TRICARE NON-NETWORK INSTITUTIONAL RESIDENTIAL TREATMENT CENTER (RTC) 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 RESIDENTIAL TREATMENT CENTER (RTC) PROVIDER APPLICATION

Facility Name: _____

Federal Tax ID Number: _____

NPI#_____

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

_____ _____

_____ _____

_____ _____

Telephone Number: _____

Date legal entity established: _____

Is the facility licensed as a RTC? ☐ 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 INSTITUTIONAL RESIDENTIAL TREATMENT CENTER (RTC) 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 RTC).

1.2 AUTHORITY FOR RTC CARE

The implementing regulations for the TRICARE, DoD Regulation, 32 Code of Federal Regulations (CFR), Part 199, provides for TRICARE cost-sharing of RTC care under certain conditions.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

It is the purpose of this Participation Agreement to recognize the undersigned RTC as a TRICARE-authorized provider of RTC 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 DHA contractors, such as private sector accounting/audit firm(s) and/or utilization review and survey forms. Authorized representatives will be specifically designated as such.

2.2 BILLING NUMBER

The billing number for all RTC services is the RTC'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 RTC'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 RTC of a TRICARE beneficiary for the purpose of occupying a bed with the reasonable expectation that the patient will remain at least 24 hours, and with the registration and assignment of an inpatient number or designation.

(b) A discharge occurs at the time that the RTC formally releases the patient from inpatient status; or when the patient is admitted to any other inpatient setting (e.g., an acute mental or medical hospital).

(c) The day of admission is considered a day of care for payment purposes; the day of discharge is not.

2.4 MENTAL DISORDER

For this agreement, a mental disorder shall be the definition in the TRICARE regulation (32 CFR 199.2): For the purposes of 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) and billed with the corresponding International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). "Conditions Not Attributable to a Mental Disorder," or **V** codes (**Z** codes in the ICD-10-CM), are not considered diagnosable mental disorders. Co-occurring mental and SUDs are common and assessment should proceed as soon as it is possible to distinguish the substance related symptoms from other independent conditions.

2.5 RESIDENTIAL TREATMENT CENTER (RTC)

As defined in 32 CFR 199.6(b)(4)(vii)(A)*(1)*, an RTC is a facility or distinct part of a facility that provides to beneficiaries under 21 years of age a medically supervised, interdisciplinary program of mental health treatment. An RTC is appropriate for patients whose predominant symptom presentation is essentially stabilized, although not resolved, and who have persistent dysfunction in major life areas. Residential treatment may be complemented by family therapy and case management for community based resources. Discharge planning should support transitional care for the patient and family, to include resources available in the geographic area where the patient will be residing. The extent and pervasiveness of the patient's problems require a protected and highly structured therapeutic environment. Residential treatment is differentiated from:

(a) Acute psychiatric care which requires medical treatment and 24-hour availability of a full range of diagnostic and therapeutic services to establish and implement an effective plan of care which will reverse life-threatening and/or severely incapacitating symptoms;

(b) Partial hospitalization, as defined in 32 CFR 199.2 which provides a less than 24-hour-perday, seven-day-per-week treatment program for patients who continue to exhibit psychiatric problems but can function with support in some of the major life areas (see the TRICARE Policy Manual (TPM), Chapter 11, Addendum F for the Partial Hospitalization Participation Agreement);

(c) An Intensive Outpatient Program (IOP), as defined in 32 CFR 199.2, which serves patients in a day or evening program not requiring 24-hour care for mental health disorders (see TPM, Chapter 11, Addendum G for the IOP Participation Agreement);

(d) A group home, which is a professionally directed living arrangement with the availability of psychiatric consultation and treatment for patients with significant family dysfunction and/or chronic but stable psychiatric disturbances;

(e) Therapeutic school, which is an educational program supplemented by psychological and psychiatric services;

(f) Facilities that treat patients with a primary diagnosis of SUD; and

(g) Facilities providing care for patients with a primary diagnosis of mental retardation or developmental disability.

2.6 THERAPEUTIC ABSENCE

A therapeutic absence in the treatment of a mental disorder involves a patient's therapeutically planned absence from the RTC. The patient is not discharged from the facility and may be away for a period of from several hours to several days. The purpose of therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before actual discharge. Therapeutic absences involving overnight stays or longer must be included in the treatment plan submitted to DHA or a designee, for review of an inpatient mental health admission.

