OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY
MB&RB

CHANGE 159
6010.55-M
APRIL 3, 2013

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002

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

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

CONREQ: 16410

PAGE CHANGE(S): See page 2 and 3.

SUMMARY OF CHANGE(S): See page 4.

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

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 175 and Aug 2002 TSM, Change No. 102.

CORN.GLENN.J.1157445967

Digitally signed by CORN.GLENN.J.1157445967
DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=TMA, cn=CORN.GLENN.J.1157445967
Date: 2013.04.01 13:17:57 -06'00'

Ann N. Fazzini
Chief, Medical Benefits and Reimbursement Branch

ATTACHMENT(S): **165 PAGE(S)**
DISTRIBUTION: **6010.55-M**

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

CHANGE 159
6010.55-M
APRIL 3, 2013

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 6	
Section 8, pages 15 and 16	Section 8, pages 15 and 16
CHAPTER 7	
Section 1, pages 5 through 8	Section 1, pages 5 through 8
Addendum G (FY 2012), pages 3 through 8	Addendum G (FY 2012), pages 3 through 8
Addendum G (FY 2013), pages 3 through 8	Addendum G (FY 2013), pages 3 through 8
CHAPTER 9	
Section 1, pages 5 and 6	Section 1, pages 5 and 6
CHAPTER 12	
Table of Contents, pages i through vi	Table of Contents, pages i through vi
Section 1, pages 7 and 8	Section 1, pages 7 and 8
Section 4, pages 27 through 32	Section 4, pages 27 through 32
Section 6, pages 7 through 47	Section 6, pages 7 through 48
Section 7, pages 1, 2, 5 - 8, and 11 - 13	Section 7, pages 1, 2, 5 - 8, and 11 - 13
Addendum B, pages 3 through 8	Addendum B, pages 3 through 8
Addendum H, pages 1 through 10	Addendum H, page 1
Addendum L (CY 2010), pages 1 through 6	★ ★ ★ ★ ★ ★
Addendum L (CY 2012), pages 1 and 2	Addendum L (CY 2012), pages 1 and 2
★ ★ ★ ★ ★ ★	Addendum L (CY 2013), pages 1 through 5
Addendum M (CY 2010), pages 1 through 17	★ ★ ★ ★ ★ ★
★ ★ ★ ★ ★ ★	Addendum M (CY 2013), pages 1 through 17
Addendum N, pages 1 through 28	Addendum N, page 1
Addendum O, pages 1 through 3	Addendum O, page 1
Addendum S, page 5	Addendum S, page 5

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 13	
Section 3, pages 21 through 57	Section 3, pages 21 through 58
CHAPTER 15	
Section 1, pages 1, 2, 5, and 6	Section 1, pages 1, 2, 5, and 6
INDEX	
pages 7 through 10	pages 7 through 10

SUMMARY OF CHANGES

CHAPTER 6

1. Section 8. This change corrects the TRICARE outlier amount.

CHAPTER 7

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

3. Addendums G (FY 2012) and G (FY 2013). This change provides the mental health DF, updates RTC information, and updates the HHA PPS for CY 2013.

CHAPTER 9

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

CHAPTER 12

5. Sections 1, 6, and 7. This change provides the mental health DF, updates RTC information, and updates the HHA PPS for CY 2013.

6. Section 4. Updated cross-references to Addendum L (CY 2013) and Addendum M (CY 2013), removed Addendum L (CY 2010) and Addendum M (CY 2010).

7. Addendums B, H, L (CY 2012), L (CY 2013), M (CY 2013), N, O, and S. This change provides the mental health DF, updates RTC information, and updates the HHA PPS for CY 2013.

CHAPTER 13

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

CHAPTER 15

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

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

The cost-outlier threshold shall be calculated as follows:

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

EXAMPLE: Using FY 1999 figures {[10,129 x ((0.7110 x Applicable wage index) + 0.2890) x 0.913] + (DRG Based Payment (wage-adjusted) x (1 + IDME))}

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

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

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

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

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

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

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

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

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

(4) Burn cases which qualify as long-stay outliers will be reimbursed as follows.

(a) Admissions occurring from October 1, 1988, through September 30, 1990 will be reimbursed using a marginal cost factor of 90%.

(b) Admissions occurring on or after October 1, 1990, will be reimbursed using a marginal cost factor of 60%.

(5) For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and children's hospitals.

(6) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for all neonates and children's hospitals.

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

g. Children's hospital outliers. Children's hospitals will be subject to the same outlier policies applicable to other hospitals except that:

(1) For long-stay outliers the threshold shall be the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS. (See the addenda to this chapter for the actual outlier thresholds and their effective dates.) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated.

(2) The following special provisions apply to cost outliers.

(a) The threshold shall be the greater of two times the DRG-based amount (wage-adjusted but prior to adjustment for IDME) or $13,500.

(b) Effective October 1, 1998, the threshold shall be the same as that applied to other hospitals.

(c) Effective October 1, 2010, the CCR was 0.3974. Effective October 1, 2011, the CCR was 0.3757. Effective October 1, 2012, the CCR was 0.3231. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

(d) The marginal cost factor shall be 80%.

rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the **Federal Register**. For FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

FISCAL YEAR	UPDATE FACTOR	FISCAL YEAR	UPDATE FACTOR
1992	4.7%	2003	3.5%
1993	4.2%	2004	3.4%
1994	4.3%	2005	3.3%
1995	3.7%	2006	3.8%
1996	0%	2007	3.4%
1997	0%	2008	3.4%
1998	0%	2009	3.2%
1999	2.4%	2010	2.1%
2000	2.9%	2011	2.6%
2001	3.4%	2012	3.0%
2002	3.3%	2013	2.6%

F. Higher Volume Hospitals and Units.

1. Higher Volume of TRICARE Mental Health Discharges During the Base Period.

a. Any hospital or unit that had an annual rate of 25 or more TRICARE mental health discharges during the period July 1, 1987 through May 31, 1988, shall be considered a higher volume hospital or unit during federal FY 1989 and all subsequent fiscal years.

b. All other hospitals and units covered by the TRICARE/CHAMPUS inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

2. Higher Volume of TRICARE Mental Health Discharges in Subsequent Fiscal Years and Hospital-Specific Per Diem Calculation.

a. In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years.

b. The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, can not exceed the cap described in this section. Once a

statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

(1) The TRICARE contractor shall be requested at least annually to submit to the TMA Office of Medical Benefits and Reimbursement Systems within 30 days of the request a listing of high volume providers that qualified as high volume during the most recent government fiscal year. Periodically, additional information may be requested by TMA concerning high volume providers. This requested information will be used in the calculation of the Deflator Factor (DF).

(2) Percent of change and DF.

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

3. New Hospitals and Units.

a. The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA)

rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

b. By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than 3 full years. A change in ownership in itself does not constitute a new hospital.

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

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

G. Payment for Hospital Based Professional Services.

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

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

H. Leave Days.

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

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

I. Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System.

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

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

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

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

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

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

- END -

FACILITY	TRICARE/CHAMPUS RATE
UHS of Laurel Heights, LP Laurel Heights Hospital 934 Briarcliff Road NE Atlanta, GA 30306 EIN: 23-3045288	764.00
Youth Villages, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-1716970	801.00
HAWAII	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	801.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	773.00
IDAHO	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	363.00
Kootenai Medical Center 2003 Lincoln Way Coeur d'Alene, ID 83814 EIN: 82-0231746	461.00
INDIANA	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	452.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	478.00

FACILITY	TRICARE/CHAMPUS RATE
KANSAS	
KVC Hospitals, Inc. Prairie Ridge Psychiatric Hospital 4300 Brenner Drive Kansas City, KS 66104 EIN: 27-1672159	479.00
KENTUCKY	
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	720.00
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	677.00
MARYLAND	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	416.00
MISSOURI	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	345.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	422.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	431.00

FACILITY	TRICARE/CHAMPUS RATE
MONTANA	
Acadia Montana 55 Basin Creek Road Butte, MT 59701 EIN: 62-1681724	463.00
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	461.00
NEVADA	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	801.00
NEW MEXICO	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	338.00
NORTH CAROLINA	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 561317433	491.00
OHIO	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	423.00
PENNSYLVANIA	
KidsPeace National Centers, Inc. 5300 KidsPeace Drive Orefield, PA 18069 EIN: 23-2654908	561.00

FACILITY	TRICARE/CHAMPUS RATE
SOUTH CAROLINA	
ABS LINCS SC, Inc. dba Palmetto Pines Behavioral Health 225 Midland Parkway Summerville, SC 29485 EIN: 57-0840074	634.00
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	460.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	768.00
TENNESSEE	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	476.00
TEXAS	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	736.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	801.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	668.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	751.00

FACILITY	TRICARE/CHAMPUS RATE
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	690.00
UTAH	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	474.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	474.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	595.00
VIRGINIA	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	785.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	796.00
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 EIN: 54-1465094	668.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	470.00
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 EIN: 20-1215130	504.00

FACILITY	TRICARE/CHAMPUS RATE
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	668.00
Poplar West HHC Poplar Springs, Inc. 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	771.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	523.00
WASHINGTON	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	644.00

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WASHINGTON	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	682.00

- END -

(2) Discounting for Bilateral Procedures.

(a) Following are the different categories/classifications of bilateral procedures:

1 Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

2 Inherent bilateral (i.e., procedure in and of itself is bilateral).

3 Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

(b) Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

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

(3) Modifiers for Discounting Terminated Surgical Procedures.

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

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

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

2 Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

(4) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines as outlined in Chapter 1, Section 3.

(5) Incidental Procedures. The rules for reimbursing incidental procedures as contained in Chapter 1, Section 3, are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not

classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

6. Updating Payment Rates.

a. The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments. Periodically the rates will be recalculated using the steps in paragraph II.A.4.d.

b. The rates were updated by 3.0% effective November 1, 2002. This update included the wage indexes as updated by Medicare.

c. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in paragraph II.A.4.d. However, we used 100 claims rather than 25 claims to calculate a rate for individual procedures, because it produced more statistically valid results while still resulting in calculated rates for about 83% of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0% and included the wage indexes as updated by Medicare.

d. The rates were reduced by 2.0% effective April 1, 2004.

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

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

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

B. Reimbursement for procedures not listed on TMA's ambulatory surgery web site. Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with Chapter 1, Section 24. Effective January 28, 2000, ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC or hospital may be cost-shared. These procedures are reimbursed at the lessor of billed charges or network discount. On May 1, 2009 (implementation of OPPS), these non-ASC procedures are subject to Chapter 13 discounting of surgical, bilateral and terminated procedures.

C. Reimbursement System On Or After May 1, 2009 (Implementation of OPPS).

1. For ambulatory surgery procedures performed in an OPPS qualified facility, the provisions in Chapter 13 shall apply.

2. For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in paragraph II.A. shall apply, except as follows:

a. Contractors will no longer be allowed to group other procedures not listed on TMA's ambulatory surgery web site. On May 1, 2009 (implementation of OPPS), these groupers will be end dated. Only ambulatory surgery procedures listed on TMA's ambulatory surgery web site are to be grouped.

CHAPTER 12

HOME HEALTH CARE

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

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

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

IMPLEMENTING INSTRUCTIONS (CONTINUED)	
Annual HHA PPS Wage Index Updates Calendar Year 2011 Calendar Year 2012 Calendar Year 2013	 Addendum M (CY 2011) Addendum M (CY 2012) Addendum M (CY 2013)
Diagnoses Associated with Diagnostic Categories Used In Case-Mix Scoring	Addendum N
Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model	Addendum O
Code Table for Converting Julian Dates to Two Position Alphabetic Values	Addendum P
Examples of Claims Submissions Under Home Health Agency Prospective Payment System (HHA PPS)	Addendum Q
Input/Output Record Layout	Addendum R
Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008	Addendum S

- END -

the establishment of a home health prospective payment rate per discipline. The 60-day utilization rates were derived from Medicare home health claims data for FY 1997 and 1998. The prospective payment rates for all six disciplines were summed to arrive at a total non-standardized prospective payment amount per 60-day EOC.

b. Figure 12-4-15 provides the calculations involved in the establishment of the non-standardized prospective payment amount per 60-day episode in FY 2001, along with adjustments for NRS, Part B therapies and OASIS implementation and ongoing costs.

FIGURE 12-4-15 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS

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

c. The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in Figure 12-4-16 for case-mix, budget neutrality and outliers in the establishment of a final standardized and budget neutral payment amount per 60-day episode for FY 2001.

FIGURE 12-4-16 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX

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

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

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

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

(1.8496 x $2,115.30) = $3,912.46

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

Labor Portion = (0.77668 x $3,912.46) = $3,038.73

Non-Labor Portion = (0.22332 x $3,912.46) = $873.73

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

(1.0190 x $3,038.73) = $3,096.47

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

($873.73 + $3,096.47) = $3,970.20

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

e. Annual Updating of HHA PPS Rates and Wage Indexes.

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

(2) Three iterations of these rates will be maintained in Addendums L (CY 2011), L (CY 2012), and L (CY 2013). These rate adjustments are also integral data elements used in updating the Pricer.

(3) Three iterations of wage indexes will also be maintained in Addendums L (CY 2011), L (CY 2012), L (CY 2013), M (CY 2011), M (CY 2012), and M (CY 2013) for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

2. Calculation of Reduced Payments.

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

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

(1) PEP Adjustment. The PEP adjustment is used to accommodate payment for EOCs less than 60 days resulting from one of the following intervening events: 1) beneficiary elected a transfer prior to the end of the 60-day EOC; or 2) beneficiary discharged after meeting all treatment goals in the original POC and subsequently readmitted to the same HHA before the end of the 60-day EOC. The PEP adjustment is based on the span of days over which the beneficiary received treatment prior to the intervening event; i.e., the days, including the start-of-care date/first billable service date through and including the last billable service date, before the intervening event. The original POC must be terminated with no anticipated need for additional home health services. A new 60-day EOC would have to be initiated upon return to a HHA, requiring a physician's recertification of the POC, a new OASIS assessment, and authorization by the contractor. The PEP adjustment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary was receiving care prior to the intervening event by the beneficiary's assigned 60-day episode payment. The PEP adjustment is only applicable for beneficiaries having more than four billable home health visits. Transfers of beneficiaries between HHAs of common ownership are only applicable when the agencies are located in different metropolitan statistical areas. Also, PEP adjustments do not apply in situations where a patient dies during a 60-day EOC. Full episode payments are made in these particular cases. For example, a beneficiary assigned to HHRG C2F1S2 and receiving care in Denver, CO was discharged from a HHA on Day 28 of a 60-day EOC and subsequently returned to the same HHA on Day 40. However, the first billable visit (i.e., a physician ordered visit under a new POC) did not occur until Day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original POC were accomplished and there was no anticipated need for home care during the balance of the 60-day episode. Since the last visit was furnished on Day 28 of the initial 60-day episode, the PEP adjustment would be equal to the assigned 60-day episode payment times 28/60, representing the proportion of the 60 days that the patient

was in treatment. Day 42 of the original episode becomes Day 1 of the new certified 60-day episode. The following steps are used in calculating the PEP adjustment:

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

(28/60) = 0.4667

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

($3,970.20 x 0.4667) = $1,852.90

(2) SCIC Payment Adjustment.

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

(3) LUPA.

(a) For Episodes Beginning Prior To January 1, 2008.

1 The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in Figure 12-4-1 plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in Figure 12-4-17.

FIGURE 12-4-17 PER VISIT PAYMENT AMOUNTS FOR LUPAS

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for NRS*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjust-ment factor	Per-visit payment amounts per 60-day episode for FY 2001
Home Health Aide	$41.75	$1.94	$0.12	$0.21	0.96674	1.05	$43.37
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74

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

FIGURE 12-4-17 PER VISIT PAYMENT AMOUNTS FOR LUPAS

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for NRS*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjustment factor	Per-visit payment amounts per 60-day episode for FY 2001
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

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

2 The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from Figure 12-4-17) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

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

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

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

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

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

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

($223.12 x 1.0190) = $227.36

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

($227.36 + $64.15) = $291.51

(b) For Episodes Beginning On Or After January 1, 2008. LUPA may be subject to an additional payment adjustment. If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only EOC the beneficiary received and the Source of Referral and Admission or Visit Code is not "B" (Transfer From Another HHA) or "C" (Readmission to Same HHA), an additional add-on payment will be made. A lump-sum established in regulation and updated annually will be added to these claims. The additional amount for CY 2008 is $87.93.

