CHAPTER 12
SECTION 2

HOME HEALTH CARE - BENEFITS AND CONDITIONS FOR COVERAGE

ISSUE DATE:

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

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

The benefits and conditions for coverage under home health care.

III. POLICY

A. Conditions for Coverage of Home Health Services. Home health agency (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.

3. The beneficiary qualifies for coverage of home health services.

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

a. Patient Confined to the Home. The condition of the beneficiary should be such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment -- including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the state -- shall not disqualify an individual from being considered to be confined to his/her home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For purposes of the

preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for nonmedical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration.

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

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

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

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

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

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

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

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

(f) Patients with a psychiatric problem if their illness is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for them to leave home unattended, even if they have no physical limitations.

(g) Aged persons who do not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

(h) Although patients must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there.

1 If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, skilled nursing facility (SNF), or rehabilitation center to provide these services on an outpatient basis.

2 However, even in these situations, for the services to be covered as home health services, the patient must be considered as confined to his/her home and in need of such outpatient services as a homebound patient will generally require; i.e., the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

3 If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the TRICARE Managed Care Support Contractor (MCSC) with the information necessary to establish that the patient is homebound as defined above.

(i) Patient's Place of Residence. A patient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution is a hospital, skilled nursing facility, or other nursing facility under Medicaid.

1 If a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services since such an institution may not be considered his/her residence.

2 When a patient remains in a participating SNF following his/her discharge from active care, the facility may not be considered his/her residence for purposes of home health coverage.

(4) The only homebound requirement for TRICARE beneficiaries under the age of 18 and obstetrical patients is that there be a written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk. The MCSCs may use any commercially available criteria which may assist them in managing the appropriateness of home health care for these special beneficiary categories.

b. Services Are Provided Under a Plan of Care Established and Approved by a Physician.

(1) Content of the Plan of Care. The term "plan of care" refers to the medical treatment plan established by the treating physician with the assistance of the home health care nurse. The plan of care must contain all pertinent diagnoses, including patient's mental status, the type of services, supplies, and equipment required, the frequency of the visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirement, all medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any additional items the HHA or

physician chooses to include. It is anticipated that a discipline-oriented plan of care will be established, where appropriate, by an HHA nurse regarding nursing and home health aide services and by skilled therapists regarding specific therapy treatment. These plans of care may be incorporated within the physician's plan of care or separately prepared.

(2) Specificity of Orders. The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

(3) Who Signs the Plan of Care. The physician who signs the plan of care must be qualified to sign the physician certification.

(4) Use of Oral (Verbal) Orders. When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies. The orders must be signed and dated with date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services.

(a) The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist.

(b) Written statements of oral orders must be countersigned and dated by the physician before the HHA bills for the care.

(c) Services which are provided from the beginning of the certification period and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician, so long as there is an oral order for the care prior to rendering the services that is documented in the medical record and subsequently included in a signed plan of care.

(d) Services that are provided in the subsequent certification period are considered to be provided under the subsequent plan of care where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.

(e) Services that are provided after the expiration of a plan of care, but before the acquisition of an oral order or a signed plan of care, cannot be considered to be provided under a plan of care.

(f) Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

(5) Frequency of Review of the Plan of Care. The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 62 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review.

(6) Facsimile Signatures. The plan of care or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

(7) Alternative Signatures. HHAs that maintain patient records by computer rather than hard copy may use electronic signatures.

(a) However, all such entries must be appropriately authenticated and dated.

(b) Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry.

(c) The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

(8) Termination of the Plan of Care. The plan of care is considered to be terminated if the patient does not receive at least one covered skilled nursing, physical therapy, speech-language pathology service, or occupational therapy visit in a 62-day period unless the physician documents that the interval without such care is appropriate to the treatment of the patient's illness or injury.

c. Under the Care of a Physician. A patient is expected to be under the care of the physician who signs the plan of care and the physician certification. It is expected, but not required for coverage, that the physician who signs the plan of care will see the patient, but there is no specified interval of time within which the patient must be seen.

d. Needs Skilled Nursing Care on an Intermittent Basis, or Physical Therapy or Speech-Language Pathology or Has Continued Need for Occupational Therapy.

(1) The patient must need one of the following types of services:

(a) Skilled nursing care that is reasonable and necessary as defined below:

1 Skilled nursing services includes application of professional nursing services and skills by an RN, LPN, or LVN, that are required to be performed under the general supervision/direction of a TRICARE authorized physician to ensure the safety of the patient and achieve the medically desired result in accordance with accepted standards of practice. Skilled nursing services must also be reasonable and necessary to the treatment of

the patient's illness or injury and must be intermittent for coverage under the home health care benefit.

