CHAPTER 3
SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

ISSUE DATE:
AUTHORITY:

I. GENERAL

A. TRICARE reimbursement of a non-network individual health care professional or other non-institutional health care provider shall be determined under the allowable charge method specified in Chapter 1, Section 7 and Chapter 5, Section 1. Other methodologies, such as the use of fee schedules, must be proposed in writing and approved by the Director, TRICARE Management Activity (TMA) (or his designee). The procedures below, are not required for reimbursement of the network provider of care. The contractor and network providers are free to negotiate any mutually agreeable reimbursement mechanism which complies with state and federal laws. Any agreement, however, in which the methodology deviates from the accepted contract proposal methodology and which is detrimental to the TRICARE beneficiary or to the government may be rejected by the Executive Director, TMA.

B. Unless otherwise stated in the TRICARE Policy Manual, inpatient or outpatient services rendered by all individual professional providers and suppliers must be billed on the CMS 1500 (08/05), except as indicated in paragraphs D. and E. below. This requirement also applies to individual professional providers employed by or under contract to an institution. When inpatient services are rendered by a provider employed by or under contract to a participating institution, the services must be billed on a participating basis. The billed charges for institutional-based providers shall be included in the calculation of the prevailings.

C. Contractors are not required to individually certify the professional providers employed by or under contract to an institutional provider billing for their services under the institution's federal tax number since these providers are not recognized as authorized TRICARE providers because of their "contracted" status (32 CFR 199.6(c)(1)). However, reimbursement for services of institutional-based professional providers is limited to the services of those providers that would otherwise meet the qualifications of individual professional providers except that they are either employed by or under contract to an institutional provider. Institutional-based professional services are subject to the allowable charge methodology; see 32 CFR 199.14(j). For TED/TEPRV reporting, refer to the TRICARE Systems Manual, Chapter 2.

D. Some institutions are required to include the institutional-based professional charges on the CMS 1450 UB-04 claim form. The contractor's system must recognize these charges as noncovered institutional charges when the CMS 1450 UB-04 indicates professional

component charges using Value Code "05" (see the CMS 1450 UB-04 Instructions Manual, FL 39 - 41). Value code "05" indicates that the charges are included on the CMS 1450 UB-04 and will also be billed separately on the CMS 1500 (08/05). The CMS 1450 UB-04 may be used by institutional providers and Home Health Care Agencies to bill for professional services. The CMS 1450 UB-04 must include all the required information needed to process the professional services and reimburse the services using the allowable charge payment methodology, to include any negotiated rates. The contractors shall contact any Home Health Care Agency that has requested to bill for professional services on the CMS 1450 UB-04 to assist them with the proper billing requirements, e.g., CPT-4 procedure codes, name of the actual provider, etc.

E. Professional charges can be billed on a CMS 1450 UB-04, either on the same claim as the facility charges or on a separate claim. If professional charges are submitted on the same CMS 1450 UB-04 claim form as other outpatient facility charges, the contractor may require the provider to submit them on a separate claim form.

II. ALLOWABLE CHARGE METHOD

A. General

1. The TRICARE allowable charge for a service or supply shall be the lowest of the billed charge, the prevailing charge, or the Medicare Economic Index (MEI) adjusted prevailing charge (known as the maximum allowable prevailing charge). The profiled amount (the prevailing charge or the maximum allowable prevailing charge, whichever is lower) to be used is based upon the date of service. Regardless of the profiled amount, no more than the billed amount may ever be allowed.

NOTE: If, under a program approved by the Executive Director, TMA, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges. When calculating the TRICARE allowable charge, use the discounted charge in place of the provider's actual billed charge unless the discounted amount is above the billed charge. When the discounted amount is above the billed charge, the actual billed charge shall be used.

2. The contractor has primary responsibility for determining allowable charges according to the law, the Regulation, and the broad principles and policy guidelines issued.

