CHAPTER 12
ADDENDUM A

DEFINITIONS AND ACRONYM TABLE

ITEM	COMMENTS
Admission Date	For HHA PPS, date of first service of episode or first service in a period of continuous care (multiple episodes) placed in Form Locator (FL) 12 of the CMS 1450 UB-04 found in TRICARE and/or NUBC (National Uniform Billing Committee) manuals. CMS manuals can be found on the web site (www.hcfa.gov/pRubforms/p2192toc.htm).
Claim	Second of two "bookends" at opening and closing of HHA PPS episode to receive one of two split percentage payments.
CMS	The Centers for Medicare and Medicaid Services and the federal portions of Medicaid and the Child Health Program.
CMS 1450	CMS's version of the CMS 1450 UB-04.
CMS 1500	The Claim form, in either paper or electronic version (NSF), used by most non-institutional health care providers and suppliers to bill TRICARE. Published as CMS Form 1500 (08/05).
DME	Durable Medical Equipment. Billed by revenue codes and/or HCPCs. Paid by CMS according to CMS DME fee schedule accessible on the web site (www.hcfa.gov/stat/pubfiles.htm)
Episode	60-day unit of payment for HHA PPS.
Grouper	A software module that "groups" information for payment classification; for HHA PPS, data from the OASIS assessment tool is grouped to form Gars and output HIPPS codes. Specifications for the HHA PPS Grouper are posted on the web site (www.hcfa.gov/medicare/hhmain.htm), and the Grouper module is also built into PPS-compatible versions of HAVEN software automating the OASIS assessment tool.
HCFA	The Health Care Financing Administration, the Federal Agency administering the TRICARE program and the federal portions of Medicaid and the Child Health Program.
HCPCS Code(s)	HCFA Common Procedural Coding System. Coding for services or items used on the CMS 1450 UB-04 in FL 44 or CMS 1500 (08/05) claim forms. A list of HCPCS is accessible on the web site (www.hcfa.gov/stat/pubfiles.htm).
HHA	Home Health Agency(ies)
(H)HRG	Home Health Resource Group. One of 80 HH episode payment rates.

ITEM	COMMENTS
HIPPS	Health Insurance Prospective Payment System. Procedural coding used in FL 44 of the CMS 1450 UB-04 in association with certain CMS prospective payment systems (skilled nursing facility, home health). Eight (8) HIPPS are assigned to each of the HHRGs for HHA PPS.
Inquiry System (HIQH)	An on-line transaction system providing information on HHA PPS episodes for specific TRICARE beneficiaries for HHAs and hospices. Like the current HIQA eligibility inquiry system, this system will be based on batch claim data available in the Common Working File, a component of TRICARE claims processing systems, available to providers via their contractors.
Line Item	Service or item-specific detail of claim. Contains repeated entries of FLs 42-48 on CMS 1450 UB-04.
LUPA	Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates instead of HHRGs.
National Standard Per Visit Rates	National rates for each of the 6 home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers.
No-RAP LUPAs	A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less.
OASIS	Outcome Assessment Information Set. The HH assessment instrument required by CMS.
Outlier	An addition to a full episode payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold. HHA PPS outliers are computed as part of TRICARE claims payment by Pricer for all non-LUPA episodes.
Patient Status Code	FL 17 of the CMS 1450 UB-04 describing patient status at discharge/end of period; of note for HHA PPS in the code list filling this location: “01” = “discharge to home/self”, “06” = “discharged/transferred home/HHA care” and “30” = “still a patient”).
PEP	Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharge with readmissions).
POC	Plan of care. TRICARE HH services for homebound beneficiaries must have a physician-established plan (see 485 below).
P/O(S)	Prosthetics and orthotics
PPS	Prospective Payment System. TRICARE payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.

ITEM	COMMENTS
Pricer	Software modules in TRICARE claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems.
RAP	Request for Anticipated Payment. First of two "bookends" at opening and closing of HHA PPS episode to receive one or two split percentage payments. Note: although the RAP uses a CMS 1450 UB-04, it is not a claim according to TRICARE statutes, and is not subject to the payment floor, among other differences from claims.
Revenue Code	Payment codes for services or items placed in FL 42 of the CMS 1450 UB-04. Note that a new revenue code 023 will be used on a distinct line item when billing episode payments (HIPPS in HCPCs field, separate line items for visits and supplies follow on claim); an "x" in the last digit of three digit revenue codes means that value can vary from 0-9.
RHHI	Regional Home Health Intermediary. Five (5) fiscal intermediaries nationally designated to process TRICARE home health and hospice claims.
SCIC	Significant Change in Condition (adjustment). When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG pro-rated to the number of service days delivered under the HHRG, and all pro-rated amounts added for the final episode payment.
Source of Admission Code	FL 15 of the CMS 1450 UB-04; of note are new codes for HHA PPS: "B" = "transfer from another home health facility", and "C" = "readmission to the same HHA".
TOB	Type of Bill (i.e., 032x, 034x). Coding representing the nature of each CMS 1450 UB-04 claim (i.e., type of benefit, such as homebound home health; payment source, such as specific TRICARE trust fund; and frequency of bill, such as initial or cancellation) -- and "x" in the last digit of numeric three digit type of bill means that value can be from 0-9.
UB-92	The claim or bill form, in either paper or electronic version, used by most institutional health care providers. Published by CMS as the CMS 1450 UB-04, but the standard itself is maintained by a non-governmental body: the National Uniform Billing Committee.
485	CMS form number for Plan of Care (see POC above).