IV. Payment Reduction

A. Reduction of Provider Payment

The contractor shall reduce provider payment for the provider's failure to obtain a preauthorization for certain types of care in accordance with the Policy Manual, Chapter 13, Section 24.1.

B. Determination of Reduction Amount

The contractor shall convert the number of days/services subject to the payment reduction to the appropriate dollar amount and deduct such amount from the provider's payment as illustrated in the examples in Section IV.G., below.

C. EOB

The contractor shall identify the days/services for which the provider's payment was reduced and the payment reduction amount on the EOB *using an appropriate* message,

D. HCSR Reporting

The contractor shall keep the information regarding payment reduction calculations in their own internal file(s) for claims processing and audit functions. The contractor shall report on the HCSR the total amount of payment reduction and the total days/services as required in the ADP Manual, Chapters 2, 5, and 6.

E. *Reserved*

F. Publication Requirement

The contractor shall widely publicize the preauthorization requirements and procedures (including the payment reduction waiver procedures in accordance with the Policy Manual, Chapter 13, Section 24.1) in their periodic bulletins and publications to providers and beneficiaries.

G. Calculation of Payment Reduction

The reduction is calculated based on the otherwise allowable amount consistent with the Policy Manual, Chapter 13, Section 24.1, before the application of deductible, beneficiary cost-share, and OHI. Following are examples of payment reduction:

1. EXAMPLE 1: Claims Paid Under DRG Payment Methodology.

Step 1: Determine full DRG allowance, total length of stay, and the number of days without preauthorization.

Billed Amount:	$21,500.00	
DRG Allowance:	$8,500.00	
Total length of stay:		*ten (10)* days
Days without preauthorization:		*two (2)* days

Step 2: Divide the days without preauthorization by the total length of stay.

Days without preauthorization, *two (2)* days= 0.2
Total length of stay, *ten (10)* days

Step 3: Multiply the DRG allowance from Step 1 by the amount resulting from Step 2, to calculate the amount for payment reduction.

$8,500.00	
x.20	
$1,700.00	- Target amount for calculation of reduction
x.10	- Multiply by *ten percent (10%)* for calculation of *ten percent (10%)* reduction
$170.00	- Amount of payment reduction

Step 4: Calculate the total government payment.

Total government payment to the facility will be DRG allowance minus beneficiary cost-share (e.g., for a retiree with FY96 per diem, cost-share in this example is $330 x *ten (10)* days = $3,300) less the amount of payment reduction as illustrated below:

DRG Allowance:	$8,500.00
Minus beneficiary cost-share for a retiree:	-3,300.00
	$5,200.00
Less the amount of payment reduction:	- 170.00
Total government payment (in the absence of OHI):	$5,030.00

2. EXAMPLE #2: Claims Paid Under Mental Health Per Diem Payment Methodology

(Includes RTCs, Mental Health Per Diem Hospitals, and Partial Hospitalization Programs)

Step 1: Determine full per diem payment and the number of days subject to payment reduction.

Billed Amount:	$12,500.00
Daily per diem:	$400.00
Number of authorized days:	*twenty-five (25)* days
Allowable amount (per diem methodology):	$10,000.00
Days without preauthorization subject to payment reduction:	*nine (9)* days

Step 2: Multiply the daily per diem by the number of days without preauthorization and calculate the amount for payment reduction.

$400.00	
x 9	
$3,600.00	This is the target amount for calculation of reduction.
x.10	Multiply by *ten percent (10%)* for calculation of *ten percent (10%)* reduction.
$360.00	Amount of payment reduction.

Step 3: Calculate the total government payment.

Total government payment to the facility will be the allowable amount minus beneficiary cost-share (e.g., for a retiree's *family member* for high volume hospital, partial program, or RTC care, cost-share in this example is *twenty-five percent (25%)* of the allowable amount) less the amount of payment reduction as illustrated below:

Allowable amount (per diem methodology):	$10,000.00
Minus beneficiary cost-share (.25x$10,000):	-2,500.00
	$7,500.00
Less the amount of payment reduction:	- 360.00
Total government payment (in the absence of OHI):	$7,140.00

3. EXAMPLE #3: Claims Paid On Per-Service Basis

Following is an example of an active duty *family member* claim for 3 visits for outpatient adjunctive dental care with the first visit without preauthorization. The payment reduction shall be applied to the first visit only (i.e., the visit without the preauthorization).

Step 1: Determine the allowable charge for the visit/service that was provided without obtaining the preauthorization.

Billed Charge:	$75.00
Allowable Charge (CMAC):	$60.00

Step 2: Calculate the amount of payment reduction.

$60.00	Target amount for calculation of reduction.
x.10	Multiply by *ten percent (10%)* for calculation of *ten percent (10%)* reduction.
$6.00	Amount of payment reduction.

Step 3: Calculate the government payment for the visit/service that was provided without obtaining preauthorization.

The government payment to the provider will be the allowable charge minus beneficiary cost-share (e.g., for an active duty *family member*, the outpatient cost-share in this example is *twenty percent (20%)* of the allowable charge) less the amount of payment reduction as illustrated below:

Allowable charge (CMAC):	$60.00
Minus beneficiary cost-share (.20 x $60):	-12.00
	$48.00
Less the amount of payment reduction:	- 6.00
Government payment for the visit/service (in the absence of OHI):	$42.00

In this example, payment reduction shall not apply to the second and third visits as preauthorization was obtained for those visits. Normal rules will apply for calculation of the government payment for the second and third visits.

V. REIMBURSEMENT ADMINISTRATION

The instructions contained in this chapter are to be followed in reimbursing all TRICARE claims provided by *non-network* providers. In those cases in which a contractor is uncertain how to apply a procedure or where a contractor encounters a situation which is not covered in this chapter, the contractor should request guidance from the Contracting Officer or Contracting Officer's Representative.

Addendum A Figures

Figure 2-4-A-1 Suggested Wording to the Beneficiary Concerning Rental vs. Purchase of DME

"We have determined under the Regulation that the total *TRICARE* benefit allowable, subject to usual deductible and cost-sharing requirements, is $_____. This amount is equal to (the allowable purchase price of the equipment) (____ months of estimated medically necessary rental, at $_____ allowable rental per month).

"You may obtain this equipment under any arrangement you wish. However, it would be advantageous for you to obtain the equipment by (rental) (purchase or lease/purchase). Any expenses you incur in excess of the *TRICARE*-allowable amount will be your own responsibility.

"If you are not satisfied with the action taken on your case, you have the right to a review. Your written request for a review must state the specific matter with which you do not agree and must be received in this office within *ninety (90)* days of this notice.

"Accordingly, *TRICARE* payments for this equipment will end with whichever of the following occurs **first**:

1. When $_____ has been reimbursed, subject to usual deductible and cost-share amounts.

2. When you no longer require the equipment medically.

3. When your *TRICARE* eligibility ends."

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.

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

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.