

Institutional Provider, Individual Provider, And Other Non-Institutional Provider Participation

Issue Date:

Authority: [32 CFR 199.6](#); 10 USC 1079(j)

1.0 DESCRIPTION

Institutional providers (United States Code (USC), Section 1079(j) of Title 10), in order to be authorized providers under TRICARE must be participating providers. Individual and other non-institutional providers, that are not participating providers, may elect to participate on a claim basis. All individual and other non-institutional providers either operating in or outside an institutional provider who are nonparticipating providers are subject to the TRICARE balance-billing limit.

2.0 BACKGROUND

Per [32 CFR 199.6\(b\)](#), institutional providers must participate on all claims. In most cases (except for providers under Diagnostic Related Groups (DRGs), Outpatient Prospective Payment System (OPPS), and the inpatient mental health per diem payment system), a participation agreement is required. By definition, participating providers whether institutional providers, individual providers, or other non-institutional providers, agree to accept the TRICARE payment as full payment for the care services or supplies. Individual providers and other non-institutional providers that are not participating providers are limited to the amount they can collect from the beneficiary.

3.0 POLICY

All institutional providers must participate under TRICARE to be authorized providers. Participation agreements are required unless the provider comes under the TRICARE DRG, TRICARE OPPS, or inpatient mental health reimbursement systems. TRICARE payments to institutional providers are complete payments. No additional payments shall be billed to the beneficiary except for any required beneficiary deductible and copayment amounts.

Individual providers including providers salaried or under contract by an institutional provider, e.g., hospital, and other non-institutional providers, e.g., ambulatory surgical centers, independent laboratories, suppliers of portable x-ray services, ambulance companies, medical equipment firms and medical supply firms, and mammography suppliers, etc. who are not participating providers may not balance bill a beneficiary an amount that exceeds the applicable balance billing limit. This means that the individual provider or non-institutional provider is required to accept the lower of the billed charge or 115% of the TRICARE allowable amount. No additional payments shall be billed to the beneficiary except for any required beneficiary

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deductible and copayment amounts.

4.0 EFFECTIVE DATE

August 1, 2003.

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