THIRD PARTY RECOVERY CLAIMS

1.0. GOVERNMENT'S RIGHT TO RECOVER MEDICAL COSTS

The following statutes provide the basic authority for the recovery of medical costs incurred as a result of "Third Party Liability."

1.1. 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 to a person suffering a disease or injury caused by the action or negligence of some third person. 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. For TRICARE beneficiaries, this includes care that may be received by the beneficiary at a Uniformed Services facility or under TRICARE, or both. The FMCRA applies only to illness or injury (including work-related injuries) caused by a third party, either intentionally or negligently, or injuries caused by a third party's failure to act when a duty to act could be implied.

EXAMPLE: A beneficiary is injured as a result of an automobile accident caused by another person and the beneficiary's medical care is paid for by TRICARE. Under this Act, the Government may recover the amounts paid by TRICARE from the negligent party.

1.2. Other Statutory Authority

The cost of medical care required as a result of the injured party's own conduct would not be recoverable under the FMCRA; however, other provisions of law often permit recovery by the Government under some insurance contracts, as set forth in paragraph 6.0., Federal claims may also arise for the recovery of medical costs under the following kinds of authorities:

- State worker's compensation laws
- State hospital lien laws
- "No-fault" automobile statutes
- Contract rights under terms of insurance policies

2.0. DEFINITIONS

2.1. Third Party Liability (TPL) Recovery

Action by the United States to recover, under authority of the Federal Medical Care Recovery Act, from a third party the costs of medical care furnished, or paid for, on behalf of a TRICARE beneficiary. The third party will be an individual (or an entity) liable for tort

damages to the injured TRICARE beneficiary. Recovery may be obtained from the third party and/or from a liability insurance carrier covering the third party. Third Party Liability Recovery is the responsibility of uniformed services claims officers.

2.2. Automobile Medical Insurance

Insurance coverage that pays for all or part of the medical expenses for injuries sustained in an automobile accident by the passengers or driver. This insurance is sometimes called basic medical payments or personal injury protection (PIP).

2.3. Liability Insurance

Insurance which provides payment based on liability for injury to persons or damage to property. It includes, but is not limited to, automobile liability insurance, homeowners liability insurance, malpractice insurance and product liability insurance.

2.4. No Fault Automobile Insurance

Insurance which pays for medical treatment necessitated by an automobile accident irrespective of fault. This kind of insurance may affect the right of the individual to sue for damages.

2.5. Self-Insured Plan

A plan under which an entity (or individual) is authorized by State or Federal Law to carry its own risk and not to insure itself with an insurance carrier.

2.6. Uninsured Or Underinsured Motorist Insurance

Insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no or insufficient liability insurance and is financially unable to pay the damages.

2.7. Personal Injury Protection Insurance

Coverage included as a part of a general automobile, homeowners or other insurance policy which provides payment for accidental injuries suffered by the policy owner or any other designated beneficiary such as a family member or passenger.

2.8. Incident

An accident or other cause of personal injury.

2.9. Episode Of Care

All services for care received in the treatment of injuries suffered in an accident. For serious injuries, this can include multiple claims from a number of providers over a prolonged period of time.

2.10. Surrogate Arrangements

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. Where the contractual arrangements do not specify an amount for reimbursement for medical expenses, the full amount of all undesignated payments shall be deemed to be for medical expenses incurred by the surrogate mother. TRICARE will cost share on the remaining balance of otherwise covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon arrangement has been exhausted.

3.0. DEPARTMENT OF DEFENSE POLICY

It is the Department of Defense's policy that TMA establish, implement, and maintain a system to identify and enforce the Government's right to recover funds expended on claims involving potential third party recovery. While monies recovered under the Federal Medical Care Recovery Act may not accrue to TMA specifically, they do represent a substantial savings to the Government.

4.0. RESPONSIBILITY FOR RECOVERY

Designated legal officers of the uniformed services are responsible for the recovery actions on TRICARE claims involving third-party liability under the FMCRA. Chapter 11, Addendum B, provides a complete listing of the offices in the TMA area to which TRICARE claims involving third-party liability are to be sent.

