TRICARE NON-NETWORK HOSPICE PROVIDER APPLICATION

*We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS -1450) forms. These forms must include the instructions on the back page.*

Please submit the completed application package to:

Fax: 844-730-1373

or

Mail to:

TRICARE West

Provider Data Management

PO Box 202106

Florence, SC 29502-2106

*Health Net Federal Services offers payments and remittances by National Provider Identifier (NPI) number. **The NPI billed on the claim will determine where payment and remittance will be sent.** It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.*

*If your business requires multiple mailing/payment addresses, please provide an NPI for each. **If you have more than one NPI, you must complete a separate application for each NPI number.***

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TRICARE NON-NETWORK HOSPICE PROVIDER APPLICATION

Facility Name: _____

Federal Tax Number: _____

NPI# _____

Office Location (Street Address): Billing Address for this NPI:

_____ _____

_____ _____

_____ _____

Telephone Number: _____

Date legal entity established: _____

Is the facility MEDICARE certified? ☐ Yes ☐ No

Certification Number: _____

Original Certification Date: _____

Current Certification Dates: _____ TO _____

PLEASE ATTACH COPY OF MEDICARE CERTIFICATION.

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PARTICIPATION AGREEMENT FOR HOSPICE PROGRAM SERVICES FOR TRICARE BENEFICIARIES

ARTICLE 1
RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, Defense Health Agency (hereinafter DHA), a field activity of the Office of Secretary of Defense, the administering activity for TRICARE/Civilian Health and Medical Program of Uniformed Services Management Activity (hereinafter DHA) and

_____, doing business as

_____, (hereinafter designated the hospice program).

1.2 Authority for Hospice Care

The implementing regulations for TRICARE, 32 Code of Federal Regulations Part 199, provides for TRICARE cost-sharing of hospice care under certain conditions.

1.3 Intent of Participation Agreement

It is the intent of this participation agreement to recognize the undersigned hospice program as a TRICARE-authorized provider of hospice care, subject to terms and conditions of this agreement, and applicable federal law and regulation.

1.4 Billing Number

The number used for billing of all hospice care is the hospice program's employer identification number (EIN). This number must be used until the provider is officially notified by DHA of a change. The hospice program's billing number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by DHA claims processors after the effective date of this hospice program under TRICARE.

ARTICLE 2
PERFORMANCE PROVISIONS

2.1 General Agreement

The hospice program agrees to render palliative hospice care to eligible TRICARE beneficiaries as required by this participation agreement and the TRICARE regulation (32 CFR 199). The terms and conditions of 32 CFR 199 applicable to the participation or treatment of TRICARE beneficiaries by hospice programs are incorporated herein by reference.

2.2 Coverage/Benefits

(a) The hospice program agrees to provide the care and services set forth in 32 CFR 199.4(e)(l9)(i).

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(b) The hospice program further agrees to provide for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency must:

(1) Routinely supply a substantial amount of core-services (i.e., nursing services; physician services; medical social services; and counseling) services for the TRICARE beneficiary and his or her family (32 CFR l99.4(e)(l9)(ii)).

(2) Maintain professional management responsibility of non-core services (i.e., home health aide services, medical appliances and supplies, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered (32 CFR 199.4(e)(19)(iii)).

(3) Make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for palliation and management of the terminal illness and related condition (32 CFR l99.4(e)(19)(iv)).

(4) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20% of the aggregate number of days of hospice care during the same period.

(5) Have an interdisciplinary group (i.e., one physician; one registered nurse; one social worker; and one pastoral or other counselor) who provides those services set forth in 32 CFR 199.4(e)(19)(i) and establishes the policies governing the provision of such services/care.

(6) Maintain central clinical records on all patients.

2.3 Conditions for Coverage

Under the terms of this agreement, the hospice program shall:

(a) Assure that there is written certification in the medical records that the TRICARE beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(1) For the initial 90-day period, the hospice must obtain written certification statements from the individual's attending physician (if the individual has an attending physician) and the medical director of the hospice or the physician member of the hospice interdisciplinary team no later than (NLT) two days after the period begins. If written certifications cannot be obtained within two calendar days, then oral certification must be obtained within two calendar days, followed by written certification NLT eight calendar days after hospice care is initiated.

