Chapter 3 Section 3

Discounts

Issue Date:
Authority:

1.0 PROVIDER DISCOUNTS

The contractor may negotiate agreements or contracts with providers which include reductions or discounts in the TRICARE reimbursement, however, the provider must agree to participate on all TRICARE claims. This section provides direction concerning processing of claims subject to such reductions in reimbursement.

2.0 AGREEMENTS

Agreements must meet the following conditions:

2.1 The provider must be TRICARE-authorized. If the provider is not currently certified, the contractor shall certify the provider through the normal provider certification process. If the provider is non-certifiable, the contractor shall notify both the provider and the Military Treatment Facility (MTF) if the MTF is involved. Contractors must ensure that clinics, Preferred Provider Organizations (PPOs), and other multi-member groups provide a list of the providers within the organization, along with their Employer Identification Numbers (EINs)/Social Security Numbers (SSNs). Contractors shall review these lists, making sure that each individual provider in the groups is authorized under TRICARE.

2.2 For all contractor negotiated agreements, the effective dates will be the first day of the month following the month the agreement was signed.

2.3 The agreement must contain date parameters (effective and termination dates). For multi-member groups, the effective date of each member will be the same unless otherwise indicated. Groups must identify the rendering physician on the claim.

2.4 The agreement must list specific procedure codes and the method and amount of discount, for example, a general description such as gynecological procedures is not acceptable.

2.5 Providers must agree to participate on all charges, whether the services provided are subject to the negotiated discount or not.

2.6 Providers cannot balance bill the beneficiary.

2.7 Provider must agree to bill the patient's other health insurance (OHI) prior to billing TRICARE.

2.8 Providers must be able to fluently speak, read, and write the English language.

3.0 METHODS

At a minimum, the following negotiated reimbursement reduction methods are authorized:

3.1 Agreements using a percent reduction method. Under the percent reduction method, provider reimbursement is reduced by a percentage rate (e.g., 20%) applied to the allowable amount for established reimbursement methods in 32 CFR 199.14. If the billed charge minus the discount amount exceeds the CHAMPUS Maximum Allowable Charge (CMAC), payment is limited to the CMAC unless an exception is allowed under demonstration authority. The discount will be taken from the applicable reimbursement methodology used for the provider, i.e., Diagnosis Related Group (DRG), mental health per diem, Residential Treatment Center (RTC) per diem, Sole Community Hospital (SCH) payment method for inpatient service, etc. The cost-share is always applied after calculation of the discounted amount.

3.2 Agreements may include a discount for the initial 1,000 claims processed (does not include adjustments) during a stated period of time (e.g., 10%) and a higher discount for claims exceeding 1,000, (e.g., 15%). In this case the contractor must have counters to tally the number of claims processed by individual, provider or group.

3.3 Agreements using negotiated per diems are authorized for hospitalization and RTC care, but the established method of payment cannot be altered, i.e., a DRG hospital cannot revert to using a per diem, unless an exception is allowed under demonstration authority. The cost-share is applied after calculation of the new allowed amount.

3.4 Agreements on which each procedure code listed in the agreement could have a different percentage discount or fee schedule.

3.5 Agreements which have different discounts for inpatient and outpatient services. This can be for both professional and institutional providers.

3.6 Agreements with provider groups when only some of the members of the group will honor the participation/discount agreement. Groups must identify the rendering physician on the claim.

4.0 CONTRACTOR RESPONSIBILITIES

4.1 The contractor shall load the name of the provider and EIN, the applicable negotiated reimbursement, and the effective date parameters within 45 days of receipt of the agreement/ contract.

4.2 The contractor shall ensure, by implementing an automated payment mechanism, that claims from affiliated providers with agreements or contracts which include negotiated reimbursements are processed using an authorized and correct reimbursement method.

