

## **Claims Adjustments and Recoupments**

### **III. OVERPAYMENTS RECOVERY - AT-RISK FUNDS**

All provisions of this section pertain to funds for which the contractor is at risk. For recovery of overpayments involving funds for which the contractor is not-at-risk, see [Section IV](#).

#### **A. Causes of Overpayments**

An overpayment adjustment and a requirement for recoupment action may be a result of: (This list is not intended to be all inclusive.)

1. An erroneous calculation of the allowable amount
2. An erroneous coding of a procedure
3. An erroneous calculation of the cost-share or deductible
4. Making a duplicate payment
5. Issuing payment to an incorrect payee
6. Failure to obtain data on all or part of the payment by other insurance
7. An erroneous billing
8. Paying for services or supplies to a patient not eligible
9. Making payment for care by an unauthorized provider
10. Making payment for a noncovered service or supply
11. Paying for a service not actually received
12. Payment having been made on services not medically necessary

#### **B. Determination of Liability for Overpayment**

The general rule for determining liability for overpayments is that the person who received the erroneous payment is responsible for the refund. This provision may be modified by applicable state laws. Should the contractor choose to not pursue overpayment recoupments, it shall not include, as part of its experience under the contract, any services related to an uncollected overpayment which it has not made a reasonable effort to recover. In the case of care delivered by a contractor owned or operated in-system provider to a person not eligible for care under **TRICARE**, the provider shall be responsible for collection and that expense shall not be attributed to **TRICARE** contract experience.

##### **1. Provider Overpayments**

Overpayment refunds shall be sought from the provider who received the incorrect payment in the following situations:

- a. The overpayment resulted because the beneficiary had paid the provider more than the deductible, copayment, or other cost-sharing amounts and this was not indicated on the claim.

- allowable.
- b.** The payment was based on an amount in excess of that
- c.** The provider received and retained duplicate **TRICARE** payments.
- d.** The overpayment was due to a mathematical or clerical error; e.g., an error in calculation of overlapping or duplicate bills. This does not include a failure to properly assess the deductible. Where a provider has been incorrectly paid a deductible, recovery shall be sought from the beneficiary.
- e.** The overpayment was for noncovered services or supplies.
- f.** The services or supplies were not received by the beneficiary, or there is no documentation to substantiate that the provider performed the services claimed. (See the [OPM Part Two, Chapter 7](#), if fraud is suspected.)
- g.** The services or supplies were furnished by a provider not authorized under **TRICARE**.
- h.** The beneficiary and the provider were paid for the same services, resulting in a duplicate payment, and the beneficiary turned his or her payment over to the provider.
- i.** The **TRICARE** payment was made to the participating provider and a primary health insurance plan also made a benefit payment to the provider or beneficiary for the same services or supplies, and the combined payments exceed the billed charges.
- j.** The payment was made to the wrong provider or to a nonparticipating provider. In such cases, the contractor shall issue payment to the correct payee and initiate recoupment action against the erroneously paid provider concurrently. The contractor shall **not** postpone issuing payment to the correct payee pending completion of the recoupment. If only in-system providers are involved, follow the agreement and/or administrative procedures for this situation.

## 2. Beneficiary Liable

Recoupment should be sought from the beneficiary in the following situations:

- a.** The overpayment was caused by incorrect application of the deductible, copayment, or other cost-share.
- b.** The patient was not an eligible beneficiary at the time services were provided and the payment was made to a participating provider for whom a good faith payment has been authorized by **TRICARE Management Activity (TMA)**. (See [Section III.B.3.b.](#), below.)
- c.** A provider who received a duplicate **TRICARE** payment certifies the payment was refunded to the beneficiary.

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**d.** The TRICARE payment was made to the beneficiary and his or her primary health insurance plan made a benefit payment for the same services or supplies.

**e.** The TRICARE payment was made to the beneficiary instead of the out-of-system participating provider. The contractor shall immediately issue payment to the out-of-system participating provider and concurrently take recoupment action against the beneficiary.

**f.** Any other instance in which the erroneous payment was made directly to the beneficiary, except [Section III.B.1.h](#).