(2) Recertification is required for any subsequent periods (for periods two, three and four) of hospice care for which the beneficiary is eligible. The hospice medical director or staff physician will be responsible for recertifying TRICARE beneficiaries for subsequent election periods. A written certification must always be in the medical records not later than two days after hospice care is initiated.

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(b) Design and print its own election statements to include the following information:

(1) identification of the particular hospice that will provide care to the individual;

(2) individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;

(3) individual's or representative's acknowledgement that he or she understands that certain TRICARE services are waived by the election;

(4) effective date of election; and

(5) signature of the individual or representative.

(c) Assure that an election statement is in the clinical records prior to signing the Notice of Admission. This includes the admission date, which must be the same date as the effective date of the hospice election. The hospice program must notify the contractor of the initiation, change or revocation of any election.

(d) Establish a written plan of care on the same day that a member of the basic interdisciplinary group assesses the patient's needs. The attending physician and medical director or physician designee must review the initial plan of care and provide their input within two calendar days following the day of the assessment.

2.4 Certification Requirements

The hospice program certifies and attaches hereto documentation that:

(a) it is Medicare approved and meets all Medicare conditions of participation (42 CFR 418); and

(b) is licensed pursuant to any applicable state or local law.

2.5 Quality of Care

(a) The hospice program shall assure that any and all eligible beneficiaries receive hospice services that are reasonable and necessary for the palliation or management of a terminal illness and meet the conditions for coverage as established in Article 2.3.

(b) The hospice program shall provide hospice services in the same manner to TRICARE beneficiaries as it provides to all patients to whom it renders service.

(c) The hospice shall not discriminate against TRICARE beneficiaries in any manner, including admission practices or provisions of special or limited treatment.

2.6 Billing Form

(a) The hospice program shall use the Centers for Medicare and Medicaid Services (CMS) 1450 UB-92 billing form (or subsequent editions.) Hospice care shall be identified in item 4 of this form.

(b) The CMS 1450 UB-92 billing form (or subsequent editions) will also use as an admission notice. This notice will be used to notify the contractor of the initiation, change or

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revocation of an election.

2.7 Compliance with DHA Medical Review Activities

(a) Submit all medical records and documentation to the contractor and, where applicable, to the Peer Review Organization within 30 days of the date of their request.

(b) Failure to submit the requested information will result in denial of the claim.

2.8 Staff Qualifications

The hospice shall comply with requirements for professional staff qualifications as established in 32 CFR 199.4 and 32 CFR 199.6.

ARTICLE 3
PAYMENT PROVISIONS

3.1 The hospice program agrees to accept reimbursement at one of four predetermined national TRICARE rates (32 CFR 199.14(9)) adjusted for regional wage differences using appropriate Medicare wage indices as payment in full, except for physician-directed services and applicable cost-shares. The hospice will be reimbursed for an amount applicable to the type and intensity of the services furnished (i.e., routine home care, continuous home care, inpatient respite care and general inpatient care) to the TRICARE beneficiary on a particular day.

(a) One rate will be paid for each level of care, except for continuous home care where reimbursement is based on the number of hours of continuous care furnished on a particular day. The following requirements must be met in order to receive reimbursement for continuous home care:

(1) More than half of the period of continuous care must be provided by either a registered or licensed practical nurse.

(2) A minimum of 8 hours must be provided during a 24-hour day which begins and ends at midnight. If less than 8 hours of care are provided within a 24-hour period, the care will be paid at the lower routine home care rate.

(b) Payment for inpatient respite care may be for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(c) The hospice program agrees to submit all claims as a participating provider. DHA agrees to make payment of the TRICARE-determined rate directly to the hospice program for any care authorized under this agreement.

(d) There may be a reclassification of care from one rate category to another as a result of medical review of hospice claims. For example, if continuous home care is provided to a TRICARE beneficiary whose condition did not require the level of care described in 32 CFR 199.14 (or did not receive it), payment is made for the services at the routine home care rate.

3.2 Physician reimbursement is dependent on the physician's relationship with both the beneficiary and the hospice program.

(a) Physicians employed by, or contracted, with, the hospice

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(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are subject to the appropriate TRICARE allowable charge methodology and are counted toward cap limitation.