2 General Principles Governing Reasonable and Necessary Skilled Nursing Care

a A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone; e.g., intravenous and intramuscular injections or insertion of catheters, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

b A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service of the patient, does not make it a skilled service when a nurse provides the service.

c A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

d The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition.

e To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, his/her particular medical needs, and accepted standards of medical and nursing practice.

f A patient's overall medical condition is a valid factor in deciding whether skilled services are needed.

g A patient's diagnosis should never be the sole factor in deciding that a service that patient needs is either skilled or not skilled.

h The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the

services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at the time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

i The determination of whether a patient needs skilled nursing care should be based solely upon the patient's unique condition and individual needs, with regard to whether the illness or injury is acute, chronic, terminal or expected to extend over a long period of time. In addition, skilled care may, dependent upon the unique condition of the patient, continue to be necessary for patients whose condition is stable.

3 Application of the Principles to Skilled Nursing Services

a Observation and Assessment of the Patient's Condition.

(1) Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized.

(2) Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such complication or further acute episode. Where indications are such that it is likely that skilled observation and assessment by a licensed nurse will result in changes in treatment of the patient, then the services would be covered.

(3) Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

b Management and Evaluation of a Patient Care Plan. Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose.

c Teaching and Training Activities.

(1) Teaching and training activities which require skilled nursing personnel to teach the patient, the patient's family or caregivers how to manage his/her treatment regimen would constitute nursing services.

(2) Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach

and not to the nature of what is being taught. Where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered.

(3) Teaching and training activities that require the skills of a licensed nurse include, but are not limited to the following:

(a) Teaching of self-administration of an injectable medication, or a complex range of medications;

(b) Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to watch for and understand signs of hyperglycemia and hypoglycemia;

(c) Teaching self-administration of medical gases;

(d) Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

(e) Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;

(f) Teaching self-catheterization;

(g) Teaching self-administration of gastrostomy or enteral feedings;

(h) Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

(i) Teaching bowel or bladder training when bowel or bladder dysfunction exists;

(j) Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;

(k) Teaching transfer techniques (e.g., from bed to chair) that are needed for safe transfer;

(l) Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;

(m) Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

(n) Teaching prosthesis care and gait training;

(o) Teaching the use and care of braces, splints and orthotics and associated skin care;

(p) Teaching the proper care and application of any specialized dressings or skin treatments (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration from radiation treatment);

(q) Teaching the preparation and maintenance of a therapeutic diet; and

(r) Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

d Administration of Medications. The services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

(1) Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.

(2) Vitamin B-12 Injections. Vitamin B-12 injections are considered specific therapy only for the following conditions:

(a) Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia.

(b) Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome,

(c) Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

(d) For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment.

(3) Insulin Injection. Insulin is customarily self-injected by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

(4) Oral Medications. The administration of oral medications by a nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the patient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The following are some examples of situations in which the administration of oral medications by a nurse would be considered reasonable or necessary skilled nursing care:

(a) Example #1. A patient with arteriosclerotic heart failure requires observation by skilled nursing personnel for signs of decompensation or adverse effects from prescribed medication. Skilled observation is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the patient's treatment regimen is essentially stabilized.

(b) Example #2. A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmias. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized.

(5) Eye Drops and Topical Ointments. The administration of eye drops and topical ointments does not require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service.

(6) Tube Feeding. Nasogastric tube, and percutaneous tube feeding (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services.

(7) Nasopharyngeal and Tracheostomy Aspiration. Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's illness or injury, would be covered as skilled nursing services.

(8) Catheters. Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter and in selected patients, urethral catheters, are considered be skilled nursing services.

(9) Wound Care. Care of wounds (including, but not limited to ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service.

(10) Ostomy Care. Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing

care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications.

(11) Heart Treatments. Heart treatments that have been specifically ordered by a physician as part of active treatment of an illness or injury and require observation by a licensed nurse to adequately evaluate the patient's progress would be considered skilled nursing services.

(12) Medical Gases. Initial phases of a regimen involving the administration of medical gases that are necessary to the treatment of the patient's illness or injury, would require skilled nursing care for skilled observation and evaluation of the patient's reaction to the gases, and to teach the patient and family when and how to properly manage the administration of the gases.

(13) Rehabilitation Nursing. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services.