(4) Therapy Threshold Adjustment.

(a) For Episodes Beginning Prior To January 1, 2008. There is a downward adjustment in the 60-day episode payment amount if the number of therapy services delivered during an episode does not meet the threshold. The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode. The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, is confirmed by the visit information submitted in line-item detail on the claim for the episode. If therapy use is below the utilization threshold (i.e., the projected range of hours for physical, occupational or speech therapy combined), there is an automatic downward adjustment in the 60-day episode payment amount.

(b) For Episodes Beginning On Or After January 1, 2008.

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

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

3. Calculation of Outlier Payments.

a. A methodology has been established under the HHA PPS to allow for outlier payments in addition to regular 60-day episode payments for beneficiaries generating excessively large treatment costs. The outlier payments under this methodology are made for

(d) When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

(e) Other codes may be required by other payers, and while they are not used by TRICARE, they may be entered on the RAP if convenient. TRICARE systems do require that the dates associated with occurrence codes be within the statement covers period of the claim (FL 6).

(25) FL 36. Occurrence Span Code and Dates Not Required. Since the statement covers period (FL 6) of the RAP is a single day, occurrence spans cannot be reported.

(26) FL 37. Internal Control Number (ICN)/Document Control Number (DCN) Required. If canceling a RAP, HHAs must enter the control number assigned to the original RAP here. ICN/DCN is not required in any other case. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payers B and C on lines B and C, respectively, in FL 37.

(27) FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required.

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

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

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

(c) Optional. Enter any NUBC approved value code to describe other values that apply to the RAP.

1 Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the

left of the dollar and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

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

(29) FL 42 and 43 Revenue Code and Revenue Description Required. One revenue code line is required on the RAP. This line is used to report a single Health Insurance Prospective Payment System (HIPPS) code (defined under FL44) which is the basis of the anticipated payment. The required revenue code and description for HHA PPS RAPs are as follows:

(a) Rev. Code 023. Home Health Services.

(b) Return the TRICARE reimbursement for the RAP in the total charges field (FL 47) of the 023 revenue code line. HHAs must zero fill FL 47.

(c) Optional. HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HHA PPS claims except another 023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

(d) Revenue codes 058X and 059X will no longer be accepted with covered charges on TRICARE home health RAPs under HHA PPS. Revenue code 0624 (investigational devices) will no longer be accepted at all on TRICARE home health RAPs under HHA PPS.

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

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

(a) Definition. HIPPS rate codes represent specific patient characteristics (or case mix) on which TRICARE payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among various provider types. HIPPS codes are used in association with special revenue codes used on CMS 1450 UB-04 claim forms for institutional providers. One revenue code is defined for each prospective payment system that calls for HIPPS codes. Currently, revenue code 022 is reserved for the Skilled Nursing Facility Prospective Payment System (SNF PPS) and revenue code 023 is reserved for the HHA PPS.

(b) HIPPS codes are placed in Form Locator (FL) 44 ("HCPCS/rate") on the form itself. The associated revenue codes are placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim. HIPPS codes are alphanumeric codes of five digits.

(c) Under the home health prospective payment system, which requires the use of HIPPS codes, a case-mix adjusted payment for up to 60 days of care will be made using one of 80 Home Health Resource Groups (HHRG). On TRICARE claims these HHRGs will be represented as HIPPS codes. These HIPPS codes are determined based on assessment made using the OASIS. Grouper software run at the HHA site will use specific data elements from the OASIS data set and assign beneficiaries to a HIPPS code. The Grouper will output the HIPPS code which HHAs must enter in FL 44 on the claim.

(d) HHA HIPPS codes are five position alphanumeric codes: the first digit is a static "H" for home health, the second, third and fourth (alphabetical) positions represent the level of intensity respective to the clinical, functional and service domains of the OASIS. The fifth position (numeric) represents which of the three domains in the HIPPS code were either calculated from complete OASIS data or derived from incomplete OASIS data. A value of "1" in the fifth position should indicate a complete data set that will be accepted by the State Repository for OASIS data. Both HHA PPS RAPs and claims must be correct to reflect the HIPPS code accepted by the State repository. Lists of current HIPPS codes used for billing during a specific Federal fiscal year are published in the TRICARE Policy Manual.

(e) Optional. If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code.

(31) FL 45. Service Date Required. On the 023 revenue code line, HHAs report the date of the first billable service provided under the HIPPS code reported on that line.

(a) If the claim "From" date in FL 6 also matches the admission date in FL 17, edit to ensure that the service date on the 023 line of the RAP matches the claim "From" date.

(b) Optional. If additional revenue codes are submitted on the RAP, report service dates as appropriate to that revenue code.

(32) FL 46. Units of Service Optional. Units of service are not required (i.e., must be zero or blank) on the 023 revenue code line. If additional revenue codes are submitted on the RAP, HHAs report units of service as appropriate to the revenue code.

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

(a) Optional. If additional revenue codes are submitted on the RAP, report any necessary charge amounts to meet the requirements of other payers or your billing software.

(b) TRICARE claims systems will not make any payment determinations based upon submitted charge amounts.

(34) FL 48. Non-Covered Charges Not Required. Report non-covered charges only on HHA PPS claims, not RAPs.

Examples. The following provides examples of revenue code lines as HHAs should complete them, based on the reporting requirements above.

Report the required 023 line as follows:					
FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**	**FL 48**
023	HAEJ1	100101		0.00	
Report additional revenue code lines as follows:					
FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**	**FL 48**
550	G0154	100101	1	150.00	

(35) FL 49. (Untitled) Not Required.

(36) FLs 50A, B, and C. Payer Identification Required. If TRICARE is the primary payer, the HHA enters "TRICARE" on line A. When TRICARE is entered on line 50A, this indicates that the HHA has developed for other insurance coverage and has determined that TRICARE is the primary payer. All additional entries across the line (FLs 51-55) supply information needed by the payer named in FL 50A. If TRICARE is the secondary or tertiary payer, HHAs identify the primary payer on line A and enter TRICARE information on line B or C as appropriate. Do not make conditional payments for TRICARE Secondary Payer (MSP) situations based on the RAP.

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

(a) If a TRICARE provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number indicating patient status 06. This claim will be paid a PEP adjustment.

(b) Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases, report the new provider number in this field.

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

(39) FLs 53A, B, and C. Assignment of Benefits Certification Indicator Not Required.

(40) FLs 54A, B, and C. Prior Payments Not Required.

(41) FLs 55A, B, and C. Estimated Amount Due Not Required.

(42) FL 56. (Untitled) Not Required.

(43) FL 57. (Untitled) Not Required.

(44) FLs 58A, B, and C. Insured's Name Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information is shown in FLs 50-54, enter the patient's name as shown on his HI care or other TRICARE notice.

(45) FLs 59A, B, and C. Patient's Relationship to Insured Not Required.

(46) FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/ Identification Number Required. On the same lettered line (A, B, or C) that corresponds to the line on which TRICARE payer information was shown on FLs 39-41, and 50-54, enter the patient's TRICARE health insurance claim number; i.e., if TRICARE is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of TRICARE Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

(47) FLs 61A, B, and C. Group Name Not Required.

(48) FLs 62A, B, and C. Insurance Group Number Not Required.

(49) FL 63. Treatment Authorization Code Required. HHAs must enter the claims-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). Verify that eighteen numeric values are reported in this field.

(a) The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen 1's.

(b) The investigational device (IDE) revenue code, 624, is not allowed on HHA PPS RAPs. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

(50) FL 64. Employment Status Code Not Required.

(51) FL 65. Employer Name Not Required.

(52) FL 66. Employer Location Not Required.

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

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

(54) FLs 68-75. Other Diagnoses Codes Required. HHAs must enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. These codes must not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

(a) For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 67A-P must match the additional diagnoses reported on the OASIS, from item M0240 (Other Diagnoses), and on the CMS Form 485, from item 13 (ICD-9-CM/Other Pertinent Diagnoses).

(b) Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the CMS Form 485, from item 13, may be reported in FLs 67A-Q on the RAP if they are reported in the narrative from item 21 of the CMS Form 485.

(55) FL 69. Admitting Diagnosis Not Required.

(56) FL 72. E-Code Not Required.

(57) FL 73. (Untitled) Not Required.

(58) FL 74. Principal Procedure Code and Date Not Required.

(59) FL 74 a-e. Other Procedure Codes and Dates Not Required.

(60) FL 76. Attending/Requesting Physician I.D. Required. HHAs must enter the UPIN and name of the attending physician who has established the plan of care with verbal orders. Deny the RAP if the UPIN indicated in this field is on the sanctioned provider list.

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

(61) FL 78 Other Physician I.D. Not Required.

(62) FL 80. Remarks Required. Remarks are necessary when canceling a RAP, to indicate the reason for the cancellation.

(63) FL 86. Date Not Required. See FL 45, line 23.

2. Claims Submission and Processing. HHAs are required to submit the following claims detail for final payment under the HHA PPS:

a. The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier.

b. HHAs may not submit this claim until after all services provided in the episode are reflected on the claim and the plan of care and any subsequent verbal order have been signed by the physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

c. HH claims must be submitted with a new type of bill - 329.

d. NUBC approved "source of admission" and "patient status codes" are required on the claim.

e. The through date of the claim equals the date of the last service provided in the episode unless the patient status is 30, in which case the through date should be day 60.

f. Providers may submit claims earlier than the 60th day if the POC goals are met and the patient is discharged, or the beneficiary died. The episode will be paid in full unless there is a readmission of a discharged beneficiary, or a transfer to another HHA prior to the day after the HHA PPS period end date.

g. Providers may submit claims earlier than the 60th day if the beneficiary is discharged with the goals of the POC met; and if readmitted or if transferred to another HHA, the episode will be paid as a PEP.

h. If the beneficiary goes into the hospital through the end of the episode, the episode is paid in full whether the patient is discharged or not.

i. A PEP is given if a transfer situation, or if all treatment goals are reached with discharge and there is a readmission within the 60-day episode. PEPs are shown on the claim by patient status code 06.

j. Providers will report all SCICs occurring in one 60-day episode on the same claim.

k. The dates on 023 lines on all claims will be the date of the first service supplied at that level of care.

l. Late charge submissions are not allowed on claims under HHA PPS. Claims must be adjusted instead.

m. Claim will be paid as a LUPA if there are four or less visits total in an episode, regardless of changes in HIPPS code.

n. The HHA PPS claim will include elements submitted on the RAP, and all other line item detail for the episode, including, at a provider's option, any durable medical equipment, oxygen or prosthetics and orthotics provided, even though this equipment will be paid in addition to the episode payment. The only exception is billing of osteoporosis drugs, which will continue to be billed separately on 34X claims by providers with episodes open. Pricer will determine claim payment as well as RAP payment for all PPS.

o. The claim will be processed as a debit/credit adjustment against the record created by the RAP.

p. The related remittance advice will show the RAP payment was recouped in full and a 100% payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

q. Claims for episodes may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100% payment is made in the next calendar or fiscal year, at that year's rates. Claim payment rates are determined using the statement "through" date on the claim.

r. HHAs should be aware that HHA PPS claims will be processed in the TRICARE claims system as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims. As the claim is processed, the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net reimbursement on the claim can be easily understood.

s. Coding Required for a HHA PPS Claim is as follows:

(1) Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number Required. The minimum entry is the agency's name, city, state, and ZIP code. The post office number or street name and number may be included. The state may be

abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the TRICARE provider number (FL 51) to verify provider identity.

(2) FL 2. (Untitled) Not Required.

(3) FL 3. Patient Control Number Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

(4) FL 4. Type of Bill Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bills accepted for HHA PPS requests for anticipated payment are any combination of the codes listed below:

(a) Code Structure (only codes used to bill TRICARE are shown).

1 1st Digit - Type of Facility 3 - Home Health

2 2nd Digit - Bill Classification (Except Clinics and Special Facilities) 2 - Hospital Based or Inpatient.

NOTE: While the bill classification of 3, defined as "Outpatient," may also be appropriate to a HHA PPS claim depending upon a beneficiary's eligibility, HHAs are encouraged to submit all claims with bill classification 2.

3 3rd Digit - Frequency

a 7 - Replacement of Prior Claim - Used to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims may be submitted at any point within the timely filing period after the payment of the original claim.

b 8 - Void/Cancel of a Prior Claim - Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP and claim must be submitted for the episode to be paid.

c 9 - Final Claim for a HHA PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7 or 8.

d HHA PPS claims are submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." Late charge bills, submitted with frequency "5," are not accepted under HHA PPS. To add services within the period of a paid HH claim, an adjustment must be submitted.

(5) FL 5. Federal Tax Number Required.

(6) FL 6. Statement Covers Period (From-Through) Required. The beginning and ending dates of the period covered by this claim. The "From" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "Through" date must be 59 days after the "From" date. The patient status code in FL 22 must be 30 in these cases. In cases where the beneficiary has been discharged or transferred within the 60-day episode period, report the date of discharge in accordance with your internal discharge procedures as the "Through" date. If a discharge claim is submitted due to change of intermediary, see FL 22 below. If the beneficiary has died, report the date of death in the through date. Any NUBC approved patient status code may be used in these cases. You may submit claims for payment immediately after the claim "Through" date. You are not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care. Submit all dates in the format MMDDYYYY.

(7) FL 7. Covered Days Not Required.

(8) FL 8. Non-covered Days Not Required.

(9) FL 9. Coinsurance Days Not Required.

(10) FL 10. Lifetime Reserve Days Not Required.

(11) FL 12. Patient's Name Required. Enter the patient's last name, first name, and middle initial.

(12) FL 13. Patient's Address Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

(13) FL 14. Patient's Birthdate Required. Enter the month, day, and year of birth (MMDDYYYY) of the patient. If the full correct date is not known, leave blank.

(14) FL 15. Patient's Sex Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

(15) FL 16. Patient's Marital Status Not Required.

(16) FL 17. Admission Date Required. Enter the same date of admission that was submitted on the RAP for the episode (MMDDYYYY).

(17) FL 18. Admission Hour Not Required.

(18) FL 19. Type of Admission Not Required.

(19) FL 20. Source of Admission Required. Enter the same source of admission code that was submitted on the RAP for the episode.

(20) FL 21. Discharge Hour Not Required.

(21) FL 22. Patient Status Required. Enter the code that most accurately describes the patient's status as of the "Through" date of the bill period (FL 6).

CODE STRUCTURE :	
CODE	**DEFINITION**
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of another organized home health service organization, or discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice or discontinued care
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility, such a hospital, SNF, ICF or freestanding hospice (hospice claims only)
42	Expired - place unknown (hospice claims only)
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharged/transferred with this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care.

(a) Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a Partial Episode Payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which a HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, TRICARE claims systems will adjust the

discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claim record to 06.

(b) In cases where an HHA is changing the contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "From" dates before the provider's termination date must be submitted to the contractor the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods - the "through" dates on or before the termination date. The provider must indicate that these claims will be partial payment (PEP) adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new intermediary.

(22) FL 23. Medical Record Number Optional. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

(23) FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes When Applicable. Enter any NUBC approved code to describe conditions and apply to the claim.

(a) Required. If adjusting a HHA PPS claim (TOB 3x7), report one of the following:

CODE	DEFINITION
D0	Change to Service Dates
D1	Change to Charges
D2	Change to Revenue Codes/HCPCS
D7	Change to Make TRICARE the Secondary Payer
D8	Change to Make TRICARE the Primary Payer
D9	Any other Change
E0	Change in Patient Status

(b) If adjusting the claim to correct a HIPPS code, report condition code D9. Enter "Remarks" in FL 84 indicating the reason for the HIPPS code change.