3. Allowable charge determinations made by contractors are not normally reviewed by TMA on a case-by-case basis. However, TMA will review allowable charge determinations of contractors through profile analysis, sample case review and periodic review of profile development procedures. Therefore, each contractor is to maintain, in accessible form, the following data:

a. The charge data used to develop prevailing charges. For every prevailing charge, this must include a list identifying each provider whose charges were used in developing the prevailing charge as well as the provider's charges. The list is to be arrayed in ascending order by the amount of the billed charges.

b. The summary data used to develop prevailing conversion factors. This is to include every prevailing charge (identified by amount, procedures, weighted frequency, and relative value units) which was used in calculating each conversion factor.

B. Data Base And Profile Updating

NOTE: Annual update of state prevailing amounts, reference Chapter 5, Section 3, paragraph III.G.

1. The 80th percentile of charges shall be determined on a date or dates specified by the Executive Director, TMA. Profile update data used shall be charges for services and supplies provided during the 12 month period ending on June 30 prior to the update. Contractors shall maintain two sets of profiles; the current profiles and the previous year's profiles. The contractor will apply profiles based on the date of service. The fee screen year is the calendar year.

2. Each contractor shall develop procedures to ensure that the data base used to develop the profile for any procedure contains only charges actually made for that procedure. Thus, edits must be developed which will eliminate charges for individual consideration cases, and charges for multiple surgery, as well as aberrant data resulting from coding errors and other data problems. A description of these procedures is to be available for TMA review.

3. All charges, except those identified above, made by individual providers for services rendered to TRICARE beneficiaries during the data base period must be included in the data base. The usual (pre-discount) charges of network providers or the contractor's or a subcontractor's private business may be included if the billing arrangement with the provider or other source of data for the data base is such that accurate data for the state will be obtained.

4. Except when an error has occurred, updated actual prevailings are not to be lower than the previous year's actual prevailings. However, if for two consecutive years the rates are lower than the established profiles, then, in the second year, the rates will be lowered to the higher of the two profiles which are below the established profile. However, if the updated prevailing charge is lower, contractors are to continue using the previous actual prevailing charge. When the updated prevailing charge is 25% or more lower than the previous prevailing charge, the contractor is to review the development of both profiles. If no errors are found, the new profile is to be increased to the level of the previous profile. If the previous profile is higher due to an error in its calculation, the updated profile will be used. The same rules apply to conversion factors when the updated conversion factor is less than the previous one. However, in all cases an actual profile on a procedure takes precedence over an allowance based on a conversion factor.

a. When the current allowance based on a conversion factor is less than the previous allowance based on an actual profile, the previous profile amount is to be used.

b. When the current allowance based on an actual profile is less than the previous allowance based on a conversion factor, the actual profile is to be used.

NOTE: This provision does not apply to those instances where profiles are initially developed for a distinct class of provider which was previously included with providers having higher profiles.

5. Once the contractor has completed the update of its profiles, further revisions in the profiles will not be permitted, except to correct erroneous calculations or to establish profiles for new services. If the contractor finds it necessary to correct profiles or to establish a profile fee for a new procedure, the action will be thoroughly documented and retained in accessible form for not less than the retention period for the claims processed during the active life of that profile.

C. Prevailing Charges

1. Prevailing charges are those charges which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of this range establishes an overall limitation on the charges which the contractor shall accept as allowable for a given procedure or service, except when unusual circumstances or medical complications warrant an additional charge (see Chapter 5, Section 4).

2. Unless the Executive Director, TMA, has made a specific exception, prevailing profiles must be developed on a statewide basis. Localities within states are not to be used, nor are prevailing profiles to be developed for any area larger than individual states.