(14) Venipuncture. Venipuncture, when the collection of the specimen is necessary to the diagnosis and treatment of the patient's illness or injury and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment in a skilled nursing facility, is considered to be a skilled nursing service.

(b) Student Nurse Visits. Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting.

1 The services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse.

2 The supervising nurse need not accompany the student nurse on each visit.

(c) Psychiatric Evaluation, Therapy, and Teaching. The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse, and the costs of the psychiatric nurse's services, may be covered as a skilled nursing service.

(d) Intermittent Skilled Nursing Care. To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

1 Part-time or Intermittent Home Health Aide and Skilled Nursing Services.

a Where a patient qualifies for coverage of home health services, TRICARE covers either part time or intermittent home health aide services and skilled nursing services.

(1) "Part-time" means any number of days per week:

(a) Up to and including 28 hours per week of skilled nursing and home health aide combined for less than 8 hours per day; or

(b) Up to 35 hours per week of skilled nursing and home health aide services combined for less than 8 hours per day, subject to review by the contractors on a case by case basis, based on documentation justifying the need for any reasonableness of such additional care.

(2) "Intermittent" means:

(a) Up to and including 28 hours per week of skilled nursing and home health aide services combined, provided on a less than daily basis;

(b) Up to 35 hours per week of skilled nursing and home health aide services combined which are provided on a less than daily basis, subject to review by fiscal intermediaries on a case by case basis, based upon documentation justifying the need for and reasonableness of such additional care; or

(c) Up to and including full-time (i.e., 8 hours per day) skilled nursing and home health aide services combined which are provided and needed 7 days per week for temporary, but not indefinite, periods of time of up to 21 days with allowances for extension in exceptional circumstances where the need for care in excess of 21 days is finite and predictable.

2 Care Provided in Excess of "Intermittent" or "Part-time" Care. Home health aide and/or skilled nursing care in excess of the amounts of care that meet these definitions of part-time or intermittent may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the definitions of part-time or intermittent.

EXAMPLE: A patient needs skilled nursing care monthly for a catheter change and the HHA also renders needed daily home health aide services 24 hours per day that will be needed for a long and indefinite period of time. The HHA bills for the skilled nursing and home health aide services which were provided before the 35th hour of service each week and bills the beneficiary (or other payer) for the remainder of the care. If the contractor determines that the 35 hours of care are reasonable and necessary, coverage would be

extended for the 35 hours of skilled nursing and home health aide visits.

(e) Skilled Therapy Services.

1 General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy.

a The service of a physical, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist.

b The skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration of maintenance of function affected by the patient's illness or injury.

c The development, implementation management and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's condition, those services require the involvement of a skilled therapist to meet the patient's needs, promote recovery, and ensure medical safety.

d Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, such services would be covered, even if the skills of a therapist are not needed to carry out the activities performed as a part of the maintenance program.

e While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.

f A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform or supervise the service or to observe the patient. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make a nonskilled service into a skilled service.

g The skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

(1) The services must be consistent with the nature and severity of the illness or injury, and the patient's particular medical needs, including the requirement that the amount, frequency and duration of the services must be reasonable;

(2) The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, and

(3) The services must be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that:

(a) The condition of the patient will improve materially in a reasonable and generally predictable period of time; or

(b) The services are necessary to the establishment of a safe and effective maintenance program.

(c) Services involving activities for the general welfare of any patient (e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation) do not constitute skilled therapy. Those services can be performed by nonskilled individuals without the supervision of a therapist.

(4) Services of skilled therapists for the purpose of teaching the patient or the patient's family or caregivers necessary techniques, exercises or precautions are covered to the extent that they are reasonable and necessary to treat illness or injury. However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.

(5) The amount, frequency, and duration of the services must be reasonable.

2 Application of the Principles to Physical Therapy Service.

a Assessment. The skills of a physical therapist to assess and periodically reassess a patient's rehabilitation needs and potential, or to develop and/ implement a physical therapy program, are covered when reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance or functional ability.

b Therapeutic Exercises. Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

c Gait Training. Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to improve materially the patient's ability to walk.

(1) Gait evaluation and training which is furnished a patient whose ability to walk has been impaired by a condition other than a neurological, muscular or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore the lost function.