5.0. CONTRACTOR RESPONSIBILITY

5.1. Identification Of Claims Subject To Third Party Recovery

5.1.1. The contractor is responsible for making a preliminary investigation of all potential third party recovery claims. Any inpatient claim with diagnosis code 800-999, regardless of dollar value, or any outpatient claim with diagnosis code 800-999 which exceeds a TRICARE liability of $500, shall be considered a potential third party claim and shall be developed with the questionnaire, "Statement of Personal Injury - Possible Third Party Liability," DD Form 2527. (See Chapter 11, Addendum A, Figure 11-A-2.) However, if the contractor can determine, based upon a specific diagnosis code (e.g. certain E codes), that there is little or no third party recovery potential, the claim need not be developed. Examples of cases that usually would not require development include a slip and fall incident at home or a one-car accident in which the TRICARE beneficiary was the only occupant. Claims with the following diagnoses do not require routine development for potential third party liability. References to the 800-999 diagnostic code category for third party liability purposes excludes these codes.

910.2 - 910.7, 911.2 - 911.7, 912.2 - 912.7, 913.2 - 913.7, 914.2 - 914.7,
915.2 - 915.7, 916.2 - 916.7, 917.2 - 917.7, 918.0, 918.2, and 919.2 - 919.7.

5.1.2. A system flag shall be set when the DD Form 2527 is mailed. Any claims which appear to be possible third party claims, after the contractor has reviewed the returned statement, shall be referred to a Uniformed Service Claims Office for determination and

recovery action, if appropriate. These claims shall be processed to completion in the usual manner prior to referral to a claims officer. Normal processing includes appropriate COB under the provisions of paragraph 6.0. and the TRICARE Systems Manual, Chapter 2.

5.1.3. Claims developed for TPL which require COB may either be denied or be treated as uncontrolled returns in accordance with paragraph 5.2.1.2. If the contractor discovers the potential other coverage through receipt of the completed DD Form 2527, the other coverage information must be developed at that point using the normal other coverage procedures in place for the contractor. If during the course of claim adjudication, the contractor becomes aware of a potential third party recovery arising as the result of malpractice (civilian provider negligence), the contractor shall process the claim(s) under the provisions of this section regardless of the procedure codes involved.

5.2. Contractor Procedures

The contractor shall have automated identification of claims with diagnoses codes 800-999. When the contractor receives a claim with diagnoses codes 800-999, the processing clerk shall follow the instructions below:

5.2.1. Continue normal processing of the claim (including any required development or other insurance actions) to the point of payment, but withhold payment pending the actions that follow:

5.2.1.1. Search existing files to determine whether there is a system flag indicating that a personal injury questionnaire has been sent within the last 35 days, or an indicator that a completed DD Form 2527 has been received for the same episode of care.

5.2.1.2. If there is no personal injury questionnaire attached to the claim, and none has been requested within the last 35 days or received previously for the same incident, suspend the claim payment regardless of whether the claim has been assigned, and send a request to the beneficiary asking that he/she complete the questionnaire. (See Figure 11-A-3.) The beneficiary must be advised that if a completed questionnaire is not returned on a timely basis, the claim cannot be processed without the requested information. Every effort shall be made to request any additional information required to process the claim at the same time the questionnaire is sent. If the claim indicates that there is other insurance, or if contractor history or DEERS reflects the existence of other health insurance, the contractor may deny the claim(s) or return the claim(s) uncontrolled and simultaneously request that the DD Form 2527 be completed.

5.2.2. If a personal injury questionnaire has been requested within the last 35 days, related claims with diagnosis codes 800-999 received subsequent to the request shall be suspended. Added requests for the DD Form 2527 are not necessary. However, the contractor shall develop such claims for any other needed information to expedite processing when the response is received. When a claim is received with services and/or supplies connected with a probable third party liability case and services and/or supplies not so connected, treatment encounter data must be reported on TEDs using claim breakdown.

5.2.3. If the requested personal injury questionnaire is not received within a 35 day period following the initial request, the contractor shall deny the claim which triggered the

TPL development and all related claims which are in suspense status waiting for receipt of the personal injury questionnaire.