4.3 The contractor shall report the discounted amount as the allowed amount.

5.0 SAMPLE NEGOTIATED REIMBURSEMENT METHODS

5.1 Negotiated per diems or negotiated percent reduction in the standard TRICARE mental health or RTC per diem (e.g., 20% reduction in the TRICARE per diem). Negotiated per diems are subject to the adjustments applied to regional TRICARE per diems (i.e., wage index factor, Indirect Medical Education (IDME) costs, etc.). A negotiated per diem for a provider shall be paid by the contractor until expiration, renewal, or renegotiation of the contract or agreement. Percentage reductions shall be applied to TRICARE allowable charges for professional services.

5.2 Negotiated professional service reimbursement reductions shall be applied to either the current or prior year's prevailing charge profile based on dates of service.

5.3 Examples

5.3.1 Percentage reduction applied to the DRG allowable amount (e.g., a 10% reduction). The following example illustrates calculation of a reduced DRG payment:

10% negotiated reduction, $265 per diem cost-share for a retiree (assuming the per diem is less than 10% of the billed charge), four day stay.	
DRG allowance	$5,000.00
Less negotiated reduction	- 500.00
Negotiated allowed amount	$4,500.00
Less cost-share ($265 x 4 x 0.90)	- 954.00
Payment to hospital	$3,546.00

5.3.2 The following example illustrates application of a percentage reduction in the standard per diem for a high volume mental health provider or an RTC:

10% negotiated reduction, 25% cost-share for retiree, $375 per diem, 30 day stay.	
Standard allowed amount ($375 x 30)	$11,250.00
Less negotiated reduction	-1,125.00
Negotiated allowed amount	$10,125.00
Less cost-share (0.25 x $10,125)	-2,531.25
Payment to facility	$7,593.75

5.3.3 The following example illustrates application of a percentage reduction in the standard per diem for a low volume mental health provider:

10% negotiated reduction, 25% cost-share for a retiree, $410 regional per diem (net of adjustments), 30 day stay billed at $500 per day.	
Standard allowed amount ($410 x 30)	$12,300.00
Less negotiated reduction	-1,230.00
Negotiated allowed amount	$11,070.00
Less cost-share (0.25 x $11,070)	-2,767.50
(**Note:** 25% of the negotiated allowed amount is less than the daily cost-share of $126.)	
Payment to facility	$8,302.50

5.3.4 The following example illustrates payment calculation for a negotiated per diem (applicable to high volume mental health providers, and RTCs):

$400 standard per diem, $350 negotiated per diem, 25% cost-share for a retiree, 30 day stay.	
Standard allowed amount ($400 x 30)	$12,000.00
Negotiated allowed amount ($350 x 30)	$10,500.00
Less cost-share (0.25 x $10,500)	- 2,625.00
Payment to facility	$7,875.00

5.3.5 Percentage reduction may be applied to the billed charge (e.g., 20% reduction in the billed charge) for inpatient or outpatient services delivered by institutional providers not reimbursed under the TRICARE DRG-based payment system or the TRICARE inpatient mental health per diem system. The following example illustrates calculation of a payment for inpatient services using the negotiated percent reduction method:

10% negotiated reduction in billed charges, 25% cost-share for a retiree, four day stay billed at $400 per day.	
Billed charge ($400 x 4)	$1,600.00
Less negotiated reduction	-160.00
Negotiated allowed amount	$1,440.00
Less cost-share (0.25 x $1,440)	-360.00
Payment to hospital	$1,080.00

5.3.6 The following example illustrates calculation of a payment for outpatient services delivered by an institutional provider using the negotiated percent reduction method:

10% negotiated reduction in billed charges, 25% cost-share for a retiree, one visit billed for $70 for care provided in a hospital emergency room.	
Billed charge	$70.00
Less negotiated reduction	-7.00
Negotiated allowed amount	$63.00
Less cost-share (0.25 x $63)	-15.75
Payment to hospital	$47.25

5.3.7 The following example illustrates application of a professional service rate reduction:

10% negotiated reduction, 25% cost-share for a retiree.	
CMAC	$80.00
Less negotiated reduction	-8.00
Negotiated allowed amount	$72.00
Cost-share (0.25 x $72)	-18.00
Payment to provider	$54.00

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