### 3. Other Considerations in Determining Liability for Overpayment

#### a. Overpaid Party is Deceased

If the contractor determines that liability for an overpayment rests with a beneficiary or provider who is deceased, the contractor shall seek recoupment of the overpayment from the estate of the deceased person under state laws. The procedures described in this section shall be followed.

#### b. Good Faith Payment

**(1)** With prior approval from TMA, a contractor may make a good faith payment to a participating provider, or allow a previous payment to stand, for care provided to a patient, but only in the following situations.

**(a)** An ineligible patient holds an ID card showing TRICARE eligibility and the provider exercised reasonable care in accepting the apparently valid ID card as evidence of eligibility;

**(b)** An ineligible patient sees a Resource Sharing provider and there is evidence from DEERS indicating the patient had been shown as eligible at the time of service; or

**(c)** An ineligible beneficiary enrolls in Prime, claims are filed and denied as TRICARE ineligible, and the contractor can document via evidence from DEERS that the individual had in fact been shown on DEERS as eligible on the date of Prime enrollment and for the period covering the dates of medical care.

**(2)** Whether the claim is initially paid or denied, the provider *is* expected to make reasonable efforts to collect payment from the ineligible patient prior to requesting approval of a good faith payment. Documentation of the unsuccessful effort is to be submitted to TMA with the request. Immediately prior to submitting a request for approval of a good faith payment, the contractor shall recheck the current DEERS records to confirm that the person is not eligible and include the documentation of the results. The contractor is not financially responsible for making good faith payments. The contractor's costs will be separately reimbursed by the government.

**(a)** If the contractor has made payment to the participating provider, the contractor must advise the participating provider and the patient of the patient's ineligibility and then follow recoupment procedures. If, during the

recoupment process, the participating provider alleges that he or she relied on the information on the patient's ID card showing **TRICARE** eligibility, the contractor must forward the file to **TMA** for consideration of a good faith payment and advise the participating provider of the action taken. The file must include documentation of all contact with the participating provider and patient.

**(b)** If the contractor has not made payment to the participating provider, the contractor must deny the claim on grounds of ineligibility of the patient. If the participating provider alleges that he/she/it relied on the information on the patient's ID card showing **TRICARE** eligibility, the contractor shall forward the file to **TMA** and advise the participating provider of the action taken. The file must include documentation of all contact with the participating provider and patient.

**(3)** A provider who erroneously furnishes services and/or supplies to an ineligible beneficiary as a result of careless identification procedures is not entitled to a good faith payment.

**(4)** Under the Defense Enrollment Eligibility Reporting System (DEERS), the Uniformed Services are responsible for providing beneficiaries with accurate and appropriate means of identification.

### **c. Overpayments Resulting from Alleged Misinformation**

An allegation by a patient or provider that information obtained from a health benefits advisor, contractor, or other party caused the overpayment does not alter the liability for the overpayment, or is it grounds for termination of recoupment activity.

### **d. Denial of Benefits Previously Provided**

In those instances in which clarification, interpretation or a change in the **TRICARE** Regulation would result in denial of services or supplies previously covered, no action should be taken to recover payments expended for those benefits paid prior to the date of such clarification or change, unless specifically directed by **TMA**.

### **e. Double Coverage Situations - Primary Health Insurance Plan Liable**

A "Primary Plan," under **TRICARE** Law and Regulation is any other health insurance coverage the patient has, except Medicaid (Title XIX) or a supplement plan which is specifically designed to pay only **TRICARE** deductibles, coinsurance and other cost-shares. (See the **OPM Part Two, Chapter 3**) The liability for refunding overpayments in all double coverage situations shall rest with the primary health insurance plan. When that plan has not already made its benefit payment to the beneficiary or provider, the contractor shall attempt recoupment directly from the primary plan in such cases. If the other plan has made payment, then the **TRICARE** payment shall normally be recouped from the party to whom the **TRICARE** payment was made.

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### f. Third Party Recoveries

When potential recovery from or actual payment by a liable third party is discovered, the contractor will take recoupment action under the provisions of [Section V](#) of this chapter.

