

Chapter 10

Section 1

General

1.0 SCOPE

1.1 This chapter consolidates procedures relating to claims adjustments and recoupments. Due to the nature of agreements between network providers and contractors, pharmacy recoupment procedures may be modified or adapted to conform to network agreements subject to approval by the TRICARE Management Activity (TMA). The **requirements** of this chapter shall apply if recoupment under the pharmacy network agreements is not successful within 60 calendar days from the date collection is initiated.

1.2 The method to be used in recouping funds depends on whether financially underwritten funds or non-financially underwritten funds are being recouped. (See [Section 3](#) for procedures for recovery of financially underwritten funds and [Section 4](#) for procedures for recovery of non-financially underwritten funds.) All recoveries made under third party liability (subrogation) statutes, whether financially underwritten or non-financially underwritten funds, shall be collected following procedures in [Section 5](#). See [Chapter 24](#) and TRICARE Policy Manual (TPM), [Chapter 12](#), for information on recoupment procedures for TRICARE Europe (TE) providers. **References** herein to provider or providers also applies to pharmacy or pharmacies.

2.0 THE FEDERAL CLAIMS COLLECTION ACT (FCCA) (31 UNITED STATES CODE (USC) 3701 ET SEQ.)

The Federal Claims Collection Act (FCCA) (31 USC 3701 et seq.) provides authority for the collection of non-financially underwritten 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 (DOJ) 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, TMA is required to make necessary claims adjustments and initiate recoupment actions for erroneous payments, when Government funds are involved.

3.0 THE FEDERAL MEDICAL CARE RECOVERY ACT (FMCRA) (42 USC 2651-2653)

The Federal Medical Care Recovery Act (FMCRA) (42 USC 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.

4.0 APPLICATION

The procedures which follow are for guidance and compliance by the contractor in 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 shall be applied.

5.0 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 TRICARE Encounter Data (TED) records. When a claim is adjusted, the contractor shall query Defense Enrollment Eligibility Reporting System (DEERS) Catastrophic Cap and Deductible Data (CCDD) and apply deductible and cap updates. Do not review any intervening claims processed between the initial claim and the adjustment for the purpose of adjusting deductible or cap amounts. The TRICARE Systems Manual (TSM), [Chapter 2](#), provides instructions for submission of claim adjustment transactions to the TMA. The contractor will normally use the original Internal Control Number (ICN) to make any adjustments to a processed claim, but there are exceptions.

6.0 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 profiles maintained by the contractor, use the prior or earlier year's profile. Refer to TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1](#) for calculation of payment amounts based on the appropriate profiles and the date of service on the claim.

6.1 Timely Filing One Year From Date Of Service/Discharge/Prescription Fill Rule

Adjustments which have the effect of a new obligation of Government funds shall be processed in accordance with the one year from date of service/date of discharge/prescription fill rule (refer to [Chapter 8, Section 3](#)). An example would be a supplemental (late) billing from a hospital. Beneficiary requested adjustments for pharmacy claims must be received by the contractor No Later Than (NLT) one year from the date of the prescription fill.

6.2 Ninety (90) Day Rule

A request for a reconsideration must be received by the contractor within 90 calendar days from the issue date of the Explanation Of Benefits (EOB). 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 35 days for failure to provide requested information.

6.3 Time Limitations For Other Adjustments

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.

7.0 VOLUNTARILY RETURNED OR REFUNDED PAYMENTS

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

7.1 Reasons For Voluntary Refunds

- Payment unwanted
- Amount of payment questioned
- Overpayment
- Incorrect payee

7.2 Disposition Of Voluntary Refunds

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:

- Research the accuracy of the payment and payee.
- Handle underpayment situations in accordance with [Section 2](#).
- Handle overpayment recoveries in accordance with [Sections 2](#) and [4](#).
- In the event of unwanted payments, the contractor shall 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 [Chapter 13](#), for assignment violations.)
- Pharmacy refunds will be deposited into applicable bank accounts and credit TEDs will be submitted.

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