(2) Repetitive exercises to improve gait or to maintain strength and endurance and assistive walking are appropriately provided by nonskilled persons and ordinarily do not require the skills of a physical therapist. Where such services are performed by a physical therapist as part of the initial design and establishment of a safe and effective maintenance program, the services would, to the extent that they are reasonable and necessary, be covered.

d Range of Motion. Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

(1) Range of motion exercises constitute skilled physical therapy only if they are part of an active treatment for a specific disease state, illness, or injury, that has resulted in a loss of restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored).

(2) Range of motion exercises unrelated to the restoration of a specific loss of function often may be provided safely and effectively by nonskilled individuals. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by nonskilled persons do not constitute physical therapy.

(3) However, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, then the services would be covered.

e Maintenance Therapy. Where repetitive services that are required to maintain function involve the use of complex and sophisticated procedures, the judgement and skill of a physical therapist might be required for the safe and effective rendition of such services. If the judgement and skill of a physical therapist is required to safely and effectively treat the illness or injury, the services would be covered as physical therapy services. While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his/her condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session), the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

f Ultrasound, Shortwave, and Microwave Diathermy Treatments. These treatments must always be performed by or under the supervision of a qualified physical therapist and are considered skilled therapy.

g Hot Packs, Infrared Treatments, Paraffin Baths and Whirlpool Baths. Heat treatments and baths of this type ordinarily do not require the skills of

a qualified physical therapist. However, the skills, knowledge and judgement of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case; e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complication.

3 Application of the General Principles to Speech-Language Pathology Services.

a The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders) and rehabilitation potential. Reevaluation would only be considered reasonable and necessary if the patient exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical condition that previously contraindicated speech-language pathology services. Where a patient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and could be billed as a separate visit.

b The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production.

c Speech-language pathology would be covered where the service can only be provided by a speech-language pathologist and where it is reasonably expected that the service will materially improve the patient's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurable at a higher level of attainment than that attained prior to the initiation of the services. There must be an anticipated improvement in the patient's communicative ability in order for coverage to be extended under the home health benefit.

d The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a patient toward speech-language communication goals in the plan of care would be covered speech-language pathology.

e The services of a speech-language pathologist to train the patient, family or other caregivers to augment the speech-language communication or treatment, or to establish an effective maintenance program would be covered speech-language pathology services.

f The services of a speech-language pathologist to assist patients with aphasia in rehabilitation of speech and language skills is covered when needed by a patient.

g The services of a speech-language pathologist to assist patients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient.

4 Application of the General Principles to Occupational Therapy. The following discussion of skilled occupational therapy services applies the principles to specific occupational therapy services about which questions are most frequently raised.

a Assessment. The skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential, or to develop and/or implement an occupational therapy program, are covered when they are reasonable and necessary because of the patient's condition.

b Planning, Implementing and Supervision of Therapeutic Programs. The planning, implementing and supervision of therapeutic programs including, but not limited to those listed below are skilled occupational therapy services, and if reasonable and necessary to the treatment of the patient's illness or injury would be covered. Contractor medical review staff will be responsible for determining the reasonableness and necessity of therapeutic programs not listed under this paragraph.

(1) Selecting and teaching task oriented therapeutic activities designed to restore physical function.

(2) Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

(3) Planning, implementing and supervising of individual therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness.

(4) Teaching compensatory techniques to improve the level of independence in the activities of daily living.

(5) The designing, fabricating and fitting of orthotic and self-help devices.

(6) Vocational and prevocational assessment and training that is directed toward the restoration of function in the activities of daily living lost due to illness or injury would be covered. Where vocational or prevocational assessment and training is related solely to specific employment opportunities, work skills or work settings, such services would not be covered because they would not be directed toward the treatment of an illness or injury.

e. Home health coverage is not available for services furnished to a qualified patient who is no longer in need of one of the qualifying skilled services specified below:

(1) Skilled nursing care on an intermittent basis

(2) Physical therapy

(3) Speech-language pathology

(4) Continued need for occupational therapy

B. Other Services Available to Beneficiaries Qualifying for Coverage Under Home Health Benefit.

1. Home Health Aide Services.

a. For home health aide services to be covered, the patient must meet the qualifying criteria as specified in:

(1) Confined to the home.

(2) Services are provided under a plan of care established and approved by a physician.

(3) Under the care of a physician.

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

(5) Services have physician certification.

b. The services provided by the home health aide must be part-time or intermittent.

c. The services must meet the definition of home health aide services and the services must be reasonable and necessary to the treatment of the patient's illness or injury.

d. The reason for the visits by the home health aide must be to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.

e. The physician's order should indicate the frequency of the home health aide services required by the patient. These services may include, but are not limited to:

(1) Personal Care. Personal care means:

(a) Bathing, dressing, grooming, caring for hair, nails and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient's health, changing the bed linens of an incontinent patient, shaving, deodorant application, skin care with lotions and/or powder, foot care and ear care.

