CHAPTER 13
SECTION 16.1

WAIVER OF LIABILITY

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I. ISSUE

Payment and liability for services or supplies retrospectively excluded by a Peer Review Organization (PRO) by reason of being not medically necessary, at an inappropriate level, custodial care, or other reason relative to reasonableness, necessity or appropriateness.

II. POLICY

A. General Applicability

1. Summary. Subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows: If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the TRICARE Basic Program by reason of being not medically necessary, not provided at an appropriate level, custodial care, or other reason relative to reasonableness, necessity or appropriateness (hereafter, all such services will be referred to as not medically necessary), then the beneficiary will not be held liable for such services and, under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did not apply.

NOTE: *The word service(s), as used in this Section, will be understood to include services and supplies.*

2. Peer Review Organizations. PROs make waiver of liability determinations. For purposes of this section, PROs include the Managed Care Support (MCS) contractors and the National Quality Monitoring Contractor (NQMC).

3. Non-network Providers. Waiver of liability applies only to services rendered by non-network providers.

4. Retrospective Determinations. Waiver of liability applies only to retrospective determinations that services are not medically necessary.

a. A determination is retrospective if the Notice of Denial is received after the excludable services were provided.

EXAMPLE: Provider requests preauthorization for certain services, but the Notice of Denial is received after the services are provided. The determination that the services are not medically necessary is retrospective because the services were rendered before the Notice of Denial was received.

EXAMPLE: Provider requests a concurrent review of ongoing inpatient care which had been authorized prior to the beneficiary's admission. If the PRO determines that continued care is not medically necessary, such determination is retrospective as to inpatient services rendered prior to the date the Notice of Denial was received.

b. A retrospective determination that services are not medically necessary includes denials of cost-sharing for related services provided during the same episode of care. Episode of care includes not only the services excluded as not medically necessary, but includes other services related to the excluded services.

5. Applicability to all TRICARE beneficiaries. Waiver of liability applies to retrospective determinations that services are not medically necessary (with the exception of services provided by network providers) regardless of whether the beneficiary is a Prime enrollee, Extra, or Standard beneficiary.

EXAMPLE: A TRICARE Prime enrollee obtains services under the point-of-service option. Cost-sharing is denied because a retrospective review determines that the services were not medically necessary. Waiver of liability applies to this retrospective denial. If it is determined that neither the beneficiary nor the provider knew, or could not reasonably be expected to know, that the services were not medically necessary, then cost-sharing will be provided in accordance with the applicable point-of-service deductibles and reimbursement rate. (Chapter 12, Section 10.1).

B. Waiver of Liability Not Applicable

1. Factual Determinations. Waiver of liability does not apply to denials based on factual determinations, which include coverage limitations under 32 CFR 199.4, the TRICARE/CHAMPUS Policy Manual, or TRICARE/CHAMPUS guidelines and other factual determinations as described in the OPM Part Three, Chapter 7, Section V. The following are examples of denials based on factual determinations:

EXAMPLE: Payment is denied for treatment for dyslexia because such services are specifically excluded under 32 CFR 199.4(g)(32).

EXAMPLE: Payment is denied for surgical extraction of hematomas after removal of the beneficiary's breast prostheses. The surgical implantation of the prostheses was a noncovered incident of treatment (augmentation mammoplasty). This denial is based upon a determination that the hematomas do not constitute separate medical conditions as required by 32 CFR 199.4(e)(9). Therefore,

treatment of the hematomas is excluded from the Basic Program. Although medical judgment may be required to determine if extraction of the hematomas represents a separate medical condition, this denial is based on a coverage limitation. The denied procedure is excluded from the Basic Program regardless of whether it was medically necessary.

EXAMPLE: Payment is denied because the provider did not comply with medical records requirements as set forth in 32 CFR 199.2 and 32 CFR 199.7. This denial is not based on a determination that the services are not medically necessary, but is based on the factual determination that the provider did not document services in accordance the TRICARE/CHAMPUS regulatory requirements.

