TRICARE NON-NETWORK INSTITUTIONAL INTENSIVE OUTPATIENT PROGRAM (IOP) 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.***

TRICARE NON-NETWORK INSTITUTIONAL INTENSIVE OUTPATIENT PROGRAM (IOP) PROVIDER APPLICATION

Facility Name: _____

Federal Tax Number: _____

NPI# _____

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

_____ _____

_____ _____

_____ _____

Telephone Number: _____

Date legal entity established: _____

1.) Is the facility licensed as an IOP? ☐ Yes ☐ No

License Number: _____

Original Licensure Date: _____

Expiration Dates: _____

Please check the appropriate accreditation:

☐ Joint Commission (TJC)

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

☐ Council on Accreditation (CoA)

☐ Other: _____

PLEASE ATTACH COPY OF STATE LICENSE AND ACCREDITATION.

TRICARE PARTICIPATION AGREEMENT FOR INTENSIVE OUTPATIENT PROGRAM (IOP) INSTITUTIONAL PROVIDERS

ARTICLE 1
RECITALS

1.1 IDENTIFICATION OF PARTIES

This Participation Agreement is between the United States of America through the Department of Defense (DoD), Defense Health Agency (hereinafter DHA), the administering activity for TRICARE and _____(hereinafter designated the IOP).

1.2 AUTHORITY FOR PARTIAL HOSPITAL CARE

The implementing regulations for DHA, 32 Code of Federal Regulations (CFR), Part 199, provides for cost-sharing of IOP care under certain conditions.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

It is the purpose of this Participation Agreement to recognize the undersigned IOP as an authorized provider of intensive outpatient care, subject to the terms and conditions of this agreement, and applicable federal law and regulation.

ARTICLE 2
DEFINITIONS

2.1 AUTHORIZED DHA REPRESENTATIVES

The authorized representative(s) of the Director, DHA, may include, but are not limited to, DHA staff, DoD personnel, and contractors, such as private sector accounting/audit firm(s) and/or utilization review and survey firm(s). Authorized representatives will be specifically designated as such.

2.2 BILLING NUMBER

The billing number for all IOP services is the IOP's Employer's Identification Number (EIN). In most situations, each EIN must enter into a separate Participation Agreement with the Director, DHA, or designee. This number must be used until the provider is officially notified by DHA or a designee of a change. The IOP's billing number is shown on the face sheet of this agreement.

2.3 ADMISSION AND DISCHARGE

(a) An admission occurs upon the formal acceptance by the IOP of a beneficiary for the purpose of participating in the therapeutic program with the registration and assignment of a patient number or designation.

(b) A discharge occurs at the time that the IOP formally releases the patient from intensive outpatient status; or when the patient is admitted to another level of care.

2.4 MENTAL DISORDER

As defined in the 32 CFR 199.2: For the purposes of the payment of benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or

psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. A Substance Use Disorder (SUD) is a mental condition that involves a maladaptive pattern of substance use leading to clinically significant impairment or distress; impaired control over substance use; social impairment; and risky use of a substance(s). Additionally, the mental disorder must be one of those conditions listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM). "Conditions Not Attributable to a Mental Disorder," or **V** codes (**Z** codes in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)), are not considered diagnosable mental disorders. Co-occurring mental and substance use disorders are common and assessment should proceed as soon as it is possible to distinguish the substance related symptoms from other independent conditions.

2.5 INTENSIVE OUTPATIENT PROGRAM (IOP)

As defined by 32 CFR 199.2(b), IOP is a treatment setting capable of providing an organized day or evening program that includes assessment, treatment, case management and rehabilitation for individuals not requiring 24-hour care for mental health disorders, to include SUDs, as appropriate for the individual patient. The program structure is regularly scheduled, individualized and shares monitoring and support with the patient's family and support system. Such programs must enter into a Participation Agreement with TRICARE, and be accredited and in substantial compliance for IOPs with the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA), or by an accrediting organization approved by the Director, DHA. The regional contractor may submit, via the TRICARE Regional Office, additional accrediting organizations for TRICARE authorization, subject to approval by the Director, DHA. IOPs are differentiated from:

