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HPOS

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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: **CENTERS FOR MEDICARE AND MEDICAID SERVICES 1500 UPDATE**

CONREQ: 16801

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change will replace all instances of CMS 1500 (08/2005) with CMS 1500 Claim Form, in the TRICARE manuals.

EFFECTIVE DATE: January 6, 2014.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 109 and Feb 2008 TRM, Change No. 94.

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ATTACHMENT(S): **19 PAGES**
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 8	
Section 1, pages 1 through 3	Section 1, pages 1 through 3
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CHAPTER 17	
Section 2, pages 3 and 4	Section 2, pages 3 and 4
CHAPTER 18	
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CHAPTER 19	
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CHAPTER 24	
Section 29, pages 15, 16, 25, and 26	Section 29, pages 15, 16, 25, and 26

Chapter 8 Section 1

General

1.0 PURPOSE

The purpose of the TRICARE claims processing procedures is to help ensure that all claims for care received by TRICARE beneficiaries are processed in a timely and consistent manner and that Government-furnished funds are expended only for those services or supplies authorized by law and Regulation. The contractor shall review all claims submitted and accept Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets. The review must ensure that sufficient information is submitted to determine:

- The patient is eligible.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- That the claim contains sufficient information to determine the allowable amount for each service or supply.

In this context, "beneficiary" includes authorized agents, see Chapter 19.

2.0 WHO MAY FILE A CLAIM

2.1 Beneficiary/Provider

Any TRICARE eligible beneficiary or any individual who meets the requirements for eligibility under TRICARE, as determined by one of the Uniformed Services, may file a claim. Any institutional or individual professional provider certified under TRICARE may file a claim on a participating basis for services or supplies provided to a beneficiary and receive payment directly from TRICARE. The contractor shall deny any charge imposed by the provider relating to completing and submitting the applicable claim form (or any other related information). Such charges shall not be billed separately to the beneficiary by the provider nor shall the beneficiary pay the provider for such charges. These charges are to be reported as noncovered charges and denied as such.

2.2 State Agency

A state agency who administers the Medicaid Program may submit a claim, if there has been an agreement signed between the agency and TRICARE Management Activity (TMA). (Refer to the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 20.)

2.3 Participating Provider - Agency Agreement With A Third Party

2.3.1 Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of third party claims, including TRICARE claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including TRICARE payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the TMA Office of General Counsel (OGC), through the Contracting Officer (CO), for resolution.

2.3.2 On a monthly basis, TMA's Office of Program Integrity (PI) provides each contractor with an updated data file of excluded third party billing agents. Based on this file, the contractor shall not accept any claims from excluded third party billing agents. Any claim received from an excluded third party billing agent shall be returned to the provider, instructing the provider that the submission of a valid claim cannot be done through a sanctioned entity, and to resubmit the claim directly, or through an approved third party billing agent. The contractor shall inform the provider that the third party billing agent has been excluded by Health and Human Services (HHS)/ Centers for Medicare and Medicaid Services (CMS) and that no claims will be accepted from the third party billing agent until it has been reinstated. The contractor shall also provide notification to the third party billing agent that no claims will be accepted from it until it has been reinstated by HHS/CMS.

3.0 TRICARE CLAIM FORMS

3.1 Acceptable Claim Forms

3.1.1 A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. For paper claims, the contractor shall accept the latest mandated version of the following claim forms for TRICARE benefits: the DoD Document (DD) Form 2642, the CMS 1500 Claim Form, and the CMS 1450 UB-04. The American Dental Association (ADA) claim forms may be used in the processing and payment of adjunctive dental claims. Electronic claims shall be accepted in HIPAA-compliant standardized electronic transactions (see Chapter 19).

3.1.2 DD Form 2642, "Patient's Request For Medical Payment" (Addendum A, Figure 8.A-1). This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. See Appendix B for a definition of "medical." Those include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. If a DD

Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the CMS 1500 Claim Form or the CMS 1450 UB-04, whichever is appropriate. The form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the TMA Administrative Office to order the DD Form 2642.

