

An Overview of TRICARE Home Health Care Coverage

TRICARE adopted a Home Health Agency Prospective Payment System (HHA-PPS) in 2004, replacing the previous retrospective fee-for-service model.

Some key elements of HHA-PPS are:

- HHAs must have a valid participation agreement with TRICARE and be Medicare certified.
- HHAs can't reduce or terminate plans of care without notifying the doctor.
- Plan of care must be approved by a physician before authorization is given.
- TRICARE requires TriWest to **pre-authorize** all HHA services.

Services that are included in the HHA-PPS payment are as follows:

- Part-time or intermittent skilled nursing care provided by or under the supervision of a registered professional nurse
- Part-time or intermittent services of a home health aide
- Physical/occupational therapy or speech-language pathology services
- Medical social services under the direction of a physician
- Routine and non-routine medical supplies
- Medical services provided by an intern or resident-in-training under an approved hospital teaching program, when the HHA is affiliated with or under common control of a hospital
- Services at a hospital, skilled nursing facility or rehabilitation center when they involve equipment too cumbersome to bring home

The following exception applies:

- If a Medicare-certified HHA is not available within the service area, TriWest may authorize care in a non-Medicare certified HHA* that qualifies for corporate services provider status under TRICARE. As a result, an alternative fee-for-service payment arrangement is required.

** This could be an HHA which has not sought Medicare certification/approval due to the specialized beneficiary categories it services—patients receiving maternity care and/or patients under the age of 18.*

Pre-Authorization Required

TRICARE policy requires pre-authorization for all home health care services. In addition to establishing appropriateness of the home health care, the authorization process is used to designate the "primary provider status" and maintain the Episode of Care authorization history for each beneficiary.

Authorizations are approved in 60-day Episodes of Care. The HHA will be required to obtain additional authorization if there is a need for subsequent Episodes of Care. If the beneficiary still requires home health care at the end of the initial 60-day episode of care, recertification will be reviewed by TriWest and an authorization completed for a new Episode of Care beginning on day 61.

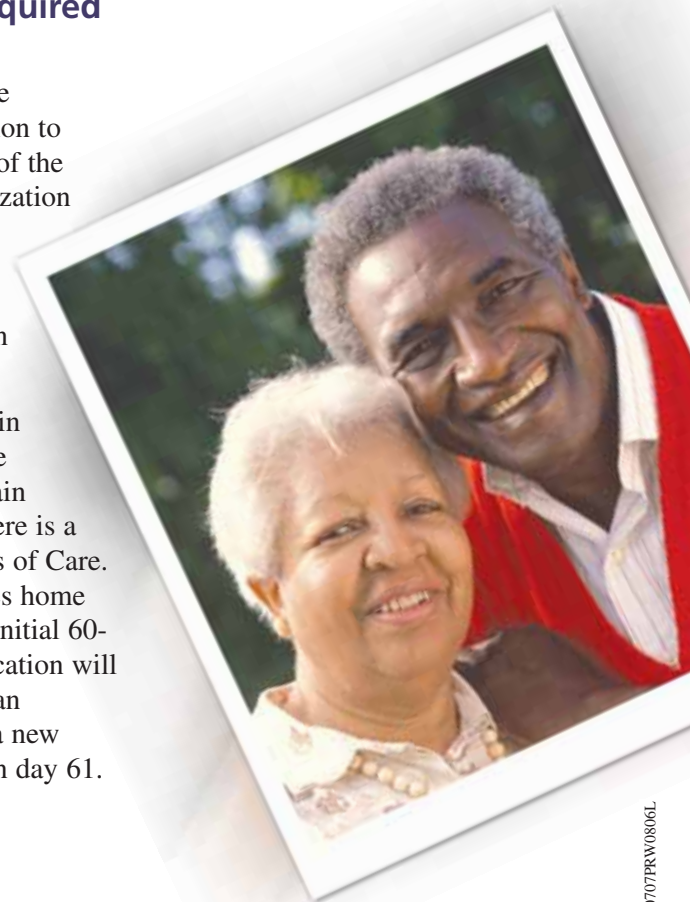
The HHA-PPS authorization approval letter will have the following fields:

Quantity: 1
CPT Code: G0154
Duration: 60 days

If an authorization is received with the above fields, the services are approved for a 60-day episode of care under PPS.

Note: The G0154 code shouldn't be used for billing the PPS. This code is only an internal TriWest indicator of the PPS level of care.

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Providers Can Establish No-Show Fee Policy

Network providers have asked for guidance regarding the billing of TRICARE beneficiaries who have missed an appointment without calling to cancel or reschedule within a specific time period (for example, within 24 hours of the scheduled appointment).

In general, TRICARE regulations do not prohibit providers from establishing practice policies regarding no-show fees. Providers, who as part of their practice standards, require beneficiaries to sign an agreement taking financial responsibility for missed appointments, are within their rights to charge beneficiaries for missing an appointment.

Non-network providers also may charge no-show fees, but like network providers, they must have a financial agreement signed by the beneficiary addressing this.

However, if no formal agreement is in place, the provider may not bill the beneficiary for the missed appointment.

For more information, contact your local network representative or call 1-888-TRIWEST. ■



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Reimbursement

Under HHA-PPS, HHAs are reimbursed with a fixed case-mix and wage-adjusted 60-day episode of care payment. The ordinary unit of payment for HHA-PPS is based on a pre-authorized 60-day Episode of Care. This episode spans a 60-day period that begins with the start of care date (with the first billable service date) furnished to a beneficiary and ending 60 days later. Payment covers the entire Episode of Care regardless of the number of days of care actually provided during the 60-day period.

