



TRICARE South Region
PDM Data Management
P .O. Box 7039
Camden. SC 29020-7039

Toll-free: 1-800-403-3950
www.myTRICARE.com by PGBA
Fax 803-462-3986

Dear Provider:

Effective October 1, 2001, TRICARE (formally known as CHAMPUS) became a secondary payer to Medicare for approximately 1.5 million Medicare-eligible DoD health care beneficiaries. On December 28, 2001, President Bush signed the National Defense Authorization Act of Fiscal Year 2002 (Pub.L.107-107). This legislation has three important provisions for SNF providers:

- * First, with one exception, the legislation revised the TRICARE Skilled Nursing Facility (SNF) benefit so that it is identical to the Medicare SNF benefit. Like Medicare, the TRICARE SNF benefit will now require a qualifying 3-day prior hospitalization. The skilled services must meet the Medicare coverage rules and be for a medical condition that was either treated during the qualifying 3-day hospital stay, or started while the beneficiary was already receiving Medicare-covered SNF care. The one exception is that, unlike Medicare, the TRICARE benefit for a spell of illness will be unlimited. After exhaustion of the Medicare benefit, TRICARE will become the primary payer if the beneficiary does not have other health insurance.
- * Second, the legislation requires that the TRICARE program adopt the Medicare SNF prospective payment system (PPS) payment methods and rates, including Minimum Data Set (MDS) assessments, Resource Utilization Group (RUG) - III classifications, and Medicare weights and per diem rates. Both of these provisions will take effect for SNF admissions on or after August 1, 2003. Children under age 10 on the date of SNF admission will not be subject to MDS assessments and SNF PPS. In addition, Critical Access Hospital swing beds will not be subject to MDS assessments and SNF PPS. Unless required by their Memorandum of Understanding or the Provider Agreement, VA facilities will not be subject to MDS assessments and SNF PPS. Facilities in Puerto Rico, Guam, the Virgin Islands, and American Samoa will not be subject to MDS assessments and SNF PPS.
- * Third, the recently signed legislation requires that SNF providers enter into a new Participation Agreement with TRICARE if they wish to be considered to be an authorized TRICARE provider. This agreement will require that TRICARE-participating SNFs will not charge a beneficiary any amount above the TRICARE allowed amount. Beneficiaries are financially responsible only for co-insurance amounts and services not covered by TRICARE. SNFs will be required to use the same certification forms for TRICARE beneficiaries as their TRICARE participation agreements if they discriminate against the TRICARE beneficiary in their admission practices or in delivery of medically necessary services due to the level of payment. Accordingly, attached with this cover letter is a TRICARE SNF Participation Agreement for your signature. Please sign and return this agreement within 15 calendar days from the date of this letter to facilitate prompt claims processing. All SNFs must sign and return this agreement if they wish to have TRICARE pay for the care of TRICARE beneficiaries. Claims for non-authorized SNFs will be denied.

There are four other changes for TRICARE SNF providers. First, SNFs must use 21x bill type and Revenue Code 022 on all TRICARE SNF PPS claims. Second, a Health Insurance Prospective Payment System (HIPPS) code must also be put on the PPS claim. This is a five-digit code. The first three digits are an alpha/numeric code identifying the RUG III classification. The last two digits





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are the indicators of the reason for the MDS assessment. Up to 100 days in a benefit period, SNFs will use the same HIPPS codes for TRICARE patients as used under Medicare. After the 100th SNF day in a benefit period, for TRICARE patients, SNFs will use an appropriate three-digit RUG-III code with a TRICARE-specific two-digit modifier that makes up the HIPPS code. The TRICARE-specific two-digit modifiers will be as follows:

120-day assessment.....	8A
120-day assessment.....	8A
150-day assessment.....	8B
180-day assessment.....	8C
210-day assessment.....	8D
240-day assessment.....	8E
270-day assessment.....	8F
300-day assessment.....	8G
330-day assessment.....	8H
360-day assessment.....	8I
Post 360-day assessments with 30-day interval.....	8X

Third, under SNF PPS, all SNF claims (21X bill type) must contain a line item listing (by revenue code) of all services rendered to the SNF inpatient resident during the dates of service on the claim. As under Medicare, SNFs are responsible for making payment to those contractors who have provided services to their TRICARE beneficiaries. The SNF must pay for any service provided to a TRICARE beneficiary by an outside supplier unless that service is excluded from consolidated billing by statute.