5.2.4. When the personal injury questionnaire is received, the system shall be flagged to indicate receipt and the questionnaire shall be evaluated to determine whether there is indication that there is a potential for third party recovery. (This evaluation is not expected to be a detailed legal analysis of the recovery potential of a case.) DD Form 2527 forms must have enough information to allow the contractor to make a determination regarding the potential for third party liability. If the DD Form 2527 returned by the beneficiary does not have enough information to allow the contractor to make such a determination, or if the DD Form 2527 has not been signed, and 35 days have not passed since the DD Form 2527 was mailed to the beneficiary, the DD Form 2527 shall be returned to the beneficiary. The beneficiary will be asked to sign the DD Form 2527 and/or told that the DD Form 2527 did not provide sufficient information to allow the contractor to make a benefit determination, as appropriate. The beneficiary shall also be advised that if the form is not properly completed and returned within ten days from the date the contractor returned the form for addition to or correction of the DD Form 2527, his or her claims will be denied. When the 35 day suspension period, or the ten day period allowed for addition to or correction of the DD Form 2527, whichever is later, has expired, the contractor shall deny the pended claims. When the properly completed and signed DD Form 2527 is returned, the contractor shall reopen the denied claims and process them in accordance with the provisions of this manual.

5.2.5. There may be times when the beneficiary cannot complete the DD Form 2527. Completion of the form by a responsible relative who signs the form is acceptable. The contractor shall confirm the relationship between the beneficiary and the individual who completed and signed the DD Form 2527.

5.2.6. When the provider can demonstrate, based upon the medical records, that there is no potential for third party liability, and the beneficiary or next of kin has refused to complete the DD Form 2527 or can not be located by the provider, there is no need to require a completed DD Form 2527 before the claims are processed. *If the DD 2527 is not returned and the provider alleges that there is no potential for third party liability, the contractor shall request that the provider submit copies of medical records. If the contractor review of the records determines that no potential TPL exists, the claim may be processed and paid without a completed DD 2527.* Cases in which there is any doubt about possible third party liability shall be resolved by referral to a claims officer. However, cases in which it is clear that there is no potential for recovery from a liable third party (such as the slip and fall incident at home or a one-car accident noted above) need not be referred to a claims officer. The contractor shall be alert to other avenues of recovery in these cases, however, such as medical payment coverage or no-fault automobile insurance. The contractor shall retain a copy of the DD Form 2527 that has been completed and returned by the beneficiary. The evaluation shall include consideration of the following:

5.2.6.1. Evaluation for possible third party liability under the FMCRA. As stated above, all claims processed to completion with potential for recovery under the FMCRA are to be referred to the appropriate claims officer. Denied claims need not be forwarded to claims officers unless they have been specifically requested.

5.2.6.2. Evaluation for third party recovery through the beneficiary's other insurance. Even if there is determined to be no potential for recovery from a liable third party, claims may possess potential for recovery from other insurance. When processing claims involving OHI, the contractor shall follow paragraph 5.2.1.2. and 6.0. and the TRICARE Reimbursement Manual, Chapter 4, Double Coverage.

5.2.6.3. Evaluation of the potential for mixed recovery under the FMCRA and other third party recovery. Many cases will have potential for recovery under both the FMCRA and other third party recovery such as other health insurance. In such cases, the contractor shall follow the COB provisions of paragraph 5.2.1.2. and 6.0. and TRICARE Reimbursement Manual, Chapter 4, Double Coverage. If a third party recovery (DD Form 2527) is received late and after the denial of related claims, the denied claims shall be reopened and processed in accordance with the provisions of this manual. Any subsequent claim related to the same incident or episode of care received after the denial of an initial claim for failure to return a third party recovery questionnaire shall be processed as a new case; i.e., with a new 35 day suspension period and a new questionnaire being sent unless a DD Form 2527 has previously been received for this episode of care.

5.2.6.4. The contractor shall provide an audit trail for each lump-sum EOB received from another health insurer. A lump-sum payment shall be applied to claims for the same episode of care in the order in which claims were received.

5.2.7. Within 15 working days following the completion of the processing of a claim for which it has been determined that third party liability might exist, the contractor shall send to the appropriate claims officer a copy of the EOBs applicable to paid claims, and the original DD Form 2527. *Before forwarding the EOBs and DD Form 2527 to the appropriate claims officer, the contractor shall contact the TRICARE Retail Pharmacy contractor and determine whether payment has been made for any prescriptions prescribed on or after the date of the accident/injury. If so, the contractor shall obtain copies of any claim record(s) and include them with the EOBs and DD Form 2527. An additional 15 work days will be allowed to permit time for claim records to be received from the retail pharmacy contractor.* The contractor shall retain a copy of the completed DD Form 2527. All processed EOBs associated with claims bearing diagnoses codes 800-999 that are related to an incident or episode of care shall be referred to the claims officer at the time the completed questionnaire is sent. Actual claim forms need not be sent to the claims officer unless they are specifically requested. See Figure 11-A-4, "Transmittal Letter to Government Claims Officers." The contractor shall maintain logs of all cases and claims referred to the Uniformed Service Claims Offices. The log shall contain the beneficiary's name, sponsor's name, SSN, claim number and amount, to whom sent, and the date sent.