(c) Required. If canceling the claim (TOB 3x8), report one of the following:

CODE	DEFINITION
D5	Cancel to Correct HICH
D6	Cancel Only to Repay a Duplicate or OIG Overpayment. Use when D5 is not appropriate

(d) Enter "Remarks" in FL 84 indicating the reason for cancellation of the claim.

(24) FLs 32, 33, 34, and 35. Occurrence Codes and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27 is not required on HHA PPS RAPs.

(a) Fields 32A-35A must be completed before fields 32B-35B.

(b) Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

(c) When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

(d) Other codes may be required by other payers, and while they are not used by TRICARE, they may be entered on the bill if convenient.

(25) FL 36. Occurrence Span Code and Dates Optional. Enter any NUBC approved code to describe occurrences that apply to the claim.

(a) Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY.

(b) Reporting of occurrence span code 74 to show the date of an inpatient admission within an episode is not required.

(26) FL 37. Internal Control Number (ICN)/Document Control Number (DCN) Required. If submitting an adjustment (type of bill 3x7) to a previously paid HHA PPS claim, enter the control assigned to the original HHA PPS claim here. Insert the ICN/DCN of the claim to be adjusted here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payers B and C on lines B and C, respectively, in FL 37.

(a) Since HHA PPS claims are processed as adjustments to the RAP, TRICARE claims systems will match all HHA PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically.

(b) Providers do not need to submit an ICN/DCN on all HHA PPS claims, only on adjustments to paid claims.

(27) FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than

TRICARE as defined in FP 58, the address of the other payer may be shown here or in 84 (Remarks).

(28) FLs 39-41. Value Codes and Amounts Required. Home Health episode payments must be based upon the site at which the beneficiary is served. Claims will not be processed with the following value code:

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

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

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

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

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

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

(b) Claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit

(revenue codes 42X, 43X, 44X, 55X, 56X and 57X) must be reported as a separate line. Any of the following revenue codes may be used:

1 27X - Medical/Surgical Supplies (also see 62X, an extension of 27X). Code indicates the charges for supply items required for patient care.

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

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

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

2 42X - Physical Therapy - Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

a Rationale - Permits identification of particular services.

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

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

3 43X - Occupational Therapy - Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

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

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

4 44X - Speech-Language Pathology - Charges for services provided to persons with impaired communications skills.

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

Required detail: HCPCS code G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes), HCPCS code G0161 (services performed by a qualified speech-language

pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathologist maintenance program, each 15 minutes), the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

5 55X - Skilled Nursing - Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

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

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

6 56X - Medical Social Services - Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

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

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

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

7 57X - Home Health Aide (Home Health) - Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

a Rationale: Necessary for TRICARE home health billing requirements.

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

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

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

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

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

(1) Rationale: TRICARE requires a separate revenue center for billing.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of New DME	MED EQUIP/NEW
3 - Purchase of Used DME	MED EQUIP/USED

SUBCATEGORY	STANDARD ABBREVIATION
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

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

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

(1) Rationale: TRICARE required detailed revenue coding.

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

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

9 Revenue code for optional reporting of wound care supplies:

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

SUBCATEGORY	STANDARD ABBREVIATION
3 - Surgical Dressings	SURG DRESSING

(1) Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 27x to identify non-routine supplies other than those used for wound care, ensure that the change amounts for the two revenue code lines are mutually exclusive.

(2) HHA may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 623. Notwithstanding the standard abbreviation "surg dressing", use this item to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

(3) Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist TRICARE's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.

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

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

(a) For revenue code lines other than 023, which detail all services within the episode period, report HCPCS codes as appropriate to that revenue code.

(b) Coding detail for each revenue code under HHA PPS is defined above under FL 43.

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

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

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

(a) For other line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HHA PPS is defined above under FL 43.

(b) Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). TRICARE claims systems will not make any payment determinations based upon submitted charge amounts.

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

(a) Claims with Both Covered and Non-Covered Charges - Report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. On the CMS 1450 UB-04 flat file, use record type 61, Field No. 10 (total charges) and Field No. 11 (non-covered charges).

(b) Claims with ALL Non-Covered Charges - Submit claims when all of the charges on the claim are non-covered (no-payment claim). Complete all items on a no-payment claim in accordance with instructions for completing payment claims, with the exception that all charges are reported as non-covered.

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

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

(36) FL 49. (Untitled) Not Required.

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

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

(a) If the TRICARE provider number changes within a 60-day episode, reflect this by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number.

(b) In this case, report the original provider number in this field.

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

(40) FLs 53A, B, and C. Assignment of Benefits Certification Indicator Not Required.

(41) FLs 54A, B, and C. Prior Payments Not Required.

(42) FLs 55A, B, and C. Estimated Amount Due Not Required.

(43) FL 56. (Untitled) Not Required.

(44) FL 57. (Untitled) Not Required.

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

(a) Another payer paid some of the charges and TRICARE is secondarily liable for the remainder;

(b) Another payer denied the claim; or

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

1 EGHPs for employed beneficiaries and their spouses;

2 EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a TRICARE Coordination Period;

3 An auto-medical, no-fault, or liability insurer;

4 Lisps for disabled beneficiaries; or

5 WC including BL.

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

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

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

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

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

(50) FL 63. Treatment Authorization Code Required. Enter the claims-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). Copy these OASIS items exactly as they appear on the OASIS assessment, matching the date formats used on the assessment.

(a) In most cases, the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

(b) The investigational device (IDE) revenue code, 624, is not allowed on HHA PPS RAPs. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

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

CODE STRUCTURE :		
CODE	**TITLE**	**DEFINITION**
1	Employed Full Time	Individual claimed full time employment.
2	Employed Part Time	Individual claimed part time employment.
3	Not Employed	Individual states that he or she is not employed full time or part time.
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory

CODE STRUCTURE (CONTINUED):		
CODE	TITLE	DEFINITION
7-8		Reserved for national assignment.
9	Unknown	Individual's employment status is unknown

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

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

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

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

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

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

(a) For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 67A-Q must match the additional diagnoses reported on the OASIS, from item M0240 (Other Diagnoses), and on the CMS Form 485, from item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields from M0240 on the OASIS, or on the CMS Form 485, from item 13, may be reported in FLs 67A-Q on the claim if they are reported in the narrative from item 21 of the CMS Form 485.

(b) In most cases, the other diagnoses codes on the claim will match those submitted on the RAP. In SCIC cases, however, the other diagnoses codes reported

must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 023 revenue code line on the claim.

(56) FL 69. Admitting Diagnosis Not Required.

(57) FL 72. E-Code Not Required.

(58) FL 73. (Untitled) Not Required.

(59) FL 74. Principal Procedure Code and Date Not Required.

(60) FL 74 a-e. Other Procedure Codes and Dates Not Required.

(61) FL 76. Attending/Requesting Physician I.D. Required. Enter the UPIN and name of the attending physician who has signed the plan of care.

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

(62) FL 77. Other Physician I.D. Not Required.

(63) FL 80. Remarks Not Required

(64) FL 86. Date Not Required. See FL 45, line 23.

†. Examples of Claims Submission Under the HHA PPS. The following types of claims submissions can be viewed in Addendum J:

(1) RAP - non-transfer situation

(2) RAP - non-transfer situation with line item service added

(3) RAP - transfer situation

(4) RAP - discharge/re-admit

(5) RAP - cancellation

(6) Claim - non-transfer situation

(7) Claim - transfer situation

(8) Claim - SCIC

(9) Claim - no-RAP-LUPA claim

(10) Claim - adjustment

(11) Claim - cancellation

u. Claims Adjustments and Cancellations.

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

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

(3) RAPs can only be canceled, and then re-billed, not adjusted.

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

(5) Partial Episode Payment Adjustments. Episodes can be truncated and given partial episode payments (PEP adjustment) if the beneficiaries choose to transfer among HHAs or if a patient is discharged and subsequently readmitted during the same 60-day period.

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

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

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

1 To accommodate this requirement, HHAs will be allowed to submit a RAP with a transfer indicator in FL 15 (Source of Admission) of CMS 1450 UB-04 even when an episode may already be open for the same beneficiary at another HHA.

2 In such cases, the previously open episode will be automatically closed in TRICARE systems as of the date services began at the HHA the beneficiary transferred to, and the new episode for the "transfer to" agency will begin on that same date.

3 Payment will be pro-rated for the shortened episode of the "transferred from" agency, adjusted to a period less than 60 days, whether according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency. The HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

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

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

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

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

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

a When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same 60-day period.

b Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA.

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

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

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

(f) Low Utilization Payment Adjustment (LUPAs). If an HHA provides 4 visits or less, it will be reimbursed on a standardized per-visit payment instead of an episode payment for a 60-day period. Such payment adjustments, and the episodes themselves, are called LUPAs.

1 On LUPA claims, non-routine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates.

2 Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history.

3 If the claim for the LUPA is later adjusted such that the number of visits becomes 5 or more, payments will be adjusted to an episode basis, rather than a visit basis.

(g) Special Submission Case: "No-RAP" LUPAs. There are also reducing adjustments in payments when the number of visits provided during the episode fall below a certain threshold (low utilization payment adjustments: LUPAs).

1 Normally, there will be two percentage payments (initial and final) paid for an HHA PPS episode - the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which an HHA knows that an episode will be four visits or less even before the episode begins, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment.

2 In such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage that otherwise would likely have been largely recouped automatically against other payments.

3 However, HHAs may submit both a RAP and claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in recoupment of funds when the claim is submitted. HHAs should also be aware that receipt of the RAP or a "No-RAP LUPA" claim causes the creation of an episode record in the system and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk for that period of not being established as the primary HHA.

4 Physician orders must be signed when these claims are submitted.

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

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

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

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

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

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

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

a One if a beneficiary does not receive the therapy hours projected, and

b Another if he or she does meet the "therapy threshold".

c Therefore, when the therapy threshold is not met, there is an automatic "fall back" HIPPS code, and TRICARE systems will correct payment without access to the full OASIS data set.

d If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case-mix for the episode with a new HIPPS code and pay the episode on the basis of the new code.

e HHAs will receive the difference between the full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code.

f The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS that was used for payment, so such cases can be clearly identified.

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

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

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

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

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

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

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

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

a. One - If the patient is re-assessed and there is no change in the HIPPS code, the same HIPPS does not have to be submitted twice, and no SCIC adjustment will apply.

b. Two - If the HIPPS code weight increased but the proration of days in the SCIC adjustment would result in a financial disadvantage to the HHA, the SCIC is not required to be reported.

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

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

(6) Outlier Payments. There are cost outliers, in addition to episode payments.

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

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

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

(d) Outlier payment amounts are wage index adjusted to reflect the MSA or CBSA in which the beneficiary was served.

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

(f) Separate outliers will not be calculated for different HIPPS codes in a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

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

v. Exclusivity and Multiplicity of Adjustments.

(1) Episode payment adjustments only apply to claims, not requests for anticipated payment (RAPs).

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

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

(4) All claims except LUPA claims will be considered for outlier payment.

(5) Payment adjustments are calculated in Pricer software.

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

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

(8) Payment for services remains specific to the individual beneficiary who is homebound and under a physician's plan of care.

w. Chart Representation of Billing Procedures.

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

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

(2) Initial Episode in Period of Continuous Care:

FIRST EPISODE		NEXT EPISODE(S)
RAP	**CLAIM**	**RAP(S) & CLAIM(S)**
Contains one HIPPS code and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Contains same HIPPS Code as RAP with Patient Status Code 30	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPS and claims throughout the period of continuous care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. Claims submitted at the end of each 60 day period
Does not give any other line-item detail for TRICARE use	Gives all line item detail for entire HH Episode	
From and Through Dates match first service delivered	From Date same as RAP, Through Date, Day 60 of HH Episode	The RAP and claim From and Through Dates in a period of continuous care are first day of HH Episode, w/ or w/o service (i.e., Day 61, 121, 181, etc.)
Creates HH Episode in authorization system	Closes HH Episode in authorization system	
Triggers initial percentage payment	Triggers final percentage payment for 60-day HH Episode	Creates or closes HH Episode

(a) The above scenarios are expected to encompass most episode billings.

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

(c) There is no number limit on medically necessary episodes in continuous care periods.

(3) A Single LUPA Episode:

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

(a) Though less likely, a LUPA can also occur in a period of continuous care.

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

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

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

(5) Episode with a PEP Adjustment - Transfer to Another Agency or Discharge-Known Readmission to Same Agency:

RAP	CLAIM
Contains one HIPPS Code and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Submitted after discharge with Patient Status Code of 06

RAP	CLAIM
Does not contain other line-item detail for TRICARE use	Contains same HIPPS Code as RAP, and gives all line-item detail for entire HH Episode
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date is discharge
Creates HH Episode in authorization system	Closes HH Episode in authorization system at date of discharge, not 60 days
Triggers initial percentage payment	Triggers final percentage payment, and total payment for the episode will be cut back proportionately (x/60), "x" being the number of days of the shortened HH Episode.

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

(b) A PEP can also occur in a period of otherwise continuous care.

(c) A PEP episode can contain a change in patient condition.

(6) Episode with a PEP Adjustment - Discharge and "Unknown" Re-Admit, Continuous Care:

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

FIRST EPISODE (RAP)	CLAIM	START OF NEXT EPISODE (RAP)
Triggers initial percentage payment	Triggers final payment, may be total payment for HH Episode at first, will be cut back proportionately (x/60) to the number of the shortened episode when next billing received	Opens next Episode in authorization system Triggers initial payment for new HH Episode

(7) Episode with a SCIC Adjustment:

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

(8) General Guidance on Line Item Billing Under HHA PPS - Quick Reference on Billing Most Line-Items on HHA PPS Requests for Anticipated Payment (RAPs) and Claims:

TYPE OF LINE ITEM	EPISODE	SERVICES/VISITS	OUTLIER
Claim Coding	New 023 revenue code with new HIPPS on HCPCS of same line	Current revenue codes 42X, 43X,44X, 55X, 56X, 57X w/Gxxxx HCPCs for increment reporting (Note: Revenue codes 58X and 59X not permitted for HHA PPS)	Determined by Pricer - Not billed by HHAs
Type of Bill (TOB)	Billed on 32X only (have 485, patient homebound)	Billed on 32X only if POC; 34X* if no 485	Appears on remittance only for HHA PPS (via Pricer)
NOTE: For HHA PPS, HHA submitted IC TOB must be 322 - may be adjusted by 328; Claim TOB must be 329- may be adjusted by 327, or 328. * - 34X claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on the system (exceptions noted on chart below).			

TYPE OF LINE ITEM	EPISODE	SERVICES/VISITS	OUTLIER
Payment Bases	PPS episode rate: (1) full episode w/ or w/out SCIC adjustment, (2) less than full episode w/PEP adjustment, (3) LUPA paid on visit basis, (4) therapy threshold adjustment	When LUPA on 32X, visits paid on adjusted national standardized per visit rates; paid as part of Outpatient PPS for 34X*	Addition to PPS episode rate payment only, not LUPA, paid on claim basis, not line item
PPS Claim?	Yes, RAPs and Claims	Yes, Claims only [34X*; no 485/non-PPS]	Yes, Claims only

NOTE: For HHA PPS, HHA submitted IC TOB must be 322 - may be adjusted by 328; Claim TOB must be 329- may be adjusted by 327, or 328.
*** - 34X claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on the system (exceptions noted on chart below).**

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

NOTES: For HHA PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).
*** - 34X claims for HH services, except as noted for specific items above, will not be paid separately if a HH episode for the same beneficiary is open on the system.**
**** - Other than DME treated as routine supplies according to TRICARE.**
***** - Routine supplies are not separately billable or payable under TRICARE home health care. When billing on type of bill 32X, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270.**

x. Other Billing Considerations.

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

(a) Type of bill 329 and 339 are not accepted without any visit charges.