4.0 CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual Internal Control Number (ICN), which will be entered into the automated system within five workdays of actual receipt. For both hardcopy and Electronic Media Claim (EMC), the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's Social Security Number (SSN), Defense Enrollment Eligibility Reporting System (DEERS) family ID, or ICN within 15 calendar days following receipt.

5.0 NEWBORN CLAIMS

5.1 Claims for newborns can be processed without eligibility on DEERS as long as:

- The newborn date of birth is within 365 days of the contractor's eligibility query; and
- The sponsor is/was eligible for TRICARE for the dates of care on the newborn claim.

5.2 Newborns are deemed enrolled in Prime as of the day of birth if the uniform service member sponsor is showing as eligible in DEERS (enrolled or non-enrolled), or the non-active duty sponsor or another family member is enrolled in Prime. This deemed enrollment period will continue for 60 calendar days from the newborn's date of birth or until the newborn is formally enrolled in Prime, whichever is earlier. If the newborn is not formally enrolled during the 60-day period, the newborn will revert to a non-enrolled status on the 61st day. Claims for care during the deemed enrollment period will be processed with Prime copayments, according to sponsor's status in DEERS. No referrals are required and Point of Service (POS) provisions do not apply during the deemed enrollment period. See the TRICARE Policy Manual (TPM), Chapter 10, Section 3.1. For additional information on newborns under the TRICARE Retired Reserve (TRR) and TRICARE Reserve Select (TRS) programs, see Chapter 22, Sections 2 and 1 respectively.

- END -

Chapter 8 Section 3

Claims Filing Deadline

1.0 TIME LIMITATIONS ON FILING TRICARE CLAIMS

1.1 All TRICARE claims shall be stamped with an Internal Control Number (ICN). The actual date of receipt shall be counted as day one. The ICN uniquely identifies each claim, includes the actual date received in the contractor's custody, and permits aging and counting of the claim for workload reporting purposes at specific system locations at any time during its processing. The contractor shall provide procedures to ensure the actual date of receipt is entered into the ICN and all required claims aging and inventory controls are applied for paperless claims.

1.2 All claims for benefits must be filed with the appropriate TRICARE contractor No Later Than (NLT) one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within one year from the date of service.

Example:

FOR SERVICE OR DISCHARGE	MUST BE RECEIVED BY THE CONTRACTOR
March 22, 2007	No later than March 22, 2008
December 31, 2007	No later than December 31, 2008

1.3 Any written request for benefits, whether or not on a claim form, shall be accepted for determining if the "claim" was filed on a timely basis. However, when other than an approved claim form is first submitted, the claimant shall be notified that only an approved TRICARE claim form is acceptable for processing a claim for benefits. The contractor shall inform the claimant in writing that in order to be considered for benefits, an approved TRICARE claim form and any additional information (if required) must be submitted and received by the contractor NLT one year from the date of service or date of discharge, or 90 calendar days from the date they were notified by the contractor, whichever is later. The claimant should submit claims on either the Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form, the CMS 1450 UB-04, or the Defense Department (DD) Form 2642 as appropriate.

2.0 EXCEPTIONS TO FILING DEADLINE

2.1 Retroactive Determinations

2.1.1 In order for an exception to be granted based on a retroactive determination, the retroactive determination must have been obtained/issued after the timely filing period elapsed. If a retroactive determination is obtained/issued within one year from the date of service/discharge, the one year timely filing period is still binding.

2.1.2 Only the Uniformed Services or the Department of Veterans Affairs (DVA) may determine retroactive eligibility. For purposes of granting an exception, retroactive issuance of a Non-Availability Statement (NAS) when applicable shall be treated as retroactive eligibility. Once a retroactive eligibility determination is made, an exception to the claims filing deadline shall be granted. A copy of the retroactive eligibility decision must be provided. In any case where a retroactive "preauthorization" determination is made to cover such services as the Extended Care Health Option (ECHO), adjunctive dental care, surgical procedures requiring preauthorization, etc., the timely filing requirements shall be waived back to the effective date of the retroactive authorization. Claims which are past the filing deadline must; however, be filed not more than 180 calendar days after the date of issue of the retroactive determination.

