NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Latent Tuberculosis Pharmacy Enrollment Form

Date:	National Provider Identifier (NPI):	Name NPI Issued to:

Check Applicable Box: ☐ Corporate Office ☐ Local Office

Provider Name:

Provider Street Address/City/State/Zip:

Mailing Address, if different from above:

Business Telephone:	Business Fax:

Corporate Office Billing Address, if different from above:

Latent Tuberculosis Pharmacy Enrollment Standards

Par. 1. Department staff will allow reimbursement of current Medicaid rates for Isoniazid, Rifampin and Vitamin B6 for patients needing Latent Tuberculosis Infection Therapy (LTBI) therapy. Twelve (12) week Isonaizid/Rifapentine directly observed LTBI regiments will not be reimbursed. The formulary is listed on the Latent Tuberculosis Checklist Document.

Par. 2. Health care providers must fill out the Latent Tuberculosis Checklist Form and fax to the Nebraska Department of Health and Human Services DHHS Tuberculosis (TB) fax (fax 402-742-8359) prior to any reimbursement with any pharmacy provider agreement. DHHS TB Program will then fax medication request to pharmacy with provider agreement.

Par. 3. Reimbursements for the program will only occur for patients with an approved Nebraska Tuberculosis Financial Assistance Application.

Par. 4. Department staff will determine client eligibility for services. The Department will honor invoices and make payments for services that were authorized and provided in accordance with the Department’s policies and standards.

Par. 5. The Enrollment may be terminated by either party at any time by giving at least thirty (30) days advance written notice to the other party to allow for arrangement of alternate service provision for clients. The notice requirement may be waived in case of emergencies such as illness, death, injury, or fire. Only such payments as have already accrued for services rendered prior to the effective date of termination shall be made to the provider upon such voluntary termination.

Par. 6. Services may only be provided by the provider listed on this form.

Par. 7. The Tuberculosis Program is funded by State of Nebraska appropriations and the amount is limited. When the annual maximum funding level for the program is reached, the Program will stop reimbursing for expenses until the next state fiscal year begins. If funding for the entire Program is depleted before the end of the state fiscal year, notice will be placed on the Program’s website.

Par. 8. If the provider is identified (or becomes identified in the future) on the Excluded Parties List System

(EPLS) website of the Office of the Inspector General (OIG) list of Excluded Individuals/Entities website, then this Enrollment will be terminated immediately.

Par. 9. If the provider violates any of these provisions, then this Enrollment may be terminated immediately, at the election of the Department. Any money due to the provider which accrued prior to such violation may be offset against the damages.

General Provider Standards

By Signing this Enrollment, the provider acknowledges it must:

1. Follow all applicable Department policies, procedures and regulations.
2. Bill for services which are actually provided.
3. Submit billing documents after service is provided and within 180 days of the date of service.
4. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90: and 41 CFR Part 60.
5. Retain financial and statistical records for six years from date of service provision to support and document all invoices.
6. Allow state offices responsible for program administration or audit to review service records. Inspections, reviews, and audits may be conducted on site.
7. Keep current any state or local license/certification required for service provision.
8. Acknowledge that any false invoice, statement, documents, or concealment of material fact may be prosecuted under applicable laws.
9. Accept that the payment determined in accordance with the policies of the Nebraska Department of Health and Human Services Tuberculosis Program is the full and complete payment for services provided and the amount paid for the invoices submitted will be accepted as payment in full from the Program and that no additional payment will be invoiced. If any additional payment is received-or will be received-from any other source, that amount will be deducted from the amount charged to the Program. Any payment received from another source after payment by the Program shall be remitted to the Program. The Program reserves the right to recuperate payments made in error, by either requesting reimbursement for said error or deducting the amount of the error from a future payment. No additional payments can be accepted from the patient.
10. Respect every client's right to confidentiality and safeguarding confidential information.
11. Operate a drug-free workplace.
12. Have the knowledge, experience, and/or skills to perform the task(s).
13. Must report any suspected abuse or neglect to law enforcement and/or appropriate Department staff per state law.
14. Under this program, approved patients are the only clients that may be served.
15. **If aware of a suspected patient death by LTBI treatment, please contact DHHS TB Program.**

Pharmacy Provider Standards

The Pharmacy acknowledges it must:

1. Submit invoices and request payments for prescriptions included in the formulary (https://www.cdc.gov/tb/topic/treatment/ltbi.htm). DHHS does not cover the 3 month Isonaizid (INH) and Rifapentine (RPT) regimen.
2. Submit invoices that include Program, client name, drug name, National Drug Code (NDC) number, drug quantity, drug strength, date of service, and whether or not the client has prescription drug insurance. Please note if no pharmacy insurance benefit is available.

Service Provider Standards

The Service Provider acknowledges it must:

1. Only claim payment for Latent Tuberculosis Medications. The Program will use current ICD and CPT coding.
2. Submit invoices that include the Program client name, date of service and appropriate ICD and CPT codes.

I certify that I have read and understand the standards as stated and referenced above. The Enrollment becomes effective after it is electronically signed by both parties pursuant to Neb. Rev. Stat. 86-621.

Provider Name:	
Name and Title of Provider Representative:	Date:
Authorized Representative-Nebraska Department of Health and Human Services:	Date: