CHAPTER 1
SECTION 28

REDUCTION OF PAYMENT FOR NONCOMPLIANCE WITH UTILIZATION REVIEW REQUIREMENTS

ISSUE DATE: July 17, 1996
AUTHORITY: 32 CFR 199.15(b)(4)(iii) and 32 CFR 199.4(a)(12)

I. ISSUE

Reduction of payment for noncompliance with utilization review requirements.

II. POLICY

In the case of a provider's failure to obtain a required preauthorization, the provider's payment shall be reduced by ten percent of the amount otherwise allowable. Under the managed care contracts, a network provider's payment can be subject to a greater than ten percent reduction or a denial if the network provider has agreed to such a reduction or denial in the agreement.

A. Types of Care Subject to Payment Reduction. For a provider's failure to obtain a required preauthorization or preadmission authorization, the provider's payment will be reduced in connection with the following types of care:

1. All nonemergency mental health admissions to hospitals.

2. All admissions for residential treatment, substance use disorder rehabilitation, and psychiatric partial hospitalization. None of these can be considered emergency care.

3. Psychoanalysis. It cannot be considered as an emergency service.

4. Adjunctive dental care.

5. Organ and stem cell transplants.

6. All non-mental health admissions requiring a Nonavailability Statement excluding routine OB and neonatal intensive care.

NOTE: For the admissions referred to in paragraph II.A.6., the reduction of payment is not applicable when a beneficiary has "other insurance" that provides primary coverage. See the TRICARE Policy Manual, Chapter 1, Section 7.1, paragraph I.H.

7. Additional procedures and services as prescribed by the managed care support contractors except when the beneficiary has "other insurance" as provided in the TRICARE Policy Manual, Chapter 1, Section 7.1, paragraph I.H.

B. Applicability of Payment Reduction. This TRICARE Policy Manual section shall apply to participating (including network providers and participating Veterans Administration facilities) and nonparticipating providers. The reduction of payment is not applicable in concurrent review (continued stay review) situations.

For a provider's failure to obtain the required preauthorization, the payment reduction shall be subject to the policy in this section.

1. In the case of an admission to a hospital, SUDRF, RTC, or a PHP, (or a SNF when applicable), under TRICARE Prime, Extra, or Standard, the payment reduction shall apply to the institutional charges and any associated professional charges of the attending or admitting provider. Services of other providers shall be subject to the payment reduction as provided under the network provider agreements.

2. The amount of the reduction for TRICARE Standard providers shall be ten percent of the amount otherwise allowable (consistent with paragraph II.C., D., and E., below) for services for which preauthorization should have been obtained, but was not obtained.

3. The amount of the reduction for TRICARE Prime and Extra providers shall be in accordance with the provider's contract with the respective contractor, but not less than ten percent.

4. The payment reduction shall apply under the Point of Service option.

C. DRG-Reimbursed Facilities. In the case of admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization, divided by the total length of stay for the admission. See example in Chapter 3, Section 4.

D. Non-DRG Facilities/Units (Includes RTCs, Mental Health Per Diem Hospitals and Partial Hospitalization Programs). In the case of admissions to non-DRG facilities/units, the reduction shall be taken only against the days of care provided without preauthorization. See example in Chapter 3, Section 4.

E. Care Paid on Per-Service Basis. For the care for which payment is on a per-service basis, e.g., outpatient adjunctive dental care, the reduction shall be taken only against the amount that relates to the services provided without prospective authorization. See example in Chapter 3, Section 4.

F. Determination of Days/Services Subject to Payment Reduction. For purposes of determining the days/services which will be subject to the payment reduction, the following shall apply:

1. When the request for authorization is made prior to the admission but is not received by the contractor until after the admission occurred, the days for payment reduction shall be counted from the date of admission to the date of receipt of the request by the contractor (not counting the date of receipt).

NOTE: In the case of alleged emergency care subsequently found not to meet the emergency criteria, the days for the payment reduction shall be counted according to this paragraph II.F.1.