2. Network Providers. Waiver of liability does not apply to services provided by network providers. However, "Hold Harmless" provisions in managed care contracts may apply and, under most circumstances, a network provider may not bill a beneficiary for services which are not TRICARE benefits.

3. Preauthorizations and Concurrent Reviews. Waiver of liability does not apply to denials of cost-sharing for services which have not yet been given.

C. Notice of Denial

1. Definitions

a. Notice of Denial. A Notice of Denial is an oral or written communication which specifies what services are being denied and for what reason (e.g., "not medically necessary," "inappropriate level of care," "custodial care"). The Notice of Denial must communicate sufficient information to explain the basis of the denial of cost-sharing. A Notice of Denial includes the following examples: 1) a letter from the provider which informs the beneficiary that the PRO has determined certain services are excludable as not medically necessary; 2) a telephone call from the PRO which informs the provider that certain services are excludable as not medically necessary; 3) an Initial Denial Determination, as defined below.

EXAMPLE: The PRO excludes services because they are not medically necessary, but the notice to the beneficiary and provider indicates the services are being excluded because of "insufficient information received." This is not a Notice of Denial because it does not communicate sufficient information to explain the basis of the denial. For purposes of determining waiver of liability, this language does not give adequate notice that the services are excludable as not medically necessary. Other examples of insufficient language include, but are not limited to, "noncovered services" and "documentation of services rendered did not meet TRICARE/CHAMPUS criteria."

b. Initial Denial Determination. An Initial Denial Determination is a written Notice of Denial generated by the PRO (including, but not limited to, Explanation of Benefits

forms and facsimile transmissions). An oral Notice of Denial given by the PRO must be followed by an Initial Denial Determination which specifies the date on which the beneficiary or provider received the oral Notice of Denial.

2. Waiver of liability statement. The Initial Denial Determination must include a statement which explains the principle of waiver of liability, if applicable, and how the principle applies to the beneficiary and the provider. (A guide for applying waiver of liability in Initial Denial Determinations is attached as Addendum 1).

EXAMPLE: If the PRO determines that the provider could reasonably be expected to know that certain services were not medically necessary, then the Initial Denial Determination must contain a statement similar to the following: "The provider could reasonably be expected to know that the excluded services were not medically necessary, because such services are not considered to be medically necessary in accordance with the acceptable standards of practice in the local medical community and the provider's knowledge of such standards."

3. Receipt of Notice of Denial. Unless there is evidence to the contrary, the date the beneficiary and provider received the Notice of Denial will be considered to be five calendar days after the date on the Initial Denial Determination. (Exception: The date of receipt of facsimile transmission will be considered to be the date on the facsimile confirmation). Evidence to the contrary includes, but is not limited to the following circumstances:

a. The beneficiary or provider makes an oral inquiry or requests a reconsideration before the fifth day after the date on the Initial Denial Determination. Under these circumstances, there is a rebuttable presumption that the date of the beneficiary's or provider's receipt of the Notice of Denial was the date of the oral inquiry or request for reconsideration.

b. A progress note in the beneficiary's record documents that the Notice of Denial was conveyed orally to the beneficiary before the fifth day after the date on the Initial Denial Determination. There is a rebuttable presumption that the beneficiary received the Notice of Denial on the date of the progress note.

c. The beneficiary or provider submits a photocopy of the envelope in which the Initial Denial Determination was mailed. The postmark date on the envelope is two days after the date on the Initial Denial Determination. There is a rebuttable presumption that the date of the beneficiary or provider's receipt of the Notice of Denial was five days after the postmark date on the envelope containing the Initial Denial Determination.

d. The Initial Denial Determination is mailed to an adult beneficiary's home while the beneficiary is an inpatient. The beneficiary will be presumed to have received the Initial Denial Determination unless the beneficiary demonstrates that he or she did not receive it. For example, the beneficiary may demonstrate that he or she did not receive the Initial Denial Determination if the beneficiary submits evidence that there was no one at the beneficiary's home to receive and deliver the Initial Denial Determination to the beneficiary. However, in most cases, the beneficiary will be found to have received the Initial Denial Determination if there is substantial evidence that a representative of the inpatient facility

hand delivered the facility's copy of the Initial Denial Determination to the beneficiary. If the beneficiary receiving inpatient care is a minor and the Initial Denial Determination was mailed to the home of the beneficiary's parent, the beneficiary is considered to have received the Notice of Denial on the same day as the parent.