5.3. Associated Claims

The claims officer will notify the contractor whether to submit subsequent associated claims. When requested, the contractor shall promptly forward copies of all EOBs applicable to subsequently received and paid claims and any other information available to the contractor regarding government costs for related care (including information concerning care received at a Uniformed Services facility) to the claims officer. The contractor shall cooperate fully in furnishing all requested information to Uniformed Services Claims Officers. No more than ten working days shall elapse between receipt of a request from a claims officer and the mailing of the requested data. Any delay beyond ten days in

responding to the claims officer requires an interim response advising the claims officer when the requested data will be transmitted. If the claims officer asks for associated claims, the contractor shall search for all related claims, including any processed prior to and subsequent to the claim which triggered the DD Form 2527. The contractor shall send legible copies of the claim forms and the associated EOBs.

5.4. Court-Ordered Restitution

Occasionally, when a TRICARE beneficiary has been injured as a result of negligent or willful action by a third party, the court having jurisdiction over the third party will order that restitution be made to TMA. Restitution is usually included in the terms of probation and it is the responsibility of the probation officer to assure that restitution is made pursuant to the court's order. The defendant in the action may be allowed to make restitution in monthly payments to the managed care support contractor (often through the Clerk of the Court or through the Probation Officer). When restitution is made pursuant to a court order, the contractor shall accept whatever payments are made, and notify the probation officer when a payment is missed. The contractor has no further responsibility for collection. Chapter 11, Sections 3 and 4, Overpayments Recovery, does not apply to court-ordered restitutions. Upon a contractor transition, the court-ordered restitution cases shall be transferred to the new contractor. The incoming contractor shall continue to collect whatever payments are forthcoming and advise the probation officer when a payment is missed. *The contractor shall deposit collections into the non-financially underwritten bank account and report the collection on the monthly Non-Financially Underwritten Funds Bank Account Reconciliation Report (Reference Chapter 3, Section 10 and Chapter 3, Addendum A, Figure 3-A-1 and Figure 3-A-2).*

5.5. Third Party Liability And DRG Claims

5.5.1. When a hospital subject to the TRICARE DRG-based payment system submits a TRICARE claim for inpatient services, it becomes bound by the participating requirements. These require that hospitals accept the TRICARE-determined allowable amount (the DRG-based amount) as payment in full. Therefore, hospitals may not bill or otherwise seek recovery from the beneficiary (or file a lien against a beneficiary's liability insurance proceeds or recovery from a liable third party) for the difference between the billed charge and the DRG allowable amount. Hospitals attempting to do so shall be advised that this constitutes a violation of the TRICARE participation requirements, may constitute Program fraud or abuse and may subject them to TMA administrative sanctions and the loss of their status as a TRICARE and Medicare provider. Situations in which a hospital persists in seeking recovery from the beneficiary for the difference between the billed charge and the DRG allowable shall be referred to the contractor's Program Integrity staff for further review and possible consultation with TMA regarding what additional actions may be taken.

5.5.2. It is important to note that prior to submission of a TRICARE claim, the hospital is not precluded from seeking recovery of its billed charge directly from the liable third party or insurer, including auto or home owners insurance, no-fault auto or uninsured motorist coverage. However, the hospital may not bill the beneficiary without filing a TRICARE claim. Once a TRICARE claim is filed, the hospital may not seek recovery of any amount, other than the applicable beneficiary deductible and cost-share, from the beneficiary, the third party or the liability insurer because of the limitations imposed by the TRICARE participation requirements.

6.0. COORDINATION OF BENEFITS - PERSONAL INJURY PROTECTION AND OTHER COVERAGE

6.1. The COB provisions of the TRICARE Reimbursement Manual, Chapter 4, shall be followed in processing any claim with potential TPL. Automobile liability insurance, no fault insurance, workers' compensation programs or plans, homeowner's insurance, or any other similar third-party payers are not considered double coverage plans and do not require development for coverage or payment of any services on claims submitted to TRICARE. However, any payments made by such a plan or program which are identifiable on the face of the claim without development and are not clearly designated for a purpose other than reimbursement for medical expenses shall be treated as double coverage payments when the contractor processes the claim.