ARTICLE 3

PERFORMANCE PROVISIONS

3.1 GENERAL AGREEMENT

(a) The RTC agrees to render RTC services to eligible TRICARE beneficiaries in need of such services, in accordance with this Participation Agreement and the TRICARE regulation (32 CFR 199). These services shall include room and board, patient assessment, psychological testing, treatment services, social services, educational services, family therapy, and such other services as are required by the TRICARE regulation (32 CFR 199).

(b) The RTC 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 RTC will be ineligible for consideration for authorized provider status for a two year period. Termination of RTC status will be pursuant to Article 13 of this agreement.

(c) The RTC agrees that it shall not be considered a TRICARE authorized provider nor may any TRICARE benefits be paid to the facility for any services provided prior to the date the facility 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 RTC agrees to limit charges for services to TRICARE beneficiaries to the rate set forth in this agreement.

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

3.3 ACCREDITATION AND STANDARDS

The RTC hereby agrees to:

(a) Be licensed to provide RTC services within the applicable jurisdiction in which it operates, if licensure is available.

(b) Be specifically accredited by and remain in compliance with standards issued by the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA), or an accrediting organization approved by the Director, DHA.

The 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 TRICARE all-inclusive per diem rate, as provided in 32 CFR 199.14(f) as payment in full for services provided.

(d) Comply with all requirements of 32 CFR 199.4 applicable to institutional providers generally concerning preauthorization, 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 TRICARE requirements for individual professional providers. (Exception: RTCs 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 all-inclusive per diem rate but the individual must work under the documented direct clinical supervision of a fully qualified mental health provider employed by the RTC). All other program services will be provided by trained, licensed staff.

(f) 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 for preauthorization.

(g) 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 to be noncovered by TRICARE. (A general statement signed at admission relative to financial liability does not fill this requirement.)

3.4 QUALITY OF CARE

(a) The RTC shall assure that any and all eligible beneficiaries receive RTC services that comply with the standards in Article 3.3.

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

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

3.5 BILLING FORM

(a) The RTC shall use the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 billing form (or most current subsequent editions).

(b) RTCs shall identify RTC care on the billing form in the remarks block by stating "RTC care".

(c) RTCs shall identify on the billing form those days that patient was absent from the facility. This includes therapeutic absences as well as unplanned absences.

(d) Charges for geographically distant family therapy must be billed in the RTC patient's name and be authorized by DHA or designee.

3.6 COMPLIANCE WITH DHA UTILIZATION REVIEW ACTIVITIES

Under the terms of this agreement, the RTC shall:

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

(b) Obtain preauthorization for all care to be rendered within the RTC. Failure to obtain preauthorization will subject the facility to payment reductions according to 32 CFR 199.15(b)(4)(iii).

(c) 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 TRICARE beneficiary. Failure to comply with documentation requirements will result in the denial of authorization of care and/or termination of provider status.

(d) Maintain medical records, including progress notes, clinical formulation, and the master treatment plan, to include documentation of standardized assessment measures for Post-Traumatic Stress Disorder (PDST), Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), using the PTSD Checklist (PCL), GAD-7, and Patient Health Questionnaire (PHQ-8), respectively, at baseline, at 60-120 intervals, and at discharge (see TPM, Chapter 1, Section 5.1 for details); in compliance with TRICARE standards and regulations.

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 a TRICARE-approved RTC, and approved by DHA or a designee. The per diem rate will be calculated according to 32 CFR 199.14(f).

(a) Effective for care on or after April 1, 1995, the per diem amount shall not exceed a cap of the 70th percentile of all established Federal Fiscal Year (FY) 1994 RTC rates nationally, weighted by total TRICARE days provided at each rate during the first half of Federal FY 1994, and updated to FY 1995. For Federal FYs 1996 and 1997, the cap shall remain unchanged. For Federal fiscal years after FY 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medical Prospective Payment System (PPS).

(b) Subject to the applicable RTC cap, adjustments to the RTC rates may be made annually.

(1) For Federal fiscal years through 1995, the adjustment shall be based on the Consumer Price Index-Urban (CPI-U) for medical care as determined applicable by the Director, DHA.