Fourth, under SNF PPS, SNFs will continue to be responsible for performing the resident assessment every 30 days after the 90th day using the MDS assessment resident assessment every 30 days after the 90th day using the MDS assessment form, for determining the medical necessity of services, for contracting with outside suppliers, for managing Certificates of Medical Necessity (CMN) from suppliers, and for making appropriate payment to contractors for services rendered to SNF patients. The 'Significant Change in Status Assessments' or 'Significant Correction of Prior Assessments' as applied under Medicare will also apply to these assessments under TRICARE. The SNFs shall use the default HIPPS rate code on the claim in case of an off-schedule or late patient assessment.

The SNF benefit and PPS provisions will also apply to those TRICARE beneficiaries who are not Medicare-eligible.

If you have any questions, please call us at 1-800-403-3950 or visit us at www.myTRICARE.com.





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SKILLED NURSING FACILITY (SNF) PARTICIPATION AGREEMENT

Agreement Between TRICARE And

_____ (Provider)

doing Business as (DBA) _____

TRICARE Provider ID/Number _____
 (To be completed by TRICARE Contractor)

Medicare Provider No. _____
 (To be completed by SNF)

NPI# _____ In order to receive payment under 32 Code of Federal Regulations (CFR) Part 199, _____ DBA _____ as the Provider of skilled nursing services, agrees to conform to the provisions of 32 CFR 199 and applicable provisions in TRICARE Manuals and applicable Medicare provisions in 42 CFR.

This Agreement, upon submission by the Provider of skilled nursing services of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by TRICARE, shall be binding on the Provider of skilled nursing services and TRICARE.

The Provider of skilled nursing services certifies that:

- a. The Provider is licensed by the State having jurisdiction for the Provider's area.
- b. The Provider is Medicare (or Medicaid) certified and will continue to maintain this certification. If at any time the provider is decertified by Medicare (or Medicaid), the provider agrees to notify the TRICARE contractor within 72 hours. Loss of Medicare (or Medicaid) certification will nullify this agreement. Note: For pediatric SNFs, Medicaid certification will be acceptable in lieu of Medicare certification.
- c. The Provider will not discriminate against the TRICARE beneficiary in their admission practices or in delivery of medically necessary services due to the level of payment.
- d. The Provider will use the same certification forms for TRICARE patients as are used and required for Medicare (or Medicaid) patients.
- e. The Provider will participate on all TRICARE SNF claims and will accept TRICARE payment as the full payment and not balance bill the TRICARE beneficiaries. The Provider will collect the applicable cost-share amounts from the TRICARE beneficiaries.

In the event of a transfer of ownership, this Agreement is automatically assigned to the new owner subject to the conditions specified in this Agreement and 42 CFR 489, to include existing plans of correction and the duration of this Agreement, if the Agreement is time limited.





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ACCEPTED FOR THE PROVIDER OF SKILLED NURSING SERVICES BY:

NAME (SIGNATURE)

TITLE

DATE

ACCEPTED FOR TRICARE Contractor by:

NAME (SIGNATURE)

TITLE

DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SKILLED NURSING SERVICES BY:

NAME (SIGNATURE)

TITLE

DATE





TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment. PGBA will initiate payment to you based on the following:

1. PGBA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.
2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.
3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. **You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:**

PGBA, LLC EFT
Fax: 803-462-3995

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a nonbanking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.
5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.

You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: _____ SIGNATURE: _____
(Print)
TITLE: _____ DATE: _____



TRICARE ERA/EFT ENROLLMENT FORM

Transaction Type:

EFT (Electronic Funds Transfer)

ERA (Electronic Remittance Advice)

General Provider Information		
Provider's Name		
Address		
City	State	ZIP
Phone	E-mail Address	
Federal Tax ID	NPI	

Electronic Remittance Advice (ERA) Information
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I hereby authorize _____ to receive
Billing Service/Clearinghouse/Trading Partner

Electronic Remittance Advices (ERA's) on my behalf. I understand that ERA's contain payment information concerning my processed TRICARE claims. I acknowledge that it is my responsibility to notify PGBA, LLC in writing if I wish to revoke this authorization.

EDIG Trading Partner ID/Submitter ID	
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Electronic Funds Transfer (EFT) Information		
Bank Name		
Address		
City	State	ZIP
Bank Contact Name	Phone	
Bank Transit/Routing Number	Account Number	
Type of Account	Saving	Checking

I hereby authorize PGBA, LLC to initiate credit entries and, if necessary, debit entries and adjust and credit entries in error. I also authorize the bank named above to credit and/or debit the same to this account.

Signature(s)	
Name/Title (<i>Please Print</i>)	Date
Signature (<i>I am authorized to endorse this enrollment on behalf of my company.</i>)	Phone

This authorization is to remain in full force and effect until PGBA, LLC has received faxed notification of its termination.