7.0. BENEFICIARY RESPONSIBILITY

NOTE: This section is provided for information only; no contractor action is required.

7.1. The beneficiary who receives care through any program in which the United States is obligated to furnish hospital, medical, surgical or dental care as a result of injury or disease which was incurred under circumstances creating tort liability in a third party is obligated under the FMCRA to help with the prosecution of the government claim. This obligation extends to the guardian, personal representative, counsel, estate, dependents or survivors of the beneficiary. The beneficiary or another person representing the beneficiary may be required:

7.2. To provide complete information regarding the circumstances related to an injury or disease. The furnishing of the information is a condition precedent to the processing of a TRICARE claim which involves, or may involve, third party liability. The contractor shall suspend processing of all such claims, pending receipt of the required information.

7.3. To assign in writing to the United States his or her claim or cause of action against the third party. Such assignment shall be limited to the reasonable value of the care and treatment provided, or to be provided.

7.4. To furnish such additional information as may be requested concerning the circumstances of the injury or disease for which care and treatment are being given and concerning any action instituted or to be instituted by or against a third person.

7.5. To notify the recovery judge advocate or such other legal officer who is representing the interests of the government of a settlement with or an offer of settlement from a third person.

7.6. To cooperate in the prosecution of all claims and actions by the United States against such third person.

8.0. REPORTING REQUIREMENTS

8.1. General

The contractor shall send a report to TMA reporting the information required in paragraph 8.2., below, regarding claims investigated and claims referred under the Federal Medical Care Recovery Act (FMCRA). Claims under this act shall be considered to be those which are presented with diagnoses codes which fall within the range from 800 through 999, and under which there is or could be tort liability of a third party for the patient's injury or disease. The report shall be mailed in time to be received at the Office of General Counsel, TMA-Aurora, by *November 1* of each year. The contractor shall use a guaranteed mail service which will ensure delivery to TMA not later than the close of business (4:30 p.m., Mountain Time) on *November 1*, or the next following business day if *November 1* is a Saturday or Sunday.

8.2. Report Content

The annual report shall include the following elements:

8.2.1. Report Heading

- Reporting Period (covering the 12 months of the previous fiscal year)
- The Contractor's Name and Region Name (if applicable)
- The Uniformed Service that the report figures are associated with (i.e., Army, Air Force, Navy & Marine Corps, Coast Guard, USPHS and NOAA).

8.2.2. Report Summary

Create a breakdown for each of the six Uniformed Services listed in paragraph 8.2.1. above which includes the following categories:

- Number of cases investigated for potential third party liability.
- Total dollar amount actually paid on all claims investigated.
- Number of cases referred to the Uniformed Services for further investigation and collection.
- Actual dollar amount paid on all claims referred to the Uniformed Services for further investigation and collection.

8.2.3. Report Details

For potential third party liability claims that were investigated and/or referred, the contractor shall list the Uniformed Services Claim Office (USCO) where the potential third party liability case was referred. The contractor shall then report the appropriate figures for the categories listed under paragraph 8.2.2. by the appropriate state(s) and/or countries listed. Please see Figure 11-5-1 for an example.

FIGURE 11-5-1 THIRD PARTY RECOVERIES FOR REGION FISCAL YEAR

(CONTRACTOR NAME) THIRD PARTY RECOVERIES FOR (REGION NAME) REGION FISCAL YEAR (YEAR)					
ARMY					
USCO Claims Office Name	*TRICARE Region*	*Number of cases involving TRICARE payments investigated for potential third party liability*	*Dollar amount of cases involving TRICARE payments investigated for potential third party liability*	*Number of cases involving TRICARE payments referred to Uniformed Services*	*Dollar amount of cases involving TRICARE payments referred to Uniformed Services*
Ft. Rucker, AL	*South*	*0*	*0*	*0*	*0*
Red Stone Arsenal, AL	*South*	*10*	*$27,500.25*	*2*	*$14,250.00*
Ft. Wainwright, AK	*West*	*20*	*$31,827.50*	*5*	*$5,367.20*
TOTAL		***30***	***$59,327.75***	***7***	***$19,617.20***