CHAPTER 4
SECTION 1

GENERAL

1.0. DEFINITION OF AUTHORIZED PROVIDER

As used by TRICARE, "Authorized Provider" means a hospital or institutional provider, physician, or other individual professional provider or other provider of services or supplies specifically authorized to provide benefits under TRICARE in 32 CFR 199.6. An authorized "network" provider is one who, in addition to meeting all the criteria to be a TRICARE provider, has signed an agreement with the contractor which includes provisions for holding the beneficiary harmless for charges, except as specifically provided by the provider agreement(s), for adherence to standards of care, for billing and for other administrative procedures. TRICARE benefits will not be paid for any service or supply furnished by any provider who is not TRICARE authorized. To be considered an authorized provider, specified educational, licensing and operational requirements must be met. The requirements are found in 32 CFR 199.6 and in the Policy Manual, Chapter 10. If a beneficiary submits a claim for services provided by a non-participating individual professional provider who is known to be legally practicing and is eligible for TRICARE-authorization, the provider shall be authorized and payment shall be made to the beneficiary. In no case shall a provider who refuses to provide proper SSN/EIN identification be paid directly.

2.0. LISTING OF PROVIDER DOES NOT GUARANTEE PAYMENT OF BENEFITS

The fact that a type of provider is authorized and certified under TRICARE does not mean a TRICARE claim will automatically be paid for services or supplies furnished by such a provider. Contractors shall determine if the provider meets all criteria for authorization as a TRICARE provider and whether the services delivered are covered and medically necessary. Each case and each claim must be evaluated on its own merits for compliance with all coverage requirements.

3.0. OUTSIDE THE UNITED STATES OR EMERGENCY SITUATIONS WITHIN THE UNITED STATES

Outside the United States, or within the United States and Puerto Rico in emergency situations, the Director, TMA (or a designee), may, after review of the facts, provide payment to, or on behalf of, a beneficiary who receives otherwise covered services and/or supplies from a provider of service that does not meet the TRICARE standards. In emergency situations, payment to civilian facilities in the United States and Puerto Rico which are not in compliance with Title VI of the Civil Rights Act of 1964 may be authorized only by the Secretary of Defense or Secretary of Health and Human Services (or their designees).

4.0. PHYSICIAN REQUIREMENT AND EXCEPTIONS

Medical services or supplies received from any provider OTHER than a doctor of medicine, doctor of osteopathy, doctor of podiatry, certified nurse midwife, clinical psychologist, certified nurse practitioner, certified clinical social worker or doctor of optometry, unless otherwise stated, must be at the direction of, prescribed by, or ordered by a physician.

5.0. PROVIDER EXCLUSIONS

When TMA determines that a provider is to be suspended or terminated, contractors will be notified by certified mail. TMA will also provide contractors with a list of providers that have been suspended, excluded, or terminated by the Department of Health and Human Services. See Chapter 14, for specific guidelines.

6.0. TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Payment of federal funds to providers who practice discrimination on the grounds of race, color or national origin is prohibited, except as provided below. Payment cannot be made for inpatient or outpatient care rendered by an institutional provider found by the Federal Government to practice discrimination in the admission or treatment of its patients, or the granting of medical staff or clinical privileges, whether the claim is submitted by the institution or by the beneficiary seeking reimbursement. TRICARE benefits can, however, be extended to authorized professional providers even though the medical services were furnished in an unauthorized institution. There are three circumstances under which the Secretary of Defense (or a designee) may authorize payment for care obtained in an ineligible facility. If the contractor receives a claim for services rendered by one of these facilities, the case will be developed to determine if the conditions listed below apply. The circumstances are:

6.1. Medical Emergency

Emergency inpatient or outpatient care was required, as defined in 32 CFR 199.2;

6.2. Care Rendered Prior To Finding Of A Violation

Care was initiated prior to a finding of violation and was continued after the violation and it was certified by the attending physician and confirmed by the contractor's medical review staff that a change in the treatment facility would be detrimental to the health of the patient; or

6.3. Other Facility Not Available

Care was provided in an ineligible facility because of the absence of an eligible facility within a reasonable distance, as determined by the contractor.