTUCKY</b>	
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	695.00
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	739.00

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 TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2013

<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>MARYLAND</b>	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	427.00
<b>MISSOURI</b>	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	354.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	433.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	443.00
<b>MONTANA</b>	
Acadia Montana 55 Basin Creek Road Butte, MT 59701 EIN: 62-1681724	476.00
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	473.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	822.00
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	347.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 56-1317433	504.00
<b>OHIO</b>	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	434.00
<b>PENNSYLVANIA</b>	
KidsPeace National Centers 5300 KidsPeace Drive Orefield, PA 18069 EIN: 23-2654908	576.00
<b>SOUTH CAROLINA</b>	
ABS LINC'S SC, Inc dba Palmetto Pines Behavioral Health 225 Midland Parkway Summerville, SC 29485 EIN: 57-0840074	651.00
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	472.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	788.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	489.00
<b>TEXAS</b>	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	756.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	822.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	686.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	771.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	708.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	487.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	487.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	611.00
<b>VIRGINIA</b>	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	806.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	817.00

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 TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2013

<b>FACILITY</b>	<b>TRICARE RATE</b>
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 EIN: 54-1465094	686.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	483.00
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 EIN: 20-1215130	518.00
The Pines Residential Treatment Center - Kempsville, The 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	686.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	792.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	537.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	682.00

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### **2.1.5.3.2 Discounting for Bilateral Procedures**

**2.1.5.3.2.1** Following are the different categories/classifications of bilateral procedures:

- Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).
- Inherent bilateral (i.e., procedure in and of itself is bilateral).
- Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

**2.1.5.3.2.2** Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

**2.1.5.3.2.3** Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

### **2.1.5.3.3 Modifiers for Discounting Terminated Surgical Procedures**

**2.1.5.3.3.1** Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

**2.1.5.3.3.2** Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

- Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the ASC tier rate, the Ambulatory Payment Classification (APC) allowable amount for OPPS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.
- Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

### **2.1.5.3.4 Unbundling of Procedures**

Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines as outlined in [Chapter 1, Section 3](#).

### **2.1.5.3.5 Incidental Procedures**

The rules for reimbursing incidental procedures as contained in [Chapter 1, Section 3](#), are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this

section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

### **2.1.6 Updating Payment Rates**

**2.1.6.1** The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments.

**2.1.6.2** The rates were updated by 0.6% effective November 1, 2009.

**2.1.6.3** The rates were updated by 0.9% effective November 1, 2011.

**2.1.6.4** The rates were updated by 1.3% effective November 1, 2012.

## **2.2 Reimbursement for Procedures Not Listed On TMA's Ambulatory Surgery Web Site**

Ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC may be cost-shared, but only if doing so results in no additional costs to the program.

## **2.3 Reimbursement System On Or After May 1, 2009 (Implementation Of OPPS)**

**2.3.1** For ambulatory surgery procedures performed in an OPPS qualified facility, the provisions in [Chapter 13](#) shall apply.

**2.3.2** For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in [paragraph 2.1](#) shall apply, except as follows:

- Contractors will no longer be allowed to group other procedures not listed on TMA's ambulatory surgery web site. On May 1, 2009 (implementation of OPPS), these groupers will be end dated. Only ambulatory surgery procedures listed on TMA's ambulatory surgery web site are to be grouped.
- Multiple and Terminated Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), the professional services shall be reimbursed according to the multiple surgery guidelines in [Chapter 13, Section 3, paragraphs 3.1.5.2](#) and [3.1.5.3](#).
- Discounting for Multiple Surgical Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), discounting for multiple surgical procedures are subject to the provisions in [Chapter 13, Section 3](#).
- Discounting for Bilateral Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraphs 3.1.5.3.6](#) and [3.1.5.3.7](#).

Chapter 11

Addendum A (FY 2013)

Hospice Care Rates - FY 2013

The following national hospice rates are for care and services provided on or after October 1, 2012, through September 30, 2013. The hospice rates applicable to the above period are:

DESCRIPTION	RATE	WAGE COMPONENT SUBJECT	UNWEIGHTED AMOUNT
Routine Home Care	\$153.45	\$105.44	\$ 48.01
Continuous Home Care	\$895.56 full rate = 24 hours of care/\$37.32 hourly rate	\$615.34	\$280.22
Inpatient Respite Care	\$158.72	\$ 85.92	\$ 72.80
General Inpatient Care	\$682.59	\$436.93	\$245.66
Allow the provider to split bills if they span the effective date. Use the previous year's rates if the provider chooses not to split the bill.			
Hospice Cap Amount:	The latest hospice cap amount, for the cap year ending October 31, 2012, is <b>\$25,377.01</b> .		

- END -



## Chapter 12

### Home Health Care (HHC)

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

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Chapter 12, Home Health Care (HHC)

<b>Section/Addendum</b>	<b>Subject/Addendum Title</b>
B	Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes
C	Home Health Consolidated Billing Code List - Therapy Codes
D	CMS Form 485 - Home Health Certification And Plan Of Care (POC) Data Elements
E	Primary Components Of A Home Care Patient Assessment
F	Outcome And Assessment Information Set (OASIS-B1)
G	Outcome and Assessment Information Set (OASIS) Items Used For Assessments Of 60-Day Episodes
H	Diagnosis Codes For Home Health Resource Group (HHRG) Assignment
I	Home Health Resource Group (HHRG) Worksheet Figure 12.I-1 HHRG For Episodes Beginning On Or After January 1, 2008 Figure 12.I-2 Abbreviated OASIS Questions
J	Health Insurance Prospective Payment System (HIPPS) Tables For Pricer
K	Home Assessment Validation and Entry (HAVEN) Reference Manual
L (CY 2011)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2011
	Figure 12.L.2011-1 National 60-Day Episode Payment Rate Updated By The Home Health Market Basket Update For CY 2011, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
	Figure 12.L.2011-2 National Per-visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2011 Home Health Market Basket Update, Before Wage Index Adjustment
	Figure 12.L.2011-3 CY 2011 LUPA Add-On Payment Amounts
	Figure 12.L.2011-4 Non-Routine Medical Supply (NRS) Conversion Factor For CY 2011
	Figure 12.L.2011-5 Relative Weights For The Six-Severity NRS System For CY 2011
	Figure 12.L.2011-6 National 60-Day Episode Payment Amounts For Beneficiaries Residing In Rural Areas, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
	Figure 12.L.2011-7 National Per-Visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The 3% Rural Add-On
	Figure 12.L.2011-8 LUPA Add-On Payment Amount For Beneficiaries Who Reside In A Rural Area

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 Chapter 12, Home Health Care (HHC)

<b>Section/Addendum</b>	<b>Subject/Addendum Title</b>
	Figure 12.L.2011-9 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
	Figure 12.L.2011-10 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
L (CY 2012)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2012
	Figure 12.L.2012-1 National 60-Day Episode Payment Rate Updated By The Home Health Market Basket Update For CY 2012, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
	Figure 12.L.2012-2 National Per-Visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2012 HH PPS Payment Update Percentage, Before Wage Index Adjustment
	Figure 12.L.2012-3 CY 2012 LUPA Add-On Payment Amounts
	Figure 12.L.2012-4 Non-Routine Medical Supply (NRS) Conversion Factor For CY 2012
	Figure 12.L.2012-5 Relative Weights For The Six-Severity NRS System For CY 2012
	Figure 12.L.2012-6 CY 2012 Payment Amounts For Services Provided In A Rural Area, Before Case-Mix Adjustment And Wage Index Adjustment
	Figure 12.L.2012-7 CY 2012 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment
	Figure 12.L.2012-8 CY 2012 LUPA Add-On Payment Amount For Services Provided In A Rural Area
	Figure 12.L.2012-9 CY 2012 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
	Figure 12.L.2012-10 CY 2012 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
L (CY 2013)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013
	Figure 12.L.2013-1 National 60-Day Episode Payment Rate Updated By The Home Health Market Basket Update For CY 2013, Before Case-Mix Adjustment And Wage Adjusted Based On The Site Of Service For The Beneficiary
	Figure 12.L.2013-2 National Per-Visit Rates For LUPAs (Not Including The LUPA Add-On Payment Amount For A Beneficiary's Only Episode Or The Initial Episode In A Sequence Of Adjacent Episodes) And Outlier Calculations Updated By The CY 2013 HHA PPS Payment Update Percentage, Before Wage Index Adjustment
	Figure 12.L.2013-3 CY 2013 LUPA Add-On Payment Amounts
	Figure 12.L.2013-4 Non-Routine Medical Supply (NRS) Conversion Factor For

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Chapter 12, Home Health Care (HHC)

**Section/Addendum    Subject/Addendum Title**

	CY 2013
Figure 12.L.2013-5	Relative Weights For The Six-Severity NRS System For CY 2013
Figure 12.L.2013-6	CY 2013 Payment Amounts For Services Provided In A Rural Area, Before Case-Mix Adjustment And Wage Index Adjustment
Figure 12.L.2013-7	CY 2013 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment
Figure 12.L.2013-8	CY 2013 LUPA Add-On Payment Amount For Services Provided In A Rural Area
Figure 12.L.2013-9	CY 2013 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area
Figure 12.L.2013-10	CY 2013 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
M (CY 2011)	Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2011
M (CY 2012)	Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2012
M (CY 2013)	Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2013
N	Diagnoses Associated With Each Of The Diagnostic Categories Used In Case-Mix Scoring
O	Diagnoses Included In The Diagnostic Categories Used For The Non-Routine Supplies (NRS) Case-Mix Adjustment Model
P	Code Table For Converting Julian Dates To Two Position Alphabetic Values
Q	Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)
Figure 12.Q-1	Request for Anticipated Payment (RAP) - Non-Transfer Situation
Figure 12.Q-2	RAP - Non-Transfer Situation With Line Item Service Added
Figure 12.Q-3	RAP - Transfer Situation
Figure 12.Q-4	RAP - Discharge/Re-Admit
Figure 12.Q-5	RAP - Cancellation
Figure 12.Q-6	Claim - Non-Transfer Situation
Figure 12.Q-7	Claim - Transfer Situation - Beneficiary Transfers To Your HHA
Figure 12.Q-8	Claim - Significant Change in Condition (SCIC) Situation
Figure 12.Q-9	Claim - No-RAP-Low Utilization Payment Adjustment (LUPA) Claim
Figure 12.Q-10	Claim Adjustment
Figure 12.Q-11	Claim - Cancellation
R	Input/Output Record Layout
S	Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

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## Chapter 12, Section 1

### Home Health Benefit Coverage And Reimbursement - General Overview

#### 3.2.7 Implementing Instructions

Since this issuance only deals with a general overview of the HHC benefit and reimbursement methodology, the following cross-reference is provided to facilitate access to specific implementing instructions within Chapter 12:

IMPLEMENTING INSTRUCTIONS	
<b>POLICIES</b>	
General Overview	Section 1
Benefits and Conditions for Coverage	<a href="#">Section 2</a>
Assessment Process	<a href="#">Section 3</a>
Reimbursement Methodology	<a href="#">Section 4</a>
Primary Provider Status and Episodes of Care	<a href="#">Section 5</a>
Claims and Billing Submission Under HHA PPS	<a href="#">Section 6</a>
Pricer Requirements and Logic	<a href="#">Section 7</a>
Medical Review Requirements	<a href="#">Section 8</a>
<b>ADDENDA</b>	
Acronym Table	<a href="#">Addendum A</a>
Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes	<a href="#">Addendum B</a>
Home Health Consolidated Billing Code List - Therapy Codes	<a href="#">Addendum C</a>
CMS Form 485 - Home Health Certification And Plan Of Care Data Elements	<a href="#">Addendum D</a>
Primary Components of Home Health Assessment	<a href="#">Addendum E</a>
Outcome and Assessment Information Set (OASIS-B1)	<a href="#">Addendum F</a>
OASIS Items Used for Assessments Of 60-Day Episodes	<a href="#">Addendum G</a>
ICD-9-CM Diagnosis Codes for <b>Home Health Resource Group (HHRG)</b> Assignment	<a href="#">Addendum H</a>
Home Health Resource Group (HHRG) Worksheet	<a href="#">Addendum I</a>
HIPPS Tables for Pricer	<a href="#">Addendum J</a>
Home Assessment Validation and Entry (HAVEN) Reference Manual	<a href="#">Addendum K</a>
Annual HHA PPS Rate Updates	
Calendar Year 2011	<a href="#">Addendum L (CY 2011)</a>
Calendar Year 2012	<a href="#">Addendum L (CY 2012)</a>
<b>Calendar Year 2013</b>	<a href="#">Addendum L (CY 2013)</a>
Annual HHA PPS Wage Index Updates	
Calendar Year 2011	<a href="#">Addendum M (CY 2011)</a>
Calendar Year 2012	<a href="#">Addendum M (CY 2012)</a>
<b>Calendar Year 2013</b>	<a href="#">Addendum M (CY 2013)</a>
Diagnoses Associated with Diagnostic Categories Used in Case-Mix Scoring	<a href="#">Addendum N</a>

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**IMPLEMENTING INSTRUCTIONS (CONTINUED)**

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Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model [Addendum O](#)

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Code Table for Converting Julian Dates to Two Position Alphabetic Values [Addendum P](#)

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Examples of Claims Submissions Under Home Health Agency Prospective Payment System (HHA PPS) [Addendum Q](#)

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Input/Output Record Layout [Addendum R](#)

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Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008 [Addendum S](#)

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- END -

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

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

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

**3.8.1.3.1** The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in [Addendums L \(CY 2011\)](#), [L \(CY 2012\)](#), and [L \(CY 2013\)](#).

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

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

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

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

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

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

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

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

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

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

**3.8.1.4** Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts has not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in [Addendums L \(CY 2011\)](#), [L \(CY 2012\)](#), [L \(CY 2013\)](#), [M \(CY 2011\)](#), [M \(CY 2012\)](#), and [M \(CY 2013\)](#).

### 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 \(CY 2011\)](#), [L \(CY 2012\)](#), and [L \(CY 2013\)](#). 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 \(CY 2011\)](#), [M \(CY 2012\)](#), and [M \(CY 2013\)](#), for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

### 3.8.2 Calculation of Reduced Payments

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

**Note:** Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) has not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in [Addendums L \(CY 2011\)](#), [L \(CY 2012\)](#), [L \(CY 2013\)](#), [M \(CY 2011\)](#), [M \(CY 2012\)](#), and [M \(CY 2013\)](#).

#### 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

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

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

$$(28/60) = 0.4667$$

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

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

**3.8.2.2 SCIC Payment Adjustment**

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

**3.8.2.3 LUPA**

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

**3.8.2.3.1.1** The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in [Figure 12.4-1](#) plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in [Figure 12.4-17](#).

**FIGURE 12.4-17 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS**

HOME HEALTH DISCIPLINE TYPE	AVERAGE COST PER VISIT				STANDARDIZATION FACTOR FOR WAGE INDEX	OUTLIER ADJUSTMENT FACTOR	PER VISIT PAYMENT AMOUNTS PER 60-DAY EPISODE FOR FY 2001
	FROM THE PPS AUDIT SAMPLE	FOR NON-ROUTINE MEDICAL SUPPLIES*	FOR ONGOING OASIS ADJUSTMENT COSTS	FOR ONE-TIME OASIS SCHEDULING CHANGE			
Home Health Aide	\$41.75	\$1.94	\$0.12	\$0.21	0.96674	1.05	\$43.37

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

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

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

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

**3.8.2.3.1.2** The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from Figure 12.4-3) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

**Note:** Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and Fixed Dollar Loss (FDL) amounts in Addendums L (CY 2011), L (CY 2012), L (CY 2013), M (CY 2011), M (CY 2012), and M (CY 2013).

**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

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**3.1.1.11.28** FLs 39-41. Value Codes and Amounts Required. Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

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

**3.1.1.11.28.2** Since the value amount is a nine-position field, enter the four digit MSA in the nine-position field in the following manner. Enter an MSA for Puerto Rico (9940) as 000994000, and the MSA for Abilene, TX (0040) as 000004000. Note that the two characters to the right of the assumed decimal point are always zeros.

**3.1.1.11.28.3** Optional. Enter any NUBC approved value code to describe other values that apply to the RAP.

- Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollar and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b". Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

**3.1.1.11.29** FL 42 and 43 Revenue Code and Revenue Description Required. One revenue code line is required on the RAP. This line is used to report a single HIPPS code (defined under FL 44) which is the basis of the anticipated payment. The required revenue code and description for HHA PPS RAPs are as follows:

- Rev. Code 023. Home Health Services.
- Return the TRICARE reimbursement for the RAP in the total charges field (FL 47) of the 023 revenue code line. HHAs must zero fill FL 47.
- Optional. HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HHA PPS claims except another 023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.
- Revenue codes 058X and 059X will no longer be accepted with covered charges on TRICARE home health RAPs under HHA PPS. Revenue code 0624 [investigational devices (IDEs)] will no longer be accepted at all on TRICARE home

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health RAPs under HHA PPS.

- HHAs may continue to report a "Total" line, with revenue care 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. However, the contractors' systems must overlay this amount with the total reimbursement for the RAP.

**3.1.1.11.30** FL 44. HCPCS/Rates Required. On the 022 revenue code line, HHAs must report the HIPPS code for which anticipated payment is being requested.

- Definition. HIPPS rate codes represent specific patient characteristics (or case mix) on which TRICARE payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among various provider types. HIPPS codes are used in association with special revenue codes used on CMS 1450 UB-04 claim forms for institutional providers. One revenue code is defined for each PPS that calls for HIPPS codes. Currently, revenue code 022 is reserved for the Skilled Nursing Facility (SNF) PPS and revenue code 023 is reserved for the HHA PPS.
- HIPPS codes are placed in FL 44 ("HCPCS/rate") on the form itself. The associated revenue codes are placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim. HIPPS codes are alphanumeric codes of five digits.
- Under the home health PPS, which requires the use of HIPPS codes, a case-mix adjusted payment for up to 60 days of care will be made using one of 80 Home Health Resource Groups (HHRGs). On TRICARE claims these HHRGs will be represented as HIPPS codes. These HIPPS codes are determined based on assessment made using the OASIS. Grouper software run at the HHA site will use specific data elements from the OASIS data set and assign beneficiaries to a HIPPS code. The Grouper will output the HIPPS code which HHAs must enter in FL 44 on the claim.
- HHA HIPPS codes are five position alphanumeric codes: the first digit is a static "H" for home health, the second, third and fourth (alphabetical) positions represent the level of intensity respective to the clinical, functional and service domains of the OASIS. The fifth position (numeric) represents which of the three domains in the HIPPS code were either calculated from complete OASIS data or derived from incomplete OASIS data. A value of "1" in the fifth position should indicate a complete data set that will be accepted by the State Repository for OASIS data. Both HHA PPS RAPs and claims must be correct to reflect the HIPPS code accepted by the State repository. Lists of current HIPPS codes used for billing during a specific Federal fiscal year are published in the TRICARE Policy Manual (TPM).
- Optional. If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code.

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

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

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

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

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

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

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

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

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

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

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

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

- Rationale - Permits identification of particular services.

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

- Required detail: HCPCS code G0151 (services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes), **HCPCS code G0159 (services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes)**, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

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**3.1.2.19.29.2.3** 43X - Occupational Therapy (OT) - Services provided by a qualified OT practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

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

- Required detail: HCPCS code G0152 (services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes), **HCPCS code G0160 (services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes)**, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

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

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

- Required detail: HCPCS code G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes), **HCPCS code G0161 (services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathologist maintenance program, each 15 minutes)**, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

**3.1.2.19.29.2.5** 55X - Skilled Nursing - Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the

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medically desired result. This code may be used for nursing home services or a service charge for home health billing.