(b) Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.

(c) Simple dressing changes that do not require the skills of a licensed nurse.

(d) Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively.

(e) Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services.

(f) Routine care of prosthetic and orthotic devices.

(2) Other Services. When a home health aide visits a patient to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.). However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

2. Medical Social Services. Medical social services that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the beneficiary meets the qualifying criteria and:

a. The services of these professionals are necessary to resolve social or emotional problems that are, or are expected to be, an impediment to the effective treatment of the patient's medical condition or his or her rate of recovery; and

b. The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively.

c. Where both of these requirements for coverage are met, services of these professionals which may be covered include, but are not limited to:

(1) Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care;

(2) Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources;

(3) Appropriate action to obtain available community resources to assist in resolving the patient's problem;

(4) Counseling services that are required by the patient; and

(5) Medical social services furnished to the patient's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (that

is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to his or her rate of recovery. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery, as well as long-term social services furnished to family members (such as ongoing alcohol counseling), are not covered.

(6) Participating in the development of the plan of treatment, preparing clinical and progress notes, participating in discharge planning and inservice programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the HHA.

3. Medical Supplies (Including for Drugs and Biologicals).

a. Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential to enabling HHA personnel to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury.

b. Routine Supplies. Routine because they are used in small quantities for patients during the usual course of most home visits.

(1) Routine supplies are supplies that are customarily used during the course of most home care visits. They are usually included in the staff's supplies and not designated for a specific patient. Routine supplies would not include those supplies that are specifically ordered by the physician or are essential to HHA personnel in order to effectuate the plan of care.

(2) Examples of supplies which are usually considered routine include, but are not limited to:

(a) Dressings and Skin Care

1 Swabs, alcohol preps, and skin pads

2 Tape removal pads

3 Cotton balls

4 Adhesive and paper tape

5 Non-sterile applicators

6 4 x 4's

7 Infection control protection

8 Non-sterile gloves

9 Aprons

10 Masks

11 Gowns

12 Blood drawing supplies

13 Specimen containers

14 Other

a Thermometers

b Tongue depressors

(3) There are occasions when the supplies listed in the above examples would be considered nonroutine and thus would be considered non-routine supply; i.e., if they are required in quantity, for recurring need, and are included in the plan of care. Examples include, but are not limited to, tape and 4 x 4's for major dressings.

c. Non-Routine Supplies. Non-routine supplies are identified by the following conditions:

(1) The HHA follows a consistent charging practice for TRICARE and non-TRICARE patients receiving the item;

(2) The item is directly identifiable to an individual patient;

(3) The cost of the item can be identified and accumulated in a separate cost center;

(4) The item is furnished at the direction of the patient's physician and is specifically identified in the plan of care.

(a) All non-routine supplies must be specifically ordered by the physician, or the physician's order for services must require the use of the specific supplies to be effectively furnished.

(b) The charge for non-routine supplies is excluded from the per visit costs.

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

(a) Dressings/Wound Care

(b) Sterile dressings

(c) Sterile gauze and toppers

(d) Kling and Kerlix rolls

(e) Telfa pads

(f) Eye pads

(g) Sterile solutions, ointments

(h) Sterile applicators

(i) Sterile gloves

(j) IV supplies

(k) Ostomy supplies

(l) Catheter and catheter supplies

1 Foley catheters

2 Drainage bags, irrigation trays

(m) Enemas and douches

(n) Syringes and needles

(o) Home testing

1 Blood glucose monitoring strips

2 Urine monitoring strips

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

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

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

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

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

4. Durable Medical Equipment. Durable medical equipment covered under the home health benefit subject to the beneficiary's applicable deductible and copayment/cost-share (refer to Chapter 2, Addendum A and Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

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

a. Approved by the Accreditation Council for Graduate Medical Education;

b. In the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

c. In the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association; or

d. In the case of an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Education of the American Podiatric Association.

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

a. Which require equipment which cannot readily be made available at the patient's place of residence, or

b. Which are furnished while he/she is at the facility to receive the services described above.

c. The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must be a qualified provider of services. However, there are special provisions for the use of the facilities of rehabilitation centers.

d. The cost of transporting an individual to a facility cannot be reimbursed as home health services.