(a) Acute psychoactive substance use treatment and from treatment of acute biomedical/mental health problems; which problems are either life-threatening and/or severely incapacitating and often occur within the context of a discrete episode of addiction-related biomedical or psychiatric dysfunction;

(b) An inpatient/residential Substance Use Disorder Rehabilitation Facility (SUDRF), as defined in 32 CFR 199.2, which serves patients with SUDs through an inpatient rehabilitation program on a 24-hour, seven-day-per week basis (see the TRICARE Policy Manual (TPM), Chapter 11, Addendum D for the SUDRF Participation Agreement);

(c) A Partial Hospitalization Program (PHP), as defined in 32 CFR 199.2, which serves patients who exhibit emotional/ behavioral dysfunction but who can function in the community for defined periods of time with support in one or more of the major life areas (see TPM, Chapter 11, Addendum F for the PHP Participation Agreement);

(d) An Opioid Treatment Program (OTP), as defined in 32 CFR 199.2, which serves patients in a treatment setting for opioid treatment (see TPM, Chapter 11, Addendum H for the OTP

(e) A group home, sober-living environment, halfway house, or three-quarter way house;

(f) Therapeutic schools, which are educational programs supplemented by addiction focused services;

(g) Facilities that treat patients with primary psychotic diagnoses other than psychoactive substance use or dependence;

(h) Facilities that care for patients with the primary diagnosis of mental retardation or developmental disability.

ARTICLE 3
PERFORMANCE PROVISIONS

3.1 GENERAL AGREEMENT

(a) The IOP agrees to render IOP services to eligible beneficiaries in need of such services, in accordance with this Participation Agreement and the 32 CFR 199. These services shall include patient assessment, treatment services, family therapy, case management, and such other services as are required by the 32 CFR 199.

(b) The IOP agrees that all certifications and information provided to the Director, DHA, incident to the process of obtaining and retaining authorized provider status is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and the IOP will be ineligible for consideration for authorized provider status for a two year period. Termination of authorized IOP status will be pursuant to Article 12 of this agreement.

(c) The IOP shall not be considered an authorized provider nor may any benefits be paid to the IOP for any services provided prior to the date the IOP is approved by the Director, DHA, or a designee as evidenced by signature on the Participation Agreement.

3.2 LIMIT ON RATE BILLED

(a) The IOP agrees to limit charges for services to beneficiaries to the rate set forth in this agreement.

(b) The IOP agrees to charge only for services to beneficiaries that qualify within the limits of law, regulation, and this agreement.

3.3 ACCREDITATION AND STANDARDS

The IOP hereby agrees to:

(a) Be licensed to provide IOP services within the applicable jurisdiction in which it operates.

(b) Be specifically accredited by and remain in compliance with standards issued for IOPs by TJC, CARF, CoA, or an accrediting organization approved by the Director, DHA. The regional contractor may submit, via the TRICARE Regional Office (TRO), additional accrediting organizations for TRICARE authorization, subject to approval by the Director, DHA.

(c) Accept the allowable IOP rate, as provided in 32 CFR 199.14(a)(2)(ix), as payment in full for services provided.

(d) Comply with all requirements of 32 CFR 199.4 applicable to institutional providers generally concerning concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters.

(e) Ensure that all mental health services are provided by qualified mental health providers who meet the requirements for individual professional providers. (Exception: IOPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification, and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide mental health services within the per diem rate but the individual must work under the direct clinical supervision of a fully qualified mental health provider employed by the IOP.) All other program services will be provided by trained, licensed staff.

(f) Ensure the provision of an active family therapy component which ensures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by an authorized mental health provider.

(g) Not bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements.

(h) Not bill the beneficiary for services excluded on the basis of 32 CFR 199.4(g)(1) (not medically or psychologically necessary), (g)(3) (inappropriate level of care), or (g)(7) (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question has been determined as noncovered. (A general statement signed at admission as to financial liability does not fill this requirement.)

3.4 QUALITY OF CARE

(a) The IOP shall assure that any and all eligible beneficiaries receive intensive outpatient services which comply with standards in Article 3.3.