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

- Required detail: HCPCS code G0154 (direct skilled nursing services of a licensed nurse (Licensed Practical Nurse (LPN) or Registered Nurse (RN)) in the home health or hospice setting, each 15 minutes), **HCPCS code G0162 (skilled services by an RN for management and evaluation of the POC, each 15 minutes [the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting])**, HCPCS code G0163 (skilled services of a licensed nurse [LPN or RN] for the observation and assessment of the patient's condition, each 15 minutes [the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting]), HCPCS code G0164 (skilled services of a licensed nurse [LPN or RN] in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

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

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

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

- Required detail: HCPCS code G0155 (services of a Clinical Social Worker (CSW) in home health or hospice setting, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

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

- Rationale: Necessary for TRICARE home health billing requirements.

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

- Required detail: HCPCS code G0156 (services of a home health/hospice aide in home health or hospice setting, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

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

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

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

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

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

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

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

- Rationale: TRICARE required detailed revenue coding.

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

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

**3.1.2.19.29.2.9** Revenue code for optional reporting of wound care supplies:

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

SUBCATEGORY	STANDARD ABBREVIATION
3 - Surgical Dressings	SURG DRESSING

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

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nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.

- You may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. TRICARE claims systems will assure this amount reflects charges associated with all revenue code lines, excluding any 023.

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

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

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

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

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

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

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

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

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

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

**3.1.2.19.36** 2FL 49. (Untitled) Not Required.

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

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

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

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

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

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

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

**3.1.2.19.43** FL 56. (Untitled) Not Required.

**3.1.2.19.44** FL 57. (Untitled) Not Required.

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

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

**3.1.2.19.45.2** Another payer denied the claim; or

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

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

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- Worker's Compensation (WC) including Black Lung (BL).

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

CODE STRUCTURE:		
CODE	TITLE	DEFINITION
01	Patient is the Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured Financial Responsibility	Self-explanatory
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.

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

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

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

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

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positions, from OASIS Item M0100). Copy these OASIS items exactly as they appear on the OASIS assessment, matching the date formats used on the assessment.

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

**3.1.2.19.51** FL 64. Employment Status Code Required. Where you are claiming payment under the circumstances described in the second paragraphs of FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified, if the information is readily available.

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

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

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

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

- The ICD-9-CM codes and principal diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS from Item M0230 (Primary Diagnosis), and on the CMS Form 485, from Item 11 (ICD-9-CM/Principle Diagnosis).

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

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

- For other diagnoses, the diagnoses and ICD-9-CM codes reported in FLs 67 A-Q must match the additional diagnoses reported on the OASIS, from Item M0240 (Other Diagnoses), and on the CMS Form 485, from Item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the POC was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields from M0240 on the OASIS, or on the CMS Form 485, from Item 13, may be reported in FLs 67 A-Q on the claim if they are reported in the narrative from Item 21 of the CMS Form 485.
- In most cases, the other diagnoses codes on the claim will match those submitted on the RAP. In SCIC cases, however, the other diagnoses codes reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

**3.1.2.19.56** FL 69. Admitting Diagnosis Not Required.

**3.1.2.19.57** FL 72. E-Code Not Required.

**3.1.2.19.58** FL 73. (Untitled) Not Required.

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

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

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

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

**3.1.2.19.62** FL 77. Other Physician ID Not Required.

**3.1.2.19.63** FL 80. Remarks Not Required.

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

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

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

**3.1.2.21** Claims Adjustments and Cancellations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- This means that PEP adjustments will not apply to the claim, but all other payment adjustments apply.

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- The “Through” date on the claim (FL 6) of CMS 1450 UB-04, closing the episode in which the beneficiary died, should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

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

- On LUPA claims, non-routine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates.
- Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on RAs and claims history.
- If the claim for the LUPA is later adjusted such that the number of visits becomes five or more, payments will be adjusted to an episode basis, rather than a visit basis.

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

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

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- If an HHA later needs to add visits to the claim, so that the claim will have more than 4 visits and no longer be a LUPA, the HHA should submit an adjustment claim so the intermediary may issue full payment based on the HIPPS code.

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

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

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

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

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

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

- One if a beneficiary does not receive the therapy hours projected, and
- Another if he or she does meet the "therapy threshold".
- Therefore, when the therapy threshold is not met, there is an automatic "fall back" HIPPS code, and TRICARE systems will correct payment without access to the full OASIS data set.
- If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case-mix for the episode with a new HIPPS code and pay the episode on the basis of the new code.
- HHAs will receive the difference between the full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code.
- The electronic RA will show both the HIPPS code submitted on the claim and the HIPPS that was used for payment, so such cases can be clearly identified.
- If the HHA later submits an adjustment claim on the episode that brings the

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therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangements which were not billed timely to the primary agency, TRICARE systems will re-price the claim and pay the full episode payment based on the original HIPPS.

- A HIPPS code may also be changed based on medical review of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**3.1.2.22** Exclusivity and Multiplicity of Adjustments.

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

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

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

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

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**3.1.2.22.5** Payment adjustments are calculated in Pricer software.

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

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

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

**3.1.2.23** Chart Representation of Billing Procedures.

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

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

**3.1.2.23.2** Initial Episode in Period of Continuous Care:

FIRST EPISODE		NEXT EPISODE(S)
RAP	CLAIM	RAP(S) & CLAIM(S)
First Episode		Next Episode(s)
RAP	Claim	RAP(s) & Claim(s)
Contains one HIPPS code and Claim-OASIS Matching Key output from Grouper software linked to OASIS.	Contains same HIPPS Code as RAP with Patient Status Code 30	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPS and claims throughout the period of continuous care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. Claims submitted at the end of each 60 day period.

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FIRST EPISODE		NEXT EPISODE(S)
RAP	CLAIM	RAP(S) & CLAIM(S)
Does not give any other line item detail for TRICARE use.	Gives all line item detail for entire home health episode.	
From and Through Dates match first service delivered.	From Date same as RAP, Through Date, Day 60 of home health episode.	The RAP and claim From and Through Dates in a period of continuous care are first day of home health episode, w/ or w/o service (i.e., Day 61, 121, 181, etc.).
Creates home health episode in authorization system.	Closes home health episode in authorization system.	
Triggers initial percentage payment.	Triggers final percentage payment for 60-day home health episode.	Creates or closes home health episode.

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

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

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

**3.1.2.23.3** A Single LUPA Episode:

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

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

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

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

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

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

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

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

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

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

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

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

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**3.1.2.23.7** Episode with a SCIC Adjustment:

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

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

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

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

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

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<b>TYPE OF LINE ITEM</b>	<b>DME** (NON-IMPLANTABLE, OTHER THAN OXYGEN &amp; P/O)</b>	<b>OXYGEN &amp; P/O (NON-IMPLANTABLE P/O)</b>	<b>NON-ROUTINE*** MEDICAL SUPPLIES</b>	<b>OSTEOPOROSIS DRUGS</b>	<b>VACCINE</b>	<b>OTHER OUTPUT ITEMS (ANTIGENS, SPLINTS &amp; CASTS)</b>
<b>Claim Coding</b>	Current revenue codes 29X, 294 for drugs/supplies for effective DME use w/HPCs.	Current revenue codes 60X (Oxygen) and 274 (P/O) w/HPCs.	Current revenue code 27X, and voluntary use of 623 for wound care supplies.	Current revenue code 636 & HCPCs.	Current revenue codes 636 (drug) and HCPCs, 771 (administration).	Current revenue code 550 & HCPCs.
<b>TOB</b>	Billed to Contractor on 32X if 485; 34X*, if no 485.	Billed to Contractor on 32X if 485; 34X*, if no 485.	Billed on 32X if 485; or 34X*, if no 485.	Billed on 34X* only.	Billed on 34X* only.	Billed on 34X* only.
<b>Payment Basis</b>	Lower of total rental cost or reasonable purchase cost.	Allowable charge methodology. Oxygen concentrator - rental or purchase.	Bundled into PPS payment if 32X (even LUPA); paid in cost report settlement for 34X*.	Average wholesale cost, and paid separately with or without open HHA PPS episode.	Average wholesale cost, and paid separately with or without open HHA PPS episode.	
<b>PPS Claims?</b>	<b>Yes</b> , Claim only [34X*, no 485/non-PPS]	<b>Yes</b> , Claim only [34X*; if no 485/non-PPS]	<b>Yes</b> , Claim only [34X*, if no POC/non-PPS]	<b>No</b> (34X*; claims only)	<b>No</b> (34X*; claims only)	<b>No</b> (34X*; claims only)

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

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

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

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

**3.1.2.24 Other Billing Considerations.**

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

- TOB 329 and 339 are not accepted without any visit charges.
- Nonvisit charges incurred after termination of the POC are payable under medical and other health services on TOB 34X.

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

- The primary agency bills for all services furnished by both agencies and keeps all

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records pertaining to the care. The primary agency's status as primary is established through the submission of a RAP.

- The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies.
- Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the system indicates an episode of care is open for a beneficiary, deny the RAP on any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

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

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

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

**3.1.2.24.5** HHA Claims With Both Covered and Non-Covered Charges. HHAs must report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. (Provider should not report the non-payment codes outlined below). On the CMS 1450 UB-04 flat file, HHAs must use record type 61, Field No. 10 (outpatient total charges) and Field No. 11 (outpatient non-covered charges) to report these charges. Providers utilizing the hard copy CMS

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

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

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

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

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

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

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

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

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

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

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

### **3.2 Reporting Requirements**

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

**3.2.1** With the implementation of HHA PPS, for each calendar quarter, contractors shall deliver a file (on a computer-readable standard IBM cartridge tape or CD-ROM or diskette) in simple EBCDIC or ASCII data format to the Office of Medical Benefits and Reimbursement Branch (MB&RB), TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066. This file must contain the full TRICARE Encounter Data (TED) number (21 characters) and the 5 digit HIPPS code for each HHA PPS claim.

**3.2.2** The quarterly report file must reflect all HHA PPS claims which have cleared all TMA edits and have been accepted on the TED database in the quarter (whether denied or allowed and regardless of government liability) and shall be delivered within 30 days after the end of each quarter. This HHA PPS report file shall have a record length of 26 and contain the two data elements according to the following file layout.

<b>DATA ELEMENT</b>	<b>START BYTE</b>	<b>END BYTE</b>
TED-NBR	1	21
HIPPS Code	22	26

- END -

## Home Health Benefit Coverage And Reimbursement - Pricer Requirements And Logic

Issue Date:

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

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

To describe the Pricer requirements for reimbursement of home health services under the Home Health Prospective Payment System (HHA PPS).

### 3.0 POLICY

#### 3.1 HHA PPS Pricer Requirements

All home health services billed on type of bill (TOB) 32X or 33X will be reimbursed based on calculations made by the home health (HH) Pricer. The HH Pricer operates as a call module within TRICARE's standard systems. The HH Pricer makes all reimbursement calculations applicable under HHA PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payments (LUPAs), significant change in condition (SCIC) adjustments and outlier payments. Standard systems must send an input record to Pricer for all claims with covered visits, and Pricer will send the output record back to the standard systems.

#### 3.1.1 General Requirements

**3.1.1.1** Pricer will return the following information on all claims: Output (Health Insurance Prospective Payment System (HIPPS) codes, weight used to price each HIPPS code, payment per HIPPS code, total payment, outlier payment and return code. If any element does not apply to the claim, Pricer will return zeros.

**3.1.1.2** Pricer will wage index adjust all PPS payments based on the Metropolitan Statistical Area (MSA) or **Core Based Statistical Area (CBSA)** reported in value code 61 on the claim.

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**3.1.1.3** Pricer will return the reimbursement amount for the HIPPS code in the 023 line of the claim for the RAPs and paid claims.

**3.1.1.4** If input is invalid, Pricer will return one of a set of error return codes to indicate the invalid element.

**3.1.1.5** Pricer must apply the fiscal year rate changes to through date on claim.

#### **3.1.2 Pricing of RAPs**

**3.1.2.1** Pricer will employ RAP logic for TOB 322 and 332 only.

**3.1.2.2** On the RAP, Pricer will multiply the wage index adjusted rate by 0.60 if the claim from date and admission date match and the initial payment indicator is = 0.

**3.1.2.3** On the RAP, Pricer will multiply the wage index adjusted rate by 0.50 if the claim from date and admission date do not match and the initial payment indicator is = 0.

**3.1.2.4** On the RAP, Pricer will multiply the wage index adjusted rate by 0.00 if the initial payment indicator equals 1.

**3.1.2.5** Pricer will return the payment amount on RAP with return code "03" for 0%, "04" for 50% payment and "05" for 60% payment.

#### **3.1.3 Pricing of Claims**

**3.1.3.1** Pricer will employ claim logic for TOB 329, 339, 327, 337, 32G, 33G, 32I, 33I, 32J, 33J, 32M, and 33M only.

**3.1.3.2** Pricer will make payment determinations for claims in the following sequence:

- LUPA
- Therapy threshold
- HHRG payments [including partial episode payment (PEP) and SCIC]
- Outlier, in accordance with logic in TRICARE paper

**3.1.3.3** Pricer will pay claims as LUPAs when there are less than 5 occurrences of all HH visit revenue codes: 42X, 43X, 44X, 55X, 56X, and 57X.

**3.1.3.4** Pricer will pay visits on LUPA claims at national standardized rates, and the total visit amounts will be final payment for the episode.

**3.1.3.5** If Pricer determines the claim to be a LUPA, all other payment calculations will be bypassed.

**3.1.3.6** Pricer will return claim LUPA payments, with return code "06".

**3.1.3.7** TRICARE will supply Pricer with a table of "fall back" HIPPS codes so HIPPS can be downcoded when thresholds are not met.

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**3.1.4.13** The system will place the payment amount returned by Pricer in the total charge and the covered charge field on the 023 line.

**3.1.4.14** The system will place any outlier amount on the claim as value code 17 amount and plug condition code 61 on the claim.

**3.1.4.15** When Pricer returns an 06 return code (LUPA payment), the system will place it on the claim header in the return code field and create a new "L" indicator in the header of the record.

**3.1.4.16** Pricer will be integrated into the system for customer service and create a new on-line screen to do it.

**3.1.5 Input/Output Record Layout**

The HH Pricer input/output file will be 450 bytes in length. The required data and format are shown below:

FILE POSITION	FORMAT	TITLE	DESCRIPTION
1-10	X(10)	NPI	This field will be used for the NPI when it is implemented.
11-22	X(12)	HIC	<b>Input Item:</b> The HIC number of the beneficiary, copied from Form Locator (FL) 60 of the claim form.
23-28	X(6)	PRO-NO	<b>Input Item:</b> The six digit OSCAR system provider number, copied from FL 51 of the claim form.
29-31	X(3)	TOB	<b>Input Item:</b> The TOB code, copied from FL 4 of the claim form.
32	X	PEP-INDICATOR	<b>Input Item:</b> A single Y/N character to indicate if a claim must be paid a PEP adjustment. Standard systems must set a "Y" if the patient status code in FL 22 of the claim is 06. An "N" is set in all other cases.
33-35	9(3)	PEP-Days	<b>Input Item:</b> The number of days to be used for PEP payment calculation. Standard systems determine this number from the span of days from and including the first line item service date on the claim, to and including the last line item service date on the claim.
36	X	INIT-PAY-INDICATOR	<b>Input Item:</b> A single character to indicate if normal percentage payments should be made on RAP, or whether payment should be based on data drawn by the standard systems from field 19 of the provider specific file.  <b>Valid Values:</b> 0 = Make normal percentage payment 1 = Pay 0%
37-43	X(7)	FILLER	Blank.
44-46	X(3)	FILLER	Blank.
47-50	X(4)	MSA	<b>Input Item:</b> The MSA or CBSA code, copied from the value code 61 amount in FLs 39-41 of the claim form.
51-52	X(2)	FILLER	Blank.
53-60	X(8)	SER-FROM-DATE	<b>Input Item:</b> The statement covers period "From" date, copied from FL 6 of the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU-DATE	<b>Input Item:</b> The statement covers period "Through" date, copied from FL 6 of the claim form. Date format must be CCYYMMDD.

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FILE POSITION	FORMAT	TITLE	DESCRIPTION
69-76	X(8)	ADMIT-DATE	<b>Input Item:</b> The admission date, copied from FL 17 of the claim form must be CCYYMMDD.
77	X	HRG-MED-REVIEW INDICATOR	<b>Input Item:</b> A single Y/N character to indicate if an HRG has been changed by medical review. Standard systems must set a "Y" if an ANSI code on the line item indicates medical review involvement. An "N" must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	<b>Input Item:</b> Standard systems must copy the HIPPS code reported by the provider on each 023 revenue code line. If an ANSI code on the line indicates medical review involvement, standard systems must copy the additional HIPPS code placed on the 023 revenue code line by the medical reviewer.
83-87	X(5)	HRG-OUTPUT-CODE	<b>Output Item:</b> The HIPPS code used by Pricer to determine the reimbursement amount on the claim. This code will match the input code in all cases except when the therapy threshold for the claim was not met.
88-90	9(3)	HRG-NO-OF-DAYS	<b>Input Item:</b> A number of days calculated by the standard systems for each HIPPS code. The number is determined from the span of days from and including the first line item service date provided under that HIPPS code, to and including the last line item service date provided under that HIPPS code.
91-96	9(7)V9 (2)	HRG-WGTS	<b>Output Item:</b> The weight used by Pricer to determine the reimbursement amount on the claim.
97-105	9(7)V9 (2)	HRG-PAY	<b>Output Item:</b> The reimbursement amount calculated by Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Five more occurrences of all HRG/HIPPS related fields defined above, since up to 6 HIPPS codes can be automatically processed for payment on any one episode.
251-254	X(4)	REVENUE-CODE	<b>Input Item:</b> One of the six home health disciplines revenue codes (42X, 43X, 44X, 55X, 56X, 57X). All six revenue codes must be passed by the standard systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY-COV-VISITS	<b>Input Item:</b> A quantity of covered visits corresponding to each of the six revenue codes. Standard systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-266	9(7)V9 (2)	REVENUE-DOLL-RATE	<b>Output Item:</b> The dollar rates used by Pricer to calculate the reimbursement for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar rates used by Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
267-275	9(7)V9 (2)	REVENUE-COST	<b>Output Item:</b> The dollar amount determined by Pricer to be the reimbursement for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
276-400	Defined above	Additional REVENUE data	Five more occurrences of all revenue related data defined above.

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FILE POSITION	FORMAT	TITLE	DESCRIPTION
401-402	9(2)	PAY-RTC	<p><b>Output Item:</b> A return code set by Pricer to define the payment circumstance of the claim or an error in input data.</p> <p><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%</p> <p><b>Error return codes:</b>                      10 = Invalid TOB                      15 = Invalid PEP Days                      20 = PEP indicator invalid                      25 = Med review indicator invalid                      30 = Invalid MSA or CBSA code                      35 = Invalid Initial Payment Indicator                      40 = Dates are _____ or are invalid                      70 = Invalid HRG code                      75 = No HRG present in first occurrence                      80 = Invalid revenue code                      85 = No revenue code present on 3X9 or adjustment TOB</p>
403-407	9(5)	REVENUE-SUM 1-3-QTY-THR	<p><b>Output Item:</b> The total therapy visits used by the Pricer to determine if therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input with revenue codes 42X, 43X, and 44X.</p>
408-412	9(5)	REVENUE-SUM 1-6-QTY-All	<p><b>Output Item:</b> The total number of visits used by the Pricer to determine if the claim must be paid LUPA. This amount will be the total of all the covered visit quantities input with all six home health discipline revenue codes.</p>
413-421	9(7)V9 (2)	OUTLIER-PAYMENT	<p><b>Output Item:</b> The outlier payment determined by Pricer to be due on the claim in addition to any HRG payment amounts.</p>
422-430	9(7)V9 (2)	TOTAL- PAYMENT	<p><b>Output Item:</b> The total reimbursement determined by Pricer to be due on the RAP or claim.</p>
431-450	X(20)	FILLER	Blank.

**3.1.5.1** Input records on RAPs will include all input items except for "REVENUE" related items, and input records on RAPs will never report more than one occurrence of "HRG" related items. Input records and claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeros.

