CHAPTER 11
SECTION 12.1

CORPORATE SERVICES PROVIDER CLASS

ISSUE DATE:
AUTHORITY: 32 CFR 199.2 and 32 CFR 199.6(f)

I. ISSUE

A general overview of the coverage and reimbursement of services provided by a Corporate Services Provider.

II. POLICY

A. Regulatory Background

TRICARE supplements the availability of health care in military hospitals and clinics. Services and items allowable as TRICARE benefits must be obtained from TRICARE authorized civilian providers to be considered for payment. The Code of Federal Regulations 32 CFR 199.6, along with the TRICARE Policy Manual, establishes the specific requirements for institutional and professional providers recognized for payment under the program. These requirements have been used to ensure that providers possess licensing/credentials and/or meet recognized standards unique to their provider status, profession, or field of medicine. In the past, TRICARE has only recognized three classes of providers; i.e., 1) an institutional provider class consisting of hospitals and other categories of similar facilities; 2) an individual professional provider class including physicians and other categories of licensed individuals who render professional services independently, and certain allied health and extra medical providers that must function under physician orders and supervision; and 3) a class of providers consisting of suppliers of items and supplies of an ancillary or supplemental nature, such as durable medical equipment. However, since the CFR and policy provisions were first established, the manner in which medical services are delivered has changed. TRICARE beneficiaries, like other health care consumers, now have access to a wide array of health care delivery systems that were not initially recognized or reimbursed under the Program. As a result, a fourth class of TRICARE provider has been established consisting of freestanding corporations and foundations that render principally professional, ambulatory or in-home care and technical diagnostic procedures. The addition of the corporate class recognizes the current range of providers with today's health care delivery structure, and gives beneficiaries access to another segment of the health care delivery industry.

B. Scope of Coverage/Reimbursement

1. Out-of-System/Non-Network Reimbursement. The intent of this provider class expansion (recognition of Corporate Services Providers as authorized providers under TRICARE) is not to create additional benefits that ordinarily would not be covered under TRICARE if provided by a more traditional health care delivery system (i.e., care traditionally offered in a hospital setting), but rather to allow those services which would otherwise be allowed except for an individual provider's affiliation with a freestanding corporate entity. A provider qualifying for corporate services provider status under TRICARE would be allowed payment for the following services and supplies:

a. Otherwise covered professional services provided by TRICARE authorized individual providers employed by or under contract with a freestanding corporate entity will be paid under the TRICARE/CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system, subject to any restrictions and limitations as may be prescribed under existing TRICARE Policy.

b. Payment will also be allowed for supplies used by a TRICARE authorized individual provider employed by or contracted with a corporate services provider in the direct treatment of a TRICARE eligible beneficiary. Allowable supplies will be reimbursed in accordance with TRICARE allowable charge methodology as described in TRICARE Reimbursement Manual, Chapter 5, Section 1.

c. Reimbursement of covered professional services and supplies will be made directly to the TRICARE authorized corporate services provider under its own tax identification number.

d. Payment will be allowable for services rendered in the authorized corporate services provider's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services.

2. Alternative Network (In-System/Network) Reimbursement Systems. There are regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems as long as they don't exceed what would have otherwise been allowed under Standard TRICARE payment methodologies as described in the TRICARE Reimbursement Manual.

a. Establishment of alternative reimbursement systems for Corporate Services Providers will allow contractors and TRICARE beneficiaries access to a wide source of competitive ambulatory and in-home services while at the same time maintaining budget neutrality; i.e., there should be no increases in benefit costs since the services would have otherwise been provided in an institutional setting on either an inpatient or outpatient basis.

b. Since it is assumed that ambulatory services will be less expensive than when provided in an institutional setting, it is expected that contractors will be able to establish rates which will result in significant savings to the government. For example, under non-network (out-of-system) reimbursement methodologies, freestanding bone marrow transplant centers will be restricted solely to payment of professional services and related

supplies which account for only 10 to 20 percent of the total program charges for autologous bone marrow transplants. The remaining 70 to 80 percent of the charges will be attributable to technical and/or facilities fees. The services will include but are not limited to: 1) laboratory charges; 2) pre-conditioning chemotherapy; 3) growth factor; 4) home health; 5) catheter placement; 6) blood products; and 7) recovery post discharge. Under the above alternative reimbursement provisions, contractors will be given the flexibility of negotiating with network providers (i.e., freestanding outpatient bone marrow transplant centers who agree to become network providers) for outpatient bone marrow transplants at rates below those performed in a hospital setting, which would include CMAC rates for professional fees plus the DRG amount.

c. The following minimal requirements should be adhered to in the establishment of alternative reimbursement methodologies for in-system/network corporate services providers in order to ensure quality of care and fiscal accountability:

(1) Alternative reimbursement methodologies may include and/or be a combination of fee schedules, discounts from usual and customary fees or CHAMPUS maximum allowable charge amounts (CMAC), flat fee arrangements (negotiated all inclusive rates), capitation arrangements, discounts off of DRGS, per diems; or such other method as is mutually agreed upon, provided such alternative payments do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies in another setting (e.g., comparable services rendered in a hospital inpatient or outpatient setting).