(2) For purposes of rates for Federal FYs 1996 and 1997:

a. For any RTC whose 1995 rate was at or above the thirtieth percentile of all established Federal FY 1995 RTC rates normally weighted by total TRICARE days provided at each rate during the first half of Federal FY 1994, that rate shall remain in effect with no additional update, throughout FYs 1996 and 1997.

b. For any RTC whose 1995 rate was below the 30th percentile level, the rate shall be adjusted by the lesser of the CPI-U for medical care, or the amount that brings the rate up to the 30th percentile level.

(3) For subsequent Federal fiscal years after FY 1997, RTC rates shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare PPS. .

(c) The initial per diem rate under this agreement is specified in Article 18.1.

4.2 RTC SERVICES INCLUDED IN PER DIEM PAYMENT

(a) DHA determined per diem rate encompasses the RTC's daily charge for RTC inpatient care and all mental health treatment determined necessary and rendered as part of the treatment plan established for the RTC patient, and accepted by DHA or a designee. This includes all individual and group psychotherapy rendered to the RTC patient, family therapy rendered to the parents of the RTC patient at or in close proximity to the facility, collateral visits with individuals other than the RTC patient determined necessary in order to gather information or implement treatment goals for the patient, and all other ancillary services provided by the RTC.

(b) The all-inclusive per diem rate also includes charges for the routine medical management of a beneficiary while residing in an RTC. Services provided by medical professionals employed by or contracted with the RTC are part of the all-inclusive per diem rate and cannot be billed separately. These routine medical services are made available to all children entering the facility and are designed to maintain the general health and welfare of the patient population. Examples of this type of care are: 1) routine health and physical examinations provided by RTC medical staff; 2) in-house pharmaceutical services; and 3) other ancillary medical services routine provided to the
RTC population.

(c) The only charges that will be allowed outside the all-inclusive rate will be for:

(1) Geographically Distant Family Therapy. Family therapy may be billed individually from the RTC all-inclusive rate if it is provided to one or both of the parents residing a minimum of 250 miles from the RTC. Family therapy must be authorized by DHA or a designee at the time the treatment plan is submitted and approved in order for the cost-sharing to occur. The RTC may elect to provide family therapy via telemedicine in accordance with existing TRICARE telemedicine and Telemental Health (TMH) requirements (see TPM, Chapter 7, Section 22.1).

(2) RTC Education Services. Educational services will be covered if the sponsor and/or RTC can demonstrate that the school district in which the TRICARE beneficiary was last enrolled refuses to pay for the educational component of the child's RTC care.

(3) Nonmental Health Services. Otherwise covered medical services related to a nonmental health condition (e.g., treatment of broken leg) and rendered by an independent provider outside the RTC are payable in addition to the all-inclusive per diem rate.

4.3 OTHER PAYMENT REQUIREMENTS

For care provided on or after July 1, 1995, TRICARE will not pay for days in which the patient is absent on leave from the RTC. The RTC must identify these days when claiming reimbursement.

4.4 PREREQUISITES FOR PAYMENT

Provided that there shall first have been a submission of claims in accordance with TRICARE procedures, the RTC shall be paid on the basis of the allowance of the rate determined

in accordance with the controlling TRICARE regulation (see Article 4.1) contingent upon certain conditions provided in the TRICARE regulation, and in particular the following:

(a) The patient seeking admission is suffering from a mental disorder that meets both the diagnostic criteria of the current edition of the DSM and the TRICARE definition of a mental disorder.

(b) The patient seeking admission does not have a primary diagnosis of SUD including management of withdrawal symptoms (detoxification).

(c) The patient seeking admission does not have a primary diagnosis of mental retardation or developmental disability.

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

(e) The medical and/or psychological necessity of the patient's admission is determined by a qualified mental health professional who meets TRICARE requirements for individual professional providers, and who is permitted by law and by the facility to refer patients for admission.

(f) A qualified mental health professional who meets TRICARE 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.

(g) All services in 32 CFR 199.4(c)(3)(ix) are provided by or under the supervision of a TRICARE-authorized mental health provider (see Article 3.3(e)).

(h) DHA or a designee has preauthorized all care rendered to the patient.

(i) The patient meets eligibility requirements for TRICARE coverage.

4.5 TRICARE-DETERMINED RATE AS PAYMENT IN FULL

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

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

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

(d) The RTC agrees to bill only the TRICARE-determined rate.

4.6 TRICARE AS SECONDARY PAYOR

(a) The RTC is subject to the provisions of 10 USC, Section 1079(j)(1). The RTC must submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage before 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 the 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 13.