C. Consolidated Billing Requirements Under HHA PPS.

1. The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician.

a. Consequently, billing for all such items and services is to be made to a single HHA overseeing that plan, and this HHA is known as the primary agency or HHA for HHA PPS billing purposes.

b. Payment will be made to the primary HHA without regard to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or whether any other contracting or consulting arrangements exist with the primary agency, or "otherwise". Payment for all items is included in the HHA PPS episode payment the primary HHA receives.

(1) Types of services that are subject to the home health consolidated billing provision:

(a) Skilled nursing care;

(b) Home health aide services;

(c) Physical therapy;

(d) Speech-language pathology;

(e) Occupational therapy;

(f) Medical social services;

(g) Routine and non-routine medical supplies;

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

(i) Care for homebound patients involving equipment too cumbersome to take to the home.

(2) Contractors will deny any claims from other than the primary HHA that contain billing for the services and items above when billed for dates of service that have not been authorized by the contractor.

(3) Lists of procedures are being incorporated as addenda to this policy in order to facilitate adherence to the home health consolidated billing requirements. Procedure codes on these lists will be denied if billed by other than the home health agency creating the episode (i.e., the primary provider designated under the contractors' preauthorization process for providing home health care to TRICARE eligible beneficiaries). The following

lists of procedures will be issued annually in conjunction with the release of the yearly HCPCS update:

(a) Chapter 12, Addendum B - list of non-routine supply codes.

(b) Chapter 12, Addendum C - list of therapy codes.

c. Services exempt from home health consolidated billing (i.e., services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of treatment):

(1) Durable Medical Equipment (DME).

(a) DME can be billed as a home health service or as a medical/other health service.

(b) DME will be paid in accordance with the reimbursement guidelines set forth in Chapter 1, Section 11, less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/ copayment provisions for services paid in addition to the HHA PPS amount).

(c) DME may be billed by a supplier to a contractor on a CMS 1500 claim form or billed by a HHA on a CMS Form 1450 (UB-92) using bill types 32X, 33X and 34X as appropriate. While the contractors' systems will allow either party to submit these claims, the following requirements will be initiated in order to prevent duplicative billing:

1 HHA providers required to submit line item dates on Durable Medical Equipment (DME) items.

2 Providers instructed to bill each month's DME rental as a separate line item.

3 HHAs allowed to bill DME not under a Plan of Care (POC) on the 34X type bill.

(d) Crossover edits will be developed to prevent duplicate billing of DME.

1 Since consolidated billing does not apply to DME, claims for equipment not authorized by the contractor will be denied. Appropriate appeal rights will apply.

2 DME can be billed by other than the Primary HHA under HHA PPS system when authorized by the contractor (i.e., by supplier/vendor or other HHA).

3 System must be able to identify duplicative billing based on dates of services.

(2) Osteoporosis Drugs.

(a) Osteoporosis drugs are subject to home heath consolidated billing, even though they are paid outside the 60-day episode amount. When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them.

(b) Osteoporosis Injections as a HHA Benefit.

1 Cover FDA approved injectable drugs for osteoporosis for female beneficiaries.

2 Only injectable drugs that meet the requirement have the generic name of calcitonin-salmon or calcitonin-human.

(c) Payment is based on the average wholesale price of the drug determined from the Drug Topics Blue Book, less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/ copayment provisions for services paid in addition to the HHA PPS amount).

1 The drug is billed on a CMS Form 1450 (UB-92) under bill type 34X with revenue code 636 and HCPCS code J0630.

2 The cost of administering the drug is included in the charge for the visit billed under bill type 32X or 33X, as appropriate.

3 If the service dates on the 34X claim fall within a HHA PPS episode that has been approved for a beneficiary, the system must edit to assure that the provider number on the 34X claim matches the provider number in the authorization. This is to reflect that, although the osteoporosis drug is paid separately from the HHA PPS episode rate, it is included in consolidated billing requirements.

(3) Pneumoccocal Pneumonia, Influenza Virus and Hepatitis B Vaccines.

(a) General Billing Requirements.

1 Bill on CMS Form 1450 (UB-92) using type of bill 34X and revenue code 636 for the vaccine and revenue code 771 for administration of the vaccine.