2.2 Administrative Error

2.2.1 If an administrative error is alleged, the contractor shall grant an exception to the claims filing deadline only if there is a basis for belief that the claimant had been prevented from timely filing due to misrepresentation, mistake or other accountable action of an officer or employee of TRICARE Management Activity (TMA) (including TRICARE Overseas) or a contractor, performing functions under TRICARE and acting within the scope of that individual's authority.

2.2.2 The necessary evidence shall include a statement from the claimant, regarding the nature and affect of the error, how he or she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed, as well as one of the following:

- A written report based on agency records (TMA or contractor) describing how the error caused failure to file within the usual time limit, or
- Copies of an agency letter or written notice reflecting the error.

Note: The statement of the claimant is not essential if the other evidence establishes that his or her failure to file within the usual time limit resulted from administrative error, and that he or she filed a claim within 90 calendar days after he or she was notified of the error. There must be a clear and direct relationship between the administrative error and the late filing of the claim. If the evidence is in the contractor's own records, the claim file shall be annotated to that effect.

2.3 Inability To Communicate And Mental Incompetency

2.3.1 For purposes of granting an exception to the claims filing deadline, mental incompetency includes the inability to communicate even if the result of a physical disability. A physician's statement, which includes dates, diagnosis(es) and treatment, attesting to the beneficiary's mental incompetency shall accompany each claim submitted. Review each statement for reasonable likelihood that mental incompetency prevented the person from timely filing.

2.3.2 If the failure to timely file was due to the beneficiary's mental incompetency and a legal guardian had not been appointed during the period of time in question, the contractor shall grant an exception to the claims filing deadline based on the required physician's statement. (See above.) If the charges were paid by someone else, i.e., spouse or parent, request evidence from the spouse or parent that the claim was paid and by whom. When the required evidence is received, make payment to the signer of the claim, with the check made out: "Pay to the order of (spouse's or parent's name) for the use and benefit of (beneficiary's name)."

3.1.3 The contractor shall verify whether the DVA-provided care has been authorized by the TMA/MMSO. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. If a required authorization is not on file, the contractor shall place the claim in a pending status and forward the appropriate documentation to the TMA/MMSO identifying the claim as a possible MOA claim for determination (following the procedures in Addendum B for the TMA/MMSO SPOC referral and review procedures). Additionally, any DVA submitted claim for a service member with a TBI, SCI, blindness, or polytrauma condition that does not have a matching authorization number shall be pended to the TMA/MMSO for payment determination.

3.1.4 MOA claims shall be reimbursed as follows:

3.1.4.1 Claims for inpatient care shall be paid using DVA interagency rates, published in the **Federal Register**. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by the TMA (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. All interagency rates except the outpatient interagency rate in the Office of Management and Budget (OMB) Federal Register Notice provided by TMA will be applicable. If the DVA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rate. (For example, a stay for SCI may include days paid with the SCI rate and days billed at a surgery rate.) MCSCs shall verify the DVA billed rate on inpatient claims matches one of the interagency rates provided by TMA. DVA claims for inpatient care submitted with an applicable interagency rate shall not be developed any further (i.e., for revenue codes, diagnosis, etc.) if care has been approved by the TMA/MMSO. Claims without an applicable interagency rate shall be denied and an Explanation of Benefits (EOB) shall be issued to the DVA, but not the beneficiary. The claim will need to be resubmitted for payment.

3.1.4.2 Claims for outpatient and ambulatory surgery professional services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied. For those services without a TRICARE allowable rate, DVA shall be reimbursed at billed charges.