(b) Nonvisit charges incurred after termination of the plan of care are payable under medical and other health services on type of bill 34X.

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

(a) The primary agency bills for all services furnished by both agencies and keeps all records pertaining to the care. The primary agency's status as primary is established through the submission of a Request for Anticipated Payment.

(b) The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies.

(c) Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the system indicates an episode of care is open for a beneficiary, deny the RAP on any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

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

(a) If, when services are resumed after a temporary suspension (one that does not extend beyond the end date of the 60-day episode), the HHA believes the beneficiary's condition is changed sufficiently to merit a SCIC adjustment, a new OASIS assessment may be performed, and change orders acquired from the physician. The episode may then be billed as a SCIC adjustment, with an additional 023 revenue code line reflecting the HIPPS code generated by the new OASIS assessment.

(b) If the suspension extends beyond the end of the current 60-day episode, HHAs must submit a discharge claim for the episode. Full payment will be due for the episode. If the beneficiary resumes care, the HHA must establish a new plan of care and

submit a RAP for a new episode. The admission date would match the episode from date, as the admission is under a new plan of care and care was not continuous.

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

(5) HHA Claims With Both Covered and Non-Covered Charges. HHAs must report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. (Provider should not report the non-payment codes outlined below). On the CMS 1450 UB-04 flat file, HHAs must use record type 61, Field No. 10 (outpatient total charges) and Field No. 11 (outpatient non-covered charges) to report these charges. Providers utilizing the hard copy CMS 1450 UB-04 report these charges in FL 47. "Total Charges," and in FL 48 "Non-Covered Charges." You must be able to accept these charges in your system and pass them on to other payers.

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

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

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

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

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

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

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

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

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

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

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

1. With the implementation of HHA PPS, for each calendar quarter, contractors shall deliver a file (on a computer-readable standard IBM cartridge tape or CD-ROM or diskette) in simple EBCDIC or ASCII data format to the Office of Medical Benefits and Reimbursement Systems, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, CO 80011-9066. This file must contain the full TED number (21 characters) and the 5-digit Health Insurance Prospective Payment System (HIPPS) code for each HHA PPS claim.

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

DATA ELEMENT	START BYTE	END BYTE
TED-NBR	1	21
HIPPS Code	22	26

- END -

CHAPTER 12
SECTION 7

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - PRICER REQUIREMENTS AND LOGIC

ISSUE DATE:

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

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

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

III. POLICY

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

1. General Requirements:

a. Pricer will return the following information on all claims: Output HIPPS codes, weight used to price each HIPPS code, payment per HIPPS code, total payment, outlier payment and return code. If any element does not apply to the claim, Pricer will return zeros.

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

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

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

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

2. Pricing of RAPs:

a. Pricer will employ RAP logic for type of bill 322 and 332 only.

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

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

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

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

3. Pricing of Claims:

a. Pricer will employ claim logic for type of bill 329, 339, 327, 337, 32G, 33G, 32I, 33I, 32J, 33J, 32M, and 33M only.

b. Pricer will make payment determinations for claims in the following sequence:

(1) LUPA

(2) Therapy threshold

(3) HHRG payments (including PEP and SCIC)

(4) Outlier, in accordance with logic in TRICARE paper

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

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

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

e. The system will pass a "Y" medical review indicator to Pricer if a HIPPS code is present in the panel field on a line, and the line item pricing indicator shows that the change came from MR. In all other cases an "N" indicator will be passed.

f. The system will assure all claims with covered visits will flow to Pricer, but only covered visits will be passed to Pricer.

g. The system will pass Pricer all six HH visit revenue codes sorted in ascending order, with a count of how many times each code appears on the claim, and those that do not appear on claims will be passed with a quantity of zero.

h. If there is one HIPPS code on the claim and the patient status is 06, SS will pass 60 days of service for the HIPPS code, regardless of visit dates on the claim.

i. If the claim is a PEP, SS will calculate the number of days between the first service date and the last service date and pass that number of days for the HIPPS code.

j. If the claim is a SCIC, SS will calculate the number of days for all HIPPS codes from the inclusive span of days between first and last service dates under the HIPPS code.

k. The system will pass a Y/N medical review indicator to Pricer for each HIPPS code on the claim.

l. The system will pass Pricer a "Y" PEP indicator if the claim shows a patient status of 06. Otherwise, the indicator will be "N".

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

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

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

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

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

FILE POSITION	FORMAT	TITLE	DESCRIPTION
1-10	X(10)	NPI	This field will be used for the National Provider Identifier when it is implemented.

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

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

FILE POSITION	FORMAT	TITLE	DESCRIPTION
255-257	9(3)	REVENUE-QTY-COV-VISITS	**Input Item:** A quantity of covered visits corresponding to each of the six revenue codes. Standard systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-266	9(7)V9 (2)	REVENUE-DOLL-RATE	**Output Item:** The dollar rates used by Pricer to calculate the reimbursement for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
267-275	9(7)V9 (2)	REVENUE-COST	**Output Item:** The dollar amount determined by Pricer to be the reimbursement for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar amounts used by Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
276-400	Defined above	Additional REVENUE data	Five more occurrences of all revenue related data defined above.
401-402	9(2)	PAY-RTC	**Output Item:** A return code set by Pricer to define the payment circumstance of the claim or an error in input data. **Payment return codes:** 00 = Final payment, where no outlier applies 01 = Final payment where outlier applies 03 = Initial percentage payment, 0% 04 = Initial percentage payment, 50% 05 = Initial percentage payment, 60% **Error return codes:** 10 = Invalid TOB 15 = Invalid PEP Days 20 = PEP indicator invalid 25 = Med review indicator invalid 30 = Invalid MSA or CBSA code 35 = Invalid Initial Payment Indicator 40 = Dates are _____ or are invalid 70 = Invalid HRG code 75 = No HRG present in 1st occurrence 80 = Invalid revenue code 85 = No revenue code present on 3X9 or adjustment TOB

second column (indicating the threshold does not need to be met for that code), copy the code from the first column to the "HRG-OUTPUT-CODE" field.

(b) If the code in the first column does not match the code in the second column, place the code in the second column in the "HRG-OUTPUT-CODE" field.

(2) 2.b. If "HHA-REVENUE-SUM1-3-QTY-THR" is greater than or equal to 10: Copy all "HRG-INPUT-CODE" entries to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculation. Use the weights associated with the codes in the "HRG-OUTPUT-CODE" fields for the further calculations involving each HRG.

c. HRG Payment Calculations.

(1) 3.a. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is "N":

(a) Find the weight for the "HRG-OUTPUT-CODE" from weight tables for the Federal fiscal year in which the "SER-THRU-DATE" falls.

(b) Multiply the weight times the Federal standard episode rate for the Federal fiscal year in which the "SER-THRU-DATE" falls. The product is the case-mix adjusted rate.

(c) Multiply the case-mix adjusted rate by 0.77668 to determine the labor portion.

(d) Multiply the labor portion by the wage index corresponding to "MSA1."

(e) Multiply the case-mix adjusted rate by 0.22332 to determine the non-labor portion.

(f) Sum the labor and non-labor portions.

(g) The sum is the wage index and case-mix adjusted payment for this HRG.

(h) Proceed to the outlier calculation (see paragraph III.A.7.d. below).

(2) 3.b. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is a "Y":

(a) Perform the calculation of the case-mix and wage adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the "PEP-DAYS" amount by 60.

(b) Multiply the case-mix and wage index adjusted payment by this proportion.

(c) The result is the PEP payment due on the claim.

(d) Proceed to the outlier calculation (see paragraph III.A.7.d. below).

(3) 3.c. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is an "N":

(a) Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above.

(b) Multiply each of the resulting amounts by the number of days in the "HRG-NO-OF-DAYS" field for the code divided by sixty. Repeat this for up to six occurrences of the "HRG-OUTPUT-CODE." These amounts will be returned in separate occurrence of the "HRG-PAY" fields, so that the standard systems can associate them with the claim's 023 lines and pass the amounts to the remittance advice. Therefore, each amount must be wage index adjusted separately.

(c) Sum all resulting dollar amounts. This is total HRG payment for the episode.

(d) Proceed to the outlier calculation (see paragraph III.A.7.d. below).

(4) 3.d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is a "Y":

(a) Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above.

(b) Multiply each of the resulting amounts by the quantity in the "PEP-DAYS" field divided by 60.

(c) Multiply the result by the quantity in the "HRG-NO-OF-DAYS" field divided by the quantity in the "PEP-DAYS" field.

(d) Repeat this for up to six occurrences of "HRG-CODE."

(e) These amounts will be returned separately in the corresponding "HRG-PAY" fields.

(f) Sum all resulting dollar amounts. This is the total HRG payment for the episode.

(g) Proceed to the outlier calculations (see paragraph III.A.7.d. below).

d. Outlier Calculations:

(1) 4.a. Wage adjust the outlier fixed loss amount for the Federal fiscal year in which the "SER-THRU-DATE" falls, using the MSA or CBSA code in the "MSA1" field.

Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

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

(a) Multiply each quantity by the corresponding rate.

(b) Sum the six results and wage index adjust the sum as described above, using the MSA or CBSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.

(3) 4.c. Subtract the outlier threshold for the episode from the imputed cost for the episode (4.d. above).

(a) If the result is greater then $0.00, calculate 0.80 times the result.

(b) Return this amount in the "OUTLIER-PAYMENT" field.

(c) Add this amount to the total dollar amount resulting from all HRG payment calculations.

(d) Return the sum to the "TOTAL-PAYMENT" field, with return code "00".

- END -

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4372	Skin barrier solid 4x4 equiv	10/01/2000	B-00-50			NRS
A4373	Skin barrier with flange	10/01/2000	B-00-50			NRS
A4374	Skin barrier extended wear	10/01/2000	B-00-50	10/01/2002	K0563, K0564	NRS
A4375	Drainable plastic pch w fcpl	10/01/2000	B-00-50			NRS
A4376	Drainable rubber pch w fcplt	10/01/2000	B-00-50			NRS
A4377	Drainable plstic pch w/o fp	10/01/2000	B-00-50			NRS
A4378	Drainable rubber pch w/o fp	10/01/2000	B-00-50			NRS
A4379	Urinary plastic pouch w fcpl	10/01/2000	B-00-50			NRS
A4380	Urinary rubber pouch w fcplt	10/01/2000	B-00-50			NRS
A4381	Urinary plastic pouch w/o fp	10/01/2000	B-00-50			NRS
A4382	Urinary hvy plstc pch w/ofp	10/01/2000	B-00-50			NRS
A4383	Urinary rubber pouch w/o fp	10/01/2000	B-00-50			NRS
A4384	Ostomy faceplt/silicone ring	10/01/2000	B-00-50			NRS
A4385	Ost skn barrier sld extwear	10/01/2000	B-00-50			NRS
A4386	Ost skn barrier w flngex wr	10/01/2000	B-00-50	10/01/2002	K0565, K0566	NRS
A4387	Ost clsd pouch w attst barr	10/01/2000	B-00-50			NRS
A4388	Drainable pch w ex wearbarr	10/01/2000	B-00-50			NRS
A4389	Drainable pch w st wearbarr	10/01/2000	B-00-50			NRS
A4390	Drainable pch ex wear convex	10/01/2000	B-00-50			NRS
A4391	Urinary pouch w ex wearbarr	10/01/2000	B-00-50			NRS
A4392	Urinary pouch w st wearbarr	10/01/2000	B-00-50			NRS
A4393	Urine pch w ex wearbar conv	10/01/2000	B-00-50			NRS
A4394	Ostomy pouch liq deodorant	10/01/2000	B-00-50			NRS
A4395	Ostomy pouch solid deodorant	10/01/2000	B-00-50			NRS
A4396	Peristomal hernia supprt blt	10/01/2000	B-00-50			NRS
A4397	Irrigation supply sleeve	10/01/2000	B-00-50			NRS
A4398	Ostomy irrigation bag	10/01/2000	B-00-50			NRS
A4399	Ostomy irrig cone/cath w brs	10/01/2000	B-00-50			NRS
A4400	Ostomy irrigation set	10/01/2000	B-00-50			NRS
A4402	Lubricant per ounce	10/01/2000	B-00-50			NRS
A4404	Ostomy ring each	10/01/2000	B-00-50			NRS
A4405	Nonpectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4406	Pectin based ostomy paste	01/01/2003	AB-02-137			NRS
A4407	Ext wear ost skn barr <=4sq"	01/01/2003	AB-02-137			NRS
A4408	Ext wear ost skn barr > 4sq"	01/01/2003	AB-02-137			NRS
A4409	Ost skn barr w flng <= 4 sq"	01/01/2003	AB-02-137			NRS
A4410	Ost skn barr w flng > 4sq"	01/01/2003	AB-02-137			NRS

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4411	Ostomy skin barrier, solid 4x4 or equiv., extended wear, w/ built-in convexity, each	01/01/2006	Tr. 710			NRS
A4412	Ostomy pouch, drainable, high output, for use on a barrier w/ flange (2 piece system) without filter, each	01/01/2006	Tr. 710			NRS
A4413	2 pc drainable ost pouch w/ filter	01/01/2003	AB-02-137			NRS
A4414	Ostomy skn barr w/ flng < 4sq	01/01/2003	AB-02-137			NRS
A4415	Ostomy skn barr w/ flng > 4sq	01/01/2003	AB-02-137			NRS
A4416	Ost pch clsd w barrier/filtr	01/01/2004	Tr. 8			NRS
A4417	Ost pch w bar/bltinconv/fltr	01/01/2004	Tr. 8			NRS
A4418	Ost pch clsd w/o bar w filtr	01/01/2004	Tr. 8			NRS
A4419	Ost pch for bar w flange/flt	01/01/2004	Tr. 8			NRS
A4420	Ost pch clsd for bar w lk fl	01/01/2004	Tr. 8			NRS
A4421 (6)	Ostomy supply misc	10/01/2000	B-00-50		N/A	NRS
A4422	Ost pouch absorbent material	01/01/2003	AB-02-137			NRS
A4423	Ost pch for bar w lk fl/fltr	01/01/2004	Tr. 8			NRS
A4424	Ost pch drain w bar & filter	01/01/2004	Tr. 8			NRS
A4425	Ost pch drain for barrier fl	01/01/2004	Tr. 8			NRS
A4426	Ost pch drain 2 piece system	01/01/2004	Tr. 8			NRS
A4427	Ost pch drain/barr lk flng/f	01/01/2004	Tr. 8			NRS
A4428	Urine ost pouch w faucet/tap	01/01/2004	Tr. 8			NRS
A4429	Urine ost pouch w bltinconv	01/01/2004	Tr. 8			NRS
A4430	Ost urine pch w b/bltin conv	01/01/2004	Tr. 8			NRS
A4431	Ost pch urine w barrier/tapv	01/01/2004	Tr. 8			NRS
A4432	Os pch urine w bar/fange/tap	01/01/2004	Tr. 8			NRS
A4433	Urine ost pch bar w lock fln	01/01/2004	Tr. 8			NRS
A4434	Ost pch urine w lock flng/ft	01/01/2004	Tr. 8			NRS
A4435	Ost pch, drainable, high output, w/extended wear barrier (1-pc system) w/or w/o filter, each	01/01/2013	R2527CP			NRS
A4455	Adhesive remover per ounce	10/01/2000	B-00-50			NRS
A4456	Adhesive remover, wipes, any type, each	01/01/2010	1827			NRS
A4458	Reusable enema bag	01/01/2003	AB-02-137			NRS
A4460	Elastic compression bandage	10/01/2000	B-00-50			NRS
A4461	Surgical dressing holder, non-reusable, each	01/01/2007	Tr.1082		A4462	NRS
A4462	Abdmnl drssng holder/binder	10/01/2000	B-00-50	01/01/2007	A4461, A4463	NRS
A4463	Surgical dressing holder, reusable, each	01/01/2007	Tr.1082		A4462	NRS

