Chapter 3 Section 4

Payment Reduction

Issue Date:
Authority: 32 CFR 199.15(b)(4)(iii)

1.0 REDUCTION OF PROVIDER PAYMENT

The contractor shall reduce provider payment for the provider's failure to obtain a preauthorization for certain types of care in accordance with Chapter 1, Section 28.

2.0 DETERMINATION OF REDUCTION AMOUNT

The contractor shall convert the number of days/services subject to the payment reduction to the appropriate dollar amount and deduct such amount from the provider's payment as illustrated in the examples in paragraph 6.0.

3.0 EXPLANATION OF BENEFITS (EOB)

The contractor shall identify the days/services for which the provider's payment was reduced and the payment reduction amount on the EOB using an appropriate message.

4.0 TED REPORTING

The contractor shall keep the information regarding payment reduction calculations in their own internal file(s) for claims processing and audit functions. The contractor shall report on the TRICARE Encounter Data (TED) the total amount of payment reduction and the total days/services as required in the TRICARE Systems Manual (TSM), Chapter 2, Sections 2, 5, and 6.

5.0 PUBLICATION REQUIREMENT

The contractor shall widely publicize the preauthorization requirements and procedures (including the payment reduction waiver procedures in accordance with Chapter 1, Section 28) in their periodic bulletins and publications to providers and beneficiaries.

6.0 CALCULATION OF PAYMENT REDUCTION

The reduction is calculated based on the otherwise allowable amount consistent with the Chapter 1, Section 28, before the application of deductible, beneficiary cost-share, and other health insurance (OHI). Following are examples of payment reduction:

Example 1: Claims Paid Under DRG Payment Methodology

Step 1: Determine full DRG allowance, total Length-Of-Stay (LOS), and the number of days without preauthorization.

Billed Amount:	$21,500.00
DRG Allowance:	$8,500.00
Total LOS:	10 days
Days without preauthorization:	2 days

Step 2: Divide the days without preauthorization by the total LOS.

Days without preauthorization, 2 days = 0.2
Total LOS, 10 days

Step 3: Multiply the DRG allowance from Step 1 by the amount resulting from Step 2, to calculate the amount for payment reduction.

$8,500.00	
x.20	
$1,700.00	- Target amount for calculation of reduction
x 0.10	- Multiply by 10% for calculation of 10% reduction
$170.00	- Amount of payment reduction

Step 4: Calculate the total government payment.

Total government payment to the facility will be DRG allowance minus beneficiary cost-share (e.g., for a retiree with FY 1996 per diem, cost-share in this example is $330 x 10 days = $3,300) less the amount of payment reduction as illustrated below:

DRG Allowance:	$8,500.00
Minus beneficiary cost-share for a retiree:	-3,300.00
	$5,200.00
Less the amount of payment reduction:	- 170.00
Total government payment (in the absence of OHI):	$5,030.00

Example 2: Claims Paid Under Mental Health Per Diem Payment Methodology

(Includes RTCs, Mental Health Per Diem Hospitals, Partial Hospitalization Programs (PHPs), and Intensive Outpatient Programs (IOPs))

Step 1: Determine full per diem payment and the number of days subject to payment reduction.

Billed Amount:	$12,500.00
Daily per diem:	$400.00
Number of authorized days:	25 days
Allowable amount (per diem methodology):	$10,000.00
Days without preauthorization subject to payment reduction:	9 days

Step 2: Multiply the daily per diem by the number of days without preauthorization and calculate the amount for payment reduction.

$400.00	
x 9	
$3,600.00	- This is the target amount for calculation of reduction.
x 0.10	- Multiply by 10% for calculation of 10% reduction.
$360.00	- Amount of payment reduction.

Step 3: Calculate the total government payment.

Total government payment to the facility will be the allowable amount minus beneficiary cost-share (e.g., for a retiree's family member for high volume hospital, partial program or IOP, or RTC care, cost-share in this example is 25% of the allowable amount) less the amount of payment reduction as illustrated below:

Allowable amount (per diem methodology):	$10,000.00
Minus beneficiary cost-share (.25 x $10,000):	-2,500.00
	$7,500.00
Less the amount of payment reduction:	- 360.00
Total government payment (in the absence of OHI):	$7,140.00

Example 3: Claims Paid On Per-Service Basis

Following is an example of an active duty family member claim for three visits for outpatient adjunctive dental care with the first visit without preauthorization. The payment reduction shall be applied to the first visit only (i.e., the visit without the preauthorization).

Step 1: Determine the allowable charge for the visit/service that was provided without obtaining the preauthorization.

Billed Charge:	$75.00
Allowable Charge (CMAC):	$60.00

Step 2: Calculate the amount of payment reduction.

$60.00	- Target amount for calculation of reduction.
x 0.10	- Multiply by 10% for calculation of 10% reduction.
$6.00	- Amount of payment reduction.

Step 3: Calculate the government payment for the visit/service that was provided without obtaining preauthorization.

The government payment to the provider will be the allowable charge minus beneficiary cost-share (e.g., for an active duty family member, the outpatient cost-share in this example is (20% of the allowable charge) less the amount of payment reduction as illustrated below:

Allowable charge (CMAC):	$60.00
Minus beneficiary cost-share (.20 x $60):	-12.00
	$48.00
Less the amount of payment reduction:	- 6.00
Government payment for the visit/service (in the absence of OHI):	$42.00

In this example, payment reduction shall not apply to the second and third visits as preauthorization was obtained for those visits. Normal rules will apply for calculation of the government payment for the second and third visits.

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