4.7 COLLECTION OF COST-SHARE

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

(b) The RTC's failure to collect or to make diligent effort to collect the beneficiary's cost-share as determined by TRICARE policy is a violation of this agreement, may result in the 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 13 of this agreement.

4.8 BENEFICIARY RIGHTS

If the RTC 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 RTC 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

EDUCATIONAL COSTS

5.1 REIMBURSEMENT OF EDUCATIONAL SERVICES

(a) All educational costs, whether they include routine education or special education costs, are excluded from reimbursement.

(b) In accordance with the TRICARE regulation 32 CFR 199.14(f)(4)(iii) the only exception to Article 5.1(a) is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, DHA, (or a designee) for review and a determination of the applicability of TRICARE benefits. If the coverage of educational services meets the exception, payment will be allowed outside the all-inclusive facility rate. The amount paid shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general educational services whichever is appropriate.

5.2 EXCLUSION FROM PER DIEM RATE

The RTC shall exclude costs for education from its daily rate.

5.3 ACCOUNTING REQUIREMENTS

The RTC's accounting system must be adequate to assure TRICARE is not billed for educational costs.

ARTICLE 6

RECORDS AND AUDIT PROVISIONS

6.1 ON-SITE AND OFF-SITE REVIEWS/AUDITS

The RTC grants the Director, DHA, or authorized representative(s), the right to conduct on-site or off-site reviews or accounting audits with full access to patients and records. The reviews or audits will 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 RTC that would confirm compliance with this agreement and designation as a TRICARE-authorized RTC provider.

(b) Conduct audits of RTC 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 TRICARE beneficiaries. 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 RTC 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.

6.2 RIGHT TO UNANNOUNCED INSPECTION OF RECORDS

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

(b) The RTC'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.

6.3 CERTIFIED COST REPORTS

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

6.4 RECORDS REQUESTED BY DHA

Upon request, the RTC shall furnish DHA or a designee with 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.

6.5 FAILURE TO COMPLY

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in the denial or reduction of payment, termination of this agreement pursuant to Article 13 of this agreement, and any other appropriate action by DHA.

ARTICLE 7

NONDISCRIMINATION

7.1 NONDISCRIMINATION

The RTC agrees to comply with the provisions of section 504 of the Rehabilitation Act of 1973 (Public Law 93-112; as amended) regarding nondiscrimination on the basis of handicap, and 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 (PPACA)as well as all regulations implementing these Acts.

ARTICLE 8

AMENDMENT

8.1 AMENDMENT BY DHA

(a) The Director, DHA, or a designee may amend the terms of this Participation Agreement by giving 120 days' notice in writing of the amendment(s) **except** amendments to the TRICARE regulation, 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 TRICARE regulation 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 TRICARE regulation shall become effective on the date the regulation amendment is effective or the date this agreement is amended, whichever date is earlier.

(b) The RTC, if it concludes it does not wish to accept the proposed amendment(s), including any amendment resulting from amendment(s) to the TRICARE regulation accomplished through rulemaking procedures, may terminate its participation as provided for in Article 13.3. However, if the RTC's notice of intent to terminate its participation is not given at least 60 days before the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for RTC care furnished between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 9

CHANGE OF OWNERSHIP

9.1 ASSIGNMENT BARRED

This agreement is nonassignable.

9.2 AGREEMENT ENDS

(a) Unless otherwise extended as specified in Article 9.3(b), this agreement ends as of 12:01a.m. on the date following 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 a change of ownership.

(2) The merger of the RTC 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 a change of ownership. The transfer of corporate stock or the merger of another corporation into the RTC corporation, however, does not constitute change of ownership. The transfer of title to property of the RTC corporation to another corporation(s), and the use of

that property for the rendering of RTC care by the corporation(s) receiving it is a change of ownership.

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

9.3 NEW AGREEMENT REQUIRED

(a) If there is a change of ownership of an RTC as specified in Article 9.3(b), then the new owner, in order to be a TRICARE-authorized RTC, must enter into a new agreement with DHA. The new owner is immediately 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 RTC contemplating or negotiating a change of ownership must notify DHA in writing at least 30 days before 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 RTC that has provided the required 30 days' advance written 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 written notification of a change of ownership will result in a denial of a request for an extension of this agreement and the termination of this agreement upon transfer of ownership as specified in Article 9.3(a).