3. Prevailing profiles also are to be developed on a nonspecialty basis. Of course, types of service are to be differentiated. For example, for a given surgical procedure the surgeon, assistant surgeon, and the anesthesiologist would all be reimbursed based on different profiles. However, reimbursement for the actual surgery would be based on only one profile, regardless of whether the surgery was performed by a specialist or a general surgeon. An exception to this rule is that when services are performed by different classes of providers; e.g., a physician vis-a-vis a non-physician, separate profiles are to be developed for each class of provider. For example, there are three distinct classes of providers who render similar psychiatric services; psychiatrists, psychologists and others (Masters of Social Workers (MSWs), marriage and family counselors, pastoral counselors, mental health counselors, etc.). Moreover, two distinct classes of providers render obstetrical services; physicians and nurse midwives. Separate profiles are to be developed for each of the classes. Since a physician can render more comprehensive services than non-physicians (and likewise for psychologists as opposed to MSWs) the profile for the lesser-qualified class of provider should never be higher than that for a higher-qualified class of provider. For example, in cases in which psychologists' profiles are higher than psychiatrists', the psychologists' profiles should be lowered to that of the psychiatrists' profiles.

4. When there are two or more procedures which are identical except for the amount of time involved (e.g., CPT[1] procedure codes 90843 and 90844), the contractor is to ensure

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that the profile for the shorter procedure does not exceed the profile for the longer procedure. In those cases in which it does, the contractor is to reduce the profile for the shorter procedure to that of the longer procedure (see Chapter 5, Section 3).

D. Conversion Factors

1. General

Submitted charges must be compared with the applicable prevailing charge to determine the allowable charge for the service. If there is insufficient actual charge data to determine the prevailing charge in the state for a service, the contractor shall calculate a prevailing charge by multiplying the appropriate prevailing charge conversion factor by the appropriate relative value units.

a. Conversion factors are to be developed for broad types of services. As a minimum, the types of service shall include medicine, surgery, anesthesia, radiology, and pathology. In addition, separate conversion factors must be developed for each class of provider which can provide a particular type of service. For example, there should be three medicine conversion factors - one for physicians, one for psychologists, and one for other non-physician providers.

b. Conversion factors are used to derive "approximate" prevailing charges. Since prevailing charges based on conversion factors are estimates of actual (but unknown) "average" charges, their reliability is only as good as the known, but often limited, data. Contractors must exercise extreme care in developing conversion factors. When beneficiaries, physicians, and suppliers inquire regarding reimbursement based on the use of a conversion factor, the contractor shall use its best judgment based on the data available to it (including information the physician or supplier may furnish) to resolve the issue.

c. In those cases in which a profile has been increased to the previous year's level, the contractor shall also use the higher previous amount in calculating a conversion factor. A conversion factor is simply a mathematical representation of what is currently being paid for similar services, and thus it should be based on the profiles actually in use.

2. Relative Value Scales

Relative value scales developed or adopted by the contractor shall be carefully reviewed and validated before they are used. The contractor is responsible for ensuring that a relative value scale which is used to estimate prevailing charges accurately reflects charge patterns in the area serviced by the contractor. When a conversion factor results in an obviously incorrect amount (either high or low), the contractor is to make an adjustment in its relative value scale which will correct the error. Such corrections are to be reviewed in subsequent profile updates to ensure they are accurate.

3. Calculation Of Prevailing Charge Conversion Factors

a. Prevailing charge conversion factors used with relative value scales to fill gaps in contractor prevailing charge screens shall be calculated from the following formula:

C/F = Prevailing charge conversion factor.
CHG = The fully adjusted prevailing charge for a procedure.
SVC = The number of times the procedure was performed by all physicians in the state.
RVU = The relative value unit assigned to the procedure.
SUM OF SVC = The total number of times all procedures for which actual prevailing charges have been established and were performed in the state.

$$C/F = \frac{\frac{CHG}{RVU} \times SVC + \frac{CHG}{RVU} \times SVC + \ldots + \frac{CHG}{RVU} \times SVC}{\text{Sum of SVC}}$$

EXAMPLE: Compute a prevailing charge conversion factor on the basis of known prevailing charges within the same type of service.

PROCEDURE	FREQUENCY	ACTUAL CHARGE	RELATIVE VALUE
1	30	$5.00	1
2	70	12.00	2
3	50	35.00	5
4	40	20.00	3
5	60	8.00	1.5
	250		

b. Method

(1) For each procedure, divide the prevailing charge by the relative value and multiply the result by the frequency of that procedure in the charge history.