(b) Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by, or under contract with, the hospice) are not part of the hospice benefit and may be billed in his/her own right.

(1) Services are subject to the appropriate allowable charge methodology but not counted toward the cap limitation.

(2) Services must be coordinated with any direct care services provided by hospice physicians.

(3) The hospice must notify the contractor of the name of the physician whenever the attending physician is not a hospice employee.

(c) No payments are allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against TRICARE beneficiaries; e.g., designate all services rendered to non-TRICARE patients as volunteer and at the same time bill for TRICARE patients.

3.3 The hospice program agrees to the cap and inpatient limitations as prescribed in 32 CFR l99.l4(g)(3).

(a) The hospice program further agrees to furnish such information as the contractor deems necessary for calculation and application of the cap amount and inpatient limitations within 30 days after the end of the cap period.

(b) Payments in excess of the cap and/or inpatient limitations must be refunded by the hospice.

(c) A hospice may request and obtain a contractor's review of calculation and application of its cap amount and inpatient limitation if the amount in controversy meets the administrative dollar level established in 32 CFR 199.14(g)(3). These calculations are not subject to the appeal procedures set forth in 32 CFR 199.10.

3.4 The hospice program agrees to hold eligible TRICARE beneficiaries harmless (not to charge the beneficiary) for the following services:

(a) those for which the provider is entitled to payment from TRICARE;

(b) those for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements (e.g., election notification, care plan and submission of requested records within 30 days);

(c) those which are not necessary for the palliation or management of the terminal illness;

Note: If the patient is informed that the services are not covered under the TRICARE hospice benefit and continues to insist that it be performed, he or she will be liable for payment. The

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above item only applies to those services and supplies prescribed by the hospice.

(d) those for which a beneficiary would be entitled to payment, but for a reduction or denial in payment as a result of quality review;

(e) those rendered during a period in which the hospice was not in compliance with one or more conditions for coverage.

3.5 TRICARE as Secondary Payor

(a) The hospice program is subject to the provisions of 10 USC Section 1079(j)(1). The hospice program must submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage before submitting a claim to TRICARE.

(b) Failure to collect first from primary health insurers and/or sponsoring agencies is a violation of this agreement, may result in denial or reduction of payment, and may result in a false claim against the United States. It may also result in termination by DHA of this agreement pursuant to Article 5.

3.6 Collection of Cost-Share

(a) The hospice program agrees to collect from the TRICARE beneficiary only those amounts applicable to the patients cost-share as defined in 32 CFR l99.14(g)(8).

(b) The collection of cost-shares by individual hospice programs is optional under TRICARE. The waiver of cost-sharing will not be considered fraudulent billing under 32 CFR 199.9.

3.7 Beneficiary's Rights

If the hospice program fails to abide by the terms of this participation agreement and DHA or its designee either denies the claim or claims and/or terminates the agreement as a result, the hospice agrees to forego its rights, if any, to pursue the amounts not paid by TRICARE from the beneficiary or the beneficiary's family.

ARTICLE 4
RECORDS AND AUDIT PROVISIONS

4.1 On-Site and Off-Site Reviews/Audits

The hospice program grants the Deputy Director, DHA or designee the right to conduct quality assurance audits or accounting (record) audits with full access to patients and records. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. The right to audit/review includes, but is not limited to:

(a) Examination of fiscal and all other records of the hospice program which would confirm compliance with this agreement and designation as an authorized TRICARE hospice provider.

(b) Audits of hospice program records including clinical, financial, and census records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided TRICARE beneficiaries. DHA or a designee shall have full

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access to records of both TRICARE and non-TRICARE patients.

(c) Examination of reports of evaluations and inspections conducted by federal, state, local government and private agencies and organizations

4.2 Right to Unannounced Inspection of Records

(a) DHA or its designee, shall have the authority to visit and inspect the hospice program at all reasonable times on an unannounced basis.

(b) The hospice program's records shall be available and open for review by DHA during normal working hours (8am to 5pm, Monday through Friday) on an unannounced basis.

4.3 Certified Cost Reports

Upon request, the hospice program shall furnish DHA or a designee audited cost reports certified by an independent auditing agency.