**3.1.5.2** The standard systems will move the following Pricer output items to the claim record.

- The return code will be placed in the claim header.
- The HRG-PAY amount for each HIPPS code will be placed in the total charges and the covered charges field of the appropriate revenue code 023 line.
- The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount.
- If the return code is "06" (indicating a LUPA), the standard systems will apportion the

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REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice.

#### 3.1.6 Decision Logic Used by Pricer on RAPs

On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

**3.1.6.1 1.a.** Find weight for "HRG-INPUT-CODE" from the table of weight for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times Federal standard episode rate for the Federal fiscal year in which the "SER-THRU-DATE" falls. The product is the case-mix adjusted rate. This case-mix adjusted rate must also be wage-index adjusted according to labor and non-labor portions of the payment established by TRICARE. Multiply the case-mix adjusted rate by 0.77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by 0.22332 to determine the non-labor portion.

**3.1.6.2 2.a.** If the "INIT-PYMNT-INDICATOR" equals 0, perform the following: Determine if the "SERV-FROM-DATE" is equal to the "ADMIT-DATE." If yes, multiply the wage index and case-mix adjusted payment by 0.6. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code "05".

**3.1.6.3 2.b.** If the "INIT-PAYMNT-INDICATOR" = 1, perform the following: Multiply the wage index and case-mix adjusted payment by 0. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code "03".

#### 3.1.7 Decision Logic Used By Pricer on Claims

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H, 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or intermediary initiated adjustments), Pricer will perform the following calculations in the numbered order:

##### 3.1.7.1 LUPA Calculations

**3.1.7.1.1 1.a.** If the "REVENUE-SUM1-6-QTY-ALL" (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per-visit rate for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust and sum the products. The result is the total payment for the episode. Return amount in the "TOTAL-PAYMENT" field with return code "06".

**3.1.7.1.2 1.b.** If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the therapy threshold determination.

- Proceed to the outlier calculations (see [paragraph 3.1.7.4](#)).

### 3.1.7.4 Outlier Calculations

**3.1.7.4.1 4.a.** Wage adjust the outlier fixed loss amount for the Federal fiscal year in which the "SER-THRU-DATE" falls, using the MSA or CBSA code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

**3.1.7.4.2 4.b.** For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per-visit rate from the revenue code table for the Federal fiscal year in which the "SER-THRU-DATE" falls.

- Multiply each quantity by the corresponding rate.
- Sum the six results and wage index adjust the sum as described above, using the MSA or CBSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.

**3.1.7.4.3 4.c.** Subtract the outlier threshold for the episode from the imputed cost for the episode (**4.d.**).

- If the result is greater than \$0.00, calculate 0.80 times the result.
- Return this amount in the "OUTLIER-PAYMENT" field.
- Add this amount to the total dollar amount resulting from all HRG payment calculations.
- Return the sum to the "TOTAL-PAYMENT" field, with return code "00".

- END -



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Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4374	Skin barrier extended wear	10/01/2000	B-00-50	10/01/2002	K0563, K0564	NRS
A4375	Drainable plastic pch w fcpl	10/01/2000	B-00-50			NRS
A4376	Drainable rubber pch w fcplt	10/01/2000	B-00-50			NRS
A4377	Drainable plstic pch w/o fp	10/01/2000	B-00-50			NRS
A4378	Drainable rubber pch w/o fp	10/01/2000	B-00-50			NRS
A4379	Urinary plastic pouch w fcpl	10/01/2000	B-00-50			NRS
A4380	Urinary rubber pouch w fcplt	10/01/2000	B-00-50			NRS
A4381	Urinary plastic pouch w/o fp	10/01/2000	B-00-50			NRS
A4382	Urinary hvy plstc pch w/ofp	10/01/2000	B-00-50			NRS
A4383	Urinary rubber pouch w/o fp	10/01/2000	B-00-50			NRS
A4384	Ostomy faceplt/silicone ring	10/01/2000	B-00-50			NRS
A4385	Ost skn barrier sld extwear	10/01/2000	B-00-50			NRS
A4386	Ost skn barrier w flngex wr	10/01/2000	B-00-50	10/01/2002	K0565, K0566	NRS
A4387	Ost clsd pouch w attst barr	10/01/2000	B-00-50			NRS
A4388	Drainable pch w ex wearbarr	10/01/2000	B-00-50			NRS
A4389	Drainable pch w st wearbarr	10/01/2000	B-00-50			NRS
A4390	Drainable pch ex wear convex	10/01/2000	B-00-50			NRS
A4391	Urinary pouch w ex wearbarr	10/01/2000	B-00-50			NRS
A4392	Urinary pouch w st wearbarr	10/01/2000	B-00-50			NRS
A4393	Urine pch w ex wearbar conv	10/01/2000	B-00-50			NRS
A4394	Ostomy pouch liq deodorant	10/01/2000	B-00-50			NRS
A4395	Ostomy pouch solid deodorant	10/01/2000	B-00-50			NRS
A4396	Peristomal hernia supprt blt	10/01/2000	B-00-50			NRS
A4397	Irrigation supply sleeve	10/01/2000	B-00-50			NRS
A4398	Ostomy irrigation bag	10/01/2000	B-00-50			NRS
A4399	Ostomy irrig cone/cath w brs	10/01/2000	B-00-50			NRS
A4400	Ostomy irrigation set	10/01/2000	B-00-50			NRS
A4402	Lubricant per ounce	10/01/2000	B-00-50			NRS
A4404	Ostomy ring each	10/01/2000	B-00-50			NRS
A4405	Nonpectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4406	Pectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4407	Ext wear ost skn barr <=4sq"	01/01/2003	AB-02-137			NRS
A4408	Ext wear ost skn barr >4sq"	01/01/2003	AB-02-137			NRS
A4409	Ost skn barr w flng <=4 sq"	01/01/2003	AB-02-137			NRS
A4410	Ost skn barr w flng >4sq"	01/01/2003	AB-02-137			NRS
A4411	Ostomy skin barrier, solid 4x4 or equiv., extended wear, w/ built-in convexity, each	01/01/2006	Tr. 710			NRS
A4412	Ostomy pouch, drainable, high output, for use on a barrier w/ flange (2 piece system) without filter, each	01/01/2006	Tr. 710			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4413	2 pc drainable ost pouch w/ filter	01/01/2003	AB-02-137			NRS
A4414	Ostomy skn barr w/ flng < 4sq	01/01/2003	AB-02-137			NRS
A4415	Ostomy skn barr w/ flng > 4sq	01/01/2003	AB-02-137			NRS
A4416	Ost pch clsd w barrier/fltr	01/01/2004	Tr. 8			NRS
A4417	Ost pch w bar/bltinconv/fltr	01/01/2004	Tr. 8			NRS
A4418	Ost pch clsd w/o bar w filtr	01/01/2004	Tr. 8			NRS
A4419	Ost pch for bar w flange/flt	01/01/2004	Tr. 8			NRS
A4420	Ost pch clsd for bar w lk fl	01/01/2004	Tr. 8			NRS
A4421 (6)	Ostomy supply misc	10/01/2000	B-00-50		N/A	NRS
A4422	Ost pouch absorbent material	01/01/2003	AB-02-137			NRS
A4423	Ost pch for bar w lk fl/fltr	01/01/2004	Tr. 8			NRS
A4424	Ost pch drain w bar & filter	01/01/2004	Tr. 8			NRS
A4425	Ost pch drain for barrier fl	01/01/2004	Tr. 8			NRS
A4426	Ost pch drain 2 piece system	01/01/2004	Tr. 8			NRS
A4427	Ost pch drain/barr lk flng/f	01/01/2004	Tr. 8			NRS
A4428	Urine ost pouch w faucet/tap	01/01/2004	Tr. 8			NRS
A4429	Urine ost pouch w bltinconv	01/01/2004	Tr. 8			NRS
A4430	Ost urine pch w b/bltin conv	01/01/2004	Tr. 8			NRS
A4431	Ost pch urine w barrier/tapv	01/01/2004	Tr. 8			NRS
A4432	Os pch urine w bar/fange/tap	01/01/2004	Tr. 8			NRS
A4433	Urine ost pch bar w lock fln	01/01/2004	Tr. 8			NRS
A4434	Ost pch urine w lock flng/ft	01/01/2004	Tr. 8			NRS
A4435	Ost pch, drainable, high output, w/ extended wear barrier (1-pc system) w/or w/o filter, each	01/01/2013	R2527CP			NRS
A4455	Adhesive remover per ounce	10/01/2000	B-00-50			NRS
A4456	Adhesive remover, wipes, any type, each	01/01/2010	1827			NRS
A4458	Reusable enema bag	01/01/2003	AB-02-137			NRS
A4460	Elastic compression bandage	10/01/2000	B-00-50			NRS
A4461	Surgical dressing holder, non-reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4462	Abdmnl drssng holder/binder	10/01/2000	B-00-50	01/01/2007	A4461, A4463	NRS
A4463	Surgical dressing holder, reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4481	Tracheostoma filter	10/01/2000	B-00-50			NRS
A4554	Disposable underpads	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4622	Tracheostomy or larngectomy	10/01/2000	B-00-50	01/01/2004	A7520, A7521, A7522	NRS
A4623	Tracheostomy inner cannula	10/01/2000	B-00-50			NRS
A4625	Trach care kit for new	10/01/2000	B-00-50			NRS

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HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4626	Tracheostomy cleaning brush	10/01/2000	B-00-50			NRS
A4649	Surgical supplies	10/01/2000	B-00-50			NRS
A4656	Needle, any size, each	01/01/2003	AB-02-137	01/01/2006	A4215	NRS
A4657	Syringe, with or without needle, each	01/01/2003	AB-02-137			NRS
A4712	Sterile water inj per 10 ml	01/01/2003	AB-02-137	01/01/2004	N/A	NRS
A4930	Sterile, gloves per pair	01/01/2003	AB-02-137			NRS
A4932	Rectal thermometer, reusable, any type, each	01/01/2007	Tr.1082			NRS
A5051	Pouch clsd w barr attached	10/01/2000	B-00-50			NRS
A5052	Clsd ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5053	Clsd ostomy pouch faceplate	10/01/2000	B-00-50			NRS
A5054	Clsd ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5055	Stoma cap	10/01/2000	B-00-50			NRS
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	01/01/2012	2317			NRS
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each	01/01/2012	2317			NRS
A5061	Pouch drainable w barrier at	10/01/2000	B-00-50	10/01/2002	K0567, K0568	NRS
A5061 (5)	Pouch drainable w barrier at	01/01/2003	AB-02-137			NRS
A5062	Drnble ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5063	Drain ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5071	Urinary pouch w/barrier	10/01/2000	B-00-50			NRS
A5072	Urinary pouch w/o barrier	10/01/2000	B-00-50			NRS
A5073	Urinary pouch on barr w/flng	10/01/2000	B-00-50			NRS
A5081	Continent stoma plug	10/01/2000	B-00-50			NRS
A5082	Continent stoma catheter	10/01/2000	B-00-50			NRS
A5093	Ostomy accessory convex inse	10/01/2000	B-00-50			NRS
A5102	Beside drain btl w/wo tube	10/01/2000	B-00-50			NRS
A5105	Urinary suspensory	10/01/2000	B-00-50			NRS
A5112	Urinary leg bag	10/01/2000	B-00-50			NRS
A5113	Latex leg strap	10/01/2000	B-00-50			NRS
A5114	Foam/fabric leg strap	10/01/2000	B-00-50			NRS
A5119	Skin barrier wipes box pr	10/01/2000	B-00-50	01/01/2006	A5120	NRS
A5120	Skin barrier, wipes or swabs, each	01/01/2006	Tr. 710			NRS
A5121	Solid skin barrier 6x6	10/01/2000	B-00-50			NRS
A5122	Solid skin barrier 8x8	10/01/2000	B-00-50			NRS
A5123	Skin barrier with flange	10/01/2000	B-00-50	10/01/2002	K0570, K0571	NRS
A5126	Disk / foam pad +or-	10/01/2000	B-00-50			NRS

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A5131	Appliance cleaner	10/01/2000	B-00-50			NRS
A5149	Incontinence / ostomy supply	10/01/2000	B-00-50	01/01/2001	A4335, A4421	NRS
A6010	Collagen based wound filler, dry foam	01/01/2002	AB-01-128			NRS
A6011	Collagen gel/paste wound fil	01/01/2003	AB-02-137			NRS
A6020	Collagen wound dressing	10/01/2000	B-00-50			NRS
A6021	Collagen dressing <=16 sq in	01/01/2001	AB-01-65			NRS
A6022	Collagen drsg>6<=48 sq in	01/01/2001	AB-01-65			NRS
A6023	Collagen dressing >48 sq in	01/01/2001	AB-01-65			NRS
A6024	Collagen dsgr wound filler	01/01/2001	AB-01-65			NRS
A6025	Gel sheet for dermal or epidermal application (e.g. silicone, hydrogel, other)	01/01/2004	Tr.8	01/01/2006	N/A	NRS
A6154	Wound pouch each	10/01/2000	B-00-50			NRS
A6196	Alginate dressing <=16 sq in	10/01/2000	B-00-50			NRS
A6197	Alginate drsg >16 <=48 sq	10/01/2000	B-00-50			NRS
A6198	Alginate dressing > 48 sq	10/01/2000	B-00-50			NRS
A6199	Alginate drsg wound filler	10/01/2000	B-00-50			NRS
A6200	Compos drsg <=16 no bdr	10/01/2000	B-00-50			NRS
A6201	Compos drsg >16<=48 no bdr	10/01/2000	B-00-50			NRS
A6202	Compos drsg >48 no bdr	10/01/2000	B-00-50			NRS
A6203	Composite drsg <= 16 sq	10/01/2000	B-00-50			NRS
A6204	Composite drsg >16<=48 sq in	10/01/2000	B-00-50			NRS
A6205	Composite drsg > 48 sq	10/01/2000	B-00-50			NRS
A6206	Contact layer <= 16 sq	10/01/2000	B-00-50			NRS
A6207	Contact layer >16<= 48 sq	10/01/2000	B-00-50			NRS
A6208	Contact layer > 48 sq	10/01/2000	B-00-50			NRS
A6209	Foam drsg <=16 sq in w/o bdr	10/01/2000	B-00-50			NRS
A6210	Foam drg >16<=48 sq in w/o b	10/01/2000	B-00-50			NRS
A6211	Foam drg > 48 sq in w/o brdr	10/01/2000	B-00-50			NRS
A6212	Foam drg <=16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6213	Foam drg >16<=48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6214	Foam drg > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6215	Foam dressing wound filler	10/01/2000	B-00-50			NRS
A6219	Gauze <= 16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6220	Gauze >16 <=48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6221	Gauze > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6222	Gauze <=16 in no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6223	Gauze >16<=48 no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6224	Gauze > 48 in no w /sal w/ o b	10/01/2000	B-00-50			NRS

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A6228	Gauze <= 16 sq in water / sal	10/01/2000	B-00-50			NRS
A6229	Gauze >16<=48 sq in watr / sal	10/01/2000	B-00-50			NRS
A6230	Gauze > 48 sq in water / salne	10/01/2000	B-00-50			NRS
A6231	Hydrogel dsq<=16 sq in	01/01/2001	AB-01-65			NRS
A6232	Hydrogel dsq>16<=48 sq in	01/01/2001	AB-01-65			NRS
A6233	Hydrogel dressing >48 sq in	01/01/2001	AB-01-65			NRS
A6234	Hydrocolld drg <=16 w / o bdr	10/01/2000	B-00-50			NRS
A6235	Hydrocolld drg >16<=48 w / o b	10/01/2000	B-00-50			NRS
A6236	Hydrocolld drg > 48 in w / o b	10/01/2000	B-00-50			NRS
A6237	Hydrocolld drg <=16 in w / bdr	10/01/2000	B-00-50			NRS
A6238	Hydrocolld drg >16<=48 w / bdr	10/01/2000	B-00-50			NRS
A6239	Hydrocolld drg > 48 in w / bdr	10/01/2000	B-00-50			NRS
A6240	Hydrocolld drg filler paste	10/01/2000	B-00-50			NRS
A6241	Hydrocolloid drg filler dry	10/01/2000	B-00-50			NRS
A6242	Hydrogel drg <=16 in w / o bdr	10/01/2000	B-00-50			NRS
A6243	Hydrogel drg >16<=48 w / o bdr	10/01/2000	B-00-50			NRS
A6244	Hydrogel drg >48 in w / o bdr	10/01/2000	B-00-50			NRS
A6245	Hydrogel drg <= 16 in w / bdr	10/01/2000	B-00-50			NRS
A6246	Hydrogel drg >16<=48 in w / b	10/01/2000	B-00-50			NRS
A6247	Hydrogel drg > 48 sq in w / b	10/01/2000	B-00-50			NRS
A6248	Hydrogel dressing	10/01/2000	B-00-50			NRS
A6251	Absorpt drg <=16 sq in w / o b	10/01/2000	B-00-50			NRS
A6252	Absorpt drg >16 <=48 w / o bdr	10/01/2000	B-00-50			NRS
A6253	Absorpt drg . 48 sq in w / o b	10/01/2000	B-00-50			NRS
A6254	Absorpt drg <=16 sq in w / bdr	10/01/2000	B-00-50			NRS
A6255	Absorpt drg >16<=48 in w / bdr	10/01/2000	B-00-50			NRS
A6256	Absorpt drg > 48 sq in w / bdr	10/01/2000	B-00-50			NRS
A6257	Transparent film <= 16 sq in	10/01/2000	B-00-50			NRS
A6258	Transparent film >16<=48 in	10/01/2000	B-00-50			NRS
A6259	Transparent film > 48 sq in	10/01/2000	B-00-50			NRS
A6261	Wound filler gel / paste / oz	10/01/2000	B-00-50			NRS
A6262	Wound filler dry form / gram	10/01/2000	B-00-50			NRS
A6266	Impreg gauze no h20 / sal / yard	10/01/2000	B-00-50			NRS
A6402	Sterile gauze <= 16 sq in	10/01/2000	B-00-50			NRS
A6403	Sterile gauze>16 <= 48 sq in	10/01/2000	B-00-50			NRS
A6404	Sterile gauze > 48 sq in	10/01/2000	B-00-50			NRS
A6405	Sterile elastic gauze / yd	10/01/2000	B-00-50			NRS
A6406	Sterile non-elastic gauze / yd	10/01/2000	B-00-50			NRS
A6407	Packing strips, non-impregnated, up to 2 inches, per lin yd	01/01/2004	Tr. 8			NRS

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A6410	Sterile eye pad	01/01/2003	AB-02-137			NRS
A6412	Eye patch, occlusive, each	01/01/2007	Tr.1082			NRS
A6440	Zinc Paste >=3"<5" w/roll	04/01/2003	AB-03-002			NRS
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width > or = 3" and < 5", per yard	01/01/2004	Tr. 8			NRS
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	01/01/2004	Tr. 8			NRS
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS

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A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6457	Tubular dressing with or without elastic, any width, per linear yard	01/01/2006	Tr. 710			NRS
A7040	One way chest drain valve	01/01/2005	Tr. 340			NRS
A7041	Water seal drainage container and tubing for use with implanted chest tube	01/01/2005	Tr. 340			NRS
A7043	Vacuum drainage bottle & tubing	01/01/2003	AB-02-137			NRS
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	01/01/2005	Tr. 340			NRS
A7501	Tracheostoma valve w diaphra	01/01/2001	AB-01-65			NRS
A7502	Replacement diaphragm/fplate	01/01/2001	AB-01-65			NRS
A7503	HMES filter holder or cap	01/01/2001	AB-01-65			NRS
A7504	Tracheostoma HMES filter	01/01/2001	AB-01-65			NRS
A7505	HMES or trach valve housing	01/01/2001	AB-01-65			NRS
A7506	HMES/trachvalve adhesivedisk	01/01/2001	AB-01-65			NRS
A7507	Integrated filter & holder	01/01/2001	AB-01-65			NRS
A7508	Housing & Integrated Adhesiv	01/01/2001	AB-01-65			NRS
A7509	Heat & moisture exchange sys	01/01/2001	AB-01-65			NRS
A7520	Tracheostomy/larynectomy tube, non-cuffed	01/01/2004	Tr. 8			NRS
A7521	Tracheostomy/larynectomy tube, cuffed	01/01/2004	Tr. 8			NRS

