



TRICARE South Region  
 Provider Data Management  
 P.O. Box 7039  
 Camden, SC 29020-7039  
 Fax 803-462-3986

Toll-Free: 1-800-403-3950

TRICARE  
 INSTITUTIONAL PROVIDER APPLICATION

FACILITY NAME: \_\_\_\_\_

FEDERAL TAX NO: \_\_\_\_\_ NPI# \_\_\_\_\_

Office Tele. No:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Billing Tele. No:(\_\_\_\_)\_\_\_\_-\_\_\_\_

OFFICE LOCATION (Street Address): MAILING ADDRESS (If different):

_____	_____
_____	_____
_____	_____

Is the facility Medicare certified: \_\_\_\_YES \_\_\_\_NO If yes:

CERTIFICATION NO  
 (ORIGINAL): \_\_\_\_\_ CATEGORY: \_\_\_\_\_

ORIGINAL CERT. DATE: \_\_/\_\_/\_\_ CURRENT CERT. DATES \_\_/\_\_/\_\_  
 TO \_\_/\_\_/\_\_

Is the facility JCAHO certified: \_\_\_\_YES \_\_\_\_NO If yes:

JCAHO  
 CLASSIFICATION: \_\_\_\_\_

ORIGINAL CLASS. DATE: \_\_/\_\_/\_\_ CURRENT CLASS. DATES \_\_/\_\_/\_\_ TO  
 \_\_/\_\_/\_\_

STATE LICENSE CLASSIFICATION  
 (ORIGINAL): \_\_\_\_\_

ORIGINAL LICENSE DATE: \_\_/\_\_/\_\_ CURRENT LICENSE DATES: \_\_/\_\_/\_\_  
 TO \_\_/\_\_/\_\_

\*\*\* YOU MUST ATTACH COPIES OF MEDICARE, JCAHO AND STATE  
 LICENSING. \*\*\*





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Is your facility classified as a:

\_\_\_\_ Sole Community Hospital (attach proof of Medicare Classification)

\_\_\_\_ Children's Hospital

\_\_\_\_ Teaching Facility            Please complete the following:

Number of Beds, excluding exempt unit \_\_\_\_\_

Number of Interns/Residents at most recent Fiscal Year end \_\_\_\_\_

Residential Treatment Centers (RTC), Substance Use Disorder Rehabilitation Facilities (SUDRF) and Psychiatric Partial Hospitalization Programs (PHP) must be certified by the National Quality Monitoring Contract (NQMC-Maximus). Their phone number is: 1-608-308-7160

NQMC- Maximus  
1600 E Northern Ave  
Ste. 100  
Phoenix AZ 85020





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HEALTH PROGRAM BENEFIT AGREEMENT

In order to receive payment under TRICARE Management Activity (TMA),  
 \_\_\_\_\_, dba \_\_\_\_\_  
 the provider of services agrees:

(A) To accept as payment for inpatient services provided to eligible beneficiaries, the TRICARE determined allowable amount. This amount will be determined in accordance with the requirements of Title 32 of the Code of Federal Regulations Part 199 (32 CFR 199).

(B) To refrain from billing the TRICARE eligible beneficiary for amounts which exceed the TRICARE determined allowable amount except for services not covered by TRICARE as described in 32 CFR 199 and for amounts which constitute the TRICARE beneficiary's liability for cost-share and deductible.

TMA agrees:

(A) to pay the hospital the full allowable amount less any applicable cost-share and deductible amounts.

This agreement shall be binding on the provider and TMA upon submission by the provider of acceptable assurance of compliance with title VI of the Civil Rights Act of 1973 as amended, and upon acceptance by the Director, TMA, or his designee.

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

The agreement may be terminated by either party by giving the other party written notice of termination. Such notice of termination is to be received by the other party no later than 30 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:

FOR TMA BY:

\_\_\_\_\_  
 NAME

\_\_\_\_\_  
 NAME

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE





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An assistant surgeon is a physician, dentist or podiatrist acting within the scope of their license who actively assists the operating surgeon in the performance of a covered surgical service. Physician assistants are also recognized as assistant surgeons under TRICARE. TRICARE benefits are allowable only when the assistant surgeon is considered **MEDICALLY NECESSARY**. Services of an assistant surgeon are considered medically necessary when the surgical procedure is of the complexity and seriousness as to warrant a surgical assistant (other than the surgical nurse or other such operating room personnel), and interns, residents or other hospital staff are **NOT** available to provide surgical assistance.

The operating surgeon must certify in writing to the nonavailability of a qualified intern, resident or other hospital physician. In lieu of the operating surgeon's certification, the hospital may certify that they do not have internal staff available at any time to perform the services of assistant surgeons.

If the statement below pertains to your facility, we will document our files accordingly. Please return this form with the signature of an authorized hospital representative with the enclosed application package.

I, \_\_\_\_\_, CERTIFY THAT THE FACILITY NOTED  
BELOW HAS NO INTERNAL STAFF AVAILABLE AT ANY TIME TO PERFORM  
THE SERVICES OF AN ASSISTANT SURGEON.

\_\_\_\_\_  
SIGNATURE TITLE DATE

NAME OF  
FACILITY: \_\_\_\_\_





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Dear Home Healthcare Provider:

As a valued TRICARE provider for Palmetto Government Benefits Administrators (PGBA, LLC) we would like to inform you of changes coming to home healthcare services in your region for homebound TRICARE beneficiaries.

Effective August 1, 2004, TRICARE will implement the Home Health Agencies Prospective Payment System (HHA-PPS) in the South. TRICARE will apply covered benefit criteria and reimbursement methodology/pricing prescribed under the HHA-PPS for all appropriate home healthcare services and claim filing. The TRICARE maximum allowable charge (TMAC) for home healthcare services will be HHA-PPS reimbursement comparable to the Medicare HHA-PPS reimbursement for each qualifying event.