4.4 Records Requested by DHA

Upon request, the hospice program shall furnish DHA or a designee such records, including medical records and patient census records, that would allow DHA or a designee to determine the quality and cost effectiveness of care rendered.

4.5 Failure to Comply

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to Article 6, and any other appropriate action by DHA.

ARTICLE 5
GENERAL ACCOUNTING OFFICE

5.1 Right to Conduct Audit

The hospice program grants the United States General Accounting Office the right to conduct audits.

ARTICLE 6
TERMINATION AND AMENDMENT

6.1 Termination of Agreement by DHA

(a) The Deputy Director, DHA, or designee, may terminate this agreement upon 30 days written notice, for cause, if the hospice program is not complying substantially with the provisions of this agreement or with applicable provisions set forth in 32 CFR 199. Causes for termination include violation of patient charging and cost reporting procedures, refusal to provide required program information or willfully providing false information, failing to meet the Conditions of Participation, and administrative remedies involving fraud, abuse, or conflict of interest as set forth in 32 CFR 199.9. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in 32 CFR 199.10.

Note: The notice provisions in this article do not limit DHA's authority to suspend claims processing or seek recoupment of claims previously paid.

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(b) After termination of the agreement, the hospice program may not file another agreement to participate unless TRICARE finds that the reason for termination of the prior agreement has been removed and that there is reasonable assurance that it will not recur.

6.2 Termination of Agreement by the Hospice Program

The hospice program may terminate this agreement by giving the Deputy Director, DHA, or designee, written notice of such intent to terminate at least 6 months in advance of the effective date of termination. If the hospice program permanently or temporarily ceases to furnish services to the community, the agreement terminates effective with the data the program goes out of business.

6.3 Amendment by DHA

(a) The Deputy Director, DHA, or designee, may amend the terms of this participation agreement by giving 120 days notice in writing of the proposed amendment(s) **except** when necessary to amend this agreement from time to time to incorporate changes to the TRICARE regulation. When changes or modifications to this agreement result from changes to the TRICARE regulation through rulemaking procedures, the Executive Director, DHA, or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective or the date this agreement is amended, whichever date is earlier.

(b) The hospice program, not wishing to accept the proposed amendment(s), including any amendment resulting from changes to the TRICARE regulation accomplished through rulemaking procedures, may terminate its participation as provided in this Article. However, if the hospice program's notice of intent to terminate its participation is not given at least 6 months prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the hospice program between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 7
CHANGE OF OWNERSHIP

7.1 Change in Ownership

(a) When an organization having a provider agreement undergoes a change in ownership, the agreement is automatically assigned to the successor provider.

(b) A change of ownership occurs whenever there is a transfer of ultimate responsibility for operational decisions of the institution to a different governing body; for example:

(1) Where a sole proprietor transfers title and property to another party;

(2) Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of the partnership and creates a successor partnership or other entity;
(3) Where an incorporated provider merges with another incorporated institution not participating in the program, and the nonparticipating institution is the surviving corporation;
(4) Where two or more corporate providers consolidate, and such consolidation results in the creation of a new corporate entity; or

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(5) Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

(c) The contractor must be notified in advance of any expected changes in ownership.

ARTICLE 8
APPEALS

8.1 Appeal Actions

Appeal of DHA actions under this agreement, to the extent they are allowable, will be pursuant to 32 CFR 199.10.

ARTICLE 9
RECOUPMENT

9.1 Recoupment

DHA shall have the authority to suspend claims processing or seek recoupment of claims previously paid as specified under the provisions of the Federal Claims Collection Act (31 USC 3701 et seq.), the Federal Medical Care Recovery Act (42 USC 2651-2653), and 32 CFR 199. Payments in excess of the cap and/or inpatient limitations are subject to the provisions as set forth above.

ARTICLE 10
NONDISCRIMINATION

10.1 Nondiscrimination

The hospice program agrees to comply with provisions of Section 504 of the Rehabilitation Act of 1973 (Public Law (PL) 93-112; as amended) regarding nondiscrimination on the basis of handicap, Title VI of the Civil Rights Act of 1964 (PL 88-352), and with the Americans With Disabilities Act of 1990 (PL 101-336), as well as all regulations implementing these Acts.

