



## NON-NETWORK HOME HEALTH AGENCY PARTICIPATION AGREEMENT

### INFORMATIONAL LETTER TO TRICARE HOME HEALTH AGENCY

As you may already be aware, Section 701 of the National Defense Authorization Act for Fiscal Year 2002, (Pub. L. 107-107) (December 28, 2001), added a new Section 10 U.S.C. 10745, establishing a comprehensive, part-time or intermittent home health care benefit to be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)). Based on these statutory provisions, TRICARE will be adopting Medicare's benefit structure and prospective payment system for reimbursement of HHAs that are currently in effect under the Medicare program. This includes adoption of the comprehensive Outcome and Assessment Information Set (OASIS) and consolidated billing requirements. The HHA prospective payment system replaces the retrospective physician-oriented fee-for-service model currently used for payment of home health services under TRICARE. Under the new prospective payment system, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's plan of care. Other items such as durable medical equipment, orthotics, prosthetics, osteoporosis drugs, oral cancer and antiemetic drugs and certain vaccines will receive a separate payment amount in addition to the prospective payment system amount for home health care services. Although the overall benefit structure and reimbursement methodology (e.g., OASIS, consolidated billing and system interface with Medicare's Pricer) remains identical to that of Medicare's, there are several major deviations from the Medicare system required to accommodate the uniqueness of TRICARE's managed care health delivery system. Following is a list of the major deviations:

#### Use of the Authorization Process in Lieu of the HHA Query System

Medicare established a national Health Insurance Query System for identifying a "primary" home health agency for billing purposes (i.e., the HHA that would receive payment for all services during a designated episode of care). The primary status was determined by which HHA happened to submit a Request for Anticipated Payment (RAP) first. The on-line query system required the establishment of a HHA PPS episode auxiliary file, which had to be continually updated as RAPs and claims were processed through the contractor's claims processing system. The Agency felt that implementation and maintenance of such an on-line transactional query system would be administratively burdensome and costly to the program. It was also felt that it would circumvent the contractor's utilization management responsibilities/requirements under the managed care concept. As a result, the contractor's existing authorization/preauthorization process will be used to determine "primary status" of the HHA. This will necessitate contractor authorization for all home health care (ie., home health care delivered under both Prime and Standard/Extra programs).

#### OASIS Verification

Under the Medicare HHA PPS, OASIS data is entered into a computer using Home Assessment and Validation Entry (HAVEN) software. The OASIS data is collected, encoded, locked and transmitted to state agencies for validation/verification.

The state agencies:

PGBA, LLC  
Provider Data Management  
P.O. Box 870156  
Surfside Beach, SC 29587-9756  
1-877-TRICARE (1-877-874-2273)  
Fax 1-888-279-3540  
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Receive encrypted transmissions from HHAs.

Validate the reported information while HHA remains on-line to ensure basic elements conform to CMS standards.

Notify HHA if the file has been accepted or rejected via communication link.

Check for errors or exceptions and generate a final validation report up to 48 hours later.

The agency felt that contractor on-line verification would not be administratively practical and that pre- and post-medical review could be used to verify the integrity of the assessment process (i.e., the OASIS data set used in generating the appropriate Home Health Resource Group).

#### Coverage of Drugs and Biologicals Paid Outside the Prospective Payment System

Medicare has a very limited home infusion drug benefit (e.g., while IV supplies are covered under the prospective payment amount, the actual IV pain medication or antibiotics are excluded from coverage). On the other hand, TRICARE has always extended coverage for home infusion drugs and biologicals under its current fee-for-service home health benefit. As a result, payment will be extended beyond the prospective payment amount for drugs and biologicals administered by other than an oral method when: 1) prescribed by a physician or practitioner; 2) approved by the Food and Drug Administration (FDA); and 3) reasonable and necessary for the individual patient. The HHA may bill for the drugs/biologicals on a UB-92 or a home infusion company and/or pharmacy delivering the medication for home administration may bill the contractor directly using a HCFA 1500 claim form with appropriate coding.

The HHA PPS will be implemented with the start health delivery date of the following regional groupings of states under each of the TRICARE Next Generation of Contracts (T-NEX); e.g., as of June 1, 2004, home health agency services in the state of Washington will be processed and paid under the HHA PPS as part of the West T-NEX regional contract.

#### North Region

Health Net Federal Services, Inc.

States in Region:

Delivery date: 1 July 2004

Illinois, Indiana, Kentucky, Michigan, Ohio, Wisconsin,  
West Virginia, Virginia (except the Northern Virginia!