## C. Procedures for Recoupment of Overpayments

For the purpose of determining the amount of the overpayment in a particular case, the contractor should include all claims overpaid for the same reason/case/episode of care.

### 1. Low Dollar Value Overpayments

It is normally not economically feasible to pursue low dollar overpayments, e.g. under \$50. The contractor should apply its corporate policy in determining the level at which to waive recoupment. However, if the overpayment is attributable to failure to properly assess the deductible, it should be recouped, even if less than established threshold.

### 2. Overpayments Recovery

The contractor should take recovery actions in accordance with applicable laws of the states in the jurisdiction. The procedures for recovery shall be documented and subject to review and approval by *TMA*. The recovery actions *shall* include issuing a letter to the participating provider requesting *payment and establishing a system for offsetting from subsequent claims. A copy of the letter to the participating provider should be sent to the beneficiary. The contractor has discretion in developing its own demand letters as long as it includes the information required by the OPM Part Two, Chapter 5, Section III.C.5. (See the Sample Letter to Beneficiary Figure 2-5-A-1). Because the recovery actions are for the collection of "at-risk" funds, demand letters should not reference the Federal Claims Collection Act as authority for collection nor should they advise debtors that delinquent debts may be collected by administrative offset from other federal monies owed, or referred to the Department of Justice for enforced collection or offset from tax refunds.*

### 3. Offset Procedures

If the initial and follow-up refund requests and the offset attempt, if any, are unsuccessful for a period of 60 days from the date of the initial demand letter, the contractor should *leave* an offset flag or similar control on the file of the overpaid party (including a provider) for the term of the *TRICARE* contract for potential future offset. If at any time all or part of an overpayment is offset, prepare *an* EOB for each claim against which offset was made and send a notice to the overpaid party explaining the overpayment and the offset. If the offset is against the provider, the provider shall be advised that reimbursement for the claim against which the offset was made may not be sought from the patient on whose behalf the services were provided.

### 4. Offset Requests from Other Agencies

Any requests for offset from other government agencies and orders for garnishment issued by courts will be handled under the laws of the state(s).

**5. Information to be Included in Refund Requests**

As a minimum, refund requests shall include a preaddressed return envelope and the following:

**a.** Claim and payment information.**(1)** Name and Address of the Beneficiary and Provider**(2)** *Sponsor* SSN**(3)** Internal Control Number**(4)** Date(s) and Type(s) of Service**(5)** Principal Amount of Debt**(6)** Date(s) of Check(s)**(7)** Name of Payee**b.** A clear explanation of why the payment was not correct.

**c.** The amount of the overpayment and how it was calculated, and the amount of the correct payment, if any.

**d.** A notice that the overpaid party is required to refund the overpayment, or make acceptable arrangements to make the refund, within thirty (30) days of the date of the request.

**e.** A notice that:

**(1)** *Interest shall be assessed at the rate of \_\_\_ percent. (Enter the rate which would be collected under the Federal Claims Collection Act or the rate allowed by applicable state law, whichever is lower.)* Interest shall begin to accrue *from the date of this letter.*

**(2)** Accrued interest will be waived if payment is received within 30 days.

**(3)** Administrative costs may also be assessed for expenses in collecting the debt. *TMA* must be informed of the procedures, policies, and any charges, which are subject to *TMA* approval.

**f.** A notice of the possibility of offset if the overpayment is not refunded.

**g.** Instructions that the refund shall be by check or money order made payable to the contractor.

**h.** A notice, when appropriate, that unless a refund is made, or arrangements for a refund are made, the case may be referred to a credit reporting agency which could result in the assessment of added administrative costs, penalties and interest.

**i.** An explanation of rights to an administrative review and/or to appeal rights. (See [Section III.C.8.](#))

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### 6. Contractor Responses to Debtors

There will be no undue time lag in responding to any communication from debtors. The contractor shall respond within normal correspondence timeliness standards, but in no case shall there be a delay in excess of *thirty (30)* days from receipt of any communication from the debtor.