(b) The IOP shall provide intensive outpatient services in the same manner to beneficiaries as it provides to all patients to whom it renders services.

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

3.5 BILLING FORM

The IOP shall use the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 billing form and the CMS 1500 Claim Form for outpatient services (or subsequent editions). IOPs shall identify IOP care on the billing form in the remarks block by stating “IOP care.”

3.6 COMPLIANCE WITH DHA UTILIZATION REVIEW ACTIVITIES

Under the terms of this agreement, the IOP shall:

(a) Appoint a single individual within the facility to serve as the point of contact for conducting utilization review activities with DHA or its designee. The IOP will inform DHA in writing of the designated individual.

(b) Promptly provide medical records and other documentation required in support of the utilization review process upon request by DHA or its designee. Confidentiality considerations are not valid reasons for refusal to submit medical records on any beneficiary. Failure to comply with documentation requirements will usually result in denial of authorization of care.

ARTICLE 4
PAYMENT PROVISIONS

4.1 RATE STRUCTURE: DETERMINATION OF RATE

The TRICARE rate is the per diem rate that TRICARE will authorize for all mental health services rendered to a patient and the patient’s family as part of the total treatment plan submitted by an approved IOP, and approved by DHA or a designee. The per diem rate will be as specified in 32 CFR 199.14(a)(2)(ix)(C).

4.2 IOP SERVICES INCLUDED IN PER DIEM PAYMENT

The per diem payment amount must be accepted as payment in full for all institutional services provided, including patient assessment, treatment services (with the exception of the psychotherapy sessions which may be allowed separately for individual or family psychotherapy when provided and billed by an authorized professional provider who is not employed by or under contract with the IOP), routine nursing services, psychological testing and assessments, case management services, overhead and any other services for which the customary practice among similar providers is included as part of institutional charges. Non-mental-health-related medical services may be separately allowed when provided and billed by an authorized independent professional provider not employed by or under contract with the IOP. This includes ambulance services when medically necessary for emergency transportation.

4.3 OTHER PAYMENT REQUIREMENTS

No payment is due for leave days, for days in which treatment is not provided, or for days on which the patient is absent from treatment (whether excused or unexcused).

4.4 PREREQUISITES FOR PAYMENT

Provided that there shall first have been a submission of claims in accordance with procedures, the IOP shall be paid based upon the allowance of the rate determined in accordance with the prevailing 32 CFR 199.14 (see Article 4.1), and contingent upon certain conditions provided in the 32 CFR 199, and in particular the following:

(a) The patient seeking admission is suffering from a mental disorder, to include SUD, which meets the diagnostic criteria of the current edition of the DSM and meets the TRICARE definition of a mental disorder.

(b) The patient meets the criteria for admission to an IOP issued by the Director, DHA.

(c) A qualified mental health professional who meets requirements for individual professional providers and who is permitted by law and by the IOP recommends that the patient be admitted to the IOP.

(d) A qualified mental health professional with admitting privileges who meets the requirements for individual professional providers will be responsible for the development, supervision, implementation, and assessment of a written, individualized, interdisciplinary clinical formulation and plan of treatment.

(e) All services are provided by or under the supervision of an authorized mental health provider (see Article 3.3(e)).

(f) The patient meets eligibility requirements for coverage.

4.5 DETERMINED RATE AS PAYMENT IN FULL

(a) The IOP agrees to accept the rate determined pursuant to the 32 CFR 199.14 (see Article 4.1) as the total charge for services furnished by the IOP to beneficiaries. The IOP agrees to accept the rate even if it is less than the billed amount, and also agrees to accept the amount paid, combined with the cost-share amount and deductible, if any, paid by or on behalf of the beneficiary, as full payment for the IOP services. The IOP agrees to make no attempt to collect from the beneficiary or beneficiary's family, except as provided in Article 4.6(a), amounts for IOP services in excess of the rate.

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

(c) The IOP agrees to submit claims for services provided to beneficiaries at least every 30 days (except to the extent delay is necessitated by efforts to first collect from other health insurance). If claims are not submitted at least every 30 days, the IOP agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed.

