CHAPTER 12
SECTION 1

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - GENERAL OVERVIEW

ISSUE DATE:

AUTHORITY: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)

I. 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 TMA and specifically included in the network provider agreement.

II. ISSUE

A general overview of the coverage and reimbursement of home health care.

III. POLICY

A. Statutory Background. Under 10 U.S.C. 1079(j)(2), the amount to be paid to hospitals, skilled nursing facilities (SNFs), and other institutional providers under TRICARE may, by regulation, be established "to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Similarly, under 10 U.S.C. 1079(h), the amount to be paid to health care professionals and other non-institutional health care providers "shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare." Section 701 of the National Defense Authorization Act for Fiscal Year 2002, (Pub. L. 107-107) (December 28, 2001), added a new Section 10 U.S.C. 1074j, establishing a comprehensive, part-time or intermittent home health care benefit to be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)). Based on these statutory provisions, TRICARE will adopt Medicare's benefit structure and prospective payment system for reimbursement of home health agencies that is currently in effect for the Medicare program as required by Section 4603 of the Balanced Budget Act of 1997, as amended by Section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, and by Sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. The above statutory provisions:

1. Include adoption of the comprehensive Outcome and Assessment Information Set (OASIS).

2. Require payment to be made on the basis of a prospective amount.

3. Allow for a new unit of payment.

4. Require the new unit of payment to reflect different patient conditions (case mix) and wage adjustments.

5. Allow for cost outliers (supplemental payment for exceptional high-cost cases).

6. Require proration of the payment when a beneficiary chooses to transfer among home health agencies (HHAs) within an episode.

7. Require services to be recorded in 15-minute increments on claims.

8. Require consolidated billing by HHAs for all services and supplies for patients under a home health plan of care (POC).

B. Scope and Conditions of Coverage.

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

a. Services that are covered under the new prospective payment rates:

(1) Part-time or intermittent skilled nursing care provided by or under the supervision of a registered professional nurse;

(2) Part-time or intermittent services of a home health aide;

(3) Physical, or occupational therapy, or speech-language pathology services;

(4) Medical social services under the direction of a physician;

(5) Routine and non-routine medical supplies;

(6) Medical services provided by an intern or resident-in-training under an approved hospital teaching program, when the HHA is affiliated with or under common control of a hospital; and

(7) Services at hospitals, SNFs or rehabilitation centers when they involve equipment too cumbersome to bring home, but not including transportation of the individual in connection with any such item or service.

b. Services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of care:

(1) Durable medial equipment;

(2) FDA approved injectable drugs for osteoporosis;

(3) Pneumoccocal pneumonia, influenza virus and hepatitis B vaccines;

(4) Oral cancer drugs and antiemetics;

(5) Orthotics and prosthetics;

(6) Ambulance services operated by the HHA;

(7) Enteral and parenteral supplies and equipment; and

(8) Other drugs and biologicals administered by other than oral method.

2. Conditions for Coverage.

a. HHA services are covered by TRICARE when the following criteria are met:

(1) The person to whom the services are provided is an eligible TRICARE beneficiary;

(2) The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the TRICARE program; and

(3) The beneficiary qualifies for coverage of home health services. To qualify for TRICARE coverage of any home health services, the beneficiary must meet each of the criteria specified below:

(a) Be confined to the home;

(b) Services are provided under a plan of care established and approved by a physician;

(c) Is under the care of the physician who signs the plan of care and the physician certification;

(d) Needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or has continued need for occupational therapy;

(e) TRICARE is the appropriate payer; and

(f) The services for which payment is claimed are not otherwise excluded from HHA PPS payment.

C. New Subsystems and Coding Requirements.

1. HHA PPS will operate on the platform of existing TRICARE claims processing systems.

2. HHA PPS will employ claims formats such as the paper and electronic UB-92 and related transaction formats -- no new fields will be added to either the remittance or the claim form.

3. Episode, as the payment unit, will also become the unit of tracking in claims systems.

4. Some new subsystems will be created and others modified to mesh with existing claims processing systems.

a. The contractor's authorization process (including data entering screens) will be used in designating primary provider status and maintaining and updating the episode information/history of each beneficiary. The managed care authorization system will be used in lieu of Medicare's remote access inquiry system [Health Insurance Query for HHAs (HIQH)]. The data requirements for tracking beneficiary episodes over time are found in Chapter 12, Section 5 ("Home Health Benefit Coverage and Reimbursement - Authorization Process").

b. Eighty (80) Home Health Resource Groups (HHRGs) for claims will be determined at HHAs by inputting OASIS data (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment) into a Home Assessment Validation and Entry (HAVEN) System. The HAVEN software package contains a Grouper module that will generate a HHRG for a particular 60-day episode of care based upon the beneficiary's condition, functional status and expected resource consumption. Updated versions of this software package may be downloaded from the CMS website. An abbreviated assessment will be conducted for TRICARE beneficiaries who are under the age of eighteen or receiving maternity care from a Medicare certified HHA. This will require the manual completion and scoring of a Home Health Resource Group Worksheet for pricing and payment under the HHA PPS. OASIS assessments are not required for authorized care in non-Medicare certified HHAs that qualify for corporate services provider status under TRICARE (i.e., HHAs which have not sought Medicare certification due to the specialized beneficiary categories they service, such as patients receiving maternity care and beneficiaries under the age of 18).

c. All HHA PPS claims will run through Pricer software, which, in addition to pricing HIPPS codes for HHRGs, will maintain six national standard visit rates to be used in outlier and LUPA determinations.

d. Episodes paid under HHA PPS will be restricted to homebound beneficiaries under existing Plans of Care (POCs); i.e., UB-92 type of bill (TOB) 32X and 33X. However, 34X bills will be used by HHAs for services not bundled into HHA PPS rates.

e. Requests for Anticipated Payment will be submitted using TOB 322 only.

f. The claim for an episode (TOB 329) will be processed in the claims processing system as an adjustment to the Request for Anticipated Payment (RAP) triggering full or final episode payment, so that the claim will become the single adjusted or finalized claim for an episode in claims history -- claims will be able to be adjusted by HHAs after submission.

g. There will be late charge bills (TOB 325 or 335) under HHA PPS -- services can only be added through adjustment of the claim (TOB 327 or 337).

h. New codes will appear on standard formats under HHA PPS:

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

j. A 023 revenue code will appear on both RAPs and claims, with new HIPPS codes for HHRGs in the HCPCs field of a line item.