National Capital Area), North Carolina, Eastern Iowa,

Rock Island, IL, Fort Campbell catchment area of Tennessee

Delivery date: 1 September 2004

Connecticut, Delaware, District of Columbia, Maine,

Maryland, Massachusetts, New Hampshire, New Jersey, New

York, Pennsylvania, Rhode Island, Vermont, Northern

Virginia, West Virginia (portion)

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South Region                      Humana Military Healthcare Services  
States in Region:  
Delivery date: 1 November 2004  
Oklahoma, Arkansas and major portions of Texas and Louisiana  
Delivery date: 1 August 2004  
Alabama, Florida, Georgia, Mississippi, Eastern Louisiana,  
South Carolina, Tennessee, small area of Arkansas, New Orleans area

West Region                        TriWest Healthcare Alliance Corp.  
States in Region:  
Delivery date: 1 June 2004  
Washington, Oregon, Northern Idaho  
Delivery date: 1 July 2004  
California, Hawaii, Alaska  
Delivery date: 1 October 2004:  
Arizona, Colorado, Idaho, Iowa, Kansas, Minnesota,  
Missouri, Montana, Nebraska, Nevada, New Mexico, North  
Dakota, South Dakota, western portion of Texas, Wyoming

As of the day of health care delivery of the new contract, all HHAs must bill all services delivered to homebound TRICARE beneficiaries under a home plan of care under the HHA PPS. The HHA PPS applies to claims billed on a CMS Form 1450 (UB-92), the Form Locator 4 (FL 4) Type of Bill (TOB) 32X or 33X. If a HHA has beneficiaries already under an established plan of care prior to this date, the open claims on or before the first day of health care delivery of the new contract must be closed and submitted for payment under standard TRICARE fee-for-service allowable charge methodology. Claims for services on or after the first day of health care delivery of the new contract will be processed and paid under the HHA PPS. Under no circumstances will a HHA claim span payment systems. Claims for service dates spanning payment systems will be returned to the HHA for splitting.

A HHA must either enter into a negotiated provider contract as a network provider or a participation agreement (see enclosed participation agreement) as a non-network provider in order to receive payment under the new HHA PPS. Both the negotiated provider contract and participation agreement will require that HHAs not charge a beneficiary any amount above the TRICARE allowed amount.

You will be notified of any TRICARE beneficiaries receiving care under your program that are exempt from the HHA PPS. Reimbursement will remain the same for these beneficiary categories.

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**TRICARE**

**HOME HEALTH AGENCY PROVIDER APPLICATION**

Home Health Agency Name: \_\_\_\_\_

Federal Tax Number: \_\_\_\_\_ Telephone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

NPI# \_\_\_\_\_

Office Location (street address):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mailing Address (if different):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date legal entity established: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the facility MEDICARE certified? \_\_\_\_ Yes \_\_\_\_ No

Please attach copy of your MEDICARE Certification letter.



## TRICARE PARTICIPATION AGREEMENT FOR MEDICARE CERTIFIED HOME HEALTH AGENCIES

In order to receive payment under TRICARE, \_\_\_\_\_ dba  
\_\_\_\_\_ as the provider of services agrees:

1. Not to charge a beneficiary for the following:
  - a) Services for which the provider is entitled to payment from TRICARE;
  - b) Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
  - c) Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;
  - d) Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and
  - e) Services rendered during a period in which the provider was not in compliance with one or more conditions or authorization:
2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;
3. To accept the TRICARE determined allowable payment combined with the costshare, deductible, and other health insurance amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE allowed services;
4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/copayment;
5. To permit access by the Executive Director, IMA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;
6. To provide to the Executive Director, TMA or designee (e.g., Managed Care Support Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;
7. To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider renders services;
8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected;

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- 9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;
- 10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation or treatment;
- 11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;
- 12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary; and
- 13. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

TRICARE Management Activity (TMA) agrees to:

Pay the above-named provider the full allowable amount less any applicable double coverage, cost-share/copayment, and deductible amounts.

This agreement shall be binding on the provider and TMA upon acceptance by the Executive Director, TMA, or designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by TMA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

FOR PROVIDER OF SERVICES BY:

OR TMA BY:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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**Non-Network UB-04 “Signature on File” for TRICARE Claims Form**

Please complete the following information and return by fax to 1-888-250-4355

This form serves the purpose of the signature requirements indicated in the TRICARE Operations Manual (Chapter 8, Section 4, Paragraph 10.0.)

“The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider’s signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim.”

I, \_\_\_\_\_ hereby authorize PGBA, LLC / Health Net  
(print/type name here)

Federal Services in the state of South Carolina to accept my signature shown below as my true signature for all claim submissions for the facility indicated below.

Facility Name: \_\_\_\_\_

Facility Tax Identification Number: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Phone Number: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

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**ELECTRONIC FUNDS TRANSFER (EFT)**

Complete and FAX/Mail to: TRICARE North EFT, PO Box 870154, Surfside Beach, SC 29587-9754 or FAX completed form to 1-888-536-2324. (For assistance contact our EDI Help desk at, 1-877-334-2524).

**PART I – PROVIDER OR SUPPLIER INFORMATION**

Tax Identification ( EIN or  SSN) \_\_\_\_\_  
National Provider Identifier \_\_\_\_\_  
Name \_\_\_\_\_  
Business Physical Address \_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**PART II – BANKING INFORMATION**

Bank name \_\_\_\_\_  
Bank Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Bank contact name: \_\_\_\_\_ Phone Number \_\_\_\_\_  
Bank Transit Number/ Routing Number (nine digit) \_\_\_\_\_ Bank Account Number \_\_\_\_\_  
Type of Account (check one)  Checking Account  Saving Account

**PART III – CONTACT PERSON**

Name \_\_\_\_\_  
Business Physical Address \_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

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 (person with signature authority) \_\_\_\_\_ Date \_\_\_\_\_

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