e. The beneficiary signed a statement (drafted by the provider) before the fifth day after the date on the Initial Denial Determination in which the beneficiary agreed to personally pay for specifically identified services that TRICARE/CHAMPUS does not cover. Under these circumstances, the signed statement is evidence the beneficiary knew that the specified services were excludable before the fifth day after the date on the Initial Denial Determination. General agreements to pay, such as those signed by the beneficiary at the time of the admission, are not evidence that the beneficiary knew specific services were excludable.

D. Beneficiary's Knowledge That Services Were Excludable

1. Definition of beneficiary. For purposes of determining beneficiary knowledge, the term beneficiary includes the beneficiary or representative of the beneficiary, including the parent of a beneficiary under 18 years of age, the beneficiary's attorney, legal guardian or representative specifically designated by the beneficiary to act on his or her behalf regarding the services at issue. An individual who is subject to the conflict of interest provisions of 32 CFR 199.10(a)(2)(ii)(B), may not act as the beneficiary's representative under this section.

2. Effect of beneficiary's knowledge. In most cases, the beneficiary's liability begins on the date the beneficiary is found to have known that the services were excludable based on the PRO's retrospective determination that such services were not medically necessary. An exception is when the beneficiary is receiving ongoing inpatient services. In this case, the beneficiary's liability for excluded services will begin on the day after the date the beneficiary is found to have known services were excludable.

3. "Determining Beneficiary's knowledge. It is presumed that the beneficiary did not know, or could not have been reasonably expected to know, that the services were excludable. However, a beneficiary will be found to know that the services were excludable: (1) following receipt by the beneficiary, or someone acting in behalf of the beneficiary (see paragraph II.D.1., above) of *written notice* that the services were excludable, or (2) that comparable services provided on a previous occasion were excluded and that notice was given by TMA, a PRO or other TRICARE contractor, a group or committee responsible for utilization review for the provider, or the provider who provided the services. Although the regulation provides that a beneficiary will be considered to know, *based on actual written notice*, that the services were excludable, if it is otherwise documented that the beneficiary in fact did know prior to receiving the services, the administrative presumption favorable to the beneficiary referred to in the first sentence of this paragraph, is rebutted. For example, if the beneficiary admits, and such admission is documented, that he or she had prior knowledge that payment for a service would be denied, no further evidence is required and the presumption of lack of knowledge is rebutted."

E. Provider's Knowledge That Services Were Excludable

1. Effect of provider's knowledge. In most cases, cost-sharing will be denied beginning on the date the provider knew, or could reasonably be expected to know, that

services were excludable. An exception is when the provider is rendering ongoing inpatient care to a beneficiary. In that case, cost-sharing will be denied beginning the day following the date on which the provider knew, or could be reasonably expected to know, services were excludable.

2. "Determining provider's knowledge. At the initial determination, in the absence of evidence in the file to the contrary, it may be presumed by the PRO that the provider knew, or could reasonably have been expected to know, that the services were excludable. However, should a denial of services be appealed to a reconsideration, the reconsideration determination must state which of the following criteria, demonstrating provider knowledge, exist."

a. The provider received the Notice of Denial or the provider was informed by the PRO that similar or comparable services were excludable as not medically necessary.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician informed the provider that services were excludable. The name of the entity or individual who informed the provider and the date on which the provider was informed will be referenced in the reconsideration determination.

c. The provider previously informed the beneficiary that services were excludable. The date on which the provider informed the beneficiary will be referenced in the reconsideration determination.

d. The provider can reasonably be expected to know that services are excludable as not medically necessary based on any of the following circumstances:

(1) Provider received TRICARE/CHAMPUS notices (including Policy Manual issuances, bulletins or other guidelines or directives from the MCS contractor, Lead Agent or TRICARE Management Activity (TMA)). It is presumed the provider received these notices five days after such notices, addressed to the provider, were placed in the U.S. mail. The title of the notice and the date the notice was provided must be referenced in the reconsideration determination.