3.1.4.3 The following care services, irrespective of health care delivery setting require authorization from MMSO and are reimbursed at billed charges (actual DVA cost) separately from DVA inpatient interagency rates, if one exists:

- Transportation
- Prosthetics
- Non-medical rehabilitative items
- Durable Medical Equipment (DME)
- Orthotics (including cognitive devices)
- Routine and adjunctive dental services
- Optometry
- Lens prescriptions
- Inpatient/outpatient TBI evaluations

- Special diagnostic procedures
- Inpatient/outpatient polytrauma transitional rehabilitation program
- Home care
- Personal care attendants
- Conjoint family therapy
- Ambulatory surgeries
- Cognitive rehabilitation
- Extended care/nursing home care

3.1.4.4 On August 4, 2009, the contractor shall process all claims received on or after this date using the guidelines established under the updated MOA regardless of the date of service. All TRICARE Encounter Data (TED) records for this care shall include Special Processing Code 17 - DVA medical provider claim.

3.1.4.5 If paid at per diem rates, the provisions of Chapter 8, Section 2, paragraph 7.2, apply when enrollment changes in the middle of an inpatient stay. If enrollment changes retroactively, prior payments will not be recouped.

3.2 Claims for Care Provided Under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES)

The contractor shall reimburse the DVA for services provided under the current national DoD/DVA MOA for "Processing Payment for Disability Compensation and Pension Examinations in the Integrated Disability Evaluation System" (IDES MOA; see Addendum C for a full text copy of the MOA for reference purposes only). The contractor shall begin processing these claims with dates of care January 1, 2011 and forward. Claims under the IDES MOA shall be processed in accordance with this chapter and the following:

3.2.1 Claims submitted by the DVA on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form for a service member's care with the Current Procedural Terminology (CPT[1]) code of 99456 (principal or secondary) shall be processed as a IDES MOA claim.

3.2.2 The contractor shall verify whether services provided under the IDES MOA have been referred and authorized by the MTF. The MTF will generate a single referral request in the Armed Forces Health Longitudinal Technology Application (AHLTA) and submit the referral to the contractor. The referral will specify the total number of Compensation and Pension (C&P) examinations authorized for payment by the contractor. It is not necessary for the referral to identify the various specialists who will render the different C&P examinations. The reason for referral will be entered by the MTF as "**DVA only: Disability Evaluation System (DES) C&P exams for fitness for duty determination - total __.**" The MTF will complete the referral as described in Chapter 8, Section 5, paragraph 6.1 including Note 4.

3.2.3 The DVA will list one C&P examination (CPT[1] code 99456) per the appropriate field of the CMS 1500 Claim Form and indicate one unit such that there is a separate line item for each C&P examination. The DVA can list related ancillary services separately in the appropriate field of the CMS 1500 Claim Form using the appropriate CPT codes.

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with the TRICARE Policy Manual (TPM), Chapter 9, (except ECHO Home Health Care (EHHC)), of $36,000.

9.0 REIMBURSEMENT

9.1 Claims for Autism Demonstration services will be submitted by the ACSP on a Centers for Medicare and Medicaid (CMS) 1500 Claim Form as follows:

9.1.1 Functional Behavioral Assessment and Analysis.

9.1.1.1 During the first month the beneficiary is enrolled in the Autism Demonstration, the ACSP will be authorized and reimbursed by the MCSC for not more than four hours for conducting the initial Functional Behavioral Assessment and Analysis and establishing the initial BP.

9.1.1.2 The Functional Behavioral Assessment and Analysis and initial BP will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

9.1.1.3 Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial BP.

9.1.1.4 Reassessment of established Autism Demonstration participants will be conducted as part of the ACSP's routine supervision services and is not separately reimbursable.

9.1.2 ABA services rendered jointly by an ABA Supervisor and an ABA Tutor, in-person, during directly supervised fieldwork of the ABA Tutor by the ABA Supervisor, will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

9.1.3 ABA services provided directly by an ABA Tutor will be invoiced using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

9.1.4 Development of the required PR and updated BP will be invoiced using CPT[1] code 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

9.1.5 Conducting the required quarterly progress meetings with the beneficiary's caregivers will be invoiced using CPT1 code 90887, "Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient."

9.2 Reimbursement of claims in accordance with paragraph 9.1.1 and will be the lesser of:

- The CHAMPUS Maximum Allowable Charge (CMAC); or
- $125 per hour for services provided by the ABA Supervisor and $50 per hour for services provided by the ABA Tutor; or
- The negotiated rate; or

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- The billed charge.