2 The vaccine and its administration may be on the same claim form (i.e., there is no requirement for a separate bill).

3 The following HCPCS codes will be used in billing for vaccines:

a 90657 - Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular injection use;

b. 90658 - Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;

c. 90732 - Pneumococcal polysaccharide vaccine, 23 valent, adult dosage, for subcutaneous or intramuscular use;

d. 90744 - Hepatitis B vaccine, pediatric or pediatric/ adolescent dosage, for intramuscular use;

e. 90746 - Hepatitis B vaccine, adult dosage, for intramuscular use;

f. 90747 - Hepatitis B vaccine, dialysis or immunosuppressed patient dosage;

g. 90748 - Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

4. The following HCPCS codes will be used in billing for administration of the vaccines:

a. G0008 - administration of the influenza virus vaccine;

b. G0009 - administration of the pneumococcal polysaccharide vaccine;

c. G0010 - administration of the hepatitis B vaccine.

5. Report code V04.8 for influenza virus vaccine, code V03.82 for pneumococcal polysaccharide vaccine (PPV), and code V05.3 for the hepatitis B vaccine if the sole purpose for the visit is to receive the vaccines, or if the vaccines are the only service billed on a claim.

(b) Special billing instructions for HHAs in various situations:

a. Where the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B), a skilled nursing visit will not be paid under the HHA benefit. However, the vaccine and its administration will be covered under clinical preventive benefits (both Prime and Standard/Extra). The administration should include charges only for the supplies being used and the cost of the injection. Travel time and other expenses (i.e., gasoline) should not be charged. The vaccine and its administration should be billed under bill type 34X using revenue code 636 along with the appropriate HCPCS code for the vaccine, and revenue code 771 along with the appropriate HCPCS code for the administration.

b. If the vaccine (influenza, PPV, or hepatitis B) is administered during the course of an otherwise covered home health visit (e.g., to perform wound care), the visit would be covered as normal but would not include the vaccine or its administration. The HHA would still be entitled to payment for the vaccine and its

administration under the clinical preventive benefit. The vaccine and its administration should be billed under bill type 34X using revenue code 636 along with the appropriate HCPCS code for the vaccine, and revenue code 771 along with the appropriate HCPCS code for the administration.

c Payment is based on the CHAMPUS Maximum Allowable Charge (CMAC) of the vaccine, along with associated administration costs, less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

(4) Oral Cancer Drugs.

(a) Self-administrable oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic agent. To be covered, an oral cancer drug must:

1 Be prescribed by a physician or practitioner as an anti-cancer chemotherapeutic agent;

2 Be a drug or biological approved by the FDA;

3 Have the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic drug or biological that is covered when furnished incidentally to a physician's service;

4 Be used for the same indications (including off-label uses) as the non-self-administrable version of the drug; and

5 Be reasonable and necessary for the individual patient.

6 Examples of covered oral cancer drugs:

a Cyclophosphamide

b Etoposide

c Methotrexate

d Melphalan

(b) Payment.

1 The reasonable cost of the cancer drugs furnished by a provider (i.e., the average wholesale price determined from the Drug Topics Blue Book), less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

2 Bill on CMS Form 1450 (UB-92), type of bill 34X.

a Enter revenue code 636 in FL 42, the name and HCPCS of the oral drug in FLs 43 and 44, and the name of the tablets or capsules in FL 46 of the UB-92.

b An exception is made for 50mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units.

c Complete the remaining items in accordance with regular billing instructions.

d A cancer diagnosis must be entered in FLs 67-75 of the UB-92 for coverage of an oral cancer drug.

(5) Antiemetic Drugs.

(a) TRICARE pays for self-administrable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of TRICARE covered oral anticancer chemotherapeutic agents when a likelihood of vomiting exists.

1 Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anticancer drug in high doses for longer periods are not covered.

2 Self-administered antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption.

3 Payment.

a The reasonable cost of the self-administered antiemetic drugs furnished by a provider (i.e., the average wholesale price determined from the Drug Topics Blue Book) less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

b Bill on CMS Form 1450 (UB-92), type of bill 34X.

(1) Enter revenue code 636 in FL42.

(2) Enter one of the following HCPCS codes in FL 44, as appropriate:

(a) K0415 - Prescription antiemetic drug, oral, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified; or

(b) K0416 - Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified.

(3) Enter the name of the self-administered drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit.

(4) Complete the remaining items in accordance with regular billing instructions.

(5) TRICARE does not pay for a visit solely for administration of self-administered antiemetic drugs in conjunction with oral anticancer drugs.

(6) Orthotics and prosthetics, can be billed as a home health service or as a medical/other health service.