(c) Prior to a transfer of ownership of an RTC, 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 RTC to ensure that it is in compliance with TRICARE requirements.

ARTICLE 10

REPORTS

10.1 INCIDENT REPORTS

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

(a) An incident of a life-threatening accident, a patient death, patient disappearances, suicide attempt, incident of cruel or abusive treatment, physical or sexual abuse, or any equally dangerous situation involving a TRICARE 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.

(d) When a TRICARE beneficiary is absent without leave and is not located within 24 hours, the incident is reported by telephone to DHA on the next business day. If the patient is not located within three days, a written report of the incident is made to DHA within seven days.

10.2 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, Operations Directorate.

10.3 REPORTS OF RTC CHANGES

The governing body or the administrator of the RTC shall submit a written report to DHA, Operations Directorate, any significant proposed changes within the RTC no later than 30 days prior to the actual date of change; failure to report such changes may result in 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 11

GENERAL ACCOUNTING OFFICE

11.1 RIGHT TO CONDUCT AUDIT

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

ARTICLE 12

APPEALS

12.1 APPEAL ACTIONS

Appeals of DHA actions under this agreement, to the extent they present an appealable issue and are allowed under the TRICARE regulation, will be pursuant to 32 CFR 199.10, and 32 CFR 199.15.

ARTICLE 13

TERMINATION

13.1 PROCEDURE FOR TERMINATION OF THE 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.

13.2 BASIS FOR TERMINATION OF THE AGREEMENT BY DHA

(a) In addition to any authority under the TRICARE regulation 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 RTC:

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

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

(3) Fails to allow audits/reviews and/or to provide records as required by Article 6 of this agreement.

(4) Fails to comply with nondiscrimination provisions of Article 7 of this agreement.

(5) Changes ownership as set forth in Article 9 of this agreement.

(6) Fails to provide incident reports, disaster or emergency reports, or reports of RTC changes, as set forth in Article 10 of this agreement.

(7) Initiates a change as specified in Article 10.3 of this agreement, without written approval by the Director, DHA, or a designee.

(8) Does not admit a TRICARE beneficiary during any consecutive 24-month period.

(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 TRICARE regulation (32 CFR 199.9). This includes the submission of falsified or altered TRICARE claims or medical records which misrepresent the type, frequency, or duration of services or supplies.

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

13.3 TERMINATION OF AGREEMENT BY THE RTC

The RTC may terminate this agreement by giving the Director, DHA, or a 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 RTC and DHA.

ARTICLE 14

RECOUPMENT

14.1 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.

ARTICLE 15

ORDER OF PRECEDENCE

15.1 ORDER OF PRECEDENCE

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

ARTICLE 16

DURATION

16.1 DURATION

This agreement will remain in effect until the expiration date specified in Article 18.1 unless terminated earlier by DHA or the RTC under Article 13. DHA may extend this agreement for 60 days beyond the established date if it is necessary to facilitate a new agreement.

16.2 REAPPLICATION

The RTC must reapply to DHA at least 90 days prior to the expiration date of this agreement if it wishes to continue as a TRICARE-authorized RTC. Failure to reapply will result in automatic expiration of this agreement on the date specified in Article 18.1.

ARTICLE 17

EFFECTIVE DATE

17.1 EFFECTIVE DATE

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

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

ARTICLE 18

AUTHORIZED PROVIDER

18.1 TRICARE-PROVIDER STATUS

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

PROGRAM	BEDS	AGES

_____ _____

Residential Treatment Center Name Amended Signature

_____ _____

Expiration Date Amended Date

_____

TRICARE Per Diem Rate

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 TRICARE entity

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

Residential Treatment Center:

_____
Signature

_____
Printed Name

_____
Printed Title

Executed on: _____, 20____

_____
Facility Name

_____
TIN

_____
NPI

DHA or Designee:

_____
Signature

_____
Printed Name

_____
Printed Title

Executed on: _____, 20____

DHA FORM 771

INSTRUCTIONS FOR SUBMITTING REIMBURSEMENT INFORMATION FOR PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS

This reimbursement information will be used to compute a Residential Treatment Center's (RTC) all-inclusive rate under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This rate of reimbursement will reflect a reasonable amount consistent with rates charged by RTCs nationally and with reimbursement already accepted from other third-party payers. All requested information will be subject to on-site verification by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) or its representatives. In accordance with Article 6 of the current CHAMPUS RTC participation agreement, failure to provide all the requested information may result in denial of an application for CHAMPUS certification or termination of a current agreement.