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A4481	Tracheostoma filter	10/01/2000	B-00-50			NRS
A4554	Disposable underpads	10/01/2000	B-00-50	01/01/2001	N/A	NRS
A4622	Tracheostomy or larngectomy	10/01/2000	B-00-50	01/01/2004	A7520, A7521, A7522	NRS
A4623	Tracheostomy inner cannula	10/01/2000	B-00-50			NRS
A4625	Trach care kit for new	10/01/2000	B-00-50			NRS
A4626	Tracheostomy cleaning brush	10/01/2000	B-00-50			NRS
A4649	Surgical supplies	10/01/2000	B-00-50			NRS
A4656	Needle, any size, each	01/01/2003	AB-02-137	01/01/2006	A4215	NRS
A4657	Syringe, with or without needle, each	01/01/2003	AB-02-137			NRS
A4712	Sterile water inj per 10 ml	01/01/2003	AB-02-137	01/01/2004	N/A	NRS
A4930	Sterile, gloves per pair	01/01/2003	AB-02-137			NRS
A4932	Rectal thermometer, reusable, any type, each	01/01/2007	Tr.1082			NRS
A5051	Pouch clsd w barr attached	10/01/2000	B-00-50			NRS
A5052	Clsd ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5053	Clsd ostomy pouch faceplate	10/01/2000	B-00-50			NRS
A5054	Clsd ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5055	Stoma cap	10/01/2000	B-00-50			NRS
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	01/01/2012	2317			NRS
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each	01/01/2012	2317			NRS
A5061	Pouch drainable w barrier at	10/01/2000	B-00-50	10/01/2002	K0567, K0568	NRS
A5061 (5)	Pouch drainable w barrier at	01/01/2003	AB-02-137			NRS
A5062	Drnble ostomy pouch w/o barr	10/01/2000	B-00-50			NRS
A5063	Drain ostomy pouch w/flange	10/01/2000	B-00-50			NRS
A5071	Urinary pouch w/barrier	10/01/2000	B-00-50			NRS
A5072	Urinary pouch w/o barrier	10/01/2000	B-00-50			NRS
A5073	Urinary pouch on barr w/flng	10/01/2000	B-00-50			NRS
A5081	Continent stoma plug	10/01/2000	B-00-50			NRS
A5082	Continent stoma catheter	10/01/2000	B-00-50			NRS
A5093	Ostomy accessory convex inse	10/01/2000	B-00-50			NRS
A5102	Beside drain btl w/wo tube	10/01/2000	B-00-50			NRS
A5105	Urinary suspensory	10/01/2000	B-00-50			NRS
A5112	Urinary leg bag	10/01/2000	B-00-50			NRS

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A5113	Latex leg strap	10/01/2000	B-00-50			NRS
A5114	Foam/fabric leg strap	10/01/2000	B-00-50			NRS
A5119	Skin barrier wipes box pr	10/01/2000	B-00-50	01/01/2006	A5120	NRS
A5120	Skin barrier, wipes or swabs, each	01/01/2006	Tr. 710			NRS
A5121	Solid skin barrier 6x6	10/01/2000	B-00-50			NRS
A5122	Solid skin barrier 8x8	10/01/2000	B-00-50			NRS
A5123	Skin barrier with flange	10/01/2000	B-00-50	10/01/2002	K0570, K0571	NRS
A5126	Disk / foam pad +or-	10/01/2000	B-00-50			NRS
A5131	Appliance cleaner	10/01/2000	B-00-50			NRS
A5149	Incontinence / ostomy supply	10/01/2000	B-00-50	01/01/2001	A4335, A4421	NRS
A6010	Collagen based wound filler, dry foam	01/01/2002	AB-01-128			NRS
A6011	Collagen gel/paste wound fil	01/01/2003	AB-02-137			NRS
A6020	Collagen wound dressing	10/01/2000	B-00-50			NRS
A6021	Collagen dressing <= 16 sq in	01/01/2001	AB-01-65			NRS
A6022	Collagen drsg> 6 <= 48 sq in	01/01/2001	AB-01-65			NRS
A6023	Collagen dressing > 48 sq in	01/01/2001	AB-01-65			NRS
A6024	Collagen dsg wound filler	01/01/2001	AB-01-65			NRS
A6025	Gel sheet for dermal or epidermal application (e.g. silicone, hydrogel, other)	01/01/2004	Tr.8	01/01/2006	N/A	NRS
A6154	Wound pouch each	10/01/2000	B-00-50			NRS
A6196	Alginate dressing <= 16 sq in	10/01/2000	B-00-50			NRS
A6197	Alginate drsg > 16 <= 48 sq	10/01/2000	B-00-50			NRS
A6198	Alginate dressing > 48 sq	10/01/2000	B-00-50			NRS
A6199	Alginate drsg wound filler	10/01/2000	B-00-50			NRS
A6200	Compos drsg <= 16 no bdr	10/01/2000	B-00-50			NRS
A6201	Compos drsg > 16 <= 48 no bdr	10/01/2000	B-00-50			NRS
A6202	Compos drsg > 48 no bdr	10/01/2000	B-00-50			NRS
A6203	Composite drsg <= 16 sq	10/01/2000	B-00-50			NRS
A6204	Composite drsg > 16 <= 48 sq in	10/01/2000	B-00-50			NRS
A6205	Composite drsg > 48 sq	10/01/2000	B-00-50			NRS
A6206	Contact layer <= 16 sq	10/01/2000	B-00-50			NRS
A6207	Contact layer > 16 <= 48 sq	10/01/2000	B-00-50			NRS
A6208	Contact layer > 48 sq	10/01/2000	B-00-50			NRS
A6209	Foam drsg <= 16 sq in w/o bdr	10/01/2000	B-00-50			NRS
A6210	Foam drg > 16 <= 48 sq in w/o b	10/01/2000	B-00-50			NRS
A6211	Foam drg > 48 sq in w/o brdr	10/01/2000	B-00-50			NRS
A6212	Foam drg <= 16 sq in w/bdr	10/01/2000	B-00-50			NRS

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A6213	Foam drg > 16 <= 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6214	Foam drg > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6215	Foam dressing wound filler	10/01/2000	B-00-50			NRS
A6219	Gauze <= 16 sq in w/bdr	10/01/2000	B-00-50			NRS
A6220	Gauze > 16 <= 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6221	Gauze > 48 sq in w/bdr	10/01/2000	B-00-50			NRS
A6222	Gauze <= 16 in no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6223	Gauze > 16 <= 48 no w / sal w/ o b	10/01/2000	B-00-50			NRS
A6224	Gauze > 48 in no w /sal w/ o b	10/01/2000	B-00-50			NRS
A6228	Gauze <= 16 sq in water / sal	10/01/2000	B-00-50			NRS
A6229	Gauze > 16 <= 48 sq in watr / sal	10/01/2000	B-00-50			NRS
A6230	Gauze > 48 sq in water / salne	10/01/2000	B-00-50			NRS
A6231	Hydrogel dsg<= 16 sq in	01/01/2001	AB-01-65			NRS
A6232	Hydrogel dsg> 16 <= 48 sq in	01/01/2001	AB-01-65			NRS
A6233	Hydrogel dressing > 48 sq in	01/01/2001	AB-01-65			NRS
A6234	Hydrocolld drg <= 16 w / o bdr	10/01/2000	B-00-50			NRS
A6235	Hydrocolld drg > 16 <= 48 w / o b	10/01/2000	B-00-50			NRS
A6236	Hydrocolld drg > 48 in w / o b	10/01/2000	B-00-50			NRS
A6237	Hydrocolld drg <= 16 in w / bdr	10/01/2000	B-00-50			NRS
A6238	Hydrocolld drg > 16 <= 48 w / bdr	10/01/2000	B-00-50			NRS
A6239	Hydrocolld drg > 48 in w / bdr	10/01/2000	B-00-50			NRS
A6240	Hydrocolld drg filler paste	10/01/2000	B-00-50			NRS
A6241	Hydrocolloid drg filler dry	10/01/2000	B-00-50			NRS
A6242	Hydrogel drg <= 16 in w / o bdr	10/01/2000	B-00-50			NRS
A6243	Hydrogel drg > 16 <= 48 w / o bdr	10/01/2000	B-00-50			NRS
A6244	Hydrogel drg > 48 in w / o bdr	10/01/2000	B-00-50			NRS
A6245	Hydrogel drg <= 16 in w / bdr	10/01/2000	B-00-50			NRS
A6246	Hydrogel drg > 16 <= 48 in w / b	10/01/2000	B-00-50			NRS
A6247	Hydrogel drg > 48 sq in w / b	10/01/2000	B-00-50			NRS
A6248	Hydrogel dressing	10/01/2000	B-00-50			NRS
A6251	Absorpt drg <= 16 sq in w / o b	10/01/2000	B-00-50			NRS
A6252	Absorpt drg > 16 <= 48 w / o bdr	10/01/2000	B-00-50			NRS
A6253	Absorpt drg 48 sq in w / o b	10/01/2000	B-00-50			NRS
A6254	Absorpt drg <= 16 sq in w / bdr	10/01/2000	B-00-50			NRS
A6255	Absorpt drg > 16 <= 48 in w / bdr	10/01/2000	B-00-50			NRS
A6256	Absorpt drg > 48 sq in w / bdr	10/01/2000	B-00-50			NRS
A6257	Transparent film <= 16 sq in	10/01/2000	B-00-50			NRS
A6258	Transparent film > 16 <= 48 in	10/01/2000	B-00-50			NRS
A6259	Transparent film > 48 sq in	10/01/2000	B-00-50			NRS
A6261	Wound filler gel / paste / oz	10/01/2000	B-00-50			NRS

HCPCS CODE	DESCRIPTOR	DATE INCLUDED (1)	INCLUDED IN TRANSMITTAL (7)	DATE EXCLUDED (1)	SUCCESSOR CODE(S)	CODE TYPE
A6262	Wound filler dry form / gram	10/01/2000	B-00-50			NRS
A6266	Impreg gauze no h20 / sal / yard	10/01/2000	B-00-50			NRS
A6402	Sterile gauze <= 16 sq in	10/01/2000	B-00-50			NRS
A6403	Sterile gauze > 16 <= 48 sq in	10/01/2000	B-00-50			NRS
A6404	Sterile gauze > 48 sq in	10/01/2000	B-00-50			NRS
A6405	Sterile elastic gauze / yd	10/01/2000	B-00-50			NRS
A6406	Sterile non-elastic gauze / yd	10/01/2000	B-00-50			NRS
A6407	Packing strips, non-impregnated, up to 2 inches, per lin yd	01/01/2004	Tr. 8			NRS
A6410	Sterile eye pad	01/01/2003	AB-02-137			NRS
A6412	Eye patch, occlusive, each	01/01/2007	Tr.1082			NRS
A6440	Zinc Paste >=3"<5" w/roll	4/01/2003	AB-03-002			NRS
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width > or = 3" and < 5", per yard	01/01/2004	Tr. 8			NRS
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	01/01/2004	Tr. 8			NRS
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	01/01/2004	Tr. 8			NRS
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	01/01/2004	Tr. 8			NRS
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	01/01/2004	Tr. 8			NRS

CHAPTER 12
ADDENDUM H

DIAGNOSIS CODES FOR HOME HEALTH RESOURCE GROUP (HHRG) ASSIGNMENT

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

- END -

CHAPTER 12
ADDENDUM L (CY 2012)

ANNUAL HHA PPS RATE UPDATES - CALENDAR YEAR 2012

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

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

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

National 60-Day Episode Payment Amounts - CY 2012

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

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

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

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

The CY 2011 national per-visit amounts were increased by the CY 2012 home health payment update percentage of 1.4%. National per-visit rates are not subjected to the nominal increase

in case-mix. The final updated CY 2012 national per-visit rates per discipline are reflected in Figure 12-L-2012-2:

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

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

Payment of LUPA Episodes

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

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

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

Severity Non-Routine Medical Supplies (NRS) System

Beginning in CY 2008, to ensure that the variation in NRS is more appropriately reflected in the HHA PPS, the original portion ($49.62) of the HHA PPS base rate that accounted for NRS, was replaced with a system that pays for NRS based on six severity groups. Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The CY 2011 NRS conversion factor was updated for CY 2012 by the

CHAPTER 12
ADDENDUM L (CY 2013)

ANNUAL HHA PPS RATE UPDATES - CALENDAR YEAR 2013

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

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

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

National 60-Day Episode Payment Amounts - CY 2013

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

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

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

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

The CY 2012 national per-visit amounts were increased by the CY 2013 home health payment update percentage of 1.3%. National per-visit rates are not subjected to the nominal increase

in case-mix. The final updated CY 2013 national per-visit rates per discipline are reflected in Figure 12-L-2013-2:

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

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

Payment of LUPA Episodes

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

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

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

Severity Non-Routine Medical Supplies (NRS) System

Beginning in CY 2008, to ensure that the variation in NRS is more appropriately reflected in the HHA PPS, the original portion ($49.62) of the HHA PPS base rate that accounted for NRS, was replaced with a system that pays for NRS based on six severity groups. Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The CY 2012 NRS conversion factor was updated for CY 2013 by the

CY 2013 HHA PPS payment update percentage of 1.3% as reflected in Figure 12-L-2013-4. The NRS conversion factor for CY 2013 is $53.97.

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

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

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

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

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

Labor And Non-Labor Percentages

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

Outlier Payments

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

Outcome and Assessment Information Set (OASIS)

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

Temporary 3% Rural Add-On for the HHA PPS

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, enacted on December 8, 2003 and as amended by Section 3131(c) of the Affordable Care Act) provides an increase of 3% of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), for episodes and visits ending on or after April 1, 2010 and before January 1, 2016. The 3% rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor when home health services are provided in

rural (non-Core Based Statistical Area (CBSA)) areas. The applicable case-mix and wage index adjustments are subsequently applied. Episodes that qualify for the 3% rural add-on will be identified by a CBSA code that begins with '999'.