(a) Orthotics and prosthetics may be billed by a supplier to a contractor on a claim form 1500 or billed by a HHA on a CMS Form 1450 (UB-92) using bill types 32X, 33X and 34X as appropriate.

(b) Payment will be paid in accordance with the reimbursement guidelines set forth in Chapter 1, Section 11, less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/ copayment provisions under each TRICARE program).

(7) Enteral and Parenteral Nutritional Therapy.

(a) Enteral and parenteral supplies and equipment can be billed as a home health service or as a medical and other health service.

(b) Payment is based on the reasonable purchase cost less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

(c) Enteral and Parenteral supplies and equipment may be billed by a supplier to a contractor on a claim form 1500, or billed by a HHA on a CMS Form 1450 (UB-92) using bill types 32X, 33X and 34X as appropriate.

(8) Drugs and Biologicals Administered By Other Than Oral Method.

(a) TRICARE will allow payment in addition to the prospective payment amount for drugs and biologicals administered by other than an oral method (i.e., drugs and biologicals that are injected either subcutaneous, intramuscular, or intravenous) when:

1 Prescribed by a physician or practitioner;

2 Approved by the FDA; and

3 Reasonable and necessary for the individual patient.

(b) Billing Methods.

1 The HHA may bill for the drugs/biologicals on a UB-92 (CMS Form 1450) under bill type 34X with revenue codes 25X or 63X and Health Care Financing Administration Common Procedure Coding System (HCPCS) National Level II Medicare "J" codes; or

2 The home infusion company and/or pharmacy delivering the medication for home administration may bill the contractor directly using the CMS Form 1500 claim form with appropriate NDC or HCPCS coding.

3 The contractors' systems will allow either party to submit these claims, but will not allow duplicative billing.

(c) Payment.

1 The reasonable cost of the drugs/biologicals furnished by a provider (refer to Chapter 1, Section 15, paragraph III.E. for the pricing of home infusion drugs furnished through a covered item of durable medical equipment) less an appropriate cost-share/copayment and deductible (refer to Figure 12-2-1, below, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

2 The cost of administering the drug is included in the charge for the visit billed under bill type 32X or 33X, as appropriate.

(9) Ambulance Transfers.

(a) Payment will be allowed outside the 60-day episode amount for ambulance services furnished directly by a HHA or provided under arrangement between a HHA and ambulance company.

(b) HHA ambulance services will be billed on CMS Form 1450 (UB-92), using bill type 34X, revenue code 54X and an appropriate base rate and/or mileage HCPCS code in FL 44 for each ambulance trip. Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, revenue code 54X must be reported on two separate and consecutive line items to accommodate both the ambulance service (base rate) and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (i.e., a patient is on board) one-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are not reported.

(c) In the case where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered using the appropriate service and mileage HCPCS.

(d) Payment of HHA ambulance services will be based on statewide prevailing (both for service and mileage) less an appropriate cost-share /copayment and

deductible (refer to Figure 12-2-1 for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

d. Cost-Sharing/Copayments. The following table provides the applicable cost-shares/copayments for services exempt from home health consolidated billing (i.e., services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of treatment). Refer to Chapter 2, Addendum A, paragraph II. and III., for TRICARE Extra and Standard annual fiscal year deductibles.

FIGURE 12-2-1 COPAYMENTS/COST-SHARES FOR SERVICES REIMBURSED OUTSIDE THE HHA PPS WHEN RECEIVING HOME HEALTH SERVICES UNDER A PLAN OF CARE

BENEFITS	TRICARE PRIME PROGRAM			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1-E4	E5 & ABOVE			
Durable Medical Equipment (DME), Orthotic and Prosthetic Devices	0% of the fee negotiated by the contractor.	0% of the fee negotiated by the contractor.	20% of the fee negotiated by the contractor	**ADFMs:** Cost-share --15% of the fee negotiated by the contractor **Retirees, their Family Members & Survivors:** Cost-share -- 20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share -- 20% of the allowable charge **Retirees, their Family Members & Survivors:** Cost-share -- 25% of the allowable charge.
Osteoporosis Injections					
Oral Cancer Drugs					
Antiemetic Drugs					
Drugs and Biologicals Administered By Other Than Oral Method					
Enteral and Parenteral Therapy					
Influenza, Pneumoccocal Pneumonia, and Hepatitis B Vaccines	$0 copayment per occurrence	$0 copayment per occurrence	$0 copayment per occurrence		
Ambulance	$0 copayment per occurrence	$0 copayment per occurrence	$20 copayment per occurrence		

- END -