Beginning August 1, 2004, all claims filed by home healthcare agencies/providers must meet the initial and continuing care guidelines defined for Medicare and adopted by TRICARE for qualifying homebound services and reimbursement. TRICARE will require a prior authorization for homebound care. Claims with dates of service on or after August 1, 2004 must be filed on CMS 1450 claim forms and reflect the appropriate HHA-PPS claim type/codes in order to process for payment. If you currently have a TRICARE beneficiary under your care for home healthcare services, please be aware that a final bill will need to be submitted with an end date prior to August 1, 2004, in order for the claim to pay according to existing guidelines.

A new treatment plan will be required to restart the patient services under the new guidelines for any beneficiary that continues home healthcare on or after August 1, 2004. Home healthcare agencies must call Humana Military Healthcare Services at 1-800-444-5445 on August 2, 2004 to speak to a case manager and initiate a new authorization for existing TRICARE patients who qualify to continue home healthcare. Prior Authorizations will be required on all new TRICARE patients referred for home healthcare services beginning August 1, 2004.

A condition for coverage under HHA PPS requires that the HHA providing the services to the beneficiary has in effect a valid agreement to participate in the TRICARE program. In TNEX, all home health agencies are classified as a Corporate Service Provider Class and are required to complete and return a signed Corporate Service Provider Class Participation Agreement to be eligible for payment under TRICARE.





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Attachments include the official government notice for implementation of TRICARE HHA-PPS that provides an overview, requirements, and effective dates, as well as a copy of the Corporate Service Provider Class Participation Agreement. Please review the enclosed TRICARE information, fill out and sign the enclosed participation agreement and mail it back to PGBA, LLC in the enclosed business reply envelope.

Thank you for your continued support and participation in the TRICARE program for PGBA, LLC. If you have any questions, please call us at 1-800-403-3950.



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Home Health Agency  
PARTICIPATION AGREEMENT  
Agreement Between TRICARE  
And

\_\_\_\_\_ (Provider)

doing business as (DBA) \_\_\_\_\_

TRICARE Provider ID/Number \_\_\_\_\_ Medicare Provider No. \_\_\_\_\_

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

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 compliance with one or more conditions of 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 cost-share, 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/co-payment;
5. To permit access by the Executive Director, TMA, 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;



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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;
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 of 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 less any applicable double coverage, cost-share, and deductible amount

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.





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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:

FOR TMA BY:

\_\_\_\_\_  
NAME

\_\_\_\_\_  
NAME

\_\_\_\_\_  
Title      Date

\_\_\_\_\_  
Title      Date



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## LETTER TO THE HOME HEALTH AGENCY (HHA)

Dear Home Health Provider:

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. 1074j, 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 as a fixed case-mix and wage-adjusted 60-day episode payment amount for professional homehealth 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



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through the contractor's 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 (i.e., 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:

1. Receive encrypted transmissions from HHAs.
2. Validate the reported information while HHA remains on-line to ensure basic elements conform to CMS standards.
3. Notify HHA if the file has been accepted or rejected via communication link.
4. 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.





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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 (TNEX); 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 TNEX regional contract.

<u>TNEX Region/Contractor</u>	<u>States</u>	<u>Start Healthcare Delivery</u>
North (Health Net Federal Services, Inc.)	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	1 July 2004
North (Health Net Federal Services, Inc.)	Connecticut, Delaware, District of Columbia, Maine Maryland, Massachusetts, New Hampshire, New Jersey, New York Pennsylvania, Rhode Island, Vermont, Northern Virginia West Virginia (portion)	1 September 2004
South (Humana Military Healthcare Services)	Oklahoma, Arkansas and major portions of Texas and Louisiana	1 November 2004
	Alabama, Florida, Georgia, Mississippi, Eastern Louisiana South Carolina, Tennessee, small area of Arkansas, New Orleans Area	1 August 2004
West (TriWest Healthcare Alliance Corp.)	Washington, Oregon, Northern Idaho	1 June 2004
	California, Hawaii, Alaska	1 July 2004





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Arizona, Colorado, Idaho, Iowa,  
Kansas, Minnesota, Missouri,  
Montana, Nebraska, Nevada,  
New Mexico, North Dakota,  
South Dakota, western portion  
of Texas, Wyoming

1 October 2004

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As of the day of health care delivery of the new contract, all HHAs must bill all services delivered to home bound TRICARE beneficiaries under a home plan of care under the HHA PPS. The HHA PPS applies to claims billed on a CMS 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 the 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.

If you should have any further questions regarding implementation of the new HHA PPS, please contact PGBA, LLC at 1-800-403-3950.



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### UB-04 "Signature on File Form" For TRICARE Claims

Beginning January 1, 2008, all UB-04 paper claim submissions for TRICARE must include a signature on the claim form in order to process. The provider signature should be applied in the "Remarks Field" (FL80) of the UB-04 claim form.

However, if you would like to eliminate the need to apply a signature in the remarks field on each and every claim submitted please complete this form and return it to the fax number provided.

IN order to prevent delays in processing your TRICARE claims we are offering this "Signature on File Form."

Please provide the information requested below and fax this form to the PGBA fax number listed. Once received at PGBA, this completed form will be retained and applied for future claim submissions from your facility thus eliminating the need to apply a signature to each individual claim filed.

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

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

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

Please fax the completed form to: 803-462-3986

Signature on this form certifies that any changes submitted by the facility on a UB-04 are true, accurate and correct. Signature on this form meets the policy requirement from TRICARE Operations Manual Chapter 8, Section 10, as stated below and negates the need for a signature in block 80 of the UB-04.

"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 signatures on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim."