10.0 ADDITIONAL MCSC RESPONSIBILITIES

The MCSC shall:

10.1 Consider and advise beneficiaries of the availability of community based or funded programs and services, when authorizing Autism Demonstration benefits.

10.2 Maintain all documents related to the Autism Demonstration in accordance with Chapter 2.

10.3 Forward to the "gaining" MCSC all Autism Demonstration related documents within 10 calendar days of being notified that a beneficiary is transferring to a location under the jurisdiction of another MCSC.

10.4 Review the beneficiary's BP prior to authorizing Autism Demonstration services.

Note: The Functional Behavioral Assessment and Analysis specified in paragraph 9.1.1 will be authorized by the MCSC prior to development of the BP.

10.5 Conduct annual audits on at least 20% of each ACSP's ABA Tutors for compliance with the requirements specified in paragraph 5.3. Upon determining non-compliance with one or more ABA Tutor qualification requirements, the MCSC will immediately initiate a compliance audit of all ABA Tutors employed by or contracted with that ACSP.

10.6 Complete and submit the monthly, quarterly, and semi-annual reports as described in the Contract Data Requirements List (CDRL), DD Form 1423.

11.0 APPLICABILITY

11.1 This Autism Demonstration is limited to TRICARE beneficiaries who meet the requirements specified in paragraph 6.0.

11.2 This Autism Demonstration is limited to the 50 United States and the District of Columbia.

11.3 All provisions of the ECHO program apply to the Autism Demonstration unless specifically modified by the Federal Register Demonstration Notice (72 FR 68130, December 4, 2007) or by this Section.

12.0 EXCLUSIONS

TRICARE will not cost-share:

12.1 Training of ABA Tutors as specified in paragraph 5.3.1.

12.2 Charges for program development, administrative services, and the assessment required for developing the PR and updating the BP.

3.5.3.1 Include current Federal, State, and County Criminal and Sex Offender reports for all locations the BCaBA or ABA Tutor has resided or worked during the previous 10 years; and

3.5.3.2 Be completed prior to the BCaBA or ABA Tutor providing ABA reinforcement to TRICARE beneficiaries.

4.0 BENEFICIARY ELIGIBILITY REQUIREMENTS

4.1 NADFMs participating in the ABA Pilot shall:

4.1.1 Be at least 18 months of age; and

4.1.2 Have been diagnosed with an ASD specified in the TPM, Chapter 7, Section 3.19 by a TRICARE-authorized Physician Primary Care Manager (P-PCM) (for the purposes of the diagnosis of ASD, TRICARE authorized P-PCMs include: TRICARE authorized family practice, internal medicine and pediatric physicians whether they work in the purchased care or direct care system. In cases where the beneficiary does not have a P-PCM (as is sometimes the case for beneficiaries with TRICARE Prime Remote (TPR)), the diagnosis may be rendered by a TRICARE authorized physician in any of the disciplines described above under P-PCM, or by a TRICARE authorized specialty ASD provider) or Specialized ASD Provider; and

4.1.3 Meet all requirements outlined in the TPM, Chapter 7, Section 3.19 including referral, authorization, initial assessment and treatment plan, and updated treatment plan.

4.2 Eligibility for benefits under the ABA ceases as of 12:01 a.m. of the day after the ABA Pilot ends.

4.3 Absence of eligibility for the ABA Pilot does not preclude eligible beneficiaries as defined in 32 CFR 199.3 otherwise allowable services under the TRICARE Basic program.

5.0 POLICY

5.1 Under the ABA Pilot, TRICARE will reimburse ACSP's only for ABA reinforcement that meet the minimum standards established by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, the BACB Guidelines: Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder, and current BACB rules and regulations when rendered by BCaBAs and ABA Tutors who meet all applicable requirements specified herein.

5.2 All ABA reinforcement under this ABA Pilot require prior written authorization by the Director, TMA or designee (i.e., the MCSC) in accordance with the requirements outlined in TPM, Chapter 7, Section 3.19.