4.6 TRICARE AS SECONDARY PAYOR

(a) The IOP is subject to the provisions of 10 United States Code (USC) Section 1079 (j)(1). The IOP must submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage prior to 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 of this agreement by DHA pursuant to Article 7.

4.7 COLLECTION OF COST-SHARE

(a) The IOP agrees to collect from the beneficiary or the parents or guardian of the beneficiary only those amounts applicable to the patient's cost-share (copayment) as defined in 32 CFR 199.4, and services and supplies which are not a benefit.

(b) The IOP's failure to collect or to make diligent effort to collect the beneficiary's cost-share (copayment) as determined by policy 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 12.

4.8 BENEFICIARY RIGHTS

If the IOP 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 IOP agrees to forego its rights, if any, to pursue the amounts not paid by TRICARE from the beneficiary or the beneficiary's family.

ARTICLE 5
RECORDS AND AUDIT PROVISIONS

5.1 ON-SITE AND OFF-SITE REVIEWS/AUDITS

The IOP grants the Director, DHA [or authorized representative(s)], the right to conduct onsite or off-site reviews or accounting audits with full access to patients and records. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review includes, but is not limited to, the right to:

(a) Examine fiscal and all other records of the IOP which would confirm compliance with this agreement and designation as an authorized IOP provider.

(b) Conduct audits of IOP 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 to beneficiaries. The Director, DHA, or a designee shall have full access to records of both TRICARE and non-TRICARE patients. Note: In most cases, only TRICARE patients' records will be audited. Examples of situations where non-TRICARE patient records would be requested may be in situations of differential quality of care assessments or to identify systemic quality and safety concerns.

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

(d) Conduct on-site inspections of the facilities of the IOP and interview employees, members of the staff, contractors, board members, volunteers, and patients, as may be required.

(e) Release copies of final review reports (including reports of on-site reviews) under the Freedom of Information Act.

5.2 RIGHT TO UNANNOUNCED INSPECTION OF RECORDS

(a) DHA and its authorized agents shall have the authority to visit and inspect the IOP at all reasonable times on an unannounced basis.

(b) The IOP's records shall be available and open for review by DHA during normal working hours, from 8 a.m. to 5 p.m., Monday through Friday, on an unannounced basis.

5.3 CERTIFIED COST REPORTS

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

5.4 RECORDS REQUESTED BY DHA

Upon request, the IOP 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.

5.5 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 12, and any other appropriate action by DHA.

ARTICLE 6
NONDISCRIMINATION

6.1 COMPLIANCE

The IOP agrees to comply with provisions of section 504 of the Rehabilitation Act of 1973 (Public Law 93-112; as amended) regarding nondiscrimination on basis of handicap, Title VI of the Civil Rights Act of 1964 (Public Law 88-352), the Americans With Disabilities Act of 1990 (Public Law 101-336), and section 1557 of the Patient Protection and Affordable Care Act as well as all regulations implementing these Acts.

ARTICLE 7
AMENDMENT

7.1 AMENDMENT BY DHA

(a) The Director, DHA, or designee may amend the terms of this Participation Agreement by giving 120 days' notice in writing of the amendment(s) except amendments to the 32 CFR 199, which shall be considered effective as of the effective date of the regulation change and do not require a formal amendment of this agreement to be effective. When changes or modifications to this agreement result from amendments to the 32 CFR 199 through rulemaking procedures, the Director, DHA, or designee, is not required to give 120 days' written notice. Amendments to this agreement resulting from amendments to the 32 CFR 199 shall become effective on the date the

regulation amendment is effective or the date this agreement is amended, whichever date is earlier.

(b) The IOP, if it concludes it does not wish to accept the proposed amendment(s), including any amendment resulting from amendment(s) to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in Article 12.3. However, if the IOP's notice of intent to terminate its participation is not given at least 60 days prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for IOP care furnished between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 8
TRANSFER OF OWNERSHIP

8.1 ASSIGNMENT BARRED

This agreement is nonassignable.
.

8.2 AGREEMENT ENDS

(a) Unless otherwise extended as specified in Article 8.3(b) this agreement ends as of 12:01 am on the date that transfer of ownership occurs.

(b) Change of ownership is defined as follows:

(1) The change in an owner(s) that has/have 50% or more ownership constitutes change of ownership.

(2) The merger of the IOP corporation (for-profit or not-for-profit) into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation, constitutes change of ownership. The transfer of corporate stock or the merger of another corporation into the IOP corporation, however, does not constitute change of ownership. The transfer of title to property of the IOP corporation to another corporation(s), and the use of that property for the rendering of partial hospital care by the corporation(s) receiving it is essential for a change of ownership.

(3) The lease of all or part of an IOP or a change in the IOP's lessee constitutes change of ownership.

8.3 NEW AGREEMENT REQUIRED

(a) If there is a change of ownership of an IOP as specified in Article 8.2(b), then the new owner, in order to be an authorized intensive outpatient program, must enter into a new agreement with DHA. The new owner is subject to any existing plan of correction, expiration date, applicable health and safety standards, ownership and financial interest disclosure requirements and any other provisions and requirements of this agreement.

(b) An IOP contemplating or negotiating a change in ownership must notify DHA in writing at least 30 days prior to the effective date of the change. At the discretion of the Director, DHA, or a designee, this agreement may remain in effect until a new Participation Agreement can be signed to provide continuity of coverage for beneficiaries. An IOP that has provided the required 30 days' advance notification of a change of ownership may seek an extension of this agreement's effect for a period not to exceed 180 days from the date of the transfer of ownership. Failure to provide 30 days' advance notification of a change of ownership will result in a denial of a request for an extension of this agreement and termination of this agreement upon transfer of ownership as specified in Article 8.2(a).

(c) Prior to a transfer of ownership of an IOP, the new owners may petition DHA in writing for a new Participation Agreement. The new owners must document that all required licenses and accreditations have been maintained, and must provide documentation regarding any program changes. Before a new Participation Agreement is executed, the Director, DHA, or a designee will review the IOP to ensure that it is in compliance with 32 CFR 199.

ARTICLE 9
REPORTS

9.1 INCIDENT REPORTS

Any serious occurrence involving a beneficiary, outside the normal routine of the IOP (see the TRICARE Operations Manual (TOM), Chapter 7, Section 4), shall be reported to DHA, Benefits Management Division, and/or a designee, as follows:

(a) An incident of a life-threatening accident, patient death, patient disappearance, suicide attempt, incident of cruel or abusive treatment, or any equally dangerous situation involving a beneficiary, shall be reported by telephone on the next business day with a full written report within seven days.

(b) The incident and the following report shall be documented in the patient's clinical record.

(c) Notification shall be provided, if appropriate, to the parents, legal guardian, or legal authorities.

9.2 DISASTER OR EMERGENCY REPORTS

Any disaster or emergency situation, natural or man-made, such as fire or severe weather, shall be reported telephonically within 72 hours, followed by a comprehensive written report within seven days to DHA.

9.3 REPORTS OF IOP CHANGES

The governing body or the administrator of the IOP shall submit in writing to DHA any proposed significant changes within the IOP no later than 30 days prior to the actual date of change; failure to report such changes may lead to termination of this agreement. A report shall be made concerning the following items:

(a) Any change in administrator or primary professional staff.

(b) Any change in purpose, philosophy or any addition or deletion of services or programs. This includes capacity or hours of operation.

(c) Any licensure, certification, accreditation or approval status change by a state agency or national organization.

(d) Any anticipated change in location or anticipated closure.

(e) Any suspension of operations for 24 hours or more.

ARTICLE 10
GENERAL ACCOUNTING OFFICE

10.1 RIGHT TO CONDUCT AUDIT

The IOP grants the United States General Accounting Office (GAO) the right to conduct audits.

ARTICLE 11
APPEALS

11.1 APPEAL ACTIONS

Appeals of DHA actions under this agreement, to the extent they are allowable, will be pursuant to the 32 CFR 199.10 and 32 CFR 199.15.