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A7522	Tracheostomy/laryngectomy tube, stainless steel	01/01/2004	Tr. 8			NRS
A7523	Tracheostomy shower protector, each	01/01/2004	Tr. 8			NRS
A7524	Tracheostomy stent/stud/button, each	01/01/2004	Tr. 8			NRS
A7525 (8)	Tracheostomy mask, each	01/01/2004	Tr. 8	01/01/2004		NRS
A7526 (8)	Tracheostomy tube collar/holder, each	01/01/2004	Tr. 8	01/01/2004		NRS
A7527	Tracheostomy/laryngectomy tube plug/stop, each	01/01/2005	Tr. 340			NRS
G0193	Endoscopic study swallow functn	01/01/2001	AB-01-65			Therapy
G0194	Sensory testing endoscopic stud	01/01/2001	AB-01-65			Therapy
G0195	Clinical eval swallowing funct	01/01/2001	AB-01-65			Therapy
G0196	Eval of swallowing with radio opa	01/01/2001	AB-01-65			Therapy
G0197	Eval of pt for prescip speech devi	01/01/2001	AB-01-65			Therapy
G0198	Patient adapation & train for spe	01/01/2001	AB-01-65			Therapy
G0199	Reevaluation of patient use spec	01/01/2001	AB-01-65			Therapy
G0200	Eval of patient prescip of voice p	01/01/2001	AB-01-65			Therapy
G0201	Modi for training in use voice pro	01/01/2001	AB-01-65			Therapy
G0279	Excorp shock tx, elbow epi	01/01/2003	AB-02-137			Therapy
G0280	Excorp shock tx other than	01/01/2003	AB-02-137			Therapy
G0281	Elec stim unattend for press	01/01/2003	AB-02-137			Therapy
G0282	Elect stim wound care not pd	01/01/2003	AB-02-137			Therapy
G0283	Elec stim other than wound	01/01/2003	AB-02-137			Therapy
G0329	Electromagntic tx for ulcers	10/01/2004	Tr. 226			Therapy
K0280	Extension drainage tubing	10/01/2000	B-00-50	01/01/2001	A4331	NRS
K0281	Lubricant catheter insertion	10/01/2000	B-00-50	01/01/2001	A4332	NRS
K0407	Urinary cath skin attachment	10/01/2000	B-00-50	01/01/2001	A4333	NRS
K0408	Urinary cath leg strap	10/01/2000	B-00-50	01/01/2001	A4334	NRS
K0409	Sterile H2O irrigation solut	10/01/2000	B-00-50	01/01/2001	A4319	NRS
K0410	Male ext cath w / adh coating	10/01/2000	B-00-50	01/01/2001	A4324	NRS
K0411	Male ext cath w / adh strip	10/01/2000	B-00-50	01/01/2001	A4325	NRS
K0561	Non-pectin based ostomy paste	10/01/2002	AB-02-092	01/01/2003	A4405	NRS
K0562	Pectin based ostomy paste	10/01/2002	AB-02-092	01/01/2003	A4406	NRS
K0563	Ext wear ost skn barr <4sq	10/01/2002	AB-02-092	01/01/2003	A4407	NRS
K0564	Ext wear ost skn barr >4sq	10/01/2002	AB-02-092	01/01/2003	A4408	NRS
K0565	Ost skn barr w flng <4sq	10/01/2002	AB-02-092	01/01/2003	A4409	NRS
K0566	Ost skn barr w flng >4sq	10/01/2002	AB-02-092	01/01/2003	A4410	NRS
K0567	1 pc drainable ost pouch	10/01/2002	AB-02-092	01/01/2003	A5061	NRS
K0568	1 pc cnvx drainabl ost pouch	10/01/2002	AB-02-092	01/01/2003	A5061	NRS

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K0569	2 pc drainable ost pouch	10/01/2002	AB-02-092	01/01/2003	A4413	NRS
K0570	Ostomy skn barr w flng <4sq	10/01/2002	AB-02-092	01/01/2003	A4414	NRS
K0571	Ostomy skn barr w flng >4sq	10/01/2002	AB-02-092	01/01/2003	A4415	NRS
K0574	Ostomy pouch filter	10/01/2002	AB-02-092	01/01/2003	A4368	NRS
K0575	Ost pouch rustle free mat	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0576	Ostomy pouch comfort panel	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0577	Ostomy pouch odor barrier	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0578	Urinary pouch faucet/drain	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0579	Ost pouch absorbent material	10/01/2002	AB-02-092	01/01/2003	A4422	NRS
K0580	Ost pouch locking flange	10/01/2002	AB-02-092	01/01/2003	N/A	NRS
K0581	Ost pch clsd w barrier/filtr	01/01/2003	AB-02-137	01/01/2004	A4416	NRS
K0582	Ost pch w bar/bltinconv/fltr	01/01/2003	AB-02-137	01/01/2004	A4417	NRS
K0583	Ost pch clsd w/o bar w filtr	01/01/2003	AB-02-137	01/01/2004	A4418	NRS
K0584	Ost pch for bar w flange/ft	01/01/2003	AB-02-137	01/01/2004	A4419	NRS
K0585	Ost pch clsd for bar w lk fl	01/01/2003	AB-02-137	01/01/2004	A4420	NRS
K0586	Ost pch for bar w lk fl/fltr	01/01/2003	AB-02-137	01/01/2004	A4423	NRS
K0587	Ost pch drain w bar & filter	01/01/2003	AB-02-137	01/01/2004	A4424	NRS
K0588	Ost pch drain for barrier fl	01/01/2003	AB-02-137	01/01/2004	A4425	NRS
K0589	Ost pch drain 2 piece system	01/01/2003	AB-02-137	01/01/2004	A4426	NRS
K0590	Ost pch drain/barr lk flng/f	01/01/2003	AB-02-137	01/01/2004	A4427	NRS
K0591	Urine ost pouch w faucet/tap	01/01/2003	AB-02-137	01/01/2004	A4428	NRS
K0592	Urine ost pouch w bltinconv	01/01/2003	AB-02-137	01/01/2004	A4429	NRS
K0593	Ost urine pch w b/bltin conv	01/01/2003	AB-02-137	01/01/2004	A4430	NRS
K0594	Ost pch urine w barrier/tapv	01/01/2003	AB-02-137	01/01/2004	A4431	NRS
K0595	Os pch urine w bar/fange/tap	01/01/2003	AB-02-137	01/01/2004	A4432	NRS
K0596	Urine ost pch bar w lock fln	01/01/2003	AB-02-137	01/01/2004	A4433	NRS
K0597	Ost pch urine w lock flng/ft	01/01/2003	AB-02-137	01/01/2004	A4434	NRS
K0614	chem/antiseptic solution, 8oz.	10/01/2003	AB-03-096			NRS
K0620	tubular elastic dressing	10/01/2003	AB-03-096			NRS
K0621	gauze, non-impreg pack strip	10/01/2003	AB-03-096	01/01/2004	A6407	NRS

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## Diagnosis Codes For Home Health Resource Group (HHRG) Assignment

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Visit <http://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/casemixgroupersoftware.html> for the current Home Health Agency Prospective Payment System (HHA PPS) Grouper, including diagnosis codes for HHRG assignments.

- END -



## Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2012

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(Final payment amounts per 60-day episodes ending on or after January 1, 2012 and before January 1, 2013 - Continuing Calendar Year (CY) update.)

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

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for CY 2012 that the standard prospective payment amount be increased by a factor equal to the applicable home health market basket update for HHAs.

### National 60-Day Episode Payment Amounts - CY 2012

In order to calculate the CY 2012 national standardized 60-day episode, the CY 2011 national standardized 60-day episode payment of \$2,192.07 was increased by the CY 2012 home health market basket update percentage of 1.4% (which reflects a 1% reduction applied to the 2.4% market basket update factor, as mandated by the Affordable Care Act) and reduced by 3.79% to account for the change in case-mix that is not related to the real change in patient acuity levels as reflected in [Figure 12.L.2012-1](#):

**FIGURE 12.L.2012-1 NATIONAL 60-DAY EPISODE PAYMENT RATE UPDATED BY THE HOME HEALTH MARKET BASKET UPDATE FOR CY 2012, BEFORE CASE-MIX ADJUSTMENT AND WAGE ADJUSTED BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY**

CY 2011 National Standardized 60-day Episode Payment Rate	Multiply by CY 2012 HH PPS payment update percentage (1.4%).	Reduce by 3.79% for nominal change in case-mix.	CY 2012 of 1.4% National Standardized 60-day Episode Payment Rate
\$2,192.07	x 1.014	x 0.9621	\$2,138.52

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

Chapter 12, Addendum L (CY 2012)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2012

**National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2012**

The CY 2011 national per-visit amounts were increased by the CY 2012 home health payment update percentage of 1.4%. National per-visit rates are not subjected to the nominal increase in case-mix. The final updated CY 2012 national per-visit rates per discipline are reflected in [Figure 12.L.2012-2](#):

**FIGURE 12.L.2012-2 NATIONAL PER-VISIT RATES FOR LUPAS (NOT INCLUDING THE LUPA ADD-ON PAYMENT AMOUNT FOR A BENEFICIARY’S ONLY EPISODE OR THE INITIAL EPISODE IN A SEQUENCE OF ADJACENT EPISODES) AND OUTLIER CALCULATIONS UPDATED BY THE CY 2012 HH PPS PAYMENT UPDATE PERCENTAGE, BEFORE WAGE INDEX ADJUSTMENT**

Home Health Discipline	CY 2011 Per-visit payment amounts per 60-day episode.	Multiply by the HH PPS payment update percentage (1.4%).	CY 2012 Per-visit Amount.
Home Health Aide	\$50.42	x 1.014	\$51.13
Medical Social Services	178.46	x 1.014	180.96
Occupational Therapy	122.54	x 1.014	124.26
Physical Therapy	121.73	x 1.014	123.43
Skilled Nursing	111.32	x 1.014	112.88
Speech-Language Pathology	132.27	x 1.014	134.12

**Payment of LUPA Episodes**

Payment for LUPA episodes changed in CY 2008 in that for LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode, an additional payment amount is added to the LUPA payment. The [Figure 12.L.2012-2](#) per-visit rate noted above are before that additional payment is added to the LUPA payment, and are the per-visit rates paid to all other LUPA episodes and used in computing outlier payments. LUPA episodes that occur as the only episode or initial episode in a sequence of adjacent episodes are adjusted by adding an additional amount to the LUPA payment before adjusting for wage index. For CY 2011, that amount was \$93.31. This additional LUPA amount was updated in the same manner as the national standardized 60-day episode payment amount and the per-visit rates as is reflected in [Figure 12.L.2012-3](#).

**FIGURE 12.L.2012-3 CY 2012 LUPA ADD-ON PAYMENT AMOUNTS**

CY 2011 LUPA Add-on Payment Amount	Multiply by the HH PPS payment update percentage (1.4%).	CY 2012 LUPA add-on Amounts
\$93.31	x 1.014	\$94.62

## Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013

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(Final payment amounts per 60-day episodes ending on or after January 1, 2013 and before January 1, 2014 - Continuing Calendar Year (CY) update.)

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

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for CY 2013 that the standard prospective payment amount be increased by a factor equal to the applicable home health market basket update for HHAs.

### National 60-Day Episode Payment Amounts - CY 2013

In order to calculate the CY 2013 national standardized 60-day episode, the CY 2012 national standardized 60-day episode payment of \$2,138.52 was increased by the CY 2013 home health market basket update percentage of 1.3% (which reflects a 1% reduction applied to the 2.3% market basket update factor, as mandated by the Affordable Care Act) and reduced by 1.32% to account for the change in case-mix that is not related to the real change in patient acuity levels as reflected in [Figure 12.L.2013-1](#):

**FIGURE 12.L.2013-1 NATIONAL 60-DAY EPISODE PAYMENT RATE UPDATED BY THE HOME HEALTH MARKET BASKET UPDATE FOR CY 2013, BEFORE CASE-MIX ADJUSTMENT AND WAGE ADJUSTED BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY**

CY 2012 National Standardized 60-day Episode Payment Rate	Multiply by CY 2013 HHA PPS payment update percentage (1.3%).	Reduce by 1.32% for nominal change in case-mix.	CY 2013 National Standardized 60-day Episode Payment Rate
\$2,138.52	x 1.013	0.9868	\$2,137.73

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

Chapter 12, Addendum L (CY 2013)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013

**National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2013**

The CY 2012 national per-visit amounts were increased by the CY 2013 home health payment update percentage of 1.3%. National per-visit rates are not subjected to the nominal increase in case-mix. The final updated CY 2013 national per-visit rates per discipline are reflected in [Figure 12.L.2013-2](#):

**FIGURE 12.L.2013-2 NATIONAL PER-VISIT RATES FOR LUPAS (NOT INCLUDING THE LUPA ADD-ON PAYMENT AMOUNT FOR A BENEFICIARY’S ONLY EPISODE OR THE INITIAL EPISODE IN A SEQUENCE OF ADJACENT EPISODES) AND OUTLIER CALCULATIONS UPDATED BY THE CY 2013 HHA PPS PAYMENT UPDATE PERCENTAGE, BEFORE WAGE INDEX ADJUSTMENT**

Home Health Discipline	CY 2012 Per-visit payment amounts per 60-day episode.	Multiply by the HHA PPS payment update percentage (1.3%).	CY 2013 Per-visit Amount.
Home Health Aide	\$51.13	x 1.013	\$51.79
Medical Social Services	180.96	x 1.013	183.31
Occupational Therapy	124.26	x 1.013	125.88
Physical Therapy	123.43	x 1.013	125.03
Skilled Nursing	112.88	x 1.013	114.35
Speech-Language Pathology	134.12	x 1.013	135.86

**Payment of LUPA Episodes**

Payment for LUPA episodes changed in CY 2008 in that for LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode, an additional payment amount is added to the LUPA payment. The [Figure 12.L.2013-2](#) per-visit rates noted above are before that additional payment is added to the LUPA payment, and are the per-visit rates paid to all other LUPA episodes and used in computing outlier payments. LUPA episodes that occur as the only episode or initial episode in a sequence of adjacent episodes are adjusted by adding an additional amount to the LUPA payment before adjusting for wage index. For CY 2012, that amount was \$94.62. This additional LUPA amount was updated in the same manner as the national standardized 60-day episode payment amount and the per-visit rates as is reflected in [Figure 12.L.2013-3](#).

**FIGURE 12.L.2013-3 CY 2013 LUPA ADD-ON PAYMENT AMOUNTS**

CY 2012 LUPA Add-on Payment Amount	Multiply by the HHA PPS payment update percentage (1.3%).	CY 2013 LUPA add-on Amounts
\$94.62	x 1.013	\$95.85

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Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013

**Severity Non-Routine Medical Supplies (NRS) System**

Beginning in CY 2008, to ensure that the variation in NRS is more appropriately reflected in the HHA PPS, the original portion (\$49.62) of the HHA PPS base rate that accounted for NRS, was replaced with a system that pays for NRS based on six severity groups. Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The CY 2012 NRS conversion factor was updated for CY 2013 by the CY 2013 HHA PPS payment update percentage of 1.3% as reflected in [Figure 12.L.2013-4](#). The NRS conversion factor for CY 2013 is \$53.97.

**FIGURE 12.L.2013-4 NON-ROUTINE MEDICAL SUPPLY (NRS) CONVERSION FACTOR FOR CY 2013**

CY 2012 NRS Conversion Factor	Multiply by the HHA PPS payment update percentage (1.3%).	CY 2013 NRS Conversion Factor
\$53.28	x 1.013	\$53.97

The payment amounts, using the above computed CY 2013 NRS conversion factor (\$53.97), for the various severity levels based on the updated conversion factor are calculated in [Figure 12.L.2013-5](#).

**FIGURE 12.L.2013-5 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR CY 2013**

Severity Level	Points (Scoring)	Relative Weight	NRS Payment Amount
1	0	0.2698	\$14.56
2	1 to 14	0.9742	52.58
3	15 to 27	2.6712	144.16
4	28 to 48	3.9686	214.19
5	49 to 98	6.1198	330.29
6	99+	10.5254	568.06

**Labor And Non-Labor Percentages**

For CY 2013, the labor percent is 78.535%, and the non-labor percent is 21.465%

**Outlier Payments**

Under the HHA PPS, outlier payments are made for episodes for which the estimated cost exceeds a threshold amount. The wage adjusted Fixed Dollar Loss (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. The FDL ratio, which is used in calculating the FDL amount, for CY 2013 is 0.45.

**Outcome and Assessment Information Set (OASIS)**

OASIS-C is a modification to the OASIS that HHAs must collect in order to participate in the TRICARE program. Implementation of OASIS-C is required effective January 1, 2010.

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Chapter 12, Addendum L (CY 2013)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013

**Temporary 3% Rural Add-On for the HHA PPS**

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

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

In order to calculate the national standardized 60-day episode payment for beneficiaries residing in a rural area, the CY 2013 national standardized 60-day episode payment of \$2,137.73 was increased by 3%.

**FIGURE 12.L.2013-6 CY 2013 PAYMENT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA, BEFORE CASE-MIX ADJUSTMENT AND WAGE INDEX ADJUSTMENT**

CY 2013 National standardized 60-day episode payment rate.	Multiplied by the 3% rural add-on.	Rural CY 2013 National standardized 60-day episode payment rate.
\$2,137.73	x 1.03	\$2,201.86

**CY 2013 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment**

The CY 2013 national per-visit amounts were increased by 3% for beneficiaries who reside in rural areas.

**FIGURE 12.L.2013-7 CY 2013 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA, BEFORE WAGE INDEX ADJUSTMENT**

Home Health Discipline	CY 2013 Per-visit rate.	Multiplied by 3% rural add-on.	Total CY 2013 Per-visit rate for a rural areas.
Home Health Aide	\$51.79	x 1.03	\$53.34
Medical Social Services	183.31	x 1.03	188.81
Occupational Therapy	125.88	x 1.03	129.66
Physical Therapy	125.03	x 1.03	128.78
Skilled Nursing	114.35	x 1.03	117.78
Speech-Language Pathology	135.86	x 1.03	139.94

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Chapter 12, Addendum L (CY 2013)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2013

**Payment of LUPA Episodes for Beneficiaries Who Reside in Rural Areas**

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted in [Figure 12.L.2013-7](#) are before that additional payment is added to the LUPA amount. The CY 2013 LUPA add-on payment was increased by 3% for beneficiaries who reside in rural areas.

**FIGURE 12.L.2013-8 CY 2013 LUPA ADD-ON PAYMENT AMOUNT FOR SERVICES PROVIDED IN A RURAL AREA**

CY 2013 LUPA Add-On Payment.	Multiplied by the 3% rural add-on.	Total CY 2013 LUPA add-on amount for rural areas.
\$95.85	x 1.03	\$98.73

**Payment for NRS**

Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The NRS conversion factor for CY 2013 payments was increased by 3% for beneficiaries who reside in rural areas.

**FIGURE 12.L.2013-9 CY 2013 NRS CONVERSION FACTOR FOR BENEFICIARIES WHO RESIDE IN A RURAL AREA**

CY 2013 NRS Conversion Factor	Multiplied by the 3% rural add-on.	Total CY 2013 NRS conversion factor for rural areas.
\$53.97	x 1.03	\$55.59

The payment amounts, using the above computed NRS conversion factor (\$55.59), for the various severity levels based on the updated conversion factor are calculated in [Figure 12.L.2013-10](#).