ARTICLE 11
ORDER OF PRECEDENCE

11.1 Order of Precedence

If there is any conflict between this agreement and any Federal statute or Federal Regulation, including the TRICARE regulation, 32 CFR Part 199 and Medicare Conditions of Participation (42 CFR 418), the statute or regulation controls.

ARTICLE 12
DURATION

12.1 Duration

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until such time as there is a voluntary or involuntary termination.

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ARTICLE 13
EFFECTIVE DATE

13.1 Date Signed

(a)This participation agreement will be effective on the date signed by the Deputy Director, DHA, or designee.

(b)This agreement must be signed by the President or Chief Executive Officer of the corporation that owns the hospice program and must be accompanied by a resolution of the hospice program's Board of Directors authorizing the signature.

ARTICLE 14
AUTHORIZED PROVIDER

14.1 Date Recognized

On the effective date of the agreement, DHA recognizes the hospice program as an authorized provider for purposes of providing hospice care to TRICARE eligible beneficiaries.

TRICARE PERFORMANCE PROVISIONS FOR INSTITUTIONAL PROVIDERS

Provider shall provide Covered Services to Beneficiaries in accordance with the following terms:

• To cooperate with the Health Net Federal Services (HNFS) in the assumption and conduct of review activities.

• To allocate adequate space for the conduct of on-site review.

• To deliver to HNFS a paper or electronic copy of all required information within 30 calendar days of a request for off-site review.

• To provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" (TOM Ch.7, Addendum A), "Hospital Issued Notice of Noncoverage" (TOM Ch. 7, Addendum B).

• To inform HNFS within three working days if they issue a notice that the beneficiary no longer requires inpatient care.

• To assure that each case subject to preadmission/preprocedure review has been reviewed and approved by the contractor.

• To agree, when they fail to obtain certification as required, that they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level (32 CFR 199.15(g)).

• To agree to provide such medical and other records and such review data and other information as may be required or requested under a Quality Management and Improvement program within ten (10) days of receipt of notice at no cost to the requesting HNFS entity.

• HNFS will provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

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Hospice Program:

_____
Signature

_____
Printed Name & Title

Executed on _____, 20_____

DHA:

_____
Signature

_____
Printed Name & Title

Executed on _____, 20_____

_____
CORPORATE NAME

_____ _____
TIN NPI

The Contractor is responsible for calculation of the cap amount and inpatient limitation for each TRICARE/CHAMPUS approved hospice program within its jurisdictional area. Therefore, if you chose to become a participating TRICARE/CHAMPUS approved hospice provider, certain data will be required by PGBA, LLC within 30 days of the end of each hospice cap year. The hospice cap year runs from September 28 of the previous cap year through September 27 of the current year.

For your convenience, we have enclosed a copy of the reporting form which will be used by hospice providers to supply the necessary information to PGBA, LLC.

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HOSPICE REPORTING FORM

CAP PERIOD ENDED – October 31, 20_____

Hospice: _____

Provider Number: _____

1.) Number of TRICARE/CHAMPUS beneficiaries electing hospice care during the period from 9/28/_____ to 9/27_____.

2.) Total payment received and receivable for the cap period from 11/1/_____through 10/31____ for services furnished to TRICARE/CHAMPUS beneficiaries during the cap period, including employed physician's services not of an administrative and/or general supervisory nature.

3.) Total reimbursement received and receivable for general inpatient respite care furnished to TRICARE/CHAMPUS beneficiaries for the period 11/1____through 10/31_____.

4.) Aggregate number of TRICARE/CHAMPUS inpatient days for both general inpatient care and inpatient respite care for the period from 11/1/_____through 10/31/____.

4a. Aggregate number of TRICARE/CHAMPUS routine days for the period from 11/1/_____through 10/31/____.

4b. Aggregate number of TRICARE/CHAMPUS continuous home care hours for the period from 11/1/_____through 10/31/____.

5.) Aggregate total number of days of hospice care provided to all TRICARE/CHAMPUS beneficiaries for the period from 11/1/_____through 10/31/____.

_____ _____

SIGNATURE DATE

_____

TITLE

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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 844-730-1373

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 NPI Number: _____

Facility Physical Address: _____

Facility Phone Number: _____

Signature of Authorized Representative: _____

Revised: 08/06/2019

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