Providers must bill for HHA PPS services on a UB92 claim form.

Providers can submit two claim forms for each Episode of Care. A Request for Anticipated Payment (RAP) can be submitted as soon as the first visit has

occurred. A final claim is submitted after all the services have been rendered during an Episode of Care or the patient is discharged. Payment for the RAP or final claim will be based on the Health Insurance Prospective Payment System (HIPPS) code that is submitted. HIPPS codes are determined by the Outcome and Assessment Information Set that the HHA completes. It should be the HIPPS code that is entered in the HCPCS/CPT code field of the UB92, **not the G0154 that is on the authorization**. TRICARE Reimbursement Manual, Chapter 12, Section 4, explains the required fields necessary under the PPS.

With a split percentage payment approach, there will be two payments—initial and final. The initial is paid in response to a RAP

and the final in response to a claim. For all initial Episodes of Care (the first 60 days), the percentage split for the two payments will be 60 percent in response to the RAP and 40 percent in response to the claim. For all subsequent Episodes, each of the two percentage payments will equal 50 percent of the total payment. Wisconsin Physicians Service will deduct the RAP payment from the final payment.

A complete description of the TRICARE guidelines regarding HHA-PPS can be found in the TRICARE Reimbursement Manual, Chapter 12, at www.tricare.osd.mil. Refer to www.triwest.com for additional information. ■

Preventive vs. Routine Services

These two terms are commonly misunderstood by providers and beneficiaries alike—preventive services and routine services. A simplified explanation follows:

- Preventive services are a covered benefit to help beneficiaries stay healthy.
- Routine services may be a TRICARE benefit; however, there must be underlying medical necessity for coverage.

Here are some of the details.

Preventive Services

Preventive care is diagnostic and includes medical procedures not related directly to a specific illness, injury or definitive set of symptoms or obstetrical care, but rather performed as periodic health screening, health assessment or health maintenance visits.

Providers should be aware that there are limitations on the frequency of preventive services by type of service. Coverage for clinical preventive services varies, depending on whether a beneficiary is using TRICARE Prime, TRICARE Standard or TRICARE Extra.

Preventive services also are provided without referrals, with the exception of active duty service members, when performed by network providers.

Routine Services

TRICARE covers individual provider services such as office visits; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation (except for chiropractic care); rehabilitation services; and medical supplies used within the office, including casts, dressings and splints. A referral or authorization may be required.

Also included are certain diagnostic radiology and ultrasound (70000-76999); diagnostic nuclear medicine (78000-78999); pathology and laboratory services (80000-89399); and cardiovascular studies (93000-93350).

The TRICARE medical health care benefit covers only adjunctive dental care and does not cover non-adjunctive dental care.

TRICARE beneficiaries are instructed to receive all care, when possible, from network providers in their designated regions.

When billing, remember that TRICARE is based on medical necessity and diagnoses should reflect that. Be careful to follow CPT and ICD-9 regulations when billing and choose a specific diagnosis.

For more information about preventive benefits and routine services, refer to the Medical Coverage section of the newly updated Provider Handbook on www.triwest.com. ■

TRICARE Provider Seminars Coming Soon to the West Region

A new round of TRICARE provider educational seminars from TriWest Healthcare Alliance is coming soon. The seminars are intended to give providers the latest information on TRICARE programs and policies.

Even if you have previously attended a TRICARE seminar, it would be beneficial for you and/or your staff to attend a seminar this fall as these informational sessions will cover new TRICARE information.

Check www.triwest.com for announcements about the Fall 2006 provider seminars and for specific seminar dates throughout the West Region. ■



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CONTACTS

TriWest Customer Service
1-888-TRIWEST
www.triwest.com

TRICARE Alaska Office
(Alaskan providers only)
1-907-743-1800

Wisconsin Physicians Service
(Electronic claims set up only)
1-800-782-2680

Express Scripts, Inc. (ESI)
(Pharmacy inquiries)
1-866-DoD-TRRx
1-866-DoD-TMOP
www.express-scripts.com/TRICARE

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Provider News is published by TRICARE Management Activity. Please provide feedback at www.tricare.mil/evaluations/feedback.



TRICARE Reserve Select Update

Effective June 21, 2006, TRICARE introduced some changes to beneficiary enrollment costs for the TRICARE Reserve Select (TRS) program. These changes apply to the premium tier under which a National Guard/Reserve member may qualify to purchase TRS coverage. TRICARE Reserve Select offers comprehensive health coverage similar to TRICARE Standard and TRICARE Extra.

Enrollment Cards

After purchasing TRS, each beneficiary receives a TRS enrollment card. Providers should make a photocopy of the front and back of the card for their files. Refer to the TRICARE Provider Handbook online at www.triwest.com to view sample TRS enrollment cards. You can also verify TRS beneficiary eligibility online at www.triwest.com

Authorizations for Care

Like other TRICARE coverage, prior authorization is required for certain services under the TRICARE Reserve

Select program. Visit the TriWest Web site at www.triwest.com or call TriWest at 1-888-TRIWEST for the Medical Necessity Review List.

Submitting Claims

TRICARE Reserve Select beneficiary claims should be submitted to Wisconsin Physicians Service in the same manner as TRICARE Standard/Extra beneficiary claims. Network providers are required to submit claims electronically. Non-network providers are encouraged to submit claims electronically.

Providers are encouraged to collect deductibles and cost-shares after receipt of the EOB indicating the beneficiary responsibility.

Please contact TriWest at 1-888-TRIWEST or visit www.triwest.com if you have questions or need additional information about TRICARE Reserve Select. ■