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

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

6. UB-92 line itemization will have to be expanded to 450 lines for the reporting of services and supplies rendered during the extended 60-day episode period.

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

D. Reimbursement. The adoption of the Medicare home health agency (HHA) prospective payment system will replace the retrospective physician-oriented fee-for-service model currently used for payment of home health services under TRICARE. Under the new prospective payment system, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's plan of care. Other health services including, but not limited to, DME and osteoporosis drugs may receive reimbursement outside of the prospective payment system. A fixed case-mix and wage adjusted 60-day episode payment will also be paid to Medicare-certified HHAs providing home health services to beneficiaries who are under the age of 18 and/or receiving maternity care. However, this payment amount will be determined through the manual completion and scoring of an abbreviated assessment form. The 23 items in this assessment will provide the minimal amount of data necessary for generating a HIPPS code for payment under the HHA PPS (see Chapter 12, Section 4, paragraph III.E. for more details regarding this abbreviated assessment process). HHAs for which there is no Medicare-certification due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of beneficiaries under the age of 18 or receiving maternity care) will be reimbursed in accordance with payment provisions established under the corporate services provider class (see the TRICARE Policy Manual, Chapter 11, Section 12.1 for payment provisions that apply to HHAs qualifying for coverage under this class of provider).

E. Authorized Providers.

1. Bachelor of Science (BS) medical social workers, social worker assistants, and home health aides that are not otherwise authorized providers under the Basic Program may provide home health services to TRICARE beneficiaries that are under a home health plan of care authorized by a physician. The services are part of a package of services for which there is a fixed case-mix and wage-adjusted 60-day episode payment.

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

NOTE: The HHA will be responsible for assuring that all individuals rendering home health services meet the qualification standards specified in Chapter 12, Section 2. The contractor will not be responsible for certification of individuals employed by or contracted with a home health agency.

3. HHAs for which Medicare-certification is not available due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of TRICARE eligible beneficiaries that are under the age of 18 or receiving maternity care) must meet the qualifying conditions for corporate services provider status as specified in the TRICARE Policy Manual, Chapter 11, Section 12.1. Those specialized HHAs qualifying for corporate services provider status will be reimbursed in accordance with the provisions outlined in Chapter 12, Section 4, paragraph III.E.1.b.

F. Transition to HHA PPS.

1. As of (TBD), all HHAs must bill all services delivered to homebound TRICARE beneficiaries under a home health plan of care under HHA PPS. The HHA PPS applies to claims billed on a CMS Form 1450 (UB-92), with Form Locator 4 (FL 4) Type of Bill (TOB) 32X or 33X. HHAs will still occasionally bill TRICARE using TOB 34X, but these claims will not be subject to PPS payment. If an HHA has beneficiaries already under an established plan of care prior to this date, the open claims for services on or before (TBD) must be closed and submitted for payment under the standard TRICARE fee-for-service allowable charge methodology. Claims for services on or after (TBD) will be processed and paid under the HHA PPS. Under no circumstances should a HHA claim span payment systems. Claims for services dates spanning payment systems will be returned to the provider for splitting.

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

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

G. Implementing Instructions. Since this issuance only deals with a general overview of the home health care benefit and reimbursement methodology, the following cross reference is provided to facilitate access to specific implementing instructions within Chapter 12, Sections 1 through 8:

IMPLEMENTING INSTRUCTIONS/SECTIONS	
POLICIES	
General Overview	Chapter 12, Section 1
Benefits and Conditions for Coverage	Chapter 12, Section 2
Assessment Process	Chapter 12, Section 3
Reimbursement Methodology	Chapter 12, Section 4
Primary Provider Status and Episodes of Care	Chapter 12, Section 5
Claims and Billing Submission Under HHA PPS	Chapter 12, Section 6
Pricer Requirements and Logic	Chapter 12, Section 7
Medical Review Requirements	Chapter 12, Section 8
ADDENDA	
Acronym Table	Chapter 12, Addendum A
List of 194 Non-routine Supply Codes	Chapter 12, Addendum B
List of 69 Therapy Codes	Chapter 12, Addendum C
CMS Form-485 Data Elements	Chapter 12, Addendum D
Primary Components of Home Health Assessment	Chapter 12, Addendum E
Outcome and Assessment Information Set (OASIS)	Chapter 12, Addendum F
OASIS Items Used for HHA PPS	Chapter 12, Addendum G
ICD9-CM Diagnosis Codes for HHRG Assignment	Chapter 12, Addendum H
Home Health Resource Group (HHRG) Worksheet	Chapter 12, Addendum I
HIPPS Table for Pricer	Chapter 12, Addendum J
HAVEN Reference Manual	Chapter 12, Addendum K
Annual HHA PPS Rate Updates	Chapter 12, Addendum L
Annual HHA PPS Wage Index Updates	Chapter 12, Addendum M
Examples of Claims Submissions Under HHA PPS	Chapter 12, Addendum N

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