(2) Add all the results of these computations.

(3) Divide the result by the sum of all the frequencies.

c. Solution

$$\frac{\left(\frac{5}{1} \times 30\right) + \left(\frac{12}{2} \times 70\right) + \left(\frac{35}{5} \times 50\right) + \left(\frac{20}{3} \times 40\right) = \left(\frac{8}{1.5} \times 60\right) =}{250}$$

$$\frac{(5 \times 30) + (6 \times 70) + (7 \times 50) + (6.67 \times 40) = (5.33 \times 60) =}{250}$$

$$\frac{150 + 420 + 350 + 266.8 + 319.8}{250} =$$

$$\frac{1506.6}{250} = \$6.03$$

d. The conversion factors calculated for any profile year shall reflect prevailing charges calculated on the basis of charge data for the applicable profile year. Also, prevailing charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is an extensive change in the relative value units assigned to procedures (as may occur if the contractor begins to use a different or updated relative value scale but not if the unit value of a single procedure is changed) in order to ensure that the change(s) in unit values do not change resultant conversion factors.

e. Since conversion factors are a calculated amount and will only be used when multiplied by a relative value, conversion factors are to be rounded only to the nearest whole cent. It will not be acceptable to round to the nearest dollar or tenth dollar (dime).

E. Procedure Codes. The CPT[2] Coding System includes Level I: CPT Codes and Level II: Alpha Character and TMA approved codes for retail and mail order pharmacy. (Reference the TRICARE Systems Manual (TSM), Chapter 2, Addendum E and F.)

F. Professional surgical procedures will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (OPPS) for services rendered on or after May 1, 2009 (implementation of OPPS). Refer to Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

G. Professional procedures which are terminated or are bilateral will be subject to discounting based on modifier guideline requirements as prescribed under the OPPS for services rendered on or after May 1, 2009 (implementation of OPPS). Refer to Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

H. Prevention Of Gross Dollar Errors. Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

I. Industry standard modifiers and condition codes may be billed on individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claims.

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III. ALLOWABLE CHARGE METHOD: APPLICATION

A. Durable Medical Equipment (DME), Durable Equipment (DE), And Supplies. Also, see Chapter 1, Section 11 and the TRICARE Policy Manual (TPM), Chapter 8, Section 2.1.

B. Physician Assistant Services. The allowable charge for physician assistant services is determined in accordance with the provisions of Chapter 1, Section 6, and is based on a percentage of the allowed charge for the service when performed by the employing physician. Only the employing physician may bill for physician assistant services. Physician assistants' billed and allowed charges must be excluded from calculation of physician profiles. Payment is made to the employing physician who is an authorized TRICARE provider.

C. Teaching Physicians. Payment for services of teaching physicians may be made on an allowable charge basis only if an attending physician relationship has been established between the teaching physician and the patient. Refer to Chapter 1, Section 4 for a full explanation of applicable prerequisites.

IV. ALTERNATIVE REIMBURSEMENT METHODS FOR NON-NETWORK PROVIDERS

The contractor, with the concurrence of the Executive Director, TMA (or a designee), may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to assure a high level of acceptance of the TRICARE-determined charge by the individual health care professionals or other non-institutional health care providers furnishing services and supplies to TRICARE beneficiaries. Alternative methods shall not result in reimbursement greater than under the allowable charge method above, nor result in a higher cost for the affected beneficiary population.

V. CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM

A. General. The CHAMPUS Maximum Allowable Charge (CMAC) System is effective for services rendered on and after May 1, 1992. Contractors shall process claims using the requirements specified in the TPM (specific TPM references follow). Adjustments shall be processed using the reimbursement system in place at the time the services were rendered. The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. For processing an adjustment on a claim which was reimbursed using CMAC, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate fee screen year, which shall be based on the date of service. Post Office Box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see Chapter 5, Section 3).

B. Locality Code. For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item

where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

1. The adjustment is changing the type of pricing from CMAC to state prevailing in which case the locality code should be blank filled, or;

2. The initial claim was priced incorrectly because of using a wrong locality code, in which case the correct locality code should be used.