**FIGURE 12.L.2013-10 CY 2013 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR BENEFICIARIES RESIDING IN A RURAL AREA**

Severity Level	Points (Scoring)	Relative Weight	Total NRS payment amount for rural areas.
1	0	0.2698	\$15.00
2	1 to 14	0.9742	54.16
3	15 to 27	2.6712	148.49
4	28 to 48	3.9686	220.61
5	49 to 98	6.1198	340.20
6	99+	10.5254	585.11

- END -



Chapter 12

Addendum M (CY 2013)

**Annual Home Health Agency Prospective Payment System  
(HHA PPS) Wage Index Updates - CY 2013**

<sup>1</sup> All counties within the State are classified as urban, with the exception of Puerto Rico. Puerto Rico has areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for CY 2013.

CBSA CODE	NON-URBAN AREA	WAGE INDEX
01	Alabama	0.7121
02	Alaska	1.2807
03	Arizona	0.9182
04	Arkansas	0.7350
05	California	1.2567
06	Colorado	1.0208
07	Connecticut	1.1128
08	Delaware	1.0171
10	Florida	0.8062
11	Georgia	0.7421
12	Hawaii	1.0728
13	Idaho	0.7583
14	Illinois	0.8438
15	Indiana	0.8472
16	Iowa	0.8351
17	Kansas	0.7997
18	Kentucky	0.7877
19	Louisiana	0.7718
20	Maine	0.8300
21	Maryland	0.8797
22	Massachusetts	1.3540
23	Michigan	0.8387
24	Minnesota	0.9053
25	Mississippi	0.7537
26	Missouri	0.7622
27	Montana	0.8600
28	Nebraska	0.8733
29	Nevada	0.9739
30	New Hampshire	1.0372
31	New Jersey <sup>1</sup>	-----
32	New Mexico	0.8879
33	New York	0.8199
34	North Carolina	0.8271
35	North Dakota	0.6891
36	Ohio	0.8470
37	Oklahoma	0.7783
38	Oregon	0.9500
39	Pennsylvania	0.8380
40	Puerto Rico <sup>1</sup>	0.4047
41	Rhode Island <sup>1</sup>	-----

CBSA CODE	NON-URBAN AREA	WAGE INDEX
42	South Carolina	0.8338
43	South Dakota	0.8124
44	Tennessee	0.7559
45	Texas	0.7978
46	Utah	0.8516
47	Vermont	0.9725
48	Virgin Islands	0.7185
49	Virginia	0.7728
50	Washington	1.0092
51	West Virginia	0.7333
52	Wisconsin	0.9142
53	Wyoming	0.9238
65	Guam	0.9611

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<sup>2</sup> At this time, there are no hospitals in these urban areas on which to base a wage index. Therefore, the urban wage index value is based on the average wage index of all urban areas within the State.

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
10180	Abilene, TX Callahan, TX Jones, TX Taylor, TX	0.8324
10380	Aguadilla-Isabela-San Sebastian, PR Aguada, PR Aguadilla, PR Anasco, PR Isabela, PR Lares, PR Moca, PR Rincon, PR San Sebastian, PR	0.3532
10420	Akron, OH Portage, OH Summit, OH	0.8729
10500	Albany, GA Baker, GA Dougherty, GA Lee, GA Terrell, GA Worth, GA	0.8435
10580	Albany-Schenectady-Troy, NY Albany, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8647
10740	Albuquerque, NM Bernalillo, NM Sandoval, NM Torrance, NM Valencia, NM	0.9542
10780	Alexandria, LA Grant, LA Rapides, LA	0.7857
10900	Allentown-Bethlehem-Easton, PA-NJ Warren, NJ Carbon, PA Lehigh, PA Northampton, PA	0.9084
11020	Altoona, PA Blair, PA	0.8898
11100	Amarillo, TX Armstrong, TX	0.8506

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
11180	Carson, TX Potter, TX Randall, TX Ames, IA Story, IA	0.9595
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2147
11300	Anderson, IN Madison, IN	0.9547
11340	Anderson, SC Anderson, SC	0.8929
11460	Ann Arbor, MI Washtenaw, MI	1.0115
11500	Anniston-Oxford, AL Calhoun, AL	0.7539
11540	Appleton, WI Calumet, WI Outagamie, WI	0.9268
11700	Asheville, NC Buncombe, NC Haywood, NC Henderson, NC Madison, NC	0.8555
12020	Athens-Clarke, GA Clarke, GA Madison, GA Oconee, GA Oglethorpe, GA	0.9488
12060	Atlanta-Sandy Springs-Marietta, GA Barrow, GA Bartow, GA Butts, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA Dawson, GA DeKalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Haralson, GA Heard, GA Henry, GA Jasper, GA Lamar, GA	0.9517

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CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
	Meriwether, GA			Calhoun, MI	
	Newton, GA		13020	Bay City, MI	0.9181
	Paulding, GA			Bay, MI	
	Pickens, GA		13140	Beaumont-Port Arthur, TX	0.8533
	Pike, GA			Hardin, TX	
	Rockdale, GA			Jefferson, TX	
	Spalding, GA			Orange, TX	
	Walton, GA		13380	Bellingham, WA	1.1415
12100	Atlantic City-Hammonton, NJ	1.1977		Whatcom, WA	
	Atlantic, NJ		13460	Bend, OR	1.1119
12220	Auburn-Opelika, AL	0.7437		Deschutes, OR	
	Lee, AL		13644	Bethesda-Rockville-Frederick, MD	1.0374
12260	Augusta-Richmond, GA-SC	0.9373		Frederick, MD	
	Burke, GA			Montgomery, MD	
	Columbia, GA		13740	Billings, MT	0.8737
	McDuffie, GA			Carbon, MT	
	Richmond, GA			Yellowstone, MT	
	Aiken, SC		13780	Binghamton, NY	0.8707
	Edgefield, SC			Broome, NY	
12420	Austin-Round Rock-San Marcos, TX	0.9746		Tioga, NY	
	Bastrop, TX		13820	Birmingham-Hoover, AL	0.8516
	Caldwell, TX			Bibb, AL	
	Hays, TX			Blount, AL	
	Travis, TX			Chilton, AL	
	Williamson, TX			Jefferson, AL	
12540	Bakersfield-Delano, CA	1.1611		St. Clair, AL	
	Kern, CA			Shelby, AL	
12580	Baltimore-Towson, MD	1.0147		Walker, AL	
	Anne Arundel, MD		13900	Bismarck, ND	0.7261
	Baltimore, MD			Burleigh, ND	
	Carroll, MD			Morton, ND	
	Harford, MD		13980	Blacksburg-Christiansburg-Radford, VA	0.8348
	Howard, MD			Giles, VA	
	Queen Anne's, MD			Montgomery, VA	
	Baltimore City, MD			Pulaski, VA	
12620	Bangor, ME	1.0184		Radford City, VA	
	Penobscot, ME		14020	Bloomington, IN	0.8752
12700	Barnstable Town, MA	1.2843		Greene, IN	
	Barnstable, MA			Monroe, IN	
12940	Baton Rouge, LA	0.8147		Owen, IN	
	Ascension, LA		14060	Bloomington-Normal, IL	0.9502
	East Baton Rouge, LA			McLean, IL	
	East Feliciana, LA		14260	Boise City-Nampa, ID	0.8897
	Iberville, LA			Ada, ID	
	Livingston, LA			Boise, ID	
	Pointe Coupee, LA			Canyon, ID	
	St. Helena, LA			Gem, ID	
	West Baton Rouge, LA			Owyhee, ID	
	West Feliciana, LA		14484	Boston-Quincy, MA	1.2378
12980	Battle Creek, MI	0.9912		Norfolk, MA	

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CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
14500	Plymouth, MA Suffolk, MA Boulder, CO Boulder, CO	1.0574	16620	Champaign, IL Ford, IL Piatt, IL Charleston, WV	0.8050
14540	Bowling Green, KY Edmonson, KY Warren, KY	0.8665		Boone, WV Clay, WV Kanawha, WV	
14740	Bremerton-Silverdale, WA Kitsap, WA	1.0829		Lincoln, WV Putnam, WV	
14860	Bridgeport-Stamford-Norwalk, CT Fairfield, CT	1.3170	16700	Charleston-North Charleston-Summerville, SC	0.8820
15180	Brownsville-Harlingen, TX Cameron, TX	0.8612		Berkeley, SC Charleston, SC Dorchester, SC	
15260	Brunswick, GA Brantley, GA Glynn, GA McIntosh, GA	0.8792	16740	Charlotte-Gastonia-Rock Hill, NC-SC	0.9215
15380	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9999		Anson, NC Cabarrus, NC Gaston, NC Mecklenburg, NC Union, NC York, SC	
15500	Burlington, NC Alamance, NC	0.8485	16820	Charlottesville, VA Albemarle, VA Fluvanna, VA Greene, VA Nelson, VA	0.9195
15540	Burlington-South Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	0.9997		Charlottesville City, VA	
15764	Cambridge-Newton-Framingham, MA Middlesex, MA	1.1262	16860	Chattanooga, TN-GA Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN Sequatchie, TN	0.8678
15804	Camden, NJ Burlington, NJ Camden, NJ Gloucester, NJ	1.0474	16940	Cheyenne, WY Laramie, WY	0.9730
15940	Canton-Massillon, OH Carroll, OH Stark, OH	0.8834	16974	Chicago-Joliet-Naperville, IL Cook, IL DeKalb, IL DuPage, IL Grundy, IL Kane, IL Kendall, IL McHenry, IL Will, IL	1.0600
15980	Cape Coral-Fort Myers, FL Lee, FL	0.9153		Chico, CA Butte, CA	1.1197
16020	Cape Girardeau-Jackson, MO-IL Alexander, IL Bollinger, MO Cape Girardeau, MO	0.8860	17140	Cincinnati-Middletown, OH-KY-IN Dearborn, IN Franklin, IN	0.9508
16180	Carson City, NV Carson City, NV	1.0559			
16220	Casper, WY Natrona, WY	1.0143			
16300	Cedar Rapids, IA Benton, IA Jones, IA Linn, IA	0.8944			
16580	Champaign-Urbana, IL	0.9907			

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	Ohio, IN			Marion, GA	
	Boone, KY			Muscogee, GA	
	Bracken, KY		18020	Columbus, IN	0.9564
	Campbell, KY			Bartholomew, IN	
	Gallatin, KY		18140	Columbus, OH	0.9763
	Grant, KY			Delaware, OH	
	Kenton, KY			Fairfield, OH	
	Pendleton, KY			Franklin, OH	
	Brown, OH			Licking, OH	
	Butler, OH			Madison, OH	
	Clermont, OH			Morrow, OH	
	Hamilton, OH			Pickaway, OH	
	Warren, OH			Union, OH	
17300	Clarksville, TN-KY	0.8082	18580	Corpus Christi, TX	0.8591
	Christian, KY			Aransas, TX	
	Trigg, KY			Nueces, TX	
	Montgomery, TN			San Patricio, TX	
	Stewart, TN		18700	Corvallis, OR	1.0715
17420	Cleveland, TN	0.7592		Benton, OR	
	Bradley, TN		18880	Crestview-Fort Walton Beach-Destin, FL	0.8916
	Polk, TN			Okaloosa, FL	
17460	Cleveland-Elyria-Mentor, OH	0.9082	19060	Cumberland, MD-WV	0.8836
	Cuyahoga, OH			Allegany, MD	
	Geauga, OH			Mineral, WV	
	Lake, OH		19124	Dallas-Plano-Irving, TX	0.9835
	Lorain, OH			Collin, TX	
	Medina, OH			Dallas, TX	
17660	Coeur d'Alene, ID	0.9218		Delta, TX	
	Kootenai, ID			Denton, TX	
17780	College Station-Bryan, TX	0.9584		Ellis, TX	
	Brazos, TX			Hunt, TX	
	Burleson, TX			Kaufman, TX	
	Robertson, TX			Rockwall, TX	
17820	Colorado Springs, CO	0.9364	19140	Dalton, GA	0.8828
	El Paso, CO			Murray, GA	
	Teller, CO			Whitfield, GA	
17860	Columbia, MO	0.8339	19180	Danville, IL	0.9977
	Boone, MO			Vermilion, IL	
	Howard, MO		19260	Danville, VA	0.8218
17900	Columbia, SC	0.8560		Pittsylvania, VA	
	Calhoun, SC			Danville City, VA	
	Fairfield, SC		19340	Davenport-Moline-Rock Island, IA-IL	0.9145
	Kershaw, SC			Henry, IL	
	Lexington, SC			Mercer, IL	
	Richland, SC			Rock Island, IL	
	Saluda, SC			Scott, IA	
17980	Columbus, GA-AL	0.8857	19380	Dayton, OH	0.9136
	Russell, AL			Greene, OH	
	Chattahoochee, GA			Miami, OH	
	Harris, GA			Montgomery, OH	

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19460	Preble, OH Decatur, AL Lawrence, AL Morgan, AL	0.7261		Monmouth, NJ Ocean, NJ Somerset, NJ	
19500	Decatur, IL Macon, IL	0.7993	20940	El Centro, CA Imperial, CA	0.8602
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia, FL	0.8716	21060	Elizabethtown, KY Hardin, KY Larue, KY	0.8294
19740	Denver-Aurora-Broomfield, CO Adams, CO Arapahoe, CO Broomfield, CO Clear Creek, CO Denver, CO Douglas, CO Elbert, CO Gilpin, CO Jefferson, CO Park, CO	1.0469	21140	Elkhart-Goshen, IN Elkhart, IN	0.9097
			21300	Elmira, NY Chemung, NY	0.8205
			21340	El Paso, TX El Paso, TX	0.8246
			21500	Erie, PA Erie, PA	0.7823
			21660	Eugene-Springfield, OR Lane, OR	1.1454
19780	Des Moines-West Des Moines, IA Dallas, IA Guthrie, IA Madison, IA Polk, IA Warren, IA	0.9616	21780	Evansville, IN-KY Gibson, IN Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY Webster, KY	0.8401
			21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.0816
19804	Detroit-Livonia-Dearborn, MI Wayne, MI	0.9361	21940	Fajardo, PR Ceiba, PR Fajardo, PR Luquillo, PR	0.3663
20020	Dothan, AL Geneva, AL Henry, AL Houston, AL	0.7398	22020	Fargo, ND-MN Clay, MN Cass, ND	0.8108
20100	Dover, DE Kent, DE	0.9893	22140	Farmington, NM San Juan, NM	0.9323
20220	Dubuque, IA Dubuque, IA	0.8662	22180	Fayetteville, NC Cumberland, NC Hoke, NC	0.8971
20260	Duluth, MN-WI Carlton, MN St. Louis, MN Douglas, WI	1.0741	22220	Fayetteville-Springdale-Rogers, AR-MO Benton, AR Madison, AR Washington, AR McDonald, MO	0.9288
20500	Durham-Chapel Hill, NC Chatham, NC Durham, NC Orange, NC Person, NC	0.9525	22380	Flagstaff, AZ Coconino, AZ	1.2369
20740	Eau Claire, WI Chippewa, WI Eau Claire, WI	0.9705	22420	Flint, MI Genesee, MI	1.1257
20764	Edison-New Brunswick, NJ Middlesex, NJ	1.0806	22500	Florence, SC Darlington, SC	0.8087

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22520	Florence, SC Florence-Muscle Shoals, AL Colbert, AL Lauderdale, AL	0.7679	24340	Grand Rapids-Wyoming, MI Barry, MI Ionia, MI Kent, MI Newaygo, MI	0.9125
22540	Fond du Lac, WI Fond du Lac, WI	0.9158	24500	Great Falls, MT Cascade, MT	0.7927
22660	Fort Collins-Loveland, CO Larimer, CO	0.9833	24540	Greeley, CO Weld, CO	0.9593
22744	Fort Lauderdale-Pompano Beach-Deerfield, Beach, FL Broward, FL	1.0363	24580	Green Bay, WI Brown, WI Kewaunee, WI Oconto, WI	0.9793
22900	Fort Smith, AR-OK Crawford, AR Franklin, AR Sebastian, AR Le Flore, OK Sequoyah, OK	0.7848	24660	Greensboro-High Point, NC Guilford, NC Randolph, NC Rockingham, NC	0.8638
23060	Fort Wayne, IN Allen, IN Wells, IN Whitley, IN	0.9633	24780	Greenville, NC Greene, NC Pitt, NC	0.9694
23104	Fort Worth-Arlington, TX Johnson, TX Parker, TX Tarrant, TX Wise, TX	0.9516	24860	Greenville-Mauldin-Easley, SC Greenville, SC Laurens, SC Pickens, SC	0.9737
23420	Fresno, CA Fresno, CA	1.1593	25020	Guayama, PR Arroyo, PR Guayama, PR Patillas, PR	0.3696
23460	Gadsden, AL Etowah, AL	0.7697	25060	Gulfport-Biloxi, MS Hancock, MS Harrison, MS Stone, MS	0.8544
23540	Gainesville, FL Alachua, FL Gilchrist, FL	0.9631	25180	Hagerstown-Martinsburg, MD-WV Washington, MD Berkeley, WV Morgan, WV	0.9422
23580	Gainesville, GA Hall, GA	0.9327	25260	Hanford-Corcoran, CA Kings, CA	1.0992
23844	Gary, IN Jasper, IN Lake, IN Newton, IN Porter, IN	0.9259	25420	Harrisburg-Carlisle, PA Cumberland, PA Dauphin, PA Perry, PA	0.9525
24020	Glens Falls, NY Warren, NY Washington, NY	0.8340	25500	Harrisonburg, VA Rockingham, VA Harrisonburg City, VA	0.9087
24140	Goldsboro, NC Wayne, NC	0.8560	25540	Hartford-West Hartford-East Hartford, CT Hartford, CT Middlesex, CT Tolland, CT	1.0869
24220	Grand Forks, ND-MN Polk, MN Grand Forks, ND	0.7250			
24300	Grand Junction, CO Mesa, CO	0.9415			

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25620	Hattiesburg, MS Forrest, MS Lamar, MS Perry, MS	0.8035		Johnson, IN Marion, IN Morgan, IN Putnam, IN Shelby, IN	
25860	Hickory-Lenoir-Morganton, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.8677	26980	Iowa City, IA Johnson, IA Washington, IA	1.0120
25980 <sup>2</sup>	Hinesville-Fort Stewart, GA Liberty, GA Long, GA	0.8843	27060	Ithaca, NY Tompkins, NY	0.9249
26100	Holland-Grand Haven, MI Ottawa, MI	0.8024	27100	Jackson, MI Jackson, MI	0.8511
26180	Honolulu, HI Honolulu, HI	1.2156	27140	Jackson, MS Copiah, MS Hinds, MS Madison, MS	0.8177
26300	Hot Springs, AR Garland, AR	0.8944		Rankin, MS Simpson, MS	
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche, LA Terrebonne, LA	0.7928	27180	Jackson, TN Chester, TN Madison, TN	0.7672
26420	Houston-Sugar Land-Baytown, TX Austin, TX Brazoria, TX Chambers, TX Fort Bend, TX Galveston, TX Harris, TX Liberty, TX Montgomery, TX San Jacinto, TX Waller, TX	0.9933	27260	Jacksonville, FL Baker, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	0.8883
26580	Huntington-Ashland, WV-KY-OH Boyd, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.8635	27340	Jacksonville, NC Onslow, NC	0.7957
26620	Huntsville, AL Limestone, AL Madison, AL	0.8667	27500	Janesville, WI Rock, WI	0.9458
26820	Idaho Falls, ID Bonneville, ID Jefferson, ID	0.9114	27620	Jefferson City, MO Callaway, MO Cole, MO Moniteau, MO Osage, MO	0.8263
26900	Indianapolis-Carmel, IN Boone, IN Brown, IN Hamilton, IN Hancock, IN Hendricks, IN	0.9870	27740	Johnson City, TN Carter, TN Unicoi, TN Washington, TN	0.7359
			27780	Johnstown, PA Cambria, PA	0.8116
			27860	Jonesboro, AR Craighead, AR Poinsett, AR	0.8084
			27900	Joplin, MO Jasper, MO Newton, MO	0.7828
			28020	Kalamazoo-Portage, MI Kalamazoo, MI	0.9834