### 7. Installment Refunds

#### a. By Beneficiaries

**(1)** If, in responding to the request for refund, the beneficiary alleges that immediate repayment of the overpayment in full would be a financial hardship and requests an installment refund plan, the contractor shall exercise its judgment in providing such a plan. The size of the overpayment and the financial status of the beneficiary are the primary considerations. If installment payments are approved, the contractor shall enter into a repayment agreement with the debtor. The repayment agreement may include a provision for payment of interest. If the debtor fails to sign and return a written agreement, the contractor may still collect installment payments. However, if the debtor fails to remit the agreed-upon monthly installments, the case shall be treated in accordance with the instructions for handling delinquent installments (see [Section III.C.7.b.](#)). The contractor shall acknowledge each payment received in writing. The acknowledgment must indicate the amount of the payment received, the amounts applied to interest, if applicable, and principal and the current balance due. The contractor shall maintain an accounting record of such payments which shall be subject to audit at all times. (See the [ADP Manual, Chapter 1](#), for instructions on adjustments to the Health Care Service Records.)

**(2)** The size of the monthly installment should normally allow for complete refund of the overpayment within *twenty-four (24)* months. Monthly installments of less than \$50 should be allowed by the contractor if evidence is presented that financial hardships or other justifiable reasons exist. If it is alleged by the beneficiary that monthly installments cannot be made to complete the refund within *twenty-four (24)* months, the case should be carefully reviewed by the contractor's management. The beneficiary should be assisted to the fullest reasonable extent by allowing reasonable terms.

**(3)** If an offset was previously established on an account, it should be lifted once a repayment agreement is established, unless the debtor requests that the offset remain. Any offsets so collected will be treated as an installment payment. Suspended claims should be processed and paid normally.

**(4)** The contractor shall make the collection of overpayments under conditions which will not create severe hardship on the beneficiary/sponsor debtor. Policies related to such collections shall be subject to TMA approval and shall comply with all applicable state and local laws governing collections and promissory notes. If the contractor elects to charge interest on overpayments, it shall not begin to accrue earlier than *thirty (30)* days following notice of the overpayment, if payment is made within the *thirty (30)* days following notice. Interest rates charged shall not exceed the rate which would be collected under the Federal Claims Collection Act or the rate allowed by applicable state law, whichever is the lower.

**b. Installment Delinquencies**

If the debtor fails to comply with an established repayment agreement, the contractor will notify the debtor of the delinquent amount and urge that the account be brought current. A written delinquency notice will be sent *thirty-five (35)* days after the established due date if an installment payment, or any portion thereof, remains outstanding. If the delinquent amount is not remitted within *thirty (30)* days of the initial delinquency notice, the contractor should take appropriate action under the laws of the appropriate state. Should the debtor fail to bring the account to a current status, but, instead, remit the missed installment or a portion thereof, the contractor shall contact the debtor and attempt to resolve the delinquency problem. A delinquent case should not be referred to collection agencies, or other similar action taken until at least two *(2)* full installment payments are past due. An offset flag may, however, be set and maintained on all delinquent installment cases.

**8. Recoupment Action and the Appeals Process**

**a.** The determination that an overpayment was made is not, in itself, an appealable issue.

**b.** If a service or supply which is not a TRICARE benefit was paid in error, the reversal of the payment decision constitutes an initial adverse determination. The overpaid party may appeal if an appealable issue exists. Such appeals are subject to the requirements and time limits outlined in *OPM Part Three, Chapter 7, Appeals and Hearings*.

**c.** Any funds recouped by offset after a reconsideration has been requested are to be identified and properly accounted. The appealing party is to be notified that the recoupment of the overpayment shall continue by offset. The contractor should **not** terminate offset action because of an appeal.

**d.** When a requirement to recoup TRICARE funds is identified in a Formal Review Decision or a Final Decision resulting from a hearing, the case will be forwarded to the contractor for recoupment action in accordance with this section.

**9. Offset Recoupment/Partial Payment**

**a.** If the full amount is recouped through offset, follow adjustment procedures in the *ADP Manual, Chapter 1*, and report the correction in the next Health Care Service Record (HCSR) submission.