5.3 The following are eligible for reimbursement, payable only to the ACSP or BCBA/BCBA-D under the ABA Pilot:

5.3.1 ABA reinforcement rendered directly to a TRICARE beneficiary on a one-on-one basis by a BCaBA or ABA Tutor under the supervision of an ABA provider licensed or certified by a State or certified by the BACB (http://www.bacb.com) as a BCBA or BCBA-D. Group ABA reinforcement is not a TRICARE benefit.

5.3.2 ABA reinforcement rendered jointly, in-person, during directly supervised fieldwork of the BCaBA or ABA Tutor by the ABA Supervisor. Only the services provided by the ABA Supervisor will be reimbursed as specified in paragraph 7.1.1.

6.0 BENEFICIARY COST SHARE LIABILITY

6.1 The sponsor/NADFM cost share, regardless of whether they are using Standard/Extra or Prime, shall be 10 percent of the lesser of:

- The CHAMPUS Maximum Allowable Charge (CMAC); or
- $125 per hour for services provided by the ABA Supervisor and $75 for services provided by a BCaBA, and/or $50 per hour for services provided by the ABA Tutor; or
- The negotiated rate; or
- The billed charge

6.2 The allowed cost of services provided accrues to the government's maximum fiscal year share of providing benefits, of $36,000.

6.3 The sponsor/beneficiary cost-shares under the ABA Pilot do not accrue the standard deductible or to meeting the catastrophic cap in the TRICARE Basic Program.

6.4 The government's maximum fiscal year cost-share for ABA Pilot benefits applies to each beneficiary, regardless of the number of dependents with the same sponsor receiving ABA Pilot benefits in that fiscal year.

7.0 REIMBURSEMENT

7.1 Claims for ABA Pilot services will be submitted by the ACSP on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form. Reimbursement is payable only to the ACSP or BCBA/BCBA-D, not to the BCaBAs or ABA Tutors. The following codes have been adopted for non-standardized usage for ABA reinforcement provided under the ABA Pilot. These codes apply for provision of ABA reinforcement in all authorized treatment settings (the office, home or community setting).

7.1.1 ABA reinforcement rendered jointly by an ABA Supervisor and a BCaBA or ABA Tutor, during directly supervised fieldwork of the BCaBA or ABA Tutor by the ABA Supervisor, will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes." Supervision means direct one-on-one supervision of ABA Tutors implementing the treatment plan in person or through real time remote means. The supervised field work of the ABA supervisor and

ARTICLE 3

REIMBURSEMENT

3.1 Claims for Demonstration services will be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form by the ACSP in accordance with the TOM, Chapter 18, Section 8, paragraph 9.0.

3.2 The ACSP shall:

(a) Submit claims to the appropriate TRICARE Managed Care Support Contractor (MCSC) in accordance with paragraph 3.1 and the TOM, Chapter 18, Section 8; and

(b) Collect the monthly sponsor cost-share specified in the TRICARE Policy Manual (TPM), Chapter 9, Section 16.1; and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement; and

(2) Services that are denied due to provider non-compliance with all applicable requirements in the TOM, Chapter 18, Section 8.

ARTICLE 4

TERM, TERMINATION, AND AMENDMENT

4.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

4.2 TERMINATION OF AGREEMENT BY TMA

(a) The Director, TMA or designee, may terminate this agreement upon written notice, for cause, if the ACSP is found not to be in compliance with the provisions set forth in 32 CFR 199.6, or is determined to be subject to the 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.

(b) In addition, the Director, TMA or designee, may terminated this agreement without cause by giving the ACSP written notice not less than 45 days prior to the effective date of such termination.

4.3 TERMINATION OF AGREEMENT BY THE ACSP

The ACSP may terminate this agreement by giving the Director, TMA or designee, written notice not less than 45 days prior to the effective date of such termination. Effective the date of

termination, the ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP may be reinstated as a TRICARE- authorized provider of Demonstration services only by entering into a new Participation Agreement.

4.4 AMENDMENT BY TMA

(a) The Director, TMA 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 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, TMA 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.