Administrative Information:

Items 1 through 8 identify the facility and establish the base period parameters for calculating the individual RTC rate. It is important that the contact person designated in item 2 be familiar with the methodology used in collection of the data. This person may be contacted at a future date if OCHAMPUS should have any questions regarding the submitted information. In items 5 through 7, provide the most recent/current dates for the information requested. Failure to do so may result in a base period that is inconsistent with the operation of you facility.

Reimbursement Information:

Item 9: For the period July1, 1987, through June 30, 1988, provide the name, mailing address, and telephone number of all third party payers for whom a rate was established and what the accepted rate was, and the number of patient days actually provided at that rate. At a minimum, this is to include all federal, state, or local government agencies (including CHAMPUS), and other private third party payers. Also include the rate charged the general public and the number of days actually provided at that rate. Individual private payers do not need to be identified.

The data requirements for RTCs beginning operation after July 1, 1988 or beginning operation before July 1, 1988, but having less than 12 months of operation by July 1, 1988, are identical to the data requirements for those facilities in operation during the entire base period, with the exception of the time frame for which the data is to be provided. The data must be provided for the first 6 to 12 months of operation, with 6 months being the absolute minimum for new facilities. A period of less than 12 months will be used only when the RTC has been in operation for less

than 12 months. Once a full 12 months is available the rate shall be recalculated and applied prospectively. If the data only covers a portion of the base period, give the dates. If there is more than one rate with an individual third party payer during the base period, provide the total number of patient days paid by that payer at each rate during the base period. Total patient days will be used in determining the most favored rate for you facility. The following is an example of how to handle multiple third party rates over your base period:

An RTC had negotiated three separate rates with a third party payer over its base period. The three rates would be reported as follows:

(1) $195/day from July 1, 1987, through October 31, 1987 – 2000 patient days;
(2) $215/day from November 1, 1987, through February 29, 1988 – 3000 patient days;
(3) $230/day from March 1, 1988 through June 30, 1988 – 2000 patient days

In this example the total number of days paid by the third party payer is 7000.

If the RTC was in operation during the base period, provide the requested data for the entire period regardless of change in ownership: for example, if your facility was in operation during the base period (July1, 1987, through June 30 1988), but was taken over by a national mental health corporation as of January 1, 1988, provide the requested data from July, 1987 through June 30, 1988 along with date of change of ownership. Failure to provide the entire base period data will result in delay in establishing your new rate.

DHA FORM 771 (Continued)

REIMBURSEMENT INFORMATION

OMB No: 0704-0295 Expires: 31 January 1994

PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS

1. FACILITY NUMBER:	2. EIN:
3. FACILITY NAME AND ADDRESS: TELEPHONE NUMBER: ( )	4. NAME OF PERSON PREPARING DATA: TITLE:

5. DATE CURRENT RTC PROGRAM OFFICIALLY OPENED FOR BUSINESS:

6. DATE OF MOST RECENT JOINT COMMISSION ON ACCREDITATION OF HEALTH ORGANIZATIONS (JCAHO):

7. DATE OF CURRENT AUTHORIZATION AS A CHAMPUS CERTIFIED RTC:

8. DATES OVER WHICH DATA WAS COLLECTED _____ TO _____

9. THIRD PARTY PAYERS ESTABLISHING OR AFFECTING RATES: Data requirements should be carefully reviewed and presented in the following format. (If additional sheets are required, copy the format and attach all completed sheets.)

NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PAYER	RATE ACCEPTED	PATIENT DAYS PROVIDED AT EACH RATE

DHA FORM 771 (Continued)

10. ADDITIONAL SERVICES: Identify each individual service not included in item #9 (If additional sheets are required, copy the format below and attach all completed sheets.

SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER PATIENT DAY (PPD)

11. EDUCATION CHARGES:

a. Are educational charges excluded from the daily rate when billing CHAMPUS:

Yes ☐ No ☐

b. What is the educational rate/charge per patient per day in you facility?

$ _____ per patient day.

I declare that I have examined the above information and all attachments, and to the best of my knowledge and belief, they are true, correct and complete.

_____

Signature Date

_____

Name (Typed or Printed)

_____

Title

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