(2) Provider's knowledge of what are considered acceptable standards of practice by the local medical community. The reconsideration determination must specify what standards of practice were not met and how these standards were not met by the provider. There is a presumption that the generally accepted norms for medical practice in the United States are the same as local standards of practice. The provider may rebut this presumption by presenting substantial evidence that the standards of practice considered acceptable by the local medical community differ from the generally accepted norms for medical practice in the United States. If the provider rebuts the presumption, the burden will be on the provider to establish and define the local standards of practice; and the burden will be on the provider to prove the excludable services were consonant with these local standards.

(3) Provider's receipt of an Initial Denial Determination, which notifies the provider that certain services are excludable as not medically necessary, is also notice to other providers (who rendered services during the same episode of care) that their services are also excludable.

(4) Preadmission authorization was required, but not obtained or concurrent review requirements were not followed. An exception is when the provider did not request preadmission authorization or concurrent review because the beneficiary failed to inform the provider of his or her status as a TRICARE/CHAMPUS beneficiary. The provider will be required to submit evidence that the beneficiary failed to disclose his or her status as a TRICARE/CHAMPUS beneficiary.

NOTE: *A provider will be found to have known services were excludable as not medically necessary under the following circumstances: The PRO granted preauthorization based on the provider's omission of information necessary to a medical necessity determination or the provider's submission of inaccurate or misleading information. If the PRO later determines, based on accurate and/or more complete information received later by the PRO, that the preauthorized services were not medically necessary, then it will be found that the provider should have known that the services were excludable as not medically necessary.*

F. Effect of Knowledge Determination on Liability and Cost-Sharing

1. Beneficiary and provider did not know services were excludable. Services retrospectively determined to be excludable as not medically necessary shall not be excluded if neither the beneficiary nor the provider knew, nor could reasonably be expected to know, that the provided services were subject to exclusion. Payment will be made for such services as if the exclusion did not apply. The beneficiary is responsible for appropriate deductible and cost-share amounts.

NOTE: *Certain providers are required to enter into Participation Agreements with TMA whereby the providers agree to accept the TRICARE/CHAMPUS all-inclusive per diem rate, TRICARE/CHAMPUS-determined rate, or the TRICARE/CHAMPUS-determined allowable charge as payment in full for services provided to beneficiaries. Cost-sharing will not be provided even when these providers did not know, nor could reasonably be expected to know, that the denied services were excludable as not medically necessary. The institutional providers who are required to enter into such agreements are Residential Treatment Centers, Psychiatric Partial Hospitalization Programs, and Substance Use Disorder Rehabilitation Facilities. However, waiver of liability still applies to the beneficiary. Therefore, these institutional providers may not bill the beneficiary for excludable services if the beneficiary's liability is waived. (Conversely, if the beneficiary's liability is not waived, the beneficiary may be billed). The individual providers who are required to enter into such agreements are Certified Marriage and Family Therapists. Certified Marriage and Family Therapists must agree to hold the beneficiary harmless and therefore can not bill the beneficiary for "noncovered care," regardless of whether the beneficiary's liability is waived.*

2. Beneficiary did not know services were excludable - Provider knew services were excludable. If the beneficiary did not know, nor could reasonably be expected to know, that services were excludable as not medically necessary, but the provider did know, or could have been reasonably expected to know, that the services were excludable as not medically necessary, then payment shall not be made for such services and the beneficiary will not be held liable for the excludable services.

a. Indemnification. The beneficiary will be entitled to a full refund of any amount paid to the provider by the beneficiary for the excluded services, including any deductible and cost-share amounts. In order to obtain a refund, the beneficiary is not required to ask the provider to return the payments the beneficiary has made for excluded

services. Instead, the beneficiary will be indemnified for any payments made by the beneficiary or other party (excluding an insurer or provider) to the provider for the excluded services. The beneficiary, or other party making payment on behalf of the beneficiary, must request indemnification in writing from the MCS contractor by the end of the sixth month following the month in which payment was made to the provider or by the end of the sixth month following the month in which the PRO or TMA advised the beneficiary that he or she was not liable for the excludable services. The time limit may be extended where good cause is shown. Good cause is defined as:

(1) Administrative error (such as, misrepresentation or mistake) of an officer or employee of TMA or a PRO, if performing functions under TRICARE/CHAMPUS and acting within the scope of that officer or employee's authority.