**b.** If a partial recoupment is made by offset, the current claim check will be voided or written to the contractor's own account. Continue collection efforts, as appropriate, on the balance. If subsequent offsets result in full recoupment, use the procedure listed above.

**c.** If a debtor has entered into an installment repayment agreement and has asked the contractor to continue to offset against future claims, the amount offset should be applied first to interest, if applicable, and then to principal, as installment payments are applied. Generally, offset amounts will be applied only to principal.

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### 10. Requests for Relief of Indebtedness

Contractors may compromise, suspend, or terminate collection actions on claims arising out of overpayments to beneficiaries if it is evident that severe hardship will be imposed and/or there is a reason of equity involved because the overpayment was the result of an initial error by the contractor. All requests from debtors for relief from all or a portion of their indebtedness, including requests for relief from the assessment of interest, penalties, and administrative charges must be carefully reviewed. This does not apply to automatic waiver of interest on accounts paid within the first *thirty (30)* days. After a case is established, the contractor must always take appropriate corrective action to stop or amend a recoupment when a contractor error is discovered.

### 11. Administrative Review of Indebtedness

**a.** If a debtor requests an administrative review of his indebtedness, the contractor will review the documentation contained in the case file and any additional information or documents submitted by the debtor. The contractor review shall be conducted by someone in a position of higher authority within the contractor organization than the individual who originated the recoupment action. Following the review, the contractor shall respond to the debtor. When the debtor questions a contractor's determination that the care is not a covered benefit, the debtor's request for review will be referred to the appropriate unit within the contractor's organization for issuance of a reconsideration pursuant to *32 CFR 199.10* unless the issue is not appealable under the provisions of the *OPM Part Three, Chapter 7*, the issue has been resolved through or is currently pending in the appeal system, or the recoupment action was initiated for one of the following reasons:

- (1)** TRICARE payment was issued without regard to other health insurance, or the TRICARE liability, after taking into consideration payments made by other health insurance, was inaccurately calculated.
- (2)** The action was initiated to recoup a duplicate payment.
- (3)** The action was initiated because an error was made in the original determination that a claim was a participating or a nonparticipating claim.
- (4)** The action was initiated because the payee was incorrect.

**b.** Based upon the above instructions, if it is inappropriate to provide the debtor a reconsideration, the contractor shall issue a response to the debtor's request for administrative review. The contractor's response shall describe the documentation reviewed, including any submitted by the debtor, and explain the reviewing party's rationale for the decision to pursue or terminate the recoupment action. The response shall explain that further administrative appeal is not available. If the review results in a decision to recoup the overpayment, the debtor will be advised that full payment or other satisfactory arrangements for repayment must be made within *thirty (30)* days. A debtor's request for an administrative review of his or her indebtedness does not result in suspension of the accrual of interest from the date of the initial demand letter.

### 12. Suspicion of Fraud

If there is reason to believe that the overpayment may have been caused by fraud, no request for refund shall be made until the fraud issue is resolved. However, the contractor should retain any amount voluntarily refunded pending resolution

of the fraud issue. These funds shall be deposited in the contractor's account and an accounting record maintained which is capable of audit. Copies, only, of documentation of the refund and all other evidence relating to the case shall be sent to the Office of Program Integrity, TMA. Any recoupment action shall be taken in accordance with [OPM Part Two, Chapter 7](#).

### **13. Bankruptcy**

When the contractor learns that any debtor has filed a petition in a bankruptcy, all recoupment actions must cease. If the debtor is on offset, the contractor must terminate the offset immediately. Until the bankruptcy is resolved, no further recoupment action must occur and the contractor shall be bound by the laws of the state and the court ruling. Bankruptcy cases for debts which were paid with at-risk funds are retained by the contractor for appropriate action. They are not forwarded to TMA.

### **14. Reporting Offsets, Partial Refunds and Recoupments**

In the case in which the contractor negotiated a phased or installment recoupment of the overpayment, the contractor is to accumulate the repayments until repayment/recoupment in the particular case is final. At that time, report to TMA all the cancellations for those HCSRs recouped in full and/or negative adjustments for those HCSRs partially recouped. Offset and partial refund repayments will be accounted for in the same manner as above. A refund of less than \$10.00 should not be reported to TMA. As previously noted, failure of a contractor to effectively pursue recovery of overpayments shall result in the exclusion of such payments in evaluating the contractor's experience under the contract.