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28100	Van Buren, MI	1.0127	29180	Lafayette, LA	0.8565
	Kankakee-Bradley, IL			Lafayette, LA	
	Kankakee, IL			St. Martin, LA	
28140	Kansas City, MO-KS	0.9614	29340	Lake Charles, LA	0.7813
	Franklin, KS			Calcasieu, LA	
	Johnson, KS			Cameron, LA	
	Leavenworth, KS		29404	Lake County-Kenosha County, IL-WI	1.0558
	Linn, KS			Lake, IL	
	Miami, KS			Kenosha, WI	
	Wyandotte, KS		29420	Lake Havasu City-Kingman, AZ	0.9760
	Bates, MO			Mohave, AZ	
	Caldwell, MO		29460	Lakeland-Winter Haven, FL	0.8262
	Cass, MO			Polk, FL	
	Clay, MO		29540	Lancaster, PA	0.9452
	Clinton, MO			Lancaster, PA	
	Jackson, MO		29620	Lansing-East Lansing, MI	1.0065
	Lafayette, MO			Clinton, MI	
	Platte, MO			Eaton, MI	
	Ray, MO			Ingham, MI	
28420	Kennewick-Pasco-Richland, WA	0.9708	29700	Laredo, TX	0.7486
	Benton, WA			Webb, TX	
	Franklin, WA		29740	Las Cruces, NM	0.9044
28660	Killeen-Temple-Fort Hood, TX	0.9102		Dona Ana, NM	
	Bell, TX		29820	Las Vegas-Paradise, NV	1.2076
	Coryell, TX			Clark, NV	
	Lampasas, TX		29940	Lawrence, KS	0.8676
28700	Kingsport-Bristol-Bristol, TN-VA	0.7325		Douglas, KS	
	Hawkins, TN		30020	Lawton, OK	0.8351
	Sullivan, TN			Comanche, OK	
	Bristol City, VA		30140	Lebanon, PA	0.7994
	Scott, VA			Lebanon, PA	
	Washington, VA		30300	Lewiston, ID-WA	0.9326
28740	Kingston, NY	0.8953		Nez Perce, ID	
	Ulster, NY			Asotin, WA	
28940	Knoxville, TN	0.7575	30340	Lewiston-Auburn, ME	0.9178
	Anderson, TN			Androscoggin, ME	
	Blount, TN		30460	Lexington-Fayette, KY	0.9023
	Knox, TN			Bourbon, KY	
	Loudon, TN			Clark, KY	
	Union, TN			Fayette, KY	
29020	Kokomo, IN	0.8756		Jessamine, KY	
	Howard, IN			Scott, KY	
	Tipton, IN			Woodford, KY	
29100	La Crosse, WI-MN	1.0070	30620	Lima, OH	0.9226
	Houston, MN			Allen, OH	
	La Crosse, WI		30700	Lincoln, NE	0.9726
29140	Lafayette, IN	0.9316		Lancaster, NE	
	Benton, IN			Seward, NE	
	Carroll, IN		30780	Little Rock-North Little Rock-Conway, AR	0.8595
	Tippecanoe, IN			Faulkner, AR	

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30860	Grant, AR	0.8456	31700	Dane, WI	1.0042	
	Lonoke, AR			Iowa, WI		
	Perry, AR			Manchester-Nashua, NH		
	Pulaski, AR			Hillsborough, NH		
	Saline, AR			Manhattan, KS		0.7839
30980	Logan, UT-ID	0.8550	31860	Geary, KS	0.9413	
	Franklin, ID			Pottawatomie, KS		
	Cache, UT			Riley, KS		
	Longview, TX			Mankato-North Mankato, MN		
31020	Gregg, TX	1.2293	31900	Blue Earth, MN	0.8993	
	Rusk, TX			Nicollet, MN		
	Upshur, TX			Mansfield, OH		
31084	Longview, WA	1.2293	32420	Richland, OH	0.3586	
	Cowlitz, WA			Mayaguez, PR		
31140	Los Angeles-Long Beach-Glendale, CA	0.8862	32580	Hormigueros, PR	0.8603	
	Los Angeles, CA			Mayaguez, PR		
	Louisville-Jefferson County, KY-IN			McAllen-Edinburg-Mission, TX		
	Clark, IN			Hidalgo, TX		
	Floyd, IN			Medford, OR		1.0400
	Harrison, IN			Jackson, OR		0.9049
	Washington, IN			Memphis, TN-MS-AR		
	Bullitt, KY			Crittenden, AR		
	Henry, KY			DeSoto, MS		
	Jefferson, KY			Marshall, MS		
	Meade, KY			Tate, MS		
	Nelson, KY			Tunica, MS		
	Oldham, KY			Fayette, TN		
	Shelby, KY			Shelby, TN		
	Spencer, KY			Tipton, TN		
	Trimble, KY			Merced, CA		1.2996
	31180			Lubbock, TX		0.8870
Crosby, TX		Miami-Miami Beach-Kendall, FL				
31340	Lubbock, TX	0.8615	33140	Miami-Dade, FL	0.9694	
	Lynchburg, VA			Michigan City-La Porte, IN		
	Amherst, VA			LaPorte, IN		
	Appomattox, VA			Midland, TX		1.0640
	Bedford, VA			Midland, TX		0.9931
	Campbell, VA			Milwaukee-Waukesha-West Allis, WI		
	Bedford City, VA			Milwaukee, WI		
	Lynchburg City, VA			Ozaukee, WI		
31420	Macon, GA	0.8584	33460	Washington, WI	1.1336	
	Bibb, GA			Waukesha, WI		
	Crawford, GA			Minneapolis-St. Paul-Bloomington, MN-WI		
	Jones, GA			Anoka, MN		
	Monroe, GA			Carver, MN		
31460	Twiggs, GA	0.8050	33460	Chisago, MN	1.1264	
	Madera-Chowchilla, CA			Dakota, MN		
31540	Madera, CA	1.1264	33460	Hennepin, MN	1.1264	
	Madison, WI			Isanti, MN		
	Columbia, WI					

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	Ramsey, MN			Macon, TN	
	Scott, MN			Robertson, TN	
	Sherburne, MN			Rutherford, TN	
	Washington, MN			Smith, TN	
	Wright, MN			Sumner, TN	
	Pierce, WI			Trousdale, TN	
	St. Croix, WI			Williamson, TN	
33540	Missoula, MT	0.9001		Wilson, TN	
	Missoula, MT		35004	Nassau-Suffolk, NY	1.2698
33660	Mobile, AL	0.7467		Nassau, NY	
	Mobile, AL			Suffolk, NY	
33700	Modesto, CA	1.2841	35084	Newark-Union, NJ-PA	1.1223
	Stanislaus, CA			Essex, NJ	
33740	Monroe, LA	0.7717		Hunterdon, NJ	
	Ouachita, LA			Morris, NJ	
	Union, LA			Sussex, NJ	
33780	Monroe, MI	0.8472		Union, NJ	
	Monroe, MI			Pike, PA	
33860	Montgomery, AL	0.7858	35300	New Haven-Milford, CT	1.2061
	Autauga, AL			New Haven, CT	
	Elmore, AL		35380	New Orleans-Metairie-Kenner, LA	0.8932
	Lowndes, AL			Jefferson, LA	
	Montgomery, AL			Orleans, LA	
34060	Morgantown, WV	0.8284		Plaquemines, LA	
	Monongalia, WV			St. Bernard, LA	
	Preston, WV			St. Charles, LA	
34100	Morristown, TN	0.6768		St. John the Baptist, LA	
	Grainger, TN			St. Tammany, LA	
	Hamblen, TN		35644	New York-White Plains-Wayne, NY-NJ	1.2914
	Jefferson, TN			Bergen, NJ	
34580	Mount Vernon-Anacortes, WA	1.0340		Hudson, NJ	
	Skagit, WA			Passaic, NJ	
34620	Muncie, IN	0.8734		Bronx, NY	
	Delaware, IN			Kings, NY	
34740	Muskegon-Norton Shores, MI	1.1007		New York, NY	
	Muskegon, MI			Putnam, NY	
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.8717		Queens, NY	
	Horry, SC			Richmond, NY	
34900	Napa, CA	1.6045		Rockland, NY	
	Napa, CA		35660	Westchester, NY	
34940	Naples-Marco Island, FL	0.9265		Niles-Benton Harbor, MI	0.8237
	Collier, FL			Berrien, MI	
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	0.9061	35840	North Port-Bradenton-Sarasota-Venice, FL	0.9375
	Cannon, TN			Manatee, FL	
	Cheatham, TN		35980	Sarasota, FL	
	Davidson, TN			Norwich-New London, CT	1.1376
	Dickson, TN			New London, CT	
	Hickman, TN		36084	Oakland-Fremont-Hayward, CA	1.6654
				Alameda, CA	

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36100	Contra Costa, CA Ocala, FL Marion, FL	0.8455	37620	Parkersburg-Marietta-Vienna, WV-OH Washington, OH Pleasants, WV	0.7487
36140	Ocean City, NJ Cape May, NJ	1.0307		Wirt, WV Wood, WV	
36220	Odessa, TX Ector, TX	0.9741	37700	Pascagoula, MS George, MS Jackson, MS	0.7662
36260	Ogden-Clearfield, UT Davis, UT Morgan, UT Weber, UT	0.9031	37764	Peabody, MA Essex, MA	1.0551
36420	Oklahoma City, OK Canadian, OK Cleveland, OK Grady, OK Lincoln, OK Logan, OK McClain, OK Oklahoma, OK	0.8810	37860	Pensacola-Ferry Pass-Brent, FL Escambia, FL Santa Rosa, FL	0.7819
36500	Olympia, WA Thurston, WA	1.1397	37900	Peoria, IL Marshall, IL Peoria, IL Stark, IL Tazewell, IL Woodford, IL	0.8882
36540	Omaha-Council Bluffs, NE-IA Harrison, IA Mills, IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Saunders, NE Washington, NE	1.0037	37964	Philadelphia, PA Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0806
36740	Orlando-Kissimmee-Sanford, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9082	38060	Phoenix-Mesa-Glendale, AZ Maricopa, AZ Pinal, AZ	1.0477
36780	Oshkosh-Neenah, WI Winnebago, WI	0.9433	38220	Pine Bluff, AR Cleveland, AR Jefferson, AR Lincoln, AR	0.7847
36980	Owensboro, KY Davies, KY Hancock, KY McLean, KY	0.8117	38300	Pittsburgh, PA Allegheny, PA Armstrong, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.8585
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura, CA	1.3079	38340	Pittsfield, MA Berkshire, MA	1.0721
37340	Palm Bay-Melbourne-Titusville, FL Brevard, FL	0.8838	38540	Pocatello, ID Bannock, ID Power, ID	0.9555
37380	Palm Coast, FL Flagler, FL	0.9880	38660	Ponce, PR Juana Diaz, PR Ponce, PR Villalba, PR	0.4314
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay, FL	0.7976	38860	Portland-South Portland-Biddeford, ME	0.9975

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38900	Cumberland, ME	1.1673	40060	Washoe, NV	0.9695
	Sagadahoc, ME			Richmond, VA	
	York, ME			Amelia, VA	
	Portland-Vancouver-Hillsboro, OR-WA			Caroline, VA	
	Clackamas, OR			Charles City, VA	
	Columbia, OR			Chesterfield, VA	
	Multnomah, OR			Cumberland, VA	
	Washington, OR			Dinwiddie, VA	
	Yamhill, OR			Goochland, VA	
	Clark, WA			Hanover, VA	
38940	Skamania, WA	0.9577		Henrico, VA	
	Port St. Lucie, FL			King and Queen, VA	
	Martin, FL			King William, VA	
39100	St. Lucie, FL	1.1325		Louisa, VA	
	Poughkeepsie-Newburgh-Middletown, NY			New Kent, VA	
	Dutchess, NY			Powhatan, VA	
39140	Orange, NY	1.2009		Prince George, VA	
	Prescott, AZ			Sussex, VA	
	Yavapai, AZ			Colonial Heights City, VA	
39300	Providence-New Bedford-Fall River, RI-MA	1.0699	40140	Hopewell City, VA	1.1396
	Bristol, MA			Petersburg City, VA	
	Bristol, RI			Richmond City, VA	
	Kent, RI			Riverside-San Bernardino-Ontario, CA	
	Newport, RI			Riverside, CA	
39340	Providence, RI	0.9133	40220	San Bernardino, CA	0.9088
	Washington, RI			Roanoke, VA	
	Provo-Orem, UT			Botetourt, VA	
	Juab, UT			Craig, VA	
	Utah, UT			Franklin, VA	
39380	Pueblo, CO	0.8518	40340	Roanoke, VA	1.0708
	Pueblo, CO			Roanoke City, VA	
39460	Punta Gorda, FL	0.8590		Salem City, VA	
	Charlotte, FL			Rochester, MN	
39540	Racine, WI	0.9158		Dodge, MN	
	Racine, WI			Olmsted, MN	
39580	Raleigh-Cary, NC	0.9488	40380	Wabasha, MN	0.8704
	Franklin, NC			Rochester, NY	
	Johnston, NC			Livingston, NY	
	Wake, NC			Monroe, NY	
39660	Rapid City, SD	0.9823	40420	Ontario, NY	0.9935
	Meade, SD			Orleans, NY	
	Pennington, SD			Wayne, NY	
39740	Reading, PA	0.9072		Rockford, IL	1.0234
	Berks, PA			Boone, IL	
39820	Redding, CA	1.4555	40484	Winnebago, IL	
	Shasta, CA			Rockingham County-Strafford County, NH	
39900	Reno-Sparks, NV	1.0328	40580	Rockingham, NH	0.8898
	Storey, NV			Strafford, NH	
				Rocky Mount, NC	

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	Edgecombe, NC			Summit, UT	
40660	Nash, NC	0.8844	41660	Tooele, UT	0.8221
	Rome, GA			San Angelo, TX	
	Floyd, GA			Irion, TX	
40900	Sacramento--Arden-Arcade--Roseville, CA	1.4752	41700	Tom Green, TX	0.8936
	El Dorado, CA			San Antonio-New Braunfels, TX	
	Placer, CA			Atascosa, TX	
	Sacramento, CA			Bandera, TX	
	Yolo, CA			Bexar, TX	
40980	Saginaw-Saginaw Township North, MI	0.8820		Comal, TX	
	Saginaw, MI			Guadalupe, TX	
41060	St. Cloud, MN	1.1010		Kendall, TX	
	Benton, MN			Medina, TX	
	Stearns, MN		41740	Wilson, TX	1.1922
41100	St. George, UT	0.8870		San Diego-Carlsbad-San Marcos, CA	
	Washington, UT		41780	San Diego, CA	0.8347
41140	St. Joseph, MO-KS	0.9856		Sandusky, OH	
	Doniphan, KS		41884	Erie, OH	1.6327
	Andrew, MO			San Francisco-San Mateo-Redwood City, CA	
	Buchanan, MO			Marin, CA	
	DeKalb, MO			San Francisco, CA	
41180	St. Louis, MO-IL	0.9420		San Mateo, CA	
	Bond, IL		41900	San German-Cabo Rojo, PR	0.4804
	Calhoun, IL			Cabo Rojo, PR	
	Clinton, IL			Lajas, PR	
	Jersey, IL			Sabana Grande, PR	
	Macoupin, IL			San German, PR	
	Madison, IL		41940	San Jose-Sunnyvale-Santa Clara, CA	1.7396
	Monroe, IL			San Benito, CA	
	St. Clair, IL			Santa Clara, CA	
	Crawford, MO		41980	San Juan-Caguas-Guaynabo, PR	0.4318
	Franklin, MO			Aguas Buenas, PR	
	Jefferson, MO			Aibonito, PR	
	Lincoln, MO			Arecibo, PR	
	St. Charles, MO			Barceloneta, PR	
	St. Louis, MO			Barranquitas, PR	
	Warren, MO			Bayamon, PR	
	Washington, MO			Caguas, PR	
	St. Louis City, MO			Camuy, PR	
41420	Salem, OR	1.1069		Canovanas, PR	
	Marion, OR			Carolina, PR	
	Polk, OR			Catano, PR	
41500	Salinas, CA	1.6074		Cayey, PR	
	Monterey, CA			Ciales, PR	
41540	Salisbury, MD	0.9260		Cidra, PR	
	Somerset, MD			Comerio, PR	
	Wicomico, MD			Corozal, PR	
41620	Salt Lake City, UT	0.9063		Dorado, PR	
	Salt Lake, UT			Florida, PR	

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	Guaynabo, PR		43300	Sherman-Denison, TX	0.8544
	Gurabo, PR			Grayson, TX	
	Hatillo, PR		43340	Shreveport-Bossier City, LA	0.8412
	Humacao, PR			Bossier, LA	
	Juncos, PR			Caddo, LA	
	Las Piedras, PR			De Soto, LA	
	Loiza, PR		43580	Sioux City, IA-NE-SD	0.9010
	Manati, PR			Woodbury, IA	
	Maunabo, PR			Dakota, NE	
	Morovis, PR			Dixon, NE	
	Naguabo, PR			Union, SD	
	Naranjito, PR		43620	Sioux Falls, SD	0.8338
	Orocovis, PR			Lincoln, SD	
	Quebradillas, PR			McCook, SD	
	Rio Grande, PR			Minnehaha, SD	
	San Juan, PR			Turner, SD	
	San Lorenzo, PR		43780	South Bend-Mishawaka, IN-MI	0.9531
	Toa Alta, PR			St. Joseph, IN	
	Toa Baja, PR			Cass, MI	
	Trujillo Alto, PR		43900	Spartanburg, SC	0.9186
	Vega Alta, PR			Spartanburg, SC	
	Vega Baja, PR		44060	Spokane, WA	1.0824
	Yabucoa, PR			Spokane, WA	
42020	San Luis Obispo-Paso Robles, CA	1.3081	44100	Springfield, IL	0.9179
	San Luis Obispo, CA			Menard, IL	
42044	Santa Ana-Anaheim-Irvine, CA	1.2038		Sangamon, IL	
	Orange, CA		44140	Springfield, MA	1.0377
42060	Santa Barbara-Santa Maria-Goleta, CA	1.2670		Franklin, MA	
	Santa Barbara, CA			Hampden, MA	
42100	Santa Cruz-Watsonville, CA	1.8062		Hampshire, MA	
	Santa Cruz, CA		44180	Springfield, MO	0.8581
42140	Santa Fe, NM	1.0400		Christian, MO	
	Santa Fe, NM			Dallas, MO	
42220	Santa Rosa-Petaluma, CA	1.6440		Greene, MO	
	Sonoma, CA			Polk, MO	
42340	Savannah, GA	0.8968		Webster, MO	
	Bryan, GA		44220	Springfield, OH	0.9236
	Chatham, GA			Clark, OH	
	Effingham, GA		44300	State College, PA	0.9510
42540	Scranton-Wilkes-Barre, PA	0.8260		Centre, PA	
	Lackawanna, PA		44600	Steubenville-Weirton, OH-WV	0.7640
	Luzerne, PA			Jefferson, OH	
	Wyoming, PA			Brooke, WV	
42644	Seattle-Bellevue-Everett, WA	1.1771		Hancock, WV	
	King, WA		44700	Stockton, CA	1.3356
	Snohomish, WA			San Joaquin, CA	
42680	Sebastian-Vero Beach, FL	0.8850	44940	Sumter, SC	0.7454
	Indian River, FL			Sumter, SC	
43100	Sheboygan, WI	0.9515	45060	Syracuse, NY	0.9829
	Sheboygan, WI			Madison, NY	

