Chapter 1 Addendum A

Sample State Agency Billing Agreement

STATE AGENCY BILLING AGREEMENT

BETWEEN

THE STATE OF _____
(State Name)

DEPARTMENT OF _____
(Name Of Executive Level Department)

_____
(Name of State Medicaid Agency, if different)

AND

THE TRICARE MANAGEMENT ACTIVITY (TMA)

The purpose of this agreement is to provide a billing procedure to enable the State to claim reimbursement from the TRICARE Management Activity (TMA), for payments for TRICARE covered medical services made by a State Medicaid Agency, on behalf of recipients who were also eligible for TRICARE at the time the services were rendered. Medical services are defined by Title XIX of the Social Security Act, and the State Plan for Medical Assistance on file at the appropriate Regional Office of the Centers for Medicare and Medicaid Services. When a beneficiary is eligible for both TRICARE and Medicaid, 32 CFR 199.8 establishes TRICARE as the primary payor.

I

TMA agrees, through its designated Managed Care Support (MCS) contracts, to:

A. Reimburse the State Agency for claims under the following conditions:

1. The claim is filed no later than one year following the date of service or the date of discharge for inpatient services. Waivers to the claims filing deadline shall be granted by the MCS contractor for the State requesting the waiver. The contractor shall review the request for waiver against limited waiver circumstances.

2. The claim contains the necessary information as defined in paragraph IID.

3. The claim is signed either by the recipient/beneficiary (patient) or by a designated State official on behalf of the patient; and if the latter, the State official may sign each claim individually or attach a signed statement to each batch of claims submitted for reimbursement at the same time. A "batch" of claims is defined as those claims submitted under a single covering document and shall not include more than two hundred fifty (250) claims. A separate certification document shall be submitted for each two hundred fifty (250) or fewer claims.

B. Provide the State with complete remittance advice in the form of an Explanation of Benefits (EOB). Consistent with the capabilities of each MCS contractor, the EOB shall include a claim identification number supplied by the State.

II

The State Agency agrees to:

A. Submit claims to the MCS contractor on an approved claim form or in an acceptable electronic media. The State Agency may submit documentation of the services rendered as an attachment to the claim form. The attached documentation must contain the required information as listed in Section D. below, unless the required information is also entered on the face of the claim. In no case shall any document or attachment be sent which does not clearly identify the patient. The attached documentation of services shall follow the basic format specified in item 24 of the CMS 1500 Claim Form or CMS 1450 UB-04 claim forms. If the services of more than one provider are included on an attachment, the name and address of the provider of each service or group of services shall be clearly indicated.

B. If the State has a standard format which it uses for coordinating benefits which does not substantially follow the format of the claim forms, then the State may negotiate with the MCS contractor on a nonconforming format. However, the agreement must be approved by TMA and any extra processing expense must be borne by the State and will be paid directly to the MCS contractor.

C. Reimburse TRICARE for all claims, where the patient is subsequently found to have been ineligible for TRICARE coverage on the date of service or which was found to have been incorrectly paid or submitted as a result of audit. The State will cooperate with TMA and other Federal Government investigative or audit agencies by making any required records available for review upon request.

D. Provide the MCS contractor with adequate information for accurate processing of each claim submitted, in accordance with the requirement of each claim form. If the CMS 1450 UB-04 is used, it will be submitted using the National Standard Codes. At a minimum, the following data elements must be included or attached:

1. Patient's name, address (at the time of service), and date of birth.
2. Sponsor's name, Social Security Number, and relationship to patient.
3. Date(s) medical service(s) was (were) received.
4. Amount billed by the provider for each service.
5. Amount paid by Medicaid for each service.
6. Procedure Code billed (in CPT-4 format) and/or narrative description and number of times the service was provided.
7. Diagnosis or diagnosis code (in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) format) or a written description of the symptoms, condition or circumstances requiring care for services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation. Diagnosis or diagnosis code (in International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) format) or a written description of the symptoms, condition or circumstances requiring care for services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation.

8. Name, address, EIN or SSN, and Type of Provider, i.e., M.D., D.O., Supplier, Institution such as a hospital, skilled nursing facility, etc.

9. Claim Identification Number for inclusion on the EOB/Payment Voucher, if agreed between the State and the MCS contractor.

10. Place of Service, if not clearly evident from the procedure.

11. Optional Copy of the Non-Availability Statement (NAS) (Form DD 1251) if the patient lives within a catchment area of a Military Treatment Facility (MTF) and non-emergency inpatient mental health services were provided in a hospital.

12. Other health insurance information shall be included on the face of the claim or on an attachment to the claim form. If the other insurance has paid for a service in full or in part, the amount of the payment shall be included, along with the other health insurer's name and address, or a copy of the other health insurer's EOB.

E. Certify, by virtue of its designated official having signed the claim, that:

1. The original provided invoice was validated prior to payment in accordance with coverage rules by both Medicaid and TRICARE.

2, The patient was, to the best knowledge and understanding of the official, as evidenced by the Defense Enrollment Eligibility Reporting System (DEERS), State data or other documented information, eligible for TRICARE coverage on the service date.

3. The claims being submitted contain all information regarding other health insurance coverage which is available to or known by the State and, where other health insurance is known, the State has filed with that coverage and the amount paid is accurately reflected on the claim.

F. Notify TMA and the MCS contractor immediately of any change of the designated state official.

G. Establish an interface with DEERS to identify TRICARE-eligible persons who may have been erroneously paid by the State Agency and implement procedures to preclude further erroneous payments subsequent to such identification, by requiring any subsequent claims for services to TRICARE-eligible persons to be initially submitted to the MCS contractor for processing.

H. Exclude, to the fullest extent possible, any submission of claims for services excluded as TRICARE benefits.

I. The State shall make a good faith effort to accommodate the documentation requirements to process a TRICARE claim.

J. The State will provide adequate information to enable the MCS contractor to process the claim or will make every reasonable effort to do so. It is understood and agreed that claims which do not have essential data or which appear to be duplicates of services previously processed by the MCS contractor, or which are services rendered by a provider not authorized under TRICARE, will be denied by the MCS contractor.

III

General Provisions:

A. The effective date of the agreement is _____.

B. This agreement shall remain in effect until TMA or the State Agency requests that it be modified or terminated.

C. Either TMA or the State Agency may terminate this agreement at any time by notifying the other in writing, at least thirty (30) days in advance of the proposed termination date.

IV

Designated State Official(s):

Name	Signature	Title	Date

V

Signing this Agreement for TMA:

Name	Signature	Title	Date

VI

Signing this Agreement for the State Agency:

Name	Signature	Title	Date

- END -