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

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

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

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

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

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

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

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

Payment of LUPA Episodes for Beneficiaries Who Reside in Rural Areas

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

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

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

Payment for NRS

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

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

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

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

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

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

- END -

CHAPTER 12
ADDENDUM M (CY 2013)

ANNUAL HHA PPS WAGE INDEX UPDATES - CALENDAR YEAR 2013

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

CBSA CODE	NON-URBAN AREA	WAGE INDEX
01	Alabama	0.7121
02	Alaska	1.2807
03	Arizona	0.9182
04	Arkansas	0.7350
05	California	1.2567
06	Colorado	1.0208
07	Connecticut	1.1128
08	Delaware	1.0171
10	Florida	0.8062
11	Georgia	0.7421
12	Hawaii	1.0728
13	Idaho	0.7583
14	Illinois	0.8438
15	Indiana	0.8472
16	Iowa	0.8351
17	Kansas	0.7997
18	Kentucky	0.7877
19	Louisiana	0.7718
20	Maine	0.8300
21	Maryland	0.8797
22	Massachusetts	1.3540
23	Michigan	0.8387
24	Minnesota	0.9053
25	Mississippi	0.7537
26	Missouri	0.7622
27	Montana	0.8600
28	Nebraska	0.8733
29	Nevada	0.9739
30	New Hampshire	1.0372
31	New Jersey[1]	-------
32	New Mexico	0.8879
33	New York	0.8199
34	North Carolina	0.8271
35	North Dakota	0.6891
36	Ohio	0.8470
37	Oklahoma	0.7783
38	Oregon	0.9500
39	Pennsylvania	0.8380
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-------
42	South Carolina	0.8338
43	South Dakota	0.8124
44	Tennessee	0.7559
45	Texas	0.7978
46	Utah	0.8516
47	Vermont	0.9725
48	Virgin Islands	0.7185
49	Virginia	0.7728
50	Washington	1.0092
51	West Virginia	0.7333
52	Wisconsin	0.9142
53	Wyoming	0.9238
65	Guam	0.9611

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

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
10180	Abilene, TX	0.8324
	Callahan, TX	
	Jones, TX	
	Taylor, TX	
10380	Aguadilla-Isabela-San Sebastian, PR	0.3532
	Aguada, PR	
	Aguadilla, PR	
	Anasco, PR	
	Isabela, PR	
	Lares, PR	
	Moca, PR	
	Rincon, PR	
	San Sebastian, PR	
10420	Akron, OH	0.8729
	Portage, OH	
	Summit, OH	
10500	Albany, GA	0.8435
	Baker, GA	
	Dougherty, GA	
	Lee, GA	
	Terrell, GA	
	Worth, GA	
10580	Albany-Schenectady-Troy, NY	0.8647
	Albany, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
10740	Albuquerque, NM	0.9542
	Bernalillo, NM	
	Sandoval, NM	
	Torrance, NM	
	Valencia, NM	
10780	Alexandria, LA	0.7857
	Grant, LA	
	Rapides, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9084
	Warren, NJ	
	Carbon, PA	
	Lehigh, PA	
	Northampton, PA	
11020	Altoona, PA	0.8898
	Blair, PA	
11100	Amarillo, TX	0.8506
	Armstrong, TX	
	Carson, TX	
	Potter, TX	
	Randall, TX	
11180	Ames, IA	0.9595
	Story, IA	
11260	Anchorage, AK	1.2147
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.9547
	Madison, IN	
11340	Anderson, SC	0.8929
	Anderson, SC	
11460	Ann Arbor, MI	1.0115
	Washtenaw, MI	
11500	Anniston-Oxford, AL	0.7539
	Calhoun, AL	
11540	Appleton, WI	0.9268
	Calumet, WI	
	Outagamie, WI	
11700	Asheville, NC	0.8555
	Buncombe, NC	
	Haywood, NC	
	Henderson, NC	
	Madison, NC	
12020	Athens-Clarke, GA	0.9488
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
	Oglethorpe, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9517
	Barrow, GA	
	Bartow, GA	
	Butts, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	Dawson, GA	
	DeKalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Haralson, GA	
	Heard, GA	
	Henry, GA	
	Jasper, GA	

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

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
	Norfolk, MA	
	Plymouth, MA	
	Suffolk, MA	
14500	Boulder, CO	1.0574
	Boulder, CO	
14540	Bowling Green, KY	0.8665
	Edmonson, KY	
	Warren, KY	
14740	Bremerton-Silverdale, WA	1.0829
	Kitsap, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.3170
	Fairfield, CT	
15180	Brownsville-Harlingen, TX	0.8612
	Cameron, TX	
15260	Brunswick, GA	0.8792
	Brantley, GA	
	Glynn, GA	
	McIntosh, GA	
15380	Buffalo-Niagara Falls, NY	0.9999
	Erie, NY	
	Niagara, NY	
15500	Burlington, NC	0.8485
	Alamance, NC	
15540	Burlington-South Burlington, VT	0.9997
	Chittenden, VT	
	Franklin, VT	
	Grand Isle, VT	
15764	Cambridge-Newton-Framingham, MA	1.1262
	Middlesex, MA	
15804	Camden, NJ	1.0474
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
15940	Canton-Massillon, OH	0.8834
	Carroll, OH	
	Stark, OH	
15980	Cape Coral-Fort Myers, FL	0.9153
	Lee, FL	
16020	Cape Girardeau-Jackson, MO-IL	0.8860
	Alexander, IL	
	Bollinger, MO	
	Cape Girardeau, MO	
16180	Carson City, NV	1.0559
	Carson City, NV	
16220	Casper, WY	1.0143
	Natrona, WY	
16300	Cedar Rapids, IA	0.8944
	Benton, IA	
	Jones, IA	
	Linn, IA	
16580	Champaign-Urbana, IL	0.9907
	Champaign, IL	
	Ford, IL	
	Piatt, IL	
16620	Charleston, WV	0.8050
	Boone, WV	
	Clay, WV	
	Kanawha, WV	
	Lincoln, WV	
	Putnam, WV	
16700	Charleston-North Charleston-Summerville, SC	0.8820
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
16740	Charlotte-Gastonia-Rock Hill, NC-SC	0.9215
	Anson, NC	
	Cabarrus, NC	
	Gaston, NC	
	Mecklenburg, NC	
	Union, NC	
	York, SC	
16820	Charlottesville, VA	0.9195
	Albemarle, VA	
	Fluvanna, VA	
	Greene, VA	
	Nelson, VA	
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.8678
	Catoosa, GA	
	Dade, GA	
	Walker, GA	
	Hamilton, TN	
	Marion, TN	
	Sequatchie, TN	
16940	Cheyenne, WY	0.9730
	Laramie, WY	
16974	Chicago-Joliet-Naperville, IL	1.0600
	Cook, IL	
	DeKalb, IL	
	DuPage, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	McHenry, IL	
	Will, IL	
17020	Chico, CA	1.1197
	Butte, CA	
17140	Cincinnati-Middletown, OH-KY-IN	0.9508

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

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

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

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

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

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
	Lonoke, AR	
	Perry, AR	
	Pulaski, AR	
	Saline, AR	
30860	Logan, UT-ID	0.8456
	Franklin, ID	
	Cache, UT	
30980	Longview, TX	0.8550
	Gregg, TX	
	Rusk, TX	
	Upshur, TX	
31020	Longview, WA	1.0081
	Cowlitz, WA	
31084	Los Angeles-Long Beach-Glendale, CA	1.2293
	Los Angeles, CA	
31140	Louisville-Jefferson County, KY-IN	0.8862
	Clark, IN	
	Floyd, IN	
	Harrison, IN	
	Washington, IN	
	Bullitt, KY	
	Henry, KY	
	Jefferson, KY	
	Meade, KY	
	Nelson, KY	
	Oldham, KY	
	Shelby, KY	
	Spencer, KY	
	Trimble, KY	
31180	Lubbock, TX	0.8870
	Crosby, TX	
	Lubbock, TX	
31340	Lynchburg, VA	0.8615
	Amherst, VA	
	Appomattox, VA	
	Bedford, VA	
	Campbell, VA	
	Bedford City, VA	
	Lynchburg City, VA	
31420	Macon, GA	0.8584
	Bibb, GA	
	Crawford, GA	
	Jones, GA	
	Monroe, GA	
	Twiggs, GA	
31460	Madera-Chowchilla, CA	0.8050
	Madera, CA	
31540	Madison, WI	1.1264
	Columbia, WI	
	Dane, WI	
	Iowa, WI	
31700	Manchester-Nashua, NH	1.0042
	Hillsborough, NH	
31740	Manhattan, KS	0.7839
	Geary, KS	
	Pottawatomie, KS	
	Riley, KS	
31860	Mankato-North Mankato, MN	0.9413
	Blue Earth, MN	
	Nicollet, MN	
31900	Mansfield, OH	0.8993
	Richland, OH	
32420	Mayaguez, PR	0.3586
	Hormigueros, PR	
	Mayaguez, PR	
32580	McAllen-Edinburg-Mission, TX	0.8603
	Hidalgo, TX	
32780	Medford, OR	1.0400
	Jackson, OR	
32820	Memphis, TN-MS-AR	0.9049
	Crittenden, AR	
	DeSoto, MS	
	Marshall, MS	
	Tate, MS	
	Tunica, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
32900	Merced, CA	1.2996
	Merced, CA	
33124	Miami-Miami Beach-Kendall, FL	1.0130
	Miami-Dade, FL	
33140	Michigan City-La Porte, IN	0.9694
	LaPorte, IN	
33260	Midland, TX	1.0640
	Midland, TX	
33340	Milwaukee-Waukesha-West Allis, WI	0.9931
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1336
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Ramsey, MN	

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
	Scott, MN	
	Sherburne, MN	
	Washington, MN	
	Wright, MN	
	Pierce, WI	
	St. Croix, WI	
33540	Missoula, MT	0.9001
	Missoula, MT	
33660	Mobile, AL	0.7467
	Mobile, AL	
33700	Modesto, CA	1.2841
	Stanislaus, CA	
33740	Monroe, LA	0.7717
	Ouachita, LA	
	Union, LA	
33780	Monroe, MI	0.8472
	Monroe, MI	
33860	Montgomery, AL	0.7858
	Autauga, AL	
	Elmore, AL	
	Lowndes, AL	
	Montgomery, AL	
34060	Morgantown, WV	0.8284
	Monongalia, WV	
	Preston, WV	
34100	Morristown, TN	0.6768
	Grainger, TN	
	Hamblen, TN	
	Jefferson, TN	
34580	Mount Vernon-Anacortes, WA	1.0340
	Skagit, WA	
34620	Muncie, IN	0.8734
	Delaware, IN	
34740	Muskegon-Norton Shores, MI	1.1007
	Muskegon, MI	
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.8717
	Horry, SC	
34900	Napa, CA	1.6045
	Napa, CA	
34940	Naples-Marco Island, FL	0.9265
	Collier, FL	
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	0.9061
	Cannon, TN	
	Cheatham, TN	
	Davidson, TN	
	Dickson, TN	
	Hickman, TN	
	Macon, TN	
	Robertson, TN	
	Rutherford, TN	
	Smith, TN	
	Sumner, TN	
	Trousdale, TN	
	Williamson, TN	
	Wilson, TN	
35004	Nassau-Suffolk, NY	1.2698
	Nassau, NY	
	Suffolk, NY	
35084	Newark-Union, NJ-PA	1.1223
	Essex, NJ	
	Hunterdon, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Pike, PA	
35300	New Haven-Milford, CT	1.2061
	New Haven, CT	
35380	New Orleans-Metairie-Kenner, LA	0.8932
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. John the Baptist, LA	
	St. Tammany, LA	
35644	New York-White Plains-Wayne, NY-NJ	1.2914
	Bergen, NJ	
	Hudson, NJ	
	Passaic, NJ	
	Bronx, NY	
	Kings, NY	
	New York, NY	
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
35660	Niles-Benton Harbor, MI	0.8237
	Berrien, MI	
35840	North Port-Bradenton-Sarasota-Venice, FL	0.9375
	Manatee, FL	
	Sarasota, FL	
35980	Norwich-New London, CT	1.1376
	New London, CT	
36084	Oakland-Fremont-Hayward, CA	1.6654
	Alameda, CA	
	Contra Costa, CA	
36100	Ocala, FL	0.8455

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

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

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

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

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
	Oswego, NY	
45104	Tacoma, WA	1.1741
	Pierce, WA	
45220	Tallahassee, FL	0.8521
	Gadsden, FL	
	Jefferson, FL	
	Leon, FL	
	Wakulla, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9032
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
45460	Terre Haute, IN	0.9113
	Clay, IN	
	Sullivan, IN	
	Vermillion, IN	
	Vigo, IN	
45500	Texarkana, TX-Texarkana, AR	0.7967
	Miller, AR	
	Bowie, TX	
45780	Toledo, OH	0.9034
	Fulton, OH	
	Lucas, OH	
	Ottawa, OH	
	Wood, OH	
45820	Topeka, KS	0.8969
	Jackson, KS	
	Jefferson, KS	
	Osage, KS	
	Shawnee, KS	
	Wabaunsee, KS	
45940	Trenton-Ewing, NJ	1.0360
	Mercer, NJ	
46060	Tucson, AZ	0.9065
	Pima, AZ	
46140	Tulsa, OK	0.8139
	Creek, OK	
	Okmulgee, OK	
	Osage, OK	
	Pawnee, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
46220	Tuscaloosa, AL	0.8533
	Greene, AL	
	Hale, AL	
	Tuscaloosa, AL	
46340	Tyler, TX	0.8361
	Smith, TX	
46540	Utica-Rome, NY	0.8653
	Herkimer, NY	
	Oneida, NY	
46660	Valdosta, GA	0.7918
	Brooks, GA	
	Echols, GA	
	Lanier, GA	
	Lowndes, GA	
46700	Vallejo-Fairfield, CA	1.5844
	Solano, CA	
47020	Victoria, TX	0.8992
	Calhoun, TX	
	Goliad, TX	
	Victoria, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0596
	Cumberland, NJ	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9208
	Currituck, NC	
	Gloucester, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Surry, VA	
	York, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0349
	Tulare, CA	
47380	Waco, TX	0.8458
	McLennan, TX	
47580	Warner Robins, GA	0.8197
	Houston, GA	
47644	Warren-Troy-Farmington Hills, MI	0.9543
	Lapeer, MI	
	Livingston, MI	
	Macomb, MI	
	Oakland, MI	
	St. Clair, MI	
47894	Washington-Arlington-Alexandria, DC-VA	1.0659
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	

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

- END -

CHAPTER 12
ADDENDUM N

DIAGNOSES ASSOCIATED WITH EACH OF THE DIAGNOSTIC CATEGORIES USED IN CASE-MIX SCORING

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

- END -

CHAPTER 12
ADDENDUM O

DIAGNOSES INCLUDED IN THE DIAGNOSTIC CATEGORIES USED FOR THE NON-ROUTINE SUPPLIES (NRS) CASE-MIX ADJUSTMENT MODEL

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

- END -

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

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

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

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

4. Outlier calculation:

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

b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the year in which the "SER-THRU-DATE" FALLS. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the MSA or CBSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.

c. Subtract the outlier threshold for the episode from the imputed cost for the episode.

d. If the result is greater than $0.00, calculate 0.80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field with return code 01.

e. If the result is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

- END -

2 The MCSC shall conduct an initial evaluation and determine if the requesting hospital meets the disproportionate share criteria in paragraph III.A.5.h.(2), and is essential for continued network adequacy. The request from the hospital for a General TMCPA along with the supporting documentation in paragraph III.A.5.h.(2)(b)1 through 4 and paragraph III.A.5.h.(2)(c), shall be submitted to the DTRO for review and determination.

3 The DTRO shall request TMA MB&RB run a query of claims history to determine if the network hospital qualifies for a General TMCPA, i.e., the hospital's payment-to-cost ratio is less than 1.3 for care provided to ADSMs and ADDs during the previous OPPS year (May 1 through April 30).

4 The DTRO shall review the supporting documentation and the report from TMA MB&RB, and determine if the network hospital qualifies for a General TMCPA. The recommendation for approval of a General TMCPA shall be submitted to the MB&RB to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for TMA Director review and approval.

5 If a hospital meets the disproportionate share criteria in paragraph III.A.5.h.(2), and is deemed essential for network adequacy to support military contingency operations, the approved hospital's General TMCPA payment will be set so the hospital's payment-to-cost ratio for TRICARE Hospital Outpatient Department (HOPD) services does not exceed a ratio of 1.30. A hospital cannot be approved for a General TMCPA payment if it results in the hospital earning more than 30% above its costs for TRICARE beneficiaries.

6 Total TRICARE OPPS payments (including the TTPAs and the Transitional TMCPA) of the qualifying hospital will be increased by the Director TMA, or designee, by way of an additional payment after the end of the OPPS year (May I through April 30). Subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS year to ensure claims that were not PTC the previous year are adjusted. The adjustment payment is separate from the applicable General TMCPA approved for the current OPPS year.

7 Upon approval of the General TMCPA request by the TMA Director, MB&RB shall notify the TRO of the approval. The TRO shall notify the Contracting Officer (CO) who shall send a letter to the MCSC notifying them of the approval.

8 The MCSCs shall submit the General TMCPA amounts on a voucher in accordance with requirements of the TOM, Chapter 3, Section 4. The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, TIN, and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year.

9 CRM shall send an approval to the contractors to issue General TMCPA payments out of the non-financially underwritten bank account based on fund availability.

10 General TMCPAs will be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

(f) TMA Director, or designee review.

1 The Director, TMA or designee is the final approval authority.

2 A decision by the Director TMA or designee to adopt, modify, or extend General TMCPAs is not subject to appeal.

(3) Non-Network TMCPAs.

TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. This determination will be based on the MCSC's and TRO's evaluation of network adequacy data related to the specific procedures for which the TMCPA is being requested as outlined under paragraph III.A.5.h.(2)(c). Non-network TMCPAs will be adjusted on a claim-by-claim basis. The associated costs would be underwritten or non-underwritten following the applicable financing rules of the contract.