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45104	Onondaga, NY	1.1741	46540	Smith, TX	0.8653
	Oswego, NY			Utica-Rome, NY	
45220	Tacoma, WA	0.8521	46660	Herkimer, NY	0.7918
	Pierce, WA			Oneida, NY	
45300	Tallahassee, FL	0.9032	46700	Valdosta, GA	1.5844
	Gadsden, FL			Brooks, GA	
45460	Jefferson, FL	0.9113	47020	Echols, GA	0.8992
	Leon, FL			Lanier, GA	
45500	Wakulla, FL	0.7967	47220	Lowndes, GA	1.0596
	Tampa-St. Petersburg-Clearwater, FL			Vallejo-Fairfield, CA	
45780	Hernando, FL	0.9034	47260	Solano, CA	0.9208
	Hillsborough, FL			Victoria, TX	
45820	Pasco, FL	0.8969	47300	Calhoun, TX	1.0349
	Pinellas, FL			Goliad, TX	
45940	Terre Haute, IN	1.0360	47380	Victoria, TX	0.8458
	Clay, IN			Waco, TX	
46060	Sullivan, IN	0.9065	47580	McLennan, TX	0.8197
	Vermillion, IN			Warner Robins, GA	
46140	Vigo, IN	0.8139	47644	Houston, GA	0.9543
	Texarkana, TX-Texarkana, AR			Warren-Troy-Farmington Hills, MI	
46220	Miller, AR	0.8533	47894	Lapeer, MI	1.0659
	Bowie, TX			Livingston, MI	
46340	Toledo, OH	0.8361		Macomb, MI	
	Fulton, OH			Oakland, MI	
	Lucas, OH			St. Clair, MI	
	Ottawa, OH			Washington-Arlington-Alexandria, DC-VA	
	Wood, OH			District of Columbia, DC	
	Topeka, KS				
	Jackson, KS				
	Jefferson, KS				
	Osage, KS				
	Shawnee, KS				
	Wabaunsee, KS				
	Trenton-Ewing, NJ				
	Mercer, NJ				
	Tucson, AZ				
	Pima, AZ				
	Tulsa, OK				
	Creek, OK				
	Okmulgee, OK				
	Osage, OK				
	Pawnee, OK				
	Rogers, OK				
	Tulsa, OK				
	Wagoner, OK				
	Tuscaloosa, AL				
	Greene, AL				
	Hale, AL				
	Tuscaloosa, AL				
	Tyler, TX				

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	Calvert, MD		48900	Wilmington, NC	0.9155
	Charles, MD			Brunswick, NC	
	Prince George's, MD			New Hanover, NC	
	Arlington, VA			Pender, NC	
	Clarke, VA		49020	Winchester, VA-WV	0.9249
	Fairfax, VA			Frederick, VA	
	Fauquier, VA			Winchester City, VA	
	Loudoun, VA			Hampshire, WV	
	Prince William, VA		49180	Winston-Salem, NC	0.8660
	Spotsylvania, VA			Davie, NC	
	Stafford, VA			Forsyth, NC	
	Warren, VA			Stokes, NC	
	Alexandria City, VA			Yadkin, NC	
	Fairfax City, VA		49340	Worcester, MA	1.1205
	Falls Church City, VA			Worcester, MA	
	Fredericksburg City, VA		49420	Yakima, WA	1.0097
	Manassas City, VA			Yakima, WA	
	Manassas Park City, VA		49500	Yauco, PR	0.4059
	Jefferson, WV			Guanica, PR	
47940	Waterloo-Cedar Falls, IA	0.8422		Guayanilla, PR	
	Black Hawk, IA			Penuelas, PR	
	Bremer, IA			Yauco, PR	
	Grundy, IA		49620	York-Hanover, PA	0.9557
48140	Wausau, WI	0.8921		York, PA	
	Marathon, WI		49660	Youngstown-Warren-Boardman, OH-PA	0.8283
48300	Wenatchee-East Wenatchee, WA	1.0037		Mahoning, OH	
	Chelan, WA			Trumbull, OH	
	Douglas, WA		49700	Mercer, PA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	0.9661		Yuba City, CA	1.2004
	Palm Beach, FL			Sutter, CA	
48540	Wheeling, WV-OH	0.6863		Yuba, CA	
	Belmont, OH		49740	Yuma, AZ	0.9517
	Marshall, WV			Yuma, AZ	
	Ohio, WV				
48620	Wichita, KS	0.8681			
	Butler, KS				
	Harvey, KS				
	Sedgwick, KS				
	Sumner, KS				
48660	Wichita Falls, TX	0.9048			
	Archer, TX				
	Clay, TX				
	Wichita, TX				
48700	Williamsport, PA	0.8230			
	Lycoming, PA				
48864	Wilmington, DE-MD-NJ	1.0687			
	New Castle, DE				
	Cecil, MD				
	Salem, NJ				

- END -



## Diagnoses Associated With Each Of The Diagnostic Categories Used In Case-Mix Scoring

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Visit <http://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/casemixgroupersoftware.html> for the current Home Health Agency Prospective Payment System (HHA PPS) Grouper, including diagnoses associated with diagnostic categories used in case-mix scoring.

- END -



## Diagnoses Included In The Diagnostic Categories Used For The Non-Routine Supplies (NRS) Case-Mix Adjustment Model

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Visit <http://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/casemixgroupersoftware.html> for the current Home Health Agency Prospective Payment System (HHA PPS) Grouper, including the NRS diagnostic codes.

- END -



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If the recorded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE-SUM 1-3-QTY-THR" field to re-code the second, third, and fourth positions of the HIPPS code according to the table below:

CLINICAL-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 2nd position value	FUNCTION-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 3rd position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-2	A	0-9	F	0-5	K
3-4	B	9-10	G	6	L
5+	C	11+	H	7-9	M
				10	N
				11-13	P

If the recorded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE-SUM 1-3-QTY-THR" field to re-code the second, third, and fourth positions of the HIPPS code according to the table below:

CLINICAL-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 2nd position value	FUNCTION-SEV-EQ1 numeric value	Resulting HRG-OUTPUT-CODE 3rd position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-4	A	0-9	F	14-15	K
5-12	B	9-10	G	16-17	L
13+	C	11+	H	18-19	M

Move the resulting re-coded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to Health Resource Group (HRG) payment calculations. Use the weights associated with the code in the "HRG-OUTPUT-CODE" field for all further calculations.

- c. If the first position of the HIPPS code submitted in "HRG-INPUT-CODE" is a 5 and the number of therapy services in "REVENUE-SUM 1-3-QTY-THR" is less than 20, read the value in the "EPISODE-TIMING" field.

If the value in the "EPISODE-TIMING" field is a 1 and the number of therapy services is in the range 0-13, re-code the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, re-code the first position of the HIPPS code to 2.

If the value in the "EPISODE-TIMING" field is a 2, and the number of therapy services in the range 0-13, re-code the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, re-code the first position of the HIPPS code to 4.

Return to Step b. and re-code the remaining positions of the HIPPS code as described above.

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- d. In all other cases, read only the "REVENUE-SUM 1-3-QTY-THR" field and re-code the 4th positions of the HIPPS code according to the table below, if necessary:

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 or 4	
REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE 4th position value
0-5	K	14-15	K
6	L	16-17	L
7-9	M	18-19	M
10	N		
11-13	P		

Move the resulting rec-oded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculation. Use the weights associated with the code in the "HRG-OUTPUT-CODE" field for all further calculations.

3. HRG payment calculations.

- a. If the "PEP-INDICATOR" is an N:

Find the weight for the first four positions of the "HRG-OUTPUT-CODE" from the weight table for the calendar year in which the "SEV-THRU-DATE" falls. Multiply the weight times the standard episode rate for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. Multiply the case-mix rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1." Multiply the case-mix adjusted rate by the current nonlabor-related percentage to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Find the non-routine supply weight corresponding to the fifth positions of the "HRG-OUTPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. The result is the case-mix adjusted payment for non-routine supplies.

Sum the payment results for both portions of the "HRG-OUTPUT-CODE" and proceed to the outlier calculation (see Step 4).

- b. If the "PEP-INDICATOR" is a Y:

Perform the calculations of the case-mix and wage index adjusted payment for the HRG and supply amounts, Determine the proportion to be used to calculate this Partial Episode Payment (PEP) by dividing the "PEP-DAYS" amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (Step 4).

4. Outlier calculation:

- a. Wage index adjust the outlier fixed loss amount for the year in which the "SER-THRU-DATE" falls, using the Metropolitan Statistical Area (MSA) or Core Based Statistical Area (CBSA) code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

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- b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the year in which the "SER-THRU-DATE" FALLS. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the MSA or CBSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.
- c. Subtract the outlier threshold for the episode from the imputed cost for the episode.
- d. If the result is greater than \$0.00, calculate 0.80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field with return code 01.
- e. If the result is less than or equal to \$0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

- END -



**3.1.5.8.2.6** TMA Director, or designee review.

- The Director, TMA or designee is the final approval authority.
- A decision by the Director TMA or designee to adopt, modify, or extend General TMCPAs is not subject to appeal.

**3.1.5.8.3 Non-Network TMCPAs**

TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. This determination will be based on the contractor's and TRO's evaluation of network adequacy data related to the specific procedures for which the TMCPA is being requested as outlined under [paragraph 3.1.5.8.2.3](#). Non-network TMCPAs will be adjusted on a claim-by-claim basis. The associated costs would be underwritten or non-underwritten following the applicable financing rules of the contract.

**3.1.5.8.4 Application of Cost-Sharing**

**3.1.5.8.4.1** Transitional and General TMCPAs are not subject to cost-sharing.

**3.1.5.8.4.2** Non-network TMCPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

**3.1.5.8.5** Reimbursement of Transitional, General, and Non-Network TMCPA costs shall be paid as pass-through costs. The contractor does not financially underwrite these costs.

**3.1.5.9 Hold Harmless TRICARE Transitional Outpatient Payments (TTOPs)**

**3.1.5.9.1** Effective January 1, 2010, TRICARE adopted Medicare's hold harmless provision. TRICARE will apply the hold harmless provision to **qualifying** hospitals as long as the provision remains in effect under Medicare.

**3.1.5.9.1.1** For CYs 2010 and 2011, the hold harmless provision applies to hospitals with 100 or fewer beds and all SCHs regardless of bed size.

**3.1.5.9.1.2** For CY 2012, for the period January 1 through February 29, 2012, the hold harmless provision applies to rural hospitals with 100 or fewer beds and all SCHs regardless of bed size. For the period March 1, through December 31, 2012, the hold harmless provision applies to small rural hospitals with 100 or fewer beds and SCHs with 100 or fewer beds.

**3.1.5.9.2** TTOPs will be made to qualifying hospitals that have OPSS costs that are greater than their TRICARE allowed amounts. The 7.1% increase for SCHs, the TTPAs for ER and clinic visits, Transitional and General TMCPAs, if applicable, will be included in the allowed amounts when determining if a hospital's OPSS costs are greater than their TRICARE allowed amounts.

**3.1.5.9.3** TRICARE will use a method similar to Medicare to reimburse these hospitals their TTOPs. TRICARE will pay qualifying hospitals an amount equal to 85% of the difference between the estimated OPSS costs and the OPSS payment.

**3.1.5.9.4 Process for TTOPs Year One (Effective January 1, 2010, through December 31, 2010) and Subsequent Years**

**3.1.5.9.4.1** TMA will run query reports of claims history to determine which hospitals qualify for TTOPs at year end; i.e., those hospitals whose costs exceeded their allowed amounts during the previous TTOPs year (January 1 through December 31).

**3.1.5.9.4.2** These query reports will be run in subsequent TTOPs years to determine those hospitals qualifying for TTOPs.

**3.1.5.9.4.3** The year end adjustment will be paid approximately six months following the end of the TTOPs year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior TTOPs year to ensure claims that were not PTC the previous year are adjusted.

**3.1.5.9.4.4** The TMA MB&RB shall provide the MCSC with a copy of the query report noting which hospitals in their region qualify for the TTOPs and the amounts to pay. A copy of the report shall also be provided to TMA's CRM.

**3.1.5.9.4.5** The contractor shall process the adjustment payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from TMA-Aurora (TMA-A), CRM, Budget.

**3.2 Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals**

**3.2.1 Items Subject to Transitional Pass-Through Payments**

**3.2.1.1 Current Orphan Drugs**

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

**Note:** Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

**3.2.1.2 Current Cancer Therapy Drugs, Biologicals, and Brachytherapy**

These items are drugs or biologicals that are used in cancer therapy, including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, biphosphonates, and a device of brachytherapy if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

### **3.2.1.3 Current Radiopharmaceutical Drugs and Biological Products**

A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPSS was implemented.

### **3.2.1.4 New Medical Devices, Drugs, and Biologicals**

New medical devices, drugs, and biologic agents, will be subject to transitional pass-through payment in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPSS payment amount.

**3.2.2** Items eligible for transitional pass-through payments are generally coded under a Level II HCPCS code with an alpha prefix of "C".

- Pass-through device categories are identified by SI of **H**
- Pass-through drugs and biological agents are identified by SI of **G**

### **3.2.3 Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009**

**3.2.3.1** Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug Competitive Acquisition Program (CAP) at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Social Security Act (SSA) rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug or biological.

**3.2.3.2** Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug CAP at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Act, rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug and biological.

**3.2.3.3** The difference between ASP + 4% and ASP + 6%, therefore would be the CY 2009 pass-through payment amount for these drugs and biologicals.

**3.2.3.4** Considering diagnostic radiopharmaceuticals to be drugs for pass-through purposes which will be reimbursed based on the ASP methodology; i.e., ASP + 6%.

**3.2.3.5** Therapeutic radiopharmaceuticals with pass-through status in CY 2009 will be paid at hospital charges adjusted to cost, the same payment methodology as other therapeutic radiopharmaceuticals in CY 2009.

**3.2.3.6** If a drug or biological that has been granted pass-through status for CY 2009 becomes covered under the Part B drug CAP (if the program is reinstated) the Centers for Medicare and Medicaid Services (CMS) will provide payment for Part B Drugs that are granted pass-through status and are covered under the Part B drug CAP at the Part B drug CAP rate.

**3.2.3.7** Beneficiary copayments/cost-sharing will be based on the entire ASP of the transition pass-through drug or biological.

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**3.2.3.8** Drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2009 for CY 2009 are displayed in [Figure 13.3-5](#).

**FIGURE 13.3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009**

CY 2008	CY 2009			
HCPCS	HCPCS	SHORT DESCRIPTOR	SI	APC
C9238	J1953	Levetiracetam injection	G	9238
C9239	J9330	Temsirolimus injection	G	1168
C9240*	J9207	Exabepilone injection	G	9240
C9241	J1267	Doripenem injection	G	9241
C9242	J1453	Fosaprepitant injection	G	9242
C9243	J9033	Bendamustine injection	G	9243
C9244	J2785	Injection, regadenoson	G	9244
C9354	C9354	Veritas collagen matrix, cm2	G	9354
C9355	C9355	Neuromatrix nerve cuff, cm	G	9355
C9356	C9356	TendoGlide Tendon prot, cm2	G	9356
C9357	Q4114	Integra flowable wound matri	G	1251
C9358	C9358	SurgiMend, 0.5cm2	G	9358
C9359	C9359	Implant, bone void filler	G	9359
J1300	J1300	Eculizumab injection	G	9236
J1571	J1571	Hepagam b im injection	G	0946
J1573	J1573	Hepagam b intravenous, inj	G	1138
J3488*	J3488	Reclast injection	G	0951
J9225*	J9225	Vantas implant	G	1711
J9226	J9226	Supprelin LA implant	G	1142
J9261	J9261	Nelarabine injection	G	0825
Q4097	J1459	Inj IVIG privigen 500 mg	G	1214
	C9245	Injection, romiplostim	G	9245
	C9246	Inj, gadoxetate	G	9246
	C9248	Inj, clevidipine butyrate	G	9248

\* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology (prior to January 1, 2009) while identified as pass-through under the OPPS.

**3.2.4 Reduction of Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals to Offset Costs Packaged Into APC Groups**

**3.2.4.1** Prior to CY 2008, certain diagnostic radiopharmaceuticals were paid separately under the OPPS if their mean per day cost were greater than the applicable year's drug packaging threshold.

**3.2.4.2** In CY 2008, CMS payment for all non-pass-through diagnostic radiopharmaceuticals were packaged as ancillary and supportive items and service.

**3.2.4.3** In CY 2009, continued to package payment for all non-pass-through diagnostic radiopharmaceuticals.

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**3.2.4.4** For OPPS pass-through purposes, radiopharmaceuticals are considered to be “drugs” where the transitional pass-through for the drugs and biologicals is the difference between the amount paid ASP + 4% or the Part B drug CAP rate and the otherwise applicable OPPS payment amount of ASP + 6%.

**3.2.4.5** There is currently one radiopharmaceutical with pass-through status under OPPS.

**3.2.4.6** New pass-through diagnostic radiopharmaceuticals with no ASP information or CAP rate will be paid at ASP + 6%, while those without ASP information will be paid based on Wholesale Acquisition Cost (WAC) or, if WAC is not available, based on 95% of the product’s most recently published Average Wholesale Price (AWP).

**3.2.4.7** Offset Calculations.

**3.2.4.7.1** An established methodology will be employed to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment (the APC device offset).

**3.2.4.7.2** New pass-through device categories will be evaluated individually to determine if there are device costs packaged into the associated procedural APC payment rate - suggesting that a device offset amount would be appropriate.

**3.2.4.8** Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPPS and will be assigned SI of **G**.

**3.2.4.8.1** Beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106% of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product’s WAC. Further if WAC data is not available, payment will be made at 95% of the AWP.

**3.2.4.8.2** Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claims with a nuclear medicine procedure, the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 will be reduced by the corresponding nuclear medicine procedure’s portion of its APC payment (offset amount) associated with diagnostic radiopharmaceutical; i.e., the payment for HCPCS code C9247 will be reduced by the estimated amount of payment that is attributable to the predecessor radiopharmaceutical that is package into payment for the associated nuclear medicine procedure reported on the same claim as HCPCS code C9247.

**3.2.4.8.3** When C9247 is billed on a claim with one or more nuclear medicine procedures, the OPPS Pricer will identify the offset amount or amounts that apply to the nuclear medicine procedures that are reported on the claim.

**3.2.4.8.4** Where there is a single nuclear medicine procedure reported on the claim with a single occurrence of C9247, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index that applies to the hospital submitting the bill.

**3.2.4.8.5** Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPPS Pricer will select the nuclear

medicine procedure with the single highest offset amount, and will adjust the selected offset amount by the wage index of the hospital submitting the claim.

**3.2.4.8.6** When a claim has more than one occurrence of C9247, the OPPS Pricer will rank potential offset amounts associated with the units of nuclear medicine procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through radiopharmaceutical on the claims and adjust the total offset amount by the wage index of the hospital submitting the claim.

**3.2.4.8.7** The adjusted offset will be subtracted from the APC payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247.

**3.2.4.8.8** The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

### **3.2.5 Transitional Pass-Through Device Categories**

#### **3.2.5.1 Excluded Medical Devices**

Equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes that are not implanted or incorporated into a body part, and that are used on more than one patient (that is, are reusable), are excluded from pass-through payment. This material is generally considered to be a part of hospital overhead costs reflected in the APC payments.

#### **3.2.5.2 Included Medical Devices**

**3.2.5.2.1** The following implantable items may be considered for the transitional pass-through payments:

- Prosthetic implants (other than dental) that replace all or part of an internal body organ.
- Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

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

#### **3.2.5.3 Pass-Through Payment Criteria for Devices**

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

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

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treated as meeting the time constraint (i.e., payment was not being made for the device as of December 31, 1996) if either:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **3.2.5.4 Duration of Transitional Pass-Through Payments**

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

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

#### **3.2.6 General Coding and Billing Instructions and Explanations**

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

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

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

**3.2.6.2** Kits. Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, codes for such kits have not been established. However, hospitals are free to purchase and use such kits.