(2) Payments in full (e.g., negotiated flat fees, all-inclusive global fees, captitation arrangements, discounts off of DRGs and per diems) are prospective reimbursement systems which may include items related or incidental to the treatment of the patient but for which coverage is not normally extended under TRICARE. These incidental services are to be included in the negotiated prospective payment rate; i.e., they can neither be billed to the beneficiary or deducted from the negotiated global rate.

3. All billing for Corporate Services Providers should be submitted on a CMS 1500. TRICARE Management Activity (TMA) will assign special processing codes (e.g., assigning a special processing code "P" for non-institutional per diem rates) to accommodate approved alternative reimbursement systems. The contractor should designate the coding that it wants to use as part of the alternative reimbursement request submitted to the Executive Director, TMA or designee for review and approval.

4. The contractor will determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's TRICARE claim characteristics. The category determination is conclusive and may not be appealed.

5. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional services fee structure (i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates).

6. While the expanded provider category will allow coverage of professional services for corporate entities qualifying for provider authorization status under the provisions of this policy, it will at the same time restrict coverage of professional services for

those corporate entities which cannot meet the criteria for corporate services provider status under TRICARE.

C. Conditions for Coverage/Authorization

1. Be a corporation or a foundation, but not a professional corporation or professional association;

2. Be institution-affiliated or freestanding;

3. Provide services and related supplies of a type rendered by TRICARE individual professional providers employed directly or contractually by a corporation, or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization;

4. Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process.

5. Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining written authorization (i.e., comply with applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected);

6. Comply with all applicable organizational and individual licensing or certification requirements that are extent in the state, county, municipality, or other political jurisdiction in which the corporate entity provides services;

7. Maintain Medicare approval for payment when the contractor determines that a category, or type, of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage, or when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in Chapter 11, Section 12.2; and

8. Has entered into a negotiated provider contract with a network provider or a participation agreement with a non-network provider which at least complies with the minimum participation agreement requirements set forth in Chapter 11, Section 12.3. The participation agreement will accompany the application form (Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDER) sent out as part of the initial authorization process for non-network providers as described below.

D. Application Process

1. The information collected on the "Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDERS" (i.e., the information collection form for which the provider is seeking TRICARE authorization status) will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services

provider under the TRICARE program (refer to Chapter 11, Addendum D for a copy of the corporate services provider application form).

2. The application will be sent out and information collected when a:

a. Provider requests permission to become a TRICARE provider;

b. Claim is filed for care received from a provider who is not listed on the contractor's provider file; or

c. Formerly TRICARE authorized provider requests reinstatement.

3. The contractor will verify that the provider meets TRICARE authorization criteria through the collection and review of applicable Medicare, JCAHO, and state and national board certificates/licenses requests on the corporate services provider application form.

4. The authorization process is streamlined (simplified) in that the individual authorization of professional providers employed by or under contract with a corporate entity will not be required as part of the authorization process.

a. Instead, the responsibility for ensuring all individuals meet TRICARE requirements is placed on the corporate entity itself.

b. This assurance is further strengthened by requiring Medicare approval for payment as a condition of authorization under TRICARE, since Medicare also relies on the delegation of certification of individual professional and allied health care providers to the corporate entity.

c. Although the actual provider of care will still have to be identified on the claim form, verification of the qualifications of employed and contracted individual providers will not be required by the contractors.

d. Reliance on Medicare approval for payment - or when Medicare approved status is not required, accreditation by a qualified accrediting organization - is administratively expeditious and cost effective for both TRICARE and providers qualifying for authorization under the new provider category.

5. The effective date of authorization will be the date the provider met the "Conditions for Coverage/Authorization" as prescribed in paragraph II.C. above or June 8, 1999, whichever is later. Retroactive authorization will apply to both network providers (providers that have entered into negotiated network contracts) and non-network providers (those providers authorized under the application process) subject to the effective date of June 8, 1999, appearing in the Corporate Services Provider Final Rule published in the Federal Register on March 10, 1999.

E. Approval Process For New Provider Categories Seeking Authorization Under the Corporate Services Provider class

1. While contractors will use the "Conditions for Coverage/Authorization" under paragraph II.C. above for initial review/screening of all new provider categories seeking authorization status under the Corporate Services Provider class, final approval will be reserved for TMA.

2. The contractors should only submit those provider categories who on initial analysis appear to meet the criteria for inclusion under the Corporate Services Provider class. The submission should include all supporting documentation, along with the contractor's rationale for recommending authorization status under the Corporate Services Provider class.

3. If TMA concurs with the contractor's recommendation, a new provider specialty code will be added.

4. A notice of the agency's determination, along with supporting documentation (a copy of the package seeking final approval status of the provider category), will be sent out to all the regional contractors for appropriate action.

5. Requests for final approval status should be submitted to TMA through the contractor's Contracting Officer Representative (COR).

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