VI. BONUS PAYMENTS IN MEDICALLY UNDERSERVED AREAS

A. An additional payment shall be made quarterly to physicians who qualify and provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. To initiate action for the additional payment, providers shall use modifiers that will signify the provider is requesting the additional payment. The modifiers are "QU" (urban HPSA), "QB" [rural HPSA], and "AR" [PSA bonus payment]. "QU", "QB" and "AR" are modifiers to the CPT/HCPCS procedure codes. The provider shall be paid an additional 10% HPSA bonus of the total amount paid, excluding interest payments, for claims that were processed during the calendar quarter for services rendered on or after June 1, 2003. The provider shall be paid an additional five percent PSA bonus of the total amount paid, excluding interest payment, for claims that were processed during the calendar quarter for services rendered on or after January 1, 2005. The contractor shall have 30 calendar days from the end of the calendar quarter to make the payments to the providers who qualify. The bonus payments could be paid to network, non-network, participating, or non-participating physicians. Special programs such as TPR, SHCP, and TSP shall be included in the bonus payment process. Contractors shall send bonus payments directly to the non-participating physician. Contractors shall report these claims on TEDs as required by the TSM, Chapter 2, Section 2.7 (Procedure Code Modifiers). See Chapter 1, Section 33 for additional information.

NOTE: Effective January 1, 2006, for services rendered on or after this date, the "QU" and "QB" modifiers shall be replaced with modifier "AQ".

1. The contractor is to inform providers of the PSA and HPSA bonus payments through stuffers and their quarterly news bulletin. The stuffers and bulletin should provide direction on what is required in order to obtain the bonus payment.

2. Basis of bonus payments to TRICARE-authorized providers is solely when a "AQ", "QU", "QB", or "AR" modifier is found on the claim.

B. Bonus payments are passthrough payments, non-financially underwritten payments. The contractor shall follow the process below. This process is similar to the payment of capital and direct medical education found under the DRG reimbursement system (see Chapter 3, Section 2, paragraph II.).

1. All bonus payments are non-financially underwritten and shall be made from the non-financially underwritten, bank account (see the TRICARE Operations Manual (TOM), Chapter 3, Section 2).

2. Bonus Payment Procedures. The contractor shall use the following procedures in making bonus payments to physicians:

a. Accumulate and tally claims paid with "QU", "QB", or "AR" modifiers.

b. Compute the amount due each physician for submitted claims during the calendar quarter for HPSA services rendered on or after June 1, 2003 and PSA services rendered on or after January 1, 2005. The PSA bonus only goes through June 30, 2008. Stop processing prior to check writing. Compute the total amount due all physicians. For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The amount due is computed from claims with the "QU", "QB" and "AR" modifiers, then based on the amount paid (see paragraph VI.B.3.d.).

c. Any interest payments shall not be included in the computation of the payable bonus amount.

d. On the first work day of the last week of the month following the quarter, submit a voucher (see paragraph VI.B.3.) by express mail to TMA, CRM (a fax copy is not necessary).

e. After receiving clearance from TMA, CRM, continue processing through check write and mail out checks within two work days.

3. Vouchers

a. Format
- Physician Name
- Physician Address
- Physician Provider Number
- Period Covered (Quarter)
- Amount Paid/Collected for Bonus (see paragraph VI.B.3.d.)
- Total Bonus Paid [5 and/or 10% of the above bullet]

b. Sort Bonus Payment
- By Type (e.g., standard or active duty)
- By Coverage (Prime, Extra, Standard)
- By Fiscal Year of Bank Account
- By Contract
- By City & State
- By Region
- By Physician
- By Physician Number

- By Specialty
- By Address & Zip
- By Participating & Non-Participating
- By Contracted (Network) and Not Contracted (Non-network)
- By Modifier ("QB", "QU" or "AR")

c. The contractor's worksheet showing the payment computation shall be attached to the quarterly voucher for each physician.

d. In general:

Bonus Payment = 5% or 10% x [Total Amount Paid (claims with "QB" and "QU" modifiers or claims with "AR" modifier) During the Quarter - Interest Payments Associated with the claims for the Bonus Payment]

VII. BALANCE BILLING LIMITATION FOR NON-PARTICIPATING PROVIDERS

A. General

For services provided on or after November 1, 1993, non-participating providers may not balance bill the beneficiary more than 115% of the allowable charge.