(4) Application of Cost-Sharing.

(a) Transitional and General TMCPAs are not subject to cost-sharing.

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

(5) Reimbursement of Transitional, and General TMCPA costs shall be paid as pass-through costs. The MCSC does not financially underwrite these costs.

i. Hold Harmless TRICARE Transitional Outpatient Payments (TTOPs).

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

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

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

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

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

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

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

(b) These query reports will be run in subsequent TTOPs years to determine those hospitals qualifying for TTOPs.

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

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

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

B. Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals.

1. Items Subject to Transitional Pass-Through Payments.

a. Current Orphan Drugs.

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

NOTE: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid

under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

b. Current Cancer Therapy Drugs, Biologicals and Brachytherapy.

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

c. Current Radiopharmaceutical Drugs and Biological Products.

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

d. New Medical Devices, Drugs, and Biologicals.

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

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

a. Pass-through device categories are identified by SI **H**.

b. Pass-through drugs and biological agents are identified by SI **G**.

3. Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009.

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

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

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

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

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

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

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

h. Drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2009 for CY 2009 are displayed in Figure 13-3-5.

FIGURE 13-3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009

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

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

FIGURE 13-3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009 (CONTINUED)

CY 2008	CY 2009			
HCPCS	HCPCS	SHORT DESCRIPTOR	SI	APC
	C9245	Injection, romiplostim	G	9245
	C9246	Inj, gadoxetate	G	9246
	C9248	Inj, clevidipine butyrate	G	9248

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

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

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

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

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

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

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

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

g. Offset Calculations.

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

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

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

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

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

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

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

(5) Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPPS Pricer will select the nuclear medicine procedure with the single highest offset amount, and will adjust the selected offset amount by the wage index of the hospital submitting the claim.

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

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

(8) The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

5. Transitional Pass-Through Device Categories.

a. Excluded Medical Devices.

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

b. Included Medical Devices.

(1) The following implantable items may be considered for the transitional pass-through payments:

(a) Prosthetic implants (other than dental) that replace all or part of an internal body organ.

(b) Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

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

c. Pass-Through Payment Criteria for Devices.

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

(1) They were not recognized for payment as a hospital outpatient service prior to 1997 (i.e., payment was not being made as of December 31, 1996). However, the medical device shall be treated as meeting the time constraint (i.e., payment was not being made for the device as of December 31, 1996) if either:

(a) The device is described by one of the initial categories established and in effect, or

(b) The device is described by one of the additional categories established and in effect, and

1 An application under the Federal Food, Drug, and Cosmetic Act has been approved; or

2 The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or

3 The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of the Act.

(2) They have been approved/cleared for use by the Food and Drug Administration (FDA).

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

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

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

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

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

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

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

(7) They are not material such as biologicals or synthetics that may be used to replace human skin.

(8) No existing or previously existing device category is appropriate for the device.

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

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

d. Duration of Transitional Pass-Through Payments.

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

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

e. General Coding and Billing Instructions and Explanations.

(1) Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-Through Devices Only):

(a) In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices - the device that resulted in fracture and the one that was implanted into the patient.

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

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

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

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

(b) HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned SI of **N** for packaged payment (i.e., hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned SI of **N**. In the case of a device kit, should a hospital choose to report the device charge alone under a

device/device category HCPCS code with SI of **N**, the hospital should report charges for other items that may be included in the kit on a separate line on the claim.

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

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

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

g. Reduction of Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups.

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

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

h. Calculation of Transitional Pass-Through Payment for a Pass-Through Device.

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

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

(3) The offset adjustment is applied only when a pass-through device is billed in addition to the APC[2].

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

Device: (C1884 - Embolization Protective System)

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

Associated procedure: HCPCS Level I[2] code 92982 (APC0083)

Payment rate = $3,289.42

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

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

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.5.h.(4) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$1,200 - $802.06 = $397.94

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

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

TRICARE payment for pass-through device C1884 = $397.94

Beneficiary cost-share liability for APC 0083 = $657.88

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

$2,631.54	TRICARE program payment for HCPCS Level I[2] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[2] code 92982
397.94	Transitional pass-through payment for device
$3,687.36	Total amount received by the provider

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Example #2 Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

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

Associated procedure: HCPCS Level I[3] code 92982 (APC0083)

Payment rate = $3,289.42

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

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

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.5.h.(4) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$1,500 - $0 = $1,500

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

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

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

Beneficiary cost-share liability for APC 0083 = $657.88

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

$2,631.54	TRICARE program payment for HCPCS Level I[3] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[3] code 92982
1,500.00	Transitional pass-through payment for device
$4,789.42	Total amount received by the provider

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

(4) Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

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

(Offset x Discount Rate x Units of Service)

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STEP 2: Sum the products of Step 1.

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

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

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

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

otherwise

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

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

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

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

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

(Line Item Device Charge ÷ Sum of Device Charges)

C. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status.

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

a. Packaged payment, or

b. Separate payment (individual APCs), or

c. Allowable charge.

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

a. Hospitals do not receive separate payment for packaged items and supplies; and

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

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

D. Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals.

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

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

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics, listed in Figure 13-3-6.

FIGURE 13-3-6 ANTIEMETICS EXEMPTED FROM CY 2008 $60 PACKAGING THRESHOLD

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

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

5. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged.

a. "Specified Covered Outpatient Drugs" Classification.

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

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

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

(a) A drug or biological for which payment was first made on or after January 1, 2003, under the transitional pass-through payment provision.

(b) A drug or biological for which a temporary HCPCS code has been assigned.

(c) Orphan drugs.

b. Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals.

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

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. Refer to Section 2, Figure 13-2-15, for a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge methodology up through December 31, 2009.

(a) Therapeutic radiopharmaceuticals must have a mean per day cost of more than $60 in order to be paid separately.

(b) Diagnostic radiopharmaceuticals and contrast agents are packaged regardless of per day cost since they are ancillary and supportive of the therapeutic procedures in which they are used.

c. Designated SI.

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

6. Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data.

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

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

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

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

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

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

7. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Non-Pass-Through Payment.

a. Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPS under Medicare, but were not eligible for pass-through status; and

(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the $60 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

8. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned.

a. The following payment methodology will enable hospitals to begin billing for drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup that could qualify them for pass-through payment under the OPPS:

(1) Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."

(2) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP from a schedule of allowable charges based on the AWP, and process the claim for payment.

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with it's approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPS update.

9. Package payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) into the payment for the associated surgical procedure.

a. As a result, HCPCS codes C9352, C9353, and J7348 are packaged and assigned SI of **N**.

b. Any new biologicals without pass-through status that are surgically inserted or implanted will be packaged beginning in CY 2009.

10. Drugs and non-implantable biologicals with expiring pass-through status.

a. CY 2009 payment methodology of packaged or separate payment based on their estimated per day costs, in comparison with the CY 2009 drug packaging threshold.

b. Packaged drugs and biologicals are assigned SI of **N** and drugs and biologicals that continue to be separately paid as non-pass-through products are assigned SI of **K**.

E. Drug Administration Coding and Payment.

1. The following HCPCS Level I drug administration codes will be assigned to their respective APCs for payment:

FIGURE 13-3-7 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion pump	S	0440
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S	0437
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	S	0438
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	S	0437
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	S	0438
90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N	
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	S	0436
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0438
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0438
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0438
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0438
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0441
96420	Chemotherapy administration, intra-arterial; push technique	S	0439
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0441
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	S	0438
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0441
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0441
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0441

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FIGURE 13-3-7 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS (CONTINUED)

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0441
96521	Refilling and maintenance of portable pump	S	0440
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	S	0440
96523	Irrigation of implanted venous access device for drug delivery systems	Q	0624
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0438
96549	Unlisted chemotherapy procedure	S	0436

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2. The following non-chemotherapy HCPCS codes have also been created that are similar to CPT codes for initiation of prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for services when provided to patients who require extended infusions for non-chemotherapy medications including drugs for pain (see Figure 13-3-8).

FIGURE 13-3-8 NON-CHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0441

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3. Packaged HCPCS Level I codes for drug administration should continue to be billed to ensure accurate payment in the future. These are bill changes for HCPCS Level I codes with SI of **N** that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

4. HCPCS Level I[4] codes 90772-90774 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

5. Drugs for which the median cost per day is greater than $60 are paid separately and are not packaged into the payment for the drug administration. Separate payment for drugs with a median cost in excess of $60 will result in more equitable payment for both the drugs and their administration.

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F. Coding and Payment Policies for Drugs and Supplies.

1. Drug Coding.

a. Drugs for which separate payment is allowed are designated by SI **K** and must be reported using the appropriate HCPCS code.

b. Drugs that are reported without a HCPCS code will be packaged under the revenue center code, under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

c. Drugs billed using revenue code 636 ("Drugs requiring detailed coding") require use of the appropriate HCPCS code, or they will be denied.

d. Reporting charges of packaged drugs is critical because packaged drug costs are used for calculating outlier payments and hospital costs for the procedure and service with which the drugs are used in the course of the annual OPPS updates.

2. Payment for the Unused Portion of a Drug.

a. Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a TRICARE patient, the provider may bill for the amount of the drug discarded, along with the amount administered.

b. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment will be made under OPPS.

EXAMPLE 1: Drug X is available only in a 100-unit size. A hospital schedules three patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen, and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

EXAMPLE 2: An appropriate hospital staff member must administer 30 units of drug X to a patient, and it is not practical to schedule another patient for the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

c. Coding for Supplies.

(1) Supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code.

(2) Charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure, or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

(3) Hospitals should report drugs that are treated as supplies because they are an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

3. Recognition of Multiple HCPCS Codes for Drugs.

a. Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a SI **B** indicating that another code existed for OPPS purposes. For example, if drug X has two HCPCS codes, one for a 1 ml dose and another for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and SI **B** to the 5 ml dose.

b. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under OPPS.

c. Beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor.

d. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

4. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices.

a. When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriated HCPCS code for the product.

b. Separate payment will be made for an implanted biological when it has pass-through status.

c. If the implantable device does not have pass-through status it will be packaged into the payment for the associated procedure.

5. Correct Reporting of Units for Drugs.

a. Units of drugs administered to patients should be accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

b. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patients, the units bill should be one. If the description for the drug code is 50 mg, but 200 mg of the drug was administered, the units billed should be four.

c. Hospitals should not bill the units based on the way the drug is packaged, stored or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units even though only one vial was administered.

G. Orphan Drugs.

1. Continue to use the following criteria for identifying single indication orphan drugs that are used solely for orphan conditions:

a. The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).

b. The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

2. Twelve single indication orphan drugs have currently been identified as having met these criteria.

3. Payment Methodology.

a. Pay all 12 single indication orphan drugs at the rate of 88% of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106% of ASP would exceed 95% of AWP, payment would be capped at 95% of AWP, which is the upper limit allowed for sole source specified covered outpatient drugs.

H. Vaccines.

1. Hospitals will be paid for influenza, pneumococcal pneumonia and hepatitis B vaccines based on allowable charge methodology; i.e., will be paid the CMAC rate for these vaccines.

2. Separately payable vaccines other than influenza, pneumococcal pneumonia and hepatitis B will be paid under their own APC.

3. See Figure 13-3-9 for vaccine administration codes and SIs.

FIGURE 13-3-9 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS

HCPCS LEVEL 1[1] CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	S	0350
G0009	Pneumococcal vaccine administration	S	0350
G0010	Hepatitis B vaccine administration	B	--
90465	Immunization admin, under 8 yrs old, with counseling; first injection	N	--
90466	Immunization admin, under 8 yrs old, with counseling; each additional injection	N	--
90467	Immunization admin, under 8 yrs old, with counseling; first intranasal or oral	N	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	S	0437
90472	Immunization admin, each additional vaccine injections	S	0436
90473	Immunization admin, one vaccine by intranasal or oral	N	
90474	Immunization admin, each additional vaccine by intranasal or oral	N	--

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I. Payment Policy for Radiopharmaceuticals.

Separately paid radiopharmaceuticals are classified as "specified covered outpatient drugs" subject to the following packaging and payment provisions:

1. The threshold for the establishment of separate APCs for radiopharmaceuticals is $60.

2. A radiopharmaceutical that is covered and furnished as part of covered outpatient department services for which a HCPCS code has not been assigned will be reimbursed an amount equal to 95% of its AWP.

3. Radiopharmaceuticals will be excluded from receiving outlier payments.

4. Applications will be accepted for pass-through status; however, in the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, payment will be set for the new radiopharmaceutical as a "specified covered outpatient drug."

J. Blood and Blood Products.

1. Since the OPPS was first implemented, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. The APCs for these products are intended to recover the costs of the products. SI **R** was created in CY 2009 to denote blood and blood products.

2. The OPPS provider also should report charges for processing and storage services on a separate line using Revenue Code 0390 (General Classification), 0392 (Blood Processing/ Storage), or 0399 (Blood Processing/Storage; Other Blood Storage and Processing), along with appropriate blood HCPCS code, the number of units transfused, and the Line Item Date Of Service (LIDOS).

3. Administrative costs for the processing and storage specific to the transfused blood product are included in the APC payment, which is based on hospitals' charges.

4. Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I[5] code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

5. Payment rates for blood and blood products will be determined based on median costs. Refer to Figure 13-3-10 for APC assignment of blood and blood product codes.

FIGURE 13-3-10 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9010		R	Whole blood for transfusion	0950
P9011		R	Split unit of blood	0967
P9012		R	Cryoprecipitate each unit	0952
P9016		R	RBC leukocytes reduced	0954
P9017		R	Plasma 1 donor frz w/in 8 hr	9508
P9019		R	Platelets, each unit	0957
P9020		R	Platelet rich plasma unit	0958
P9021		R	Red blood cells unit	0959
P9022		R	Washed red blood cells unit	0960
P9023		R	Frozen plasma, pooled, sd	0949
P9031		R	Platelets leukocytes reduced	1013
P9032		R	Platelets, irradiated	9500
P9033		R	Platelets leukoreduced irradiated	0968
P9034		R	Platelets, pheresis	9507
P9035		R	Platelets pheresis leukoreduced	9501
P9036		R	Platelet pheresis irradiated	9502
P9037		R	Platelet pheresis leukoreduced irradiated	1019
P9038		R	RBC irradiated	9505
P9039		R	RBC deglycerolized	9504
P9040		R	RBC leukoreduced irradiated	0969
P9043		R	Plasma protein fract, 5%, 50 ml	0956
P9044		R	Cryoprecipitate reduced plasma	1009
P9048		R	Granulocytes, pheresis unit	9506

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FIGURE 13-3-10 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9051	C1010	R	Blood, L/R, CMV-NEG	1010
P9052	C1011	R	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	R	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	R	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	R	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	R	Blood, L/R, Irradiated	1018
P9057	C1020	R	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	R	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	R	Plasma, frz within 24 hours	0955
P9060	C9503	R	Fresh frozen plasma, ea unit	9503

6. For CY 2009, blood clotting factors will be paid at ASP + 4%, plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physician's offices.

K. Adjustment to Payment in Cases of Devices Replaced with Partial Credit for the Replaced Device.

1. Hospitals will be required to append the modifier "FC" to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in Figure 13-3-11. Hospitals should not append the modifier to the HCPCS procedure code if the device is not listed in Figure 13-3-11.

2. Claims containing the "FC" modifier will not be accepted unless the modifier is on a procedure code with SI **S**, **T**, **V**, or **X**.

3. If the APC to which the procedure is assigned is one of the APCs listed in Figure 13-3-12, the Pricer will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in Figure 13-3-12 for partial credit device replacement (i.e., 50% of the device offset when both a device code listed in Figure 13-3-11 is present on the claim and the procedure code maps to an APC listed in Figure 13-3-12) multiplied by the unadjusted payment rate.

4. The partial credit adjustment will occur before wage adjustment and before the assessment to determine if the reductions for multiple procedures (signified by the presence of more than on procedure on the claim with a SI of **T**), discontinued service (signified by modifier 73) or reduced service (signified by modifier 52) apply.

