CHAPTER 1
SECTION 7

REIMBURSEMENT OF COVERED SERVICES PROVIDED BY INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

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AUTHORITY: 32 CFR 199.6 and 32 CFR 199.14(j)

I. 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 TMA and specifically included in the network provider agreement.

II. ISSUE

How are covered patient related services of individual health care professionals and professionals that would otherwise meet the qualifications of individual professional 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?

III. POLICY

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

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

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 professionals in a DRG hospital, a DRG exempt hospital, an ambulatory surgery center, or in a facility without a TRICARE/CHAMPUS all-inclusive rate.

NOTE: Facility charges for inpatient and outpatient services will continue to be billed on the UB-92. This would include inpatient 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 professional provider in the treatment of the patient. 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. Services provided by individual professional providers of care and other non-institutional health care providers are to be billed only on the CMS 1500 or the TRICARE 2642 for payment. Individual health care professionals (e.g. physicians) and non-institutional providers (e.g. suppliers) are to use the CMS 1500. Institutional providers (e.g. hospitals) are to use the CMS 1500 or the UB-92 (if adequate 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 professional and other non-institutional health care provider services may want to use the TRICARE 2642 claim form for payment.

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