NOTE: When the billed amount is less than 115% of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance

Billed charge	$500
Allowable charge	$200
Amount billed to beneficiary (115% of $200)	$230

EXAMPLE 2: Other Health Insurance

Billed charge	$500
Allowable charge	$200
Amount paid by other health insurance to the beneficiary	$200
Amount billable to beneficiary (115% of $200)	$230

NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the non-participating provider except, when it can be determined, that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

EXAMPLE 3: Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	$100.00
CMAC	$110.00
Allowed amount	$100.00
10% abatement ($100 x 0.10)	$10.00
Adjusted allowed amount ($100 - $10)	$90.00
Provider billed charge to beneficiary (Limited to billed amount.)	$100.00

EXAMPLE 4: Non-Participating Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	$150.00
CMAC	$100.00
Allowed amount	$100.00
10% abatement ($100 x 0.10)	$10.00
Adjusted allowed amount ($100 - $10)	$90.00
Provider billed charge to beneficiary ($90.00 x 115%)	$103.50

1. Provider bulletins shall be used to notify authorized providers of the balance billing limitation of the amount that may be billed by a non-participating provider to the beneficiary.

2. Contractors shall notify beneficiaries of the balance billing limitation and the amount that may be legally billed by a non-participating provider to the beneficiary through stuffers.

3. The following language shall be used to respond to beneficiary inquiries concerning the TRICARE non-participating provider balance billing provision. Routine stuffers shall not be used to convey this information.

NOTE: In accordance with 32 CFR 199, a balance billing limitation for services provided by non-participating providers was effective on and after November 1, 1993. This provision limits non-participating providers from billing TRICARE beneficiaries more than 115% of the TRICARE allowable charge which is shown on the Explanation Of Benefits (EOB). Please note when the provider's billed charge is less than 115% of the TRICARE allowed amount, the billed charge becomes the billable amount to the beneficiary. However, this restriction does not apply to noncovered services. Nonparticipating providers who do not comply with the limitation shall be subject to exclusion from the TRICARE program as authorized providers and may be excluded as a Medicare provider. If a non-participating provider bills and/or collects more from the beneficiary than the amount the provider may bill, contact the contractor's Program Integrity Department in writing. The beneficiary should include information which documents the higher billed amount, such as a copy of the EOB, bills from the non-participating provider to the beneficiary, demand letter from the non-participating provider to the beneficiary requesting an amount above the 115% of the

allowable amount, and copies of cancelled checks that would identify excessive amounts paid by the beneficiary to the non-participating provider.

B. Failure To Comply

1. If a non-participating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

2. When the contractor receives a complaint that a non-participating provider is balance billing a beneficiary for an amount greater than 115% of the allowable charge, the contractor's Program Integrity Department shall investigate the complaint, communicate their findings to the beneficiary and take action against the provider, if appropriate. A beneficiary complaint letter will serve as a release form in order to educate the provider and as the basis for resolving the balance billing requirement. Only information where there is a need to know such as the billed charges should be discussed or released.

3. To exclude a provider from the TRICARE program, a pattern of such billing practices must be established along with documented evidence that the provider was advised of the balance billing limitation for non-participating providers, but continued to bill beneficiaries higher amounts after being notified.

4. Documented evidence could include certified registered mail, special provider news bulletins, and documented telephone conversations and/or meetings with the provider concerning his/her TRICARE billing practices as they related to the balance billing limitation. In addition, the contractor's Program Integrity Department shall follow the instructions in the TOM, Chapter 14, Section 6.

C. Granting of Waiver Of Limitation

When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the non-participating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115% limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the TRICARE appeals process.

- END -