

Chapter 1

Section 7

Reimbursement Of Covered Services Provided By Individual Health Care Providers And Other Non-Institutional Health Care Providers

Issue Date: July 5, 1991

Authority: [32 CFR 199.6](#) and [32 CFR 199.14\(j\)](#)

Revision: C-10, November 15, 2017

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

This policy is related to reimbursement of covered beneficiary related services of individual health care providers and professionals that would otherwise meet the qualifications of individual health care providers except that they are either employed by or under contract to an institutional provider, and other non-institutional health care providers to be reimbursed.

3.0 POLICY

3.1 Covered services provided by all TRICARE authorized individual health care providers and other non-institutional health care providers shall be reimbursed using the allowable charge methodology unless otherwise stated.

3.1.1 This policy applies to all categories of individual health care providers and professionals that would otherwise meet the qualifications of individual health care providers except that they are either employed by or under contract to an institutional provider, and other non-institutional providers regardless of the beneficiary services provided.

3.1.2 This policy applies to all locations, inpatient or outpatient, where services are provided by these providers. These services could be provided by individual health care providers in a Diagnosis Related Groups (DRG) hospital, a DRG exempt hospital, an Ambulatory Surgery Center (ASC), or in a facility without a TRICARE all-inclusive rate.

Note: Facility charges for inpatient and outpatient services shall continue to be billed on the current Centers for Medicare and Medicaid Services (CMS) 1450 UB-04. This would include inpatient

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services that are and have been included in the reimbursement under the DRG-based payment system or the mental health per diem payment system. Outpatient facility charges would include services that aid the individual health care provider in the treatment of the **beneficiary**. These charges may include such services as the use of hospital facilities factoring in overhead costs of utilities, billing, equipment and maintenance costs, insurance, nursing staff, etc., including emergency room services (nonprofessional services), the services of nurses, technicians, and other aides, medical supplies (gauze, oxygen, ointments, dressings, splints, casts, prosthetic devices), and drugs and biologicals which cannot be self-administered.

3.1.3 Services provided by individual **authorized health care** providers and other non-institutional health care providers **shall** be billed only on the **current** CMS 1500 Claim Form or the TRICARE 2642 for payment. Individual health care **providers** (e.g., physicians) and non-institutional providers (e.g., suppliers) are to use the CMS 1500 Claim Form. Institutional providers (e.g., hospitals) are to use the CMS 1500 Claim Form or the CMS 1450 UB-04 (if adequate Common Procedure Terminology (CPT) coding information is submitted) to bill for the professional component of physicians and other authorized professional providers. Beneficiaries (or their representatives) who complete and file their own claims for individual health care **providers** and other non-institutional health care provider services may want to use the TRICARE 2642 claim form for payment.

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