(b) An ACSP who does not accept the proposed amendment(s), including any amendment resulting from changes to 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the ACSP notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the ACSP between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 5

EFFECTIVE DATE

5.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, TMA or designee.

TMA	ACSP
_____	_____
By: Typed Name and Title	By: Typed Name and Title

Executed on _____, 20____

- END -

3.1.2 Providers who are citizens of the U.S., practicing outside the U.S. (e.g., Puerto Rico), are not considered to be "foreign providers". If the provider practicing outside the U.S. is a U.S. citizen and meets the HHS definition of a "covered entity", the provider is required to obtain an NPI for the submission of HIPAA-compliant electronic standard transactions and comply with the Final Rule. Electronic transactions submitted by "covered entities", who are U.S. citizens, that are not HIPAA-compliant must be denied as appropriate.

3.2 Subpart Enumeration

Subpart Enumeration is the responsibility of the Organizational Provider. In accordance with the Final Rule, Organizational Providers will determine to what extent subpart enumeration is required and identify which of the subparts, if any, of their organizational entity will be identified via a separate enumerator. The Organizational Provider will also determine how the various enumerators obtained will be used for billing purposes.

4.0 CONTRACTOR RESPONSIBILITIES

4.1 Contractors shall comply with the HIPAA Standard for Unique Health Identifier for Health Care Providers Final Rule.

4.2 Contractors shall accept NPIs when submitted by providers and use the NPI as the primary identifier to identify health care providers in all HIPAA-compliant electronic standard transactions in accordance with the transaction Implementation Guide. It is noted that during the dual use period, in addition to the NPI, additional identifiers may be used.

4.3 Contractors shall deny all claims transactions that do not meet the requirements of the Final Rule.

4.4 Since the National Uniform Billing Committee (NUBC) and the National Uniform Claims Committee (NUCC) have modified the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 and the CMS 1500 Claim Form to accommodate the use of the NPI on the paper forms, contractors are required to accept and use the NPI if submitted on the paper form for provider identification and claims adjudication.

4.5 Contractors shall verify NPIs using the check digit algorithm in accordance with the Final Rule, 45 CFR Part 162.

4.6 Contractors shall maintain the NPI in their internal provider file. Upon direction of the PCO and future revision of the TRICARE Systems Manual (TSM), Chapter 2 to address the NPI requirements for the TRICARE Encounter Provider (TEPRV) records and TRICARE Encounter Data (TED) record, contractors shall create and submit to TMA a new TRICARE Encounter Provider (TEPRV) record when a provider submits their NPI to the contractor.

- Type 1 NPI for professional providers.
- Type 2 NPI for organizational providers.

- Type 2 NPI for subparts of organizational providers that have been separately enumerated, e.g., different NPIs for different departments within an institution, the contractor shall list the Type 2 NPI for each subpart identified by the provider.

4.7 Contractors shall map NPIs for providers to TMA Provider Number(s) and subidentifier(s).

4.8 Contractors shall:

4.8.1 Covered Individual (Type 1) Health Care Providers

- Ensure HIPAA transactions received identify the provider's NPI on all HIPAA-compliant electronic standard transactions in accordance with the Implementation Guide for the Transaction.

- Ensure electronic transactions submitted by business associates of the individual provider use their NPIs and NPIs of other health care providers and subparts appropriately for the submission of HIPAA-compliant electronic standard transactions in accordance with the Implementation Guide for the Transaction.

4.8.2 Covered Organizational (Type 2) Health Care Providers

- Ensure that transactions submitted by the organizational entity and/or its subparts use the NPI on HIPAA-compliant electronic standard transactions.

- Ensure that transactions submitted by the organizational subparts comply with the NPI implementation specifications.

- Ensure that business associates of the organizational entity and/or its subparts use their NPIs and NPIs of other health care providers and subparts appropriately for the submission of HIPAA-compliant electronic standard transactions.

