Certified Labor Doula (CLD) provider participation agreement

Required:

Name: _____

Practitioner NPI #: _____

In order to receive payment under TRICARE, _____
DBA _____, as the provider of services agrees:

1. Not to charge a beneficiary for the following:
   a. Services for which the provider is entitled to payment from TRICARE;
   b. Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
   c. Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;
   d. Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and
   e. Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:
2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;
3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and Other Health Insurance (OHI) amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE-allowed services;
4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;
5. To permit access by the Director, Defense Health Agency (DHA), or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;
6. To provide to the Director, DHA, or designee (e.g., Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in an managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;
7. To cooperate fully with a designated utilization and clinical quality management organization, which has a contract with the DoD for the geographic area, in which the provider renders services;
8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/co-payment may be expected;
9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;
10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment;
    Clinical records are required to document the outcomes of standardized assessment measures for PTSD, GAD, and MDD using the PTSD Checklist (PCL), GAD-7, and Patient Health Questionnaire (PHQ)-8, respectively, at baseline, at 60-120 day intervals, and at discharge (See Ch. 1, Sec. 5.1 for details);

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11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE-authorized provider discharges the payment liability of the beneficiary; and

13. Notify the referring military provider or military hospital or clinic/eMSM referral management office (on behalf of the military provider) when a Service member or beneficiary, in the provider's clinical judgment, meets any of the following criteria:
    a. Harm to self – The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition;
    b. Harm to others – There is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence;
    c. Harm to mission – There is a serious risk of harm to a specific military operational mission. Such a serious risk may include disorders that significantly impact impulsivity, insight, reliability and judgment;
    d. Inpatient care – Admitted or discharged from any inpatient mental health or substance use treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards;
    e. Acute medical conditions interfering with duty – Experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the beneficiary's ability to perform assigned duties;
    f. Substance abuse treatment program – Entered into, or is being discharged from, a formal outpatient or inpatient treatment program.

14. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

DHA agrees to:

Pay the above-named provider the full allowable amount less any applicable double-coverage, cost-share/co-payment and deductible amounts.

This agreement shall be binding on the provider and DHA upon acceptance by the executive director, DHA or designee. This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by DHA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

For provider of services by:

Provider name: _____

Phone: _____ Email: _____

Signature of provider: _____

For DHA by:

Name: _____ Title: _____

Signature: _____ Executed on date: _____

Please return participation agreement to: Fax: (844) 684-7461

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