2. When the request for authorization is made to the contractor after the admission occurred, the days for payment reduction shall be counted from the date of admission to the date of approval of the request by the contractor (not counting the date of approval).

3. For the care paid on a per-service basis, e.g., outpatient adjunctive dental care, payment reduction shall apply to those services/sessions provided prior to receipt of the authorization request by the contractor.

G. Other Health Insurance (OHI) and Beneficiary Cost-Share.

1. When a beneficiary has OHI that provides primary coverage, certain services shall not be subject to payment reduction. See paragraph II.A.6. and paragraph II.A.7.

2. The reduction of payment is calculated based on the otherwise allowable amount (consistent with paragraph II.C., D., and E., above) before the application of deductible, beneficiary cost-share, and OHI.

3. The beneficiary is still required to pay a cost-share for the days or services for which the payment is reduced. The beneficiary cost-share shall be calculated applying the normal cost-share rules before the reduction is taken.

4. The amount applied/credited toward the deductible cannot be greater than the amount for which the beneficiary remains liable after the government payment.

H. Preauthorization Process.

1. Preauthorization may be requested from a contractor in person, by telephone, FAX, or mail. The date of receipt of a request shall be the date (business day) on which a contractor receives the request to authorize the medical necessity and appropriateness of care for which it has jurisdiction.

NOTE: The date a preauthorization request is mailed to the contractor and postmarked shall determine the date the request was made (not received). If a request for preauthorization does not have a postmark, it shall be deemed made on the date received by the contractor.

2. In general, the decision regarding the preauthorization shall be issued by the contractor within one business day of the receipt of a request from the provider, and shall be followed with a written confirmation (if initial notice is verbal).

3. A preauthorization is valid for the period of time, appropriate to the type of care involved. It shall state the number of days/type of care for which it is valid. In general, preauthorizations will be valid for 30 days. If the services are not obtained within the number of days specified, a new preauthorization request is required. For organ and stem cell transplants the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in the TRICARE Policy Manual, or until the approved transplant occurs.

I. Patient Not Liable. The patient (or the patient's family) may not be billed for the amount of the payment reduction due to the provider's noncompliance with the preauthorization requirements.

J. Emergency Admissions/Services.

1. Payment reductions shall not be applied in connection with bona fide emergency admissions or services. The authorization required for a continuation of services in connection with bona fide emergency admission will not be subject to payment reduction.

2. Contractor having jurisdiction for the medical review of the admission is required to review for emergency when requested by the provider. In addition to the review of alleged emergency admissions, the contractor is required to issue an initial determination providing the review decision which is appealable.

NOTE: Psychoanalysis and all admissions for residential treatment, substance use disorder rehabilitation, or psychiatric partial hospitalization are the types of services/ admissions requiring preauthorization that cannot be considered as emergencies.

K. Waiver of Payment Reduction.

1. The contractor may waive the payment reduction only when a provider could not have known that the patient was a TRICARE beneficiary, e.g., when there is a retroactive eligibility determination by a Uniformed Service, or when the patient does not disclose eligibility to the provider.

2. The criteria for determining when a provider could have been expected to know of the preauthorization requirements shall be the same as applied under the Waiver of Liability provisions.

3. If at any time a payment reduction is revised after claims processing, claim processors will follow existing procedures for processing any resulting payment adjustments.

L. Appeal Rights.

1. The days/services for which the provider's payment is reduced are approved days/services and not subject to appeal.

2. The denial of a waiver request and clerical/calculation errors in connection with the payment reduction are not subject to appeal but are subject to administrative review by the contractor upon request.

3. Adverse decisions regarding alleged emergency admissions/services are appealable in cases involving payment reductions following the normal appeal procedures.

M. Mental Health Day Limits. The days for which the provider payments are reduced count toward the applicable mental health day limits.

III. EFFECTIVE DATE March 1, 1997.

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