4.9 Compliance Date

As of May 23, 2007, contractors must be able to process HIPAA-compliant standard electronic transactions submitted with an NPI as the primary provider identifier. Contractors shall deny all transactions that do not meet the requirements of the Final Rule. In addition, contractors must also be able to process transactions submitted with the legacy identifiers for atypical providers or other non-covered entities. If CMS grants an extension to the dual use period or any other changes to the transition period, the contractors will be notified by PCO letter.

4.10 Application Of NPI To TMA Processes And Systems

Upon full implementation of the Final Rule, the NPI shall be used as the primary provider identifier for all TRICARE authorized providers who meet the HHS definition of "covered entities" and submit HIPAA-compliant electronic standard transactions. The contractor shall also accept the NPI as the primary identifier on paper claims from providers who obtain an NPI and use it.

ENCLOSURE 2

APPENDIX A

SAMPLE

HEALTH CARE PROVIDER/ASSOCIATED SUPPORT PERSONNEL STAFFING LETTER OF AGREEMENT BETWEEN (MTF NAME) AND (HEALTH CARE PROVIDER NAME)

SUBJECT: Items Negotiated between the Two Parties

1. The **(MTF name)** or provider will endeavor to provide adequate nursing assistants, receptionists, and billing support for care provided under this Agreement. Nursing support personnel will attend a one day Newcomer's Orientation class, a three-day Nursing Orientation class, and all other training which the MTF normally requires of its own nursing support personnel. Such training may consist of courses on direct patient care, safety, and systems & security, but will not include military-related courses. Additionally, new receptionists/nursing assistants will contact the MTF or clinic Health Benefits Advisor for a briefing on TRICARE requirements and TRICARE eligibility. The MTF will be responsible for providing appointment and ancillary support services.
2. The Health Care Provider agrees to receive all TRICARE eligible patients. Patients who are determined to be TRICARE ineligible will be referred back to the MTF for reappointment.
3. The **(MTF name)** or provider recognizes that continuity of patient care is of the utmost importance to the MTF, and will endeavor to furnish support staff who are available for the duration of the Agreement.

MTF COMMANDER _____

_____ Commander

_____ Provider

Date: _____

Date: _____

ENCLOSURE 2

APPENDIX B

SAMPLE

CLAIMS SUBMISSION REQUIREMENTS

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
2. All Partnership claims are to be submitted on either a CMS 1500 Claim Form or DD 2642 claims form. No beneficiary-submitted claims will be processed.
3. The claim form must clearly indicate that it is from a participating provider by checking the "Yes" block next to "participating" on the appropriate TRICARE-approved claim form.
4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the MTF, and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.

ENCLOSURE 3

APPENDIX A

SAMPLE

HEALTH CARE PROVIDER/ASSOCIATED SUPPORT PERSONNEL STAFFING LETTER OF AGREEMENT BETWEEN (MTF NAME) AND (HEALTH CARE PROVIDER/CONTRACTOR)

SUBJECT: Items Negotiated between the Two Parties

1. The **(MTF Name)** or Health Care Provider will endeavor to provide adequate nursing assistants, receptionists, and billing support for care provided under this Agreement. Nursing support personnel will attend a one day Newcomer's Orientation class, a three-day Nursing Orientation class, and all other training which the MTF normally requires of its own nursing support personnel. Such training may consist of courses on direct patient care, safety, and systems & security, but will not include military-related courses. Additionally, new receptionists/nursing assistants will contact the MTF or clinic Health Benefits Advisor for a briefing on TRICARE requirements and TRICARE eligibility. The MTF will be responsible for providing appointment and ancillary support services.
2. The Health Care Provider agrees to receive all TRICARE eligible patients. Patients who are determined to be TRICARE ineligible will be referred back to the MTF for reappointment.
3. The **(MTF Name)** or Health Care Provider recognizes that continuity of patient care is of the utmost importance to the MTF, and will endeavor to furnish support staff who are available for the duration of the Agreement.

MTF COMMANDER _____

_____ Commander

_____ Provider

Date: _____

Date: _____

ENCLOSURE 3

APPENDIX B

SAMPLE

CLAIMS SUBMISSION REQUIREMENTS

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
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4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the MTF, and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.