**3.2.6.2.1** If the kits contain individual items that separately qualify for transitional pass-through payment, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

**3.2.6.2.2** HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned SI

of **N** for packaged payment (i.e., hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned SI of **N**. In the case of a device kit, should a hospital choose to report the device charge alone under a device/device category HCPCS code with SI of **N**, the hospital should report charges for other items that may be included in the kit on a separate line on the claim.

**3.2.6.3 Multiple Units.** Hospitals must bill for multiple units of items that qualify for transitional pass-through payments, when such items are used with a single procedure, by entering the number of units used on the bill.

**3.2.6.4 Reprocessed Devices.** Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with the enforcement guidance of the FDA relating to the reprocessing of devices applicable at the time the service is delivered.

**3.2.6.5 Current Device Categories Subject to Pass-Through Payment**

Two device categories were established for pass-through payment as of January 1, 2007, HCPCS code C1821 (interspinous process distraction device (implantable)) and HCPCS code L8690 (auditory osseointegrated device, includes all internal and external components), will be active categories for pass-through payment for two years as of January 1, 2007, i.e., these categories will expire from pass-through payment as of December 31, 2008.

**3.2.7 Reduction of Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups**

**3.2.7.1** Each new device category will be reviewed on a case-by-case basis to determine whether device costs associated with the new category were packaged into the existing APC structure.

**3.2.7.2** If it is determined that, for any new device category, no device costs associated with the new category were packaged into existing APCs, the offset amount for the new category would be set to \$0 for CY 2008.

**3.2.8 Calculation of Transitional Pass-Through Payment for a Pass-Through Device**

**3.2.8.1** Device pass-through payment is calculated by applying the statewide CCR to the hospital's charges on the claim and subtracting any appropriate pass-through offset. Statewide CCRs are based on the geographical CBSA (two digit = rural, five digit = urban).

**3.2.8.2** The following are two examples of the device pass-through calculations, one incorporating a device offset amount applicable to CY 2003 and the other only applying the CCR (offsets set to \$0 for CY 2005).

**3.2.8.3** The offset adjustment is applied only when a pass-through device is billed in addition to the APC.

**Example 1:** Transitional Pass-Through Payment Calculation with Offset

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,200.00

Associated procedure: HCPCS Level I<sup>2</sup> code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (Standard ADFM who has met his/her yearly deductible)

Total offset amount to be applied for each APC that contains device costs = \$802.06

**Note:** The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph 3.2.8.4](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:  $\$1,200 - \$802.06 = \$397.94$

TRICARE program payment (before wage index adjustment) for APC 0083:

$\$3,289.42 - \$657.88 = \$2,631.54$

TRICARE payment for pass-through device C1884 = \$397.94

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54 TRICARE program payment for HCPCS Level I<sup>3</sup> code 92982 when used with device code C1884

657.88 Beneficiary coinsurance amount for HCPCS Level I<sup>3</sup> code 92982

+ 397.94 Transitional pass-through payment for device

\$3,687.36 Total amount received by the provider

**Example 2:** Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,500.00

Associated procedure: HCPCS Level I<sup>3</sup> code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard ADFM who has met his/her yearly deductible)

Total offset amount to be applied for each APC that contains device costs = \$0.

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**Note:** The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph 3.2.8.4](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:  $\$1,500 - \$0 = \$1,500$

TRICARE program payment (before wage index adjustment) for APC 0083:

$\$3,289.42 - \$657.88 = \$2,631.54$

TRICARE payment for pass-through device C1884 =  $\$1,500$

Beneficiary cost-share liability for APC 0083 =  $\$657.88$

Total amount received by provider for APC 0083 and pass-through device C1884:

$\$2,631.54$  TRICARE program payment for HCPCS Level I<sup>4</sup> code 92982 when used with device code C1884

$657.88$  Beneficiary coinsurance amount for HCPCS Level I<sup>4</sup> code 92982

$+1,500.00$  Transitional pass-through payment for device

$\$4,789.42$  Total amount received by the provider

**Note:** Transitional payments for devices (SI of **H**) are not subject to beneficiary cost-sharing/copayments.

**3.2.8.4** Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

**Step 1:** For each APC with an offset multiply the offset by the discount percent (whether it is 50%, 75%, 100%, or 200%) and the units of service.

(Offset x Discount Rate x Units of Service)

**Step 2:** Sum the products of Step 1.

**Step 3:** Wage adjust the sum of the products calculated in Step 2.

(Step 2 Amount x Labor % x Wage Index) + Step 2 Amount x Nonlabor %)

**Step 4:** If the units of service from the procedures with offsets are greater than the device units of service, then Step 3 is adjusted by device units divided by procedure offset units.

[(Step 2 Amount x Labor % x Wage Index) + (Step 2 Amount x Nonlabor %)] x (Device Units ÷ Offset Procedure Units)]

**otherwise**

(Step 2 Amount x Labor % x Wage Index) Step 2 Amount x Non-Labor %)

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**Example:** If there are two procedures with offsets but only one device, then the final offset is reduced by 50%.

**Step 5:** If there is only one line item with a device, then the amount calculated in Step 4 is subtracted from the line item charge adjusted to cost.

[Step 4 Amount - (Line Item Charge x State CCR)]

**Example:** If there are multiple devices, then the amount from Step 4 is allocated to the line items with devices based on their charges.

(Line Item Device Charge ÷ Sum of Device Charges)

### 3.3 Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

**3.3.1** Radiopharmaceuticals, drugs, and biologicals which do not have pass-through status, are paid in one of three ways:

- Packaged payment, or
- Separate payment (individual APCs), or
- Allowable charge.

**3.3.2** The cost of drugs and radiopharmaceuticals are generally packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished:

- Hospitals do not receive separate payment for packaged items and supplies; and
- Hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or services.

**3.3.3** Although diagnostic and therapeutic radiopharmaceutical agents are not classified as drugs or biologicals, separate payment has been established for them under the same packaging threshold policy that is applied to drugs and biologicals; i.e., the same adjustments will be applied to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

### 3.4 Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals

**3.4.1** Generally, the cost of drugs and radiopharmaceuticals are packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished. However, packaging for certain drugs and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

**3.4.2** Payments for drugs and radiopharmaceuticals are packaged into the APCs with which they are billed if the median cost per day for the drug or radiopharmaceutical is less than \$60. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds \$60.

**3.4.3** An exception to the packaging rule is being made for injectable oral forms of antiemetics, listed in [Figure 13.3-6](#).

**FIGURE 13.3-6 ANTIEMETICS EXEMPTED FROM CY 2008 \$60 PACKAGING THRESHOLD**

HCPCS CODE	SHORT DESCRIPTOR
J1260	Dolasetron mesylate
J1626	Granisetron HCl Injection
J2405	Ondansetron HCl Injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl 1 mg oral
Q0179	Ondansetron HCl 8 mg oral
Q0180	Dolasetron Mesylate oral

**3.4.4** Continuing to package payment for all non-pass-through diagnostic radiopharmaceuticals and contrast agents, regardless of their per day costs for CY 2009.

**3.4.5 Payment For Drugs, Biologicals, And Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged**

**3.4.5.1 “Specified Covered Outpatient Drugs” Classification**

**3.4.5.1.1** Special classification (i.e., “specified covered outpatient drug”) is required for certain separately payable radiopharmaceutical agents and drugs or biologicals for which there are specifically mandated payments.

**3.4.5.1.2** A “specified covered outpatient drug” is a covered outpatient drug for which a separate APC exists and that is either a radiopharmaceutical agent or drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

**3.4.5.1.3** The following drugs and biologicals are designated exceptions to the “specified covered outpatient drugs” definition (i.e., not included within the designated category classification):

- A drug or biological for which payment was first made on or after January 1, 2003, under the transitional pass-through payment provision.
- A drug or biological for which a temporary HCPCS code has been assigned.
- Orphan drugs.

**3.4.5.2 Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals**

**3.4.5.2.1** Specified outpatient drugs and biologicals will be paid a combined rate of the ASP + 4% which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS. In the absence of ASP data, the WAC will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95% of the most recent AWP.

**3.4.5.2.2** Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. Refer to [Section 2, Figure 13.2-14](#), for a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge methodology up through December 31, 2009.

- Therapeutic radiopharmaceuticals must have a mean per day cost of more than \$60 in order to be paid separately.
- Diagnostic radiopharmaceuticals and contrast agents are packaged regardless of per day cost since they are ancillary and supportive of the therapeutic procedures in which they are used.

### **3.4.5.3 Designated SI**

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the SI of **K** - non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

### **3.4.6 Payment for New Drugs and Biologicals With HCPCS Codes and Without Pass-Through Application and Reference AWP or Hospital Claims Data**

**3.4.6.1** These new drugs and biologicals with HCPCS codes as of January 1, 2008, but which do not have pass-through status and are without OPPS hospital claims data, will be paid at ASP + 4% consistent with its final payment methodology for other separately payable non-pass-through drugs and biologicals.

**3.4.6.2** Payment for all new non-pass-through diagnostic radiopharmaceuticals will be packaged.

**3.4.6.3** In the absence of ASP data, the WAC will be used for the product to establish the initial payment rate for new non-pass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data. If the WAC is also unavailable, payment will be made at 95% of the product's most recent AWP.

**3.4.6.4** SI K will be assigned to HCPCS codes for new drugs and biologicals for which pass-through application has not been received.

**3.4.6.5** Payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2008, but which do not have pass-through status, will be assigned SI H and continue to be reimbursed under the cost-to-charge methodology up through December 31, 2009.

**3.4.6.6** In order to determine the packaging status of these items for CY 2008 an estimate of the per day cost of each of these items was calculated by multiplying the payment rate for each product based on ASP + 4%, by a estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. Items for which the estimated per day cost is less than or equal to \$60 will be packaged. For drugs currently covered under the CAP the payment rates calculated under that program that were in effect as of April 1, 2008 will be used for purposes of packaging decisions.

## Critical Access Hospitals (CAHs)

Issue Date: November 6, 2007

Authority: [32 CFR 199.14\(a\)\(3\)](#) and [\(a\)\(6\)\(ii\)](#)

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 DESCRIPTION

A CAH is a small facility that provides limited inpatient and outpatient hospital services primarily in rural areas and meets the applicable requirements established by [32 CFR 199.6\(b\)\(4\)\(xvi\)](#)

### 3.0 ISSUE

How are CAHs to be reimbursed?

### 4.0 POLICY

#### 4.1 Background

**4.1.1** Hospitals are authorized TRICARE institutional providers under 10 United States Code (USC) 1079(j)(2) and (4). Under 10 USC 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "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 [Medicare]". Under [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(1\)](#) through [\(9\)](#) it specifically lists those hospitals that are exempt from the Diagnosis Related Group (DRG)-based payment system. Prior to December 1, 2009, CAHs were not listed as excluded, thereby making them subject to the DRG-based payment system.

**4.1.2** Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (MRHFPs), under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole Community Hospitals (SCHs), have taken the necessary steps to be designated as CAHs. Since the statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same

type under Medicare to the extent practicable, effective December 1, 2009, TRICARE is exempting CAHs from the DRG-based payment system and adopting a reasonable cost method similar to Medicare principles for reimbursing CAHs. To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a MRHFP, or must be located in a **Core Based Statistical Area (CBSA)** of such a State and be treated as being located in a rural area based on a law or regulation of the State, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or CAH unless it is designated by the State, prior to January 1, 2006, to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a Length-Of-Stay (LOS), as determined on an annual average basis, of no longer than 96 hours. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by the Centers of Medicare and Medicaid Services (CMS).

## **4.2 Scope of Benefits**

### **4.2.1 Inpatient Services**

**4.2.1.1** Prior to December 1, 2009, inpatient services provided by CAHs are subject to the DRG-based payment system.

**4.2.1.2** For admissions on or after December 1, 2009, payment for inpatient services of a CAH other than services of a distinct part unit, shall be reimbursed under the reasonable cost method, reference [paragraph 4.3](#).

**4.2.1.3** Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by an acute care hospital to its inpatients. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

- The facility has been certified as a CAH by CMS;
- The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care; and
- The facility has been granted swing-bed approval by CMS.

**4.2.1.4** Payment for post-hospital SNF care furnished by a CAH, shall be reimbursed under the reasonable cost method.

**4.2.1.5** Payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients. Payment for professional medical services furnished in a CAH to CAH inpatients is made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a Hospital Outpatient Department (HOPD). For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a Physician Assistant (PA) or a Nurse Practitioner (NP). These services are to

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that are unnecessary in the efficient delivery of services covered by the program.

**4.3.1** TMA shall calculate an overall inpatient CCR and overall outpatient CCR, obtained from data on the hospital's most recently filed Medicare cost report as of July 1 of each year.

**4.3.2** The inpatient and outpatient CCRs are calculated using Medicare charges, e.g., Medicare costs for outpatient services are derived by multiplying an overall hospital outpatient CCR (by department or cost center) by Medicare charges in the same category.

**4.3.3** The following methods are used by TMA to calculate the CCRs for CAHs. The worksheet and column references are to the CMS Form 2552-96 (Cost Report for Electronic Filing of Hospitals).

<b>INPATIENT CCRs</b>	
<b>Numerator</b>	Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).
<b>Denominator</b>	Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.
<b>OUTPATIENT CCRs</b>	
<b>Numerator</b>	Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.
<b>Denominator</b>	Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

**4.3.4** To reimburse the vast majority of CAHs for all their costs in an administratively feasible manner, TRICARE will identify CCRs that are outliers using the method used by Medicare to identify outliers in its Outpatient Prospective Payment System (OPPS) reimbursement methods. Specifically, Medicare classifies CCR outliers as values that fall outside of three standard deviations from the geometric mean. Applying this method to the CAH data, those limits will be considered the threshold limits on the CCR for reimbursement purposes. **The CAH Fiscal Year (FY) is effective on December 1 of each year.** For FY 2011, the inpatient CCR cap is 2.57 and the outpatient CCR cap is 1.31. For FY 2012, the inpatient CCR cap is 2.46 and the outpatient CCR cap is 1.32. **For FY 2013, the inpatient CCR cap is 2.48 and the outpatient CCR cap is 1.36.** Thus, for FY 2013, TRICARE will pay the lesser of 2.48 multiplied by the billed charges or 101% of costs (using the hospital's CCR and billed charges) for inpatient services and the lesser of 1.36 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

**Step 1:** Inpatient, pay the lesser of:

FY cap x billed charges (minus non-covered charges) OR  
1.01 x (hospital-specific CCR x billed charges (minus non-covered charges))

**Step 2:** Outpatient, pay the lesser of:

FY cap x billed charges OR  
1.01 x (hospital-specific CCR x billed charges)

**4.3.5** TMA shall provide a list of CAHs to the Managed Care Support Contractors (MCSCs) with their corresponding inpatient and outpatient CCRs by November 1 each year. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information

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System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

**4.3.6** TMA shall also provide the MCSCs the State median inpatient and outpatient CAH CCRs to use when a hospital specific CCR is not available.

#### **4.4 CAH Listing**

**4.4.1** TMA will maintain the CAH listing on the TMA's web site at <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and will notify the contractors by e-mail when the list is updated.

**4.4.2** For payment purposes for those facilities that were listed on both the CAH and Sole Community Hospital (SCH) lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

**4.4.3** The effective date on the CAH list is the date supplied by the Centers for Medicare and Medicaid Services (CMS) upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

**4.4.4** After June 1, 2006, if a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

**4.4.5** If the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to update the listings on the web.

**4.5** CAHs participating in the demonstration in the state of Alaska, from July 1, 2007 through November 30, 2009, are exempt from the DRG-based payment system and are subject to the payment rates under the TRICARE Demonstration Project. For information on the demonstration, refer to the TRICARE Operations Manual (TOM), [Chapter 18, Section 7](#).

**4.6** Prior to December 1, 2009, the contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

#### **4.7 Billing and Coding Requirements**

**4.7.1** The contractors shall use type of institution 91 for CAHs.

## Acronyms And Abbreviations

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AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHCA	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
AC	Active Component
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
ACSP	Autism Demonstration Corporate Services Provider
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
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member

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ADH	Atypical Ductal Hyperplasia
ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFB	Air Force Base
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	Ambulatory Infusion Suite Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALH	Atypical Lobular Hyperplasia
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
AMCB	American Midwifery Certification Board
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous [Myeloid] 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
<b>ARCIS</b>	<b>Archives and Records Centers Information System</b>
ART	Assisted Reproductive Technology

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ARU	Automated Response Unit
ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ASRM	American Society for Reproductive Medicine
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BE&SD	Beneficiary Education and Support Division
BH	Behavioral Health
BI	Background Investigation
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement Protection Act

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BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
<b>BPPV</b>	<b>Benign Paroxysmal Positional Vertigo</b>
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAP	Competitive Acquisition Program
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
<b>CBL</b>	<b>Commercial Bill of Lading</b>
CBP	Competitive Bidding Program

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CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
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
CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant

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CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf
CIF	Central Issuing Facility Common Intermediate Format
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMR	Cardiovascular Magnetic Resonance
CMS	Centers for Medicare and Medicaid Services
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
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation

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COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
<b>CRP</b>	<b>Canalith Repositioning Procedure</b>
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Composite Tissue Allotransplantation Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices

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DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigative Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDD	Degenerative Disc Disease
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
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

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DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMR	Direct Member Reimbursement
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
DOC	Dynamic Orthotic Cranioplasty (Band)
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
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone

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DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
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
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
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 Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy

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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
<b>eFRC</b>	<b>Electronic Federal Records Center</b>
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
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
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
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits

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### Appendix A

#### Acronyms And Abbreviations

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EOP	Explanation of Payment
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)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
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
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
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability

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### Acronyms And Abbreviations

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FOIA	Freedom of Information Act
<b>FOUO</b>	<b>For Official Use Only</b>
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone
FSO	Facility Security Officer
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
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 Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record

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HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HDR	High Dose Radiation
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
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
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 Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language

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HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
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
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
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
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan

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IG	Implementation Guidance
IgA	Immunoglobulin A
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 Instant Message/Messaging Intramuscular
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
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
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

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IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
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
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]

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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
MBI	Molecular Breast Imaging
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 Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test

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MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
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
MUE	Medically Unlikely Edits
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
NACLCL	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration

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NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
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
NG	National Guard
NGPL	No Government Pay List
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
NMA	Non-Medical Attendant
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

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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
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
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
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights <b>Optical Character Recognition</b>
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
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

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OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
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
OTCD	Ornithine Transcarbamylase Deficiency
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
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
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
PCSIB	Purchased Care Systems Integration Branch

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PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
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
<b>PII</b>	<b>Personally Identifiable Information</b>
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure

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PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
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
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
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
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
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
PSD	Personnel Security Division

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PSG	Polysomnography
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
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
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	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement

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RF	Radiofrequency
RFA	Radiofrequency Ablation
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
<b>ROMF</b>	<b>Record Object Metadata File</b>
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
<b>RRS</b>	<b>Records Retention Schedule</b>
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
<b>SAMHSA</b>	<b>Substance Abuse and Mental Health Services Administration</b>
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program

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SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
<b>SIRT</b>	<b>Selective Internal Radiation Therapy</b>
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

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SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
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
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)

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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
TIP	Thermal Intradiscal Procedure
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
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
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
TOPO	TRICARE Overseas Program Office
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

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

### Appendix A

#### Acronyms And Abbreviations

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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
TRIAP	TRICARE Assistance Program
<b>TRIP</b>	<b>Temporary Records Information Portal</b>
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
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
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco

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

### Appendix A

#### Acronyms And Abbreviations

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UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouses
URL	Universal Resource Locator
US	Ultrasound 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
VAC	Vacuum-Assisted Closure
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)

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Appendix A

Acronyms And Abbreviations

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VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
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
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
<b>WHS</b>	<b>Washington Headquarters Services</b>
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
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
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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