

Claims Adjustments and Recoupments

Chapter 5

I. GENERAL

A. Scope

This chapter consolidates procedures relating to claims adjustments and recoupments. The method to be used in recouping funds depends on whether at-risk funds or not-at-risk funds are being recouped. Contractors are required to identify whether recoupment is being made for at-risk-funds or not-at-risk funds and to initiate recoupment following the appropriate provisions of this Chapter. (See the [OPM Part Two, Chapter 5, Section III](#) for procedures for recovery of at-risk funds and the [OPM Part Two, Chapter 5, Section IV](#) for procedures for recovery of not-at-risk funds.) All recoupments made under third party liability (subrogation) statutes, whether at-risk or not-at-risk funds, will be collected following procedures in the [OPM Part Two, Chapter 5, Section V](#). See the [Policy Manual, Chapter 12](#), for information on recoupment procedures for TRICARE Europe providers.

1. The Federal Claims Collection Act (FCCA) (31 U.S.C. 3701 et seq.)

The Federal Claims Collection Act (FCCA) (31 U.S.C. 3701 et seq.) provides authority for the collection of not-at-risk fund recoupments. The FCCA was enacted to avoid unnecessary litigation in collecting debts owed to the United States. This statute, implemented by joint regulations of the Department of Justice and the General Accounting Office, requires federal agencies to attempt collection of all federal claims of the United States arising from their respective activities. Under this act, TRICARE Management Activity (TMA) is required to make necessary claims adjustments and initiate recoupment actions for erroneous payments, when government funds are involved.

2. The Federal Medical Care Recovery Act (FMCRA) (42 U.S.C. 2651-2653)

The Federal Medical Care Recovery Act (FMCRA) (42 U.S.C. 2651-2653), provides for the recovery of the costs of medical care furnished by the United States for the treatment of a disease or injury caused by the action or negligence of a third party. Under this act, the United States has a right to recover the reasonable value of the care and treatment from the person(s) responsible for the injury.

B. Application

The procedures which follow are for guidance and compliance by contractors in the processing of adjustment claims and the recoupment of funds which have been incorrectly disbursed as underpayments or overpayments for whatever reason. Also included are procedures for correcting and making proper and timely disbursements when an underpayment is determined to exist and for processing claims which fall within the diagnostic code ranges relating to injuries where third party liability may be involved. In some cases, the contractor may be required to pursue and collect overpayments which occurred under a contract administered by a third party administrator, such as Continued Health Care Benefit Program (CHCBP). This could occur when the contractor has taken over a region and overpayments are subsequently discovered or when an installment collection is still in progress. Procedures of this chapter will be applied.

C. Error Correction

The contractor shall correct all erroneously processed claims. The required corrective actions may include making additional payments of \$1.00 or more, adjusting deductibles and cost-shares, adjusting amounts applied toward the catastrophic cap, recouping overpayments and correcting health care records. When a claim is adjusted, the contractor shall query Central Deductible Catastrophic Cap File (CDCF) and apply deductible and cap as directed by the CDCF query response. Do not review any intervening claims processed between the initial claim and the adjustment for the purpose of adjusting deductible or cap amounts. The ADP Manual, [Chapter 1](#), provides instructions for submission of claim adjustment transactions to the TMA. Contractors will normally use the original ICN to make any adjustments to a processed claim, but there are exceptions.

D. Time Limitations on Requests for Adjustments

(Applies to all *non-network* claims; for *network* claims, it applies only to beneficiary submitted claims.) Acceptance of a request for an adjustment to a processed claim is subject to the time limitation guidelines below: (These guidelines do not apply to required adjustments identified by the contractor, TMA or an audit agency.)

NOTE:

For adjustments made to claims that predate the two (2) profiles maintained by the contractor, use the prior or earlier year's profile. Refer to the [OPM Part Two, Chapter 4, Section I.B.](#) for calculation of payment amounts based on the appropriate profiles and the date of service on the claim.

1. Timely Filing - December 31 Rule

Adjustments which have the effect of a new obligation shall be processed in accordance with the December 31 rule (refer to the [OPM Part Two, Chapter 1](#)). An example would be a supplemental (late) billing from a hospital.

2. Timely Filing One Year From Date Of Service/ Discharge Rule

Adjustments which have the effect of a new obligation of Government funds shall be processed in accordance with the one (1) year from date of service/date of discharge rule (refer to the [OPM Part Two, Chapter 1, Section IV.B.](#)). An example would be a supplemental (late) billing from a hospital.

3. 90-Day Rule

A request for a reconsideration must be received by the contractor within *ninety* (90) calendar days from the issue date of the explanation of benefits. Examples include the claimant providing additional information about a service or supply already processed (paid or denied) or the claimant's questioning the accuracy of processing. This does not include claims denied at *thirty-five* (35) days for failure to provide requested information. The December 31 rule, or *ninety* (90) days after the request for information, whichever is later, applies in these cases.

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4. Statute of Limitations

Requests for adjustments which do not fall into the above categories must be mailed within nine months (with an additional 10-day grace period) of the date of the initial EOB. Examples include the refiling of a claim after a retroactive eligibility determination or the report of nonreceipt of a benefit check.

E. Voluntarily Returned or Refunded Payments

Occasionally, benefit payments will be returned to the contractor on a voluntary basis separate from any recoupment action.

1. Reasons for Voluntary Refunds

- a. Payment unwanted
- b. Amount of payment questioned
- c. Overpayment
- d. Incorrect payee

2. Disposition of Voluntary Refunds

The contractor shall determine handling procedures for checks in accordance with its corporate procedures, provided generally accepted accounting procedures are used. If payment is confirmed as accurate and the check is still negotiable, the contractor shall return it to the correct payee within five workdays of receipt. In all returned check cases the correct payee must be expeditiously identified and paid. Some special procedural requirements are:

- a. Research the accuracy of the payment and payee.
- b. Handle underpayment situations in accordance with [Section II](#).
- c. Handle overpayment recovery situations in accordance with

[Section III](#).

- d. In the event of unwanted payments, contractors must inform the participating provider that return of a TRICARE payment does not relieve the obligations assumed by submitting a participating claim. The provider cannot return a payment and then bill the beneficiary. (See the [OPM Part Two, Chapter 7](#), for handling of assignment violations.)