## **D. Interest, Penalties and Administrative Costs**

**1.** The debtor shall be notified in the initial demand letter that interest, if required by established corporate policy, and allowed by state law and the TRICARE contract, will accrue from the date of that letter. However, the collection of interest shall be automatically waived on the debt or any portion thereof which is paid within *thirty (30)* days after the date of the initial demand letter.

**2.** If the contractor applies penalties, debtors shall be notified in the initial demand letter. A penalty shall not exceed six percent (*6%*) per year, if to be charged. It will only be applied on any portion of the debt which is delinquent for more than *ninety (90)* days. Administrative costs, based on costs incurred in processing and handling the debt because it became delinquent, may be added to the amount of the indebtedness.

**3.** The contractor shall collect interest ONLY when the debtor enters into an installment repayment agreement as described in [Section III.C.7.](#), above. The rate of interest shall be the rate established as provided in [Section III.D.1.](#), above. Each installment payment shall be applied first to the accrued interest and then to the outstanding principal balance.

**4.** Interest will not be charged on previously accrued interest. When the debtor and the contractor enter into an installment repayment agreement, interest will be charged for the period which began with the date of the initial demand letter and ended on the due date of the first payment. Interest shall be calculated at the current rate, on that portion of the debt which was outstanding *thirty (30)* days after the date of the initial

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demand letter. Interest will be applied to the debtor's account for any balance remaining after the due date of the first installment payment. The payments will be first applied to interest and then to principal. Subsequently, interest shall be computed daily on the outstanding principal balance, at the rate current when the debtor entered into a repayment agreement, or at the rate specified in the note, if the debtor signs a promissory note. The note rate shall be that which is current at the time the note is signed.

**5.** The rate of interest shall remain fixed unless a debtor defaults on a repayment agreement and seeks to enter into a new agreement. The new interest rate will be set reflecting the current value of funds, and in accordance with the contractor's rate and/or state laws at the time the new agreement is executed. The current value of funds is the value of funds to the U.S. Treasury. The current value of funds is the value of funds to the U.S. Treasury.

### E. Recoupment of Hospice Overpayments

The contractor shall calculate the cap and inpatient amounts for each TRICARE hospice program and request a refund for those exceeding the calculated amounts (refer to the [Policy Manual, Chapter 13, Section 22.1D](#) for additional information).

**1.** The contractor will be given discretion in developing its own letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed in the [Policy Manual, Chapter 13, Section 22.1D](#).

**2.** If the hospice fails to submit the refund, the contractor will issue additional demand letters as required under the [Section III.C.](#) and [Section IV.C.](#) Copies of the demand letters will not be sent to the beneficiary, and providers will not be placed on offset to collect overpayments.

**3.** The processing of recoupments under a managed care support contract is dependent on whether at-risk funds (payment of services for residents within the contract area) or not-at-risk funds (payment for services provided to beneficiaries that come from outside the contract area) are being used. In the case of at-risk funds, recoupments are retained by the contractor while those associated with not-at-risk funds shall be returned to TMA.

**a.** Under the above provision, the contractor shall apportion the hospice recoupment (i.e., the amount paid in excess of the aggregate cap amount and/or inpatient limitation) based on the number of TRICARE beneficiaries receiving care in a hospice who reside within the contract area versus those coming in from outside the area.

#### **Example:**

*It is determined at the end of the cap year that Denver Hospice had been paid \$20,000 more than the cap allowed for the previous cap period. There were a total of **thirty (30)** TRICARE beneficiaries electing hospice care during the period, of which **five (5)** resided outside the catchment area. The separation of funding would dictate that 16.7 percent of the recoupment be returned to TRICARE while the remaining amount would be retained by the contractor.*

**b.** If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, the not-at-risk portion of the

recoupment case will be transferred to TMA in compliance with the [Section IV.C.](#) of this chapter.