ARTICLE 12
TERMINATION AND AMENDMENT

12.1 TERMINATION OF AGREEMENT BY DHA

The Director, DHA, or a designee, may terminate this agreement in accordance with procedures for termination of institutional providers as specified in 32 CFR 199.9.

12.2 BASIS FOR TERMINATION OF AGREEMENT BY DHA

(a) In addition to any authority under the 32 CFR 199.9 to terminate or exclude a provider, the Director, DHA, or a designee may terminate this agreement upon 30 days' written notice, for cause, if the IOP:

(1) Is not in compliance with the requirements of the Dependents Medical Care Act, as amended (10 USC 1071 et seq.), the 32 CFR 199, or with performance provisions stated in Article 3 of this Participation Agreement.

(2) Fails to comply with payment provisions set forth in Article 4 of this Participation Agreement.

(3) Fails to allow audits/reviews and/or to provide records as required by Article 5 of this Participation Agreement.

(4) Fails to comply with nondiscrimination provisions of Article 6 of this Participation Agreement.

(5) Changes ownership as set forth in Article 8 of this Participation Agreement.

(6) Fails to provide incident reports, disaster or emergency reports, or reports of IOP changes as set forth in Article 9 of this Participation Agreement.

(7) Initiates a program change without written approval by DHA or a designee; program changes include but are not limited to: changes in the physical location; population served; number of beds; type of license; expansion of program(s); or development of new program(s).

(8) Does not admit a beneficiary during any period of 24 months.

(9) Suspends operations for a period of 120 days or more.

(10) Is determined to be involved in provider fraud or abuse, as established by 32 CFR 199.9. This includes the submission of falsified or altered claims or medical records which misrepresent the type, frequency, or duration of services or supplies.

(b) The Director, DHA, or designee may terminate this agreement without prior notice in the event that the IOP's failure to comply with the industry standards for IOPs presents an immediate danger to life, health, or safety.

12.3 TERMINATION OF AGREEMENT BY THE IOP

The IOP may terminate this agreement by giving the Director, DHA, or designee, written notice of such intent to terminate. The effective date of a voluntary termination under this article shall be 60 days from the date of notification of intent to terminate or, upon written request, as agreed between the IOP and DHA.

ARTICLE 13
RECOUPMENT

13.1 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 199.14.

ARTICLE 14
ORDER OF PRECEDENCE

14.1 ORDER OF PRECEDENCE

If there is any conflict between this agreement and any Federal statute or regulation including the 32 CFR 199, the statute or regulation controls.

ARTICLE 15
DURATION

15.1 DURATION

This agreement shall remain in effect until the expiration date specified in Article 17.1 unless terminated earlier by DHA or the IOP under Article 12. DHA may extend this agreement for 60 days beyond the established date if necessary to facilitate a new agreement.

15.2 REAPPLICATION

The IOP must reapply to DHA at least 90 days prior to the expiration date of this agreement if it wishes to continue as an authorized IOP. Failure to reapply will result in the automatic termination of this agreement on the date specified in Article 17.1.

ARTICLE 16
EFFECTIVE DATE

16.1 EFFECTIVE DATE

(a) This Participation Agreement will be effective on the date signed by the Director, DHA, or a designee.

(b) This agreement must be signed by the President, Chief Executive Officer (CEO), or designee of the IOP.

ARTICLE 17
AUTHORIZED PROVIDER

17.1 PROVIDER STATUS

On the effective date of the agreement, DHA recognizes the IOP as an authorized provider for the purpose of providing intensive outpatient care to eligible beneficiaries within the framework of the program(s) identified below.

INTENSIVE OUTPATIENT PROGRAM (IOP) NAME(S)	CAPACITY	AGE RANGE	DAYS OF OPERATION

TRICARE PERFORMANCE PROVISIONS FOR INSTITUTIONAL PROVIDERS

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

• To cooperate with 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.

Intensive Outpatient Program Facility:

_____
By: Signature

_____
Printed Name and Title

Executed on: _____, 20_____

_____
TIN

_____
NPI

DHA:

_____
By: Signature

_____
Printed Name and Title

Executed on: _____, 20_____

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