L. Payment When Devices Are Replaced Without Cost or Where Credit for a Replacement Device is Furnished to the Hospital.

1. Payments will be reduced for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. The

amount of the reduction to the APC rate will be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC has pass-through status.

2. This permits equitable adjustments to the OPPS payments contingent on meeting all of the following criteria:

a. All procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures are performed;

b. The required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures, at least temporarily; and

c. The offset percent for the APC (i.e., the median cost of the APC without device costs divided by the median cost of the APC with device costs) must be significant--significant offset percent is defined as exceeding 40%.

3. The presence of the modifier "FB" ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free samples)"] would trigger the adjustment in payment if the procedure code to which modifier "FB" was amended appeared in Figure 13-3-11 and was also assigned to one of the APCs listed in Figure 13-3-12. OPPS payments for implantation procedures to which the "FB" modifier is appended are reduced to 100% of the device offset for no-cost/full credit cases.

FIGURE 13-3-11 DEVICES FOR WHICH "FC" AND "FB" MODIFIERS MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL OR PARTIAL CREDIT FOR A REPLACEMENT DEVICE

DEVICE HCPCS CODE	SHORT DESCRIPTOR
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1789	Prosthesis, breast, imp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp

FIGURE 13-3-11 DEVICES FOR WHICH "FC" AND "FB" MODIFIERS MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL OR PARTIAL CREDIT FOR A REPLACEMENT DEVICE (CONTINUED)

DEVICE HCPCS CODE	SHORT DESCRIPTOR
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

FIGURE 13-3-12 ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2009

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0039	S	Level I Implantation of Neurostimulator	84	42
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	57	29
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	62	31
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	72	36
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74	37
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes	43	21
0107	T	Insertion of Cardioverter-Defibrillator	89	45
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89	44
0222	S	Level II Implantation of Neurological Device	85	42

FIGURE 13-3-12 ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2009 (CONTINUED)

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	62	31
0227	T	Implantation of Drug Infusion Devices	82	41
0229	T	Transcatheter Placement of Intravascular Shunts	84	42
0259	T	Level IV ENT Procedures	88	44
0315	S	Level III Implantation of Neurostimulator	59	29
0385	S	Level I Prosthetic Urological Procedures	69	34
0386	S	Level II Prosthetic Urological Procedures	71	36
0418	T	Insertion of Left Ventricular Pacing Elect	59	29
0425	T	Level II Arthroplasty or Implantation with Prosthesis	46	23
0648	T	Level IV Breast Surgery	77	38
0625	T	Level IV Vascular Access Procedures	76	38
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	71	36
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	71	35
0680	S	Insertion of Patient Activated Event Recorders	71	36
0681	T	Knee Arthroplasty	71	35

4. If the APC to which the device code (i.e., one of the codes in Figure 13-3-11) is assigned is on the APCs listed in Figure 13-3-12, the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in Figure 13-3-12 times the unadjusted payment rate.

5. In cases in which the device is being replaced without cost, the hospital will report a token device charge. However, if the device is being inserted as an upgrade, the hospital will report the difference between its usual charge for the device being replaced and the credit for the replacement device.

6. Multiple procedure reductions would also continue to apply even after the APC payment adjustment to remove payment for the device cost, because there would still be the expected efficiencies in performing the procedure if it was provided in the same operative session as another surgical procedure. Similarly, if the procedure was interrupted before administration of anesthesia (i.e., there was modifier 52 or 73 on the same line as the procedure), a 50% reduction would be taken from the adjusted amount.

M. Policies Affecting Payment of New Technology Services.

1. A process was developed that recognizes new technologies that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals and brachytherapy, or current radiopharmaceutical drugs and biologicals products. This process, along with transitional pass-throughs, provides additional payment for a significant share of new technologies.

2. Special APC groups were created to accommodate payment for new technology services. In contrast to the other APC groups, the new technology APC groups did not take into account clinical aspects of the services they were to contain, but only their costs.

3. The SI **K** is used to denote the APCs for drugs, biologicals and pharmaceuticals that are paid separately from, and in addition to, the procedure or treatment with which they are associated, yet are not eligible for transitional pass-through payment.

4. New items and services will be assigned to these new technology APCs when it is determined that they cannot appropriately be placed into existing APC groups. The new technology APC groups provide a mechanism for initiating payment at an appropriate level within a relatively short time frame.

5. As in the case of items qualifying for the transitional pass-through payment, placement in a new technology APC will be temporary. After information is gained about actual hospital costs incurred to furnish a new technology service, it will be moved to a clinically-related APC group with comparable resource costs.

6. If a new technology service cannot be moved to an existing APC because it is dissimilar clinically and with respect to resource costs from all other APCs, a separate APC will be created for such services.

7. Movement from a new technology APC to a clinically-related APC will occur as part of the annual update of APC groups.

8. The new technology APC groups have established payment rates for the APC groups based on the midpoint of ranges of possible costs; for example, the payment amount for a new technology group reflecting a range of costs from $300 to $500 would be set at $400. The cost range for the groups reflects current cost distributions, and TRICARE reserves the right to modify the ranges as it gains experience under the OPPS.

9. There are two parallel series of technology APCs covering a range of costs from less than $50 to $6,000.

a. The two parallel sets of technology APCs are used to distinguish between those new technology services designated with a SI of **S** and those designated as **T**. These APCs allow assignment to the same APC group procedures that are appropriately subject to a multiple procedure payment reduction (**T**) with those that should not be discounted (**S**).

b. Each set of technology APC groups have identical group titles and payment rates, but a different SI.

c. The new series of APC numbers allow for the narrowing of the cost bands and flexibility in creating additional bands as future needs may dictate. Following are the narrowed incremental cost bands for the two series of new technology APCs:

(1) From $0 to $50 in increments of $10.

(2) From $50 to $100 in a single $50 increment.

(3) From $100 through $2,000 in intervals of $100.

(4) From $2,000 through $6,000 in intervals of $500.

10. Beneficiary cost-sharing/copayment amounts for items and services in the new technology APC groups are dependent on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). (Refer to Chapter 2, Addendum A for applicable deductible cost-sharing/copayment amounts for outpatient hospital services.)

11. Process and Criteria for Assignment to a New Technology APC Group.

a. Services Paid Under New Technology APCs.

(1) Limit eligibility for placement in new technology APCs to complete services and procedures.

(2) Items, material, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC.

(3) A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate), or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy).

(a) In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end.

(b) Drugs, supplies, devices, and equipment in and of themselves are not distinct procedures with a beginning, middle and end. Rather drugs, supplies, devices, and equipment are used in the performance of a procedure.

(4) Unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology.

b. Criteria for determining whether a service will be assigned to a new technology APC.

(1) The most important criterion in determining whether a technology is "truly new" and appropriate for a new APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS Level I and II codes. In other words, a "truly new" service is one that cannot be appropriately described by existing HCPCS codes, and a new HCPCS code needs to be established in order to describe the new procedure.

(2) The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update; i.e., the item is one service that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.

(3) The service does not qualify for an additional payment under the transitional pass-through provisions.

(4) The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. It is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC.

(5) The service falls within the scope of TRICARE benefits.

(6) The service is determined to be reasonable and necessary.

NOTE: The criterion that the service must have a HCPCS code in order to be assigned to a new technology APC has been removed. This is supported by the rationale that in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, a new HCPCS code will be created that describes the new technology service. The new HCPCS would be solely for hospitals to use when billing under the OPPS.

N. Coding And Payment Of ED Visits.

1. CPT defines an ED as "an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must available 24 hours a day."

2. Prior to CY 2007, under the OPPS the billing of ED CPT codes was restricted to services furnished at facilities that met this CPT definition. Based on the above definition, facilities open less than 24 hours a day could not report ED CPT codes.

3. Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital's Dedicated Emergency Department (DED) and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867(h) of the Act specifically phohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status.

4. These provisions are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). The EMTALA regulations define DED as any department or facility of the hospital, regardless of whether it is located on or off the main campus, that meets at least one of the following requirements:

a. It is licensed by the State in which it is located under applicable State law as an Emergency Room (ER) or ED;

b. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

c. During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointment.

5. There are some departments or facilities of hospitals that met the definition of a dedicated ED under the EMTALA regulations, but did not meet the more restrictive CPT definition of ED. For example, a hospital department or facility that met the definition of a DED might not have been available 24 hours a day, seven days a week.

6. To determine whether visits to EDs of facilities (referred to as Type B ED) that incur EMTALA obligations, but do not meet the more prescriptive expectations that are consistent with the CPT definition of an ED (referred to as Type A ED) have different resource costs than visits to either clinics or Type A EDs, five G codes were developed for use by hospitals to report visits to all entities that meet the definition of a DED under the EMTALA regulations, but that are not Type A EDs. These codes are called "Type B ED visit codes." EDs meeting the definition of a DED under the EMTALA regulations, but which are not Type A EDs (i.e., they may meet the DED definition but are not available 24 hours a day, seven days a week).

FIGURE 13-3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDS

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0380	Level 1 Hosp Type B Visit	Level 1 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0381	Level 2 Hosp Type B Visit	Level 2 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

FIGURE 13-3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDS

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0382	Level 3 Hosp Type B Visit	Level 3 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0383	Level 4 Hosp Type B Visit	Level 4 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0384	Level 5 Hosp Type B Visit	Level 5 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

7. The five new Type B ED visit codes for services provided in a Type B ED will be assigned to the five newly established Clinical Visit APCs 0604, 0605, 0606, 0607, and 0608.

8. For CY 2007, the five CPT E/M ED visit codes for services provided in a Type A ED were assigned to the five newly-created ED Visit APCs 0609, 0613, 0614, 0615, and 0616.

9. The definition of Type A and Type B EDs was not modified for CY 2008 because its current definition accurately distinguished between these two types of ED.

10. For CY 2008, Type A ED visits will continue to be paid based on the five ED Visit APCs, while Type B ED visits would continue to be paid based on the five Clinic Visit APCs.

11. A new **G** code (G0390 - Trauma response team activation associated with hospital critical care services) was also created (effective January 1, 2007) to be used in addition to CPT[6] procedure codes 99291 and 99292 to address the meaningful cost difference between critical care when billed with and without trauma activation.

a. If critical care is provided without trauma activation, the hospital will bill with either CPT[6] procedure code 99291, receiving payment for APC 0617.

b. However if trauma activation occurs, the hospital would be called to bill one unit of "G" code (G0390), report with revenue code 68x on the same date of service, thereby receiving payment for APC 0618.

12. The CPT Evaluation and Management (E/M) codes and other HCPCS codes currently assigned to the clinic visit APCs have been mapped in Figure 13-3-14 to 11 new APCs; five for clinic visits; five for ED visits; and one for critical care services, based on median costs and clinical consideration.

FIGURE 13-3-14 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCS FOR CY 2007

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 1 Hospital Clinic Visits	0604	92012	Eye exam, established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		99241	Office consultation
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam Pt lops
		G0379	Direct admit hospital observ
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99243	Office consultation (Level 3)
		99242	Office consultation (Level 2)
		99273	Confirmatory consultation (Level 3)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	90862	Medication management
		92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)

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FIGURE 13-3-14 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCS FOR CY 2007 (CONTINUED)

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 3 Hospital Clinic Visits (Continued)	0606	99274	Confirmatory consultation (Level 4)
		99244	Office consultation (Level 4)
		M0064	Visit for drug monitoring
Level 4 Hospital Clinic Visits	0607	99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour
Trauma Activation	0618	G0390	Trauma Respon. w/hosp criti

O. OPPS PRICER.

1. Common PRICER software will be provided to the contractor that includes the following data sources:

a. National APC amounts

b. Payment status by HCPCS code

c. Multiple surgical procedure discounts

d. Fixed dollar threshold

e. Multiplier threshold

f. Device offsets

g. Other payment systems pricing files (CMAC, DMEPOS, and statewide prevailings)

2. The following data elements will be extracted and forwarded to the outpatient PRICER for line item pricing.

a. Units;

b. HCPCS/Modifiers;

c. APC;

d. Status payment indicator;

e. Line item date of service;

f. Primary diagnosis code; and

g. Other necessary OCE output.

3. The following data elements will be passed into the PRICER by the contractors:

a. Wage indexes (same as DRG wage indexes);

b. Statewide CCRs as provided in the CMS Final Rule and listed on TMA's OPPS web site at http://www.tricare.mil/opps;

c. Locality Code: Based on CBSA - two digit = rural and five digit = urban;

d. Hospital Type: Rural SCH = 1 and All Others = 0

4. The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary EOB with exception for an electronic 835 transaction. Paper EOBs and remits will reflect APCs at the line level and will also include indication of outlier payments and pricing information for those services reimbursed under other than OPPS methodology's, e.g., CMAC (SI of **A**) when applicable.

5. If a claim has more than one service with a SI of **T** or a SI of **S** within the coding range of 10000 - 69999, and any lines with SI of **T** or a SI within the coding range of 10000 - 69999 have less than $1.01 as charges, charges for all lines will be summed and the charges will then be divided up proportionately to the payment rates for each line (refer to Figure 13-3-15). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

FIGURE 13-3-15 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	$19,999	$6,000	$12,000
T	$1	$3,000	$6,000
T	$0	$1,000	$2,000
Total	$20,000	$10,000	$20,000

NOTE: Because total charges here are $20,000 and the first SI of T gets $6,000 of the $10,000 total payment, the new charge for that line is $6,000/$10,000 x $20,000 = $12,000.

P. TRICARE Specific Procedures/Services.

1. TRICARE specific APCs have been assigned for half-day PHPs.

2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI of **A** (i.e., services that are paid under some payment method other than OPPS) until they can be placed into existing or new APC groups.

Q. Validation Reviews.

OPPS claims are not subject to validation review.

R. Hospital-Based Birthing Centers.

Hospital-based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for CPT[7] procedure code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

IV. EFFECTIVE DATE May 1, 2009.

- END -

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CHAPTER 15
SECTION 1

CRITICAL ACCESS HOSPITALS (CAHS)

ISSUE DATE: November 6, 2007
AUTHORITY: 32 CFR 199.14(a)(4), (a)(6)(iii), and (a)(6)(iv)

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

II. DESCRIPTION

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

III. ISSUE

How are CAHs to be reimbursed?

IV. POLICY

A. Background.

1. Hospitals are authorized TRICARE institutional providers under 10 United States Code (USC) 1079(j)(2) and (4). Under 10 USC 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare].". Under 32 CFR 199.14(a)(1)(ii)(D)*(1)* through (9) it specifically lists those hospitals that are exempt from the Diagnosis Related Groups (DRG)-based payment system. Prior to December 1, 2009, CAHs were not listed as excluded, thereby making them subject to the DRG-based payment system.

2. Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole

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

B. Scope of Benefits.

1. Inpatient Services.

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

b. For admissions on or after December 1, 2009, payment for inpatient services of a CAH other than services of a distinct part unit, shall be reimbursed under the reasonable cost method, reference paragraph IV.C.

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

(1) The facility has been certified as a CAH by CMS;

(2) The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care; and

(3) The facility has been granted swing-bed approval by CMS.

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

improved road is any road that is maintained by a local, state, or federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

NOTE: CAHs that are not exempt from the allowable charge methodology may not report condition code B2.

C. Reasonable Cost Methodology. Reasonable cost is based on the actual cost of providing services and excluding any costs, that are unnecessary in the efficient delivery of services covered by the program.

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

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

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

Inpatient CCRs

Numerator Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).

Denominator Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.

Outpatient CCRs

Numerator Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.

Denominator Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

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

charges) for inpatient services and the lesser of 1.36 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

STEP 1: Inpatient, pay the lesser of:

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

STEP 2: Outpatient, pay the lesser of:

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

5. TMA shall provide a list of CAHs to the Managed Care Support Contractors (MCSCs) with their corresponding inpatient and outpatient CCRs by November 1 each year. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

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

D. CAH Listing.

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

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

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

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

H (Continued)

H (Continued)