(2) Mental incompetence of the beneficiary or, in the case of a minor child, mental incompetence of his or her guardian, parent or sponsor.

(3) Adjudication delays by other health insurance (when not attributable to the beneficiary), if such adjudication is required under 32 CFR 199.8 (Double Coverage).

3. Beneficiary and provider knew services were excludable. If both the beneficiary and the provider knew, or could reasonably be expected to know, that services were excludable as not medically necessary, then payment will not be made for such services and the beneficiary will be responsible for payment for the excluded services.

4. Beneficiary knew services were excludable - Provider did not know services were excludable. If the beneficiary knew, but the provider did not know, nor could reasonably be expected to know, that services were excludable as not medically necessary, cost-sharing will not be allowed under the criteria set forth in 32 CFR 199.4(h), which allows cost-sharing for otherwise excludable services. The beneficiary will be responsible for payment for the excluded services.

EXAMPLE: A beneficiary sought preauthorization for care from the PRO, which was denied because it was deemed not medically necessary. The beneficiary then went to a non-network provider and did not inform the provider of the previous denial of preauthorization (or prior denials of authorization for similar or comparable services). The beneficiary received the same or similar/comparable services for which preauthorization was denied. Under these circumstances, cost-sharing will not be provided and the provider may seek payment from the beneficiary or other insurance, as applicable.

5. Provider did not know services were excludable because provider did not know beneficiary was a TRICARE/CHAMPUS beneficiary. If the beneficiary did not tell the provider that he or she was a TRICARE/CHAMPUS beneficiary, then waiver of liability will not apply. It would not be equitable to allow the beneficiary to claim the protection waiver of liability provisions if the beneficiary did not inform the provider of his or her status as a TRICARE/CHAMPUS beneficiary. Cost-sharing will not be provided for services determined by the PRO to be not medically necessary and the provider may seek payment from the beneficiary or other insurance, as applicable.

G. Appeals of Medical Necessity and Waiver of Liability Determinations. A guide for applying waiver of liability in MCS contractor reconsideration determinations is attached as Addendum 2. A guide for applying waiver of liability in NQMC reconsideration determinations is attached as Addendum 3.

1. Beneficiary. A beneficiary may appeal both a determination that services were excludable as not medically necessary and a waiver of liability determination that the beneficiary knew, or could reasonably be expected to know, that the services were excludable as not medically necessary. The beneficiary may request an appeal regardless of whether these determinations are made in an Initial Denial Determination, a reconsideration determination, or a formal review decision issued by TMA.

2. Provider.

a. A provider may appeal both a determination that services were excludable as not medically necessary and a waiver of liability determination that the provider knew, or could reasonably be expected to know, that services were excludable as not medically necessary, if these determinations are made in an Initial Denial Determination or reconsideration determinations issued by the MCS contractor.

b. A provider may appeal a reconsideration determination issued by the NQMC only on the issue of whether the provider knew, or could have been reasonably expected to know, that services were excludable as not medically necessary. (32 CFR 199.15(i)). The provider may not appeal an NQMC determination that services were excludable as not medically necessary.

3. Appeal Rights. An Initial Denial Determination and a reconsideration determination must instruct the beneficiary and the provider as to what issues each may appeal and will contain the address to which a request for appeal is to be mailed as applicable.

III. EFFECTIVE DATE

Implementation of the TRICARE PRO waiver of liability for denial determinations is effective for hospital admissions that occur on or after April 8, 1989, and outpatient service on or after December 6, 1993. Implementation of waiver of liability provisions for denial determinations for inpatient mental health care is effective for admissions that occur on or after November 18, 1991. Implementation of waiver of liability provisions for denial determinations for partial hospitalization care is effective for admissions that occur on or after September 29, 1993.

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