OVERPAYMENTS RECOVERY - FINANCIALLY UNDERWRITTEN FUNDS

All provisions of this section pertain to funds for which the contractor is financially underwritten. For recovery of overpayments involving funds for which the contractor is not financially underwritten, see Chapter 11, Section 4.

1.0. CAUSES OF OVERPAYMENTS

An overpayment adjustment and a requirement for recoupment action may be a result of: (This list is not intended to be all inclusive.)

- An erroneous calculation of the allowable amount
- An erroneous coding of a procedure
- An erroneous calculation of the cost-share or deductible
- Making a duplicate payment
- Issuing payment to an incorrect payee
- Failure to obtain data on all or part of the payment by other insurance
- An erroneous billing
- Paying for services or supplies to a patient not eligible
- Making payment for care by an unauthorized provider
- Making payment for a noncovered service or supply
- Paying for a service not actually received
- Payment having been made on services not medically necessary

2.0. DETERMINATION OF LIABILITY FOR OVERPAYMENT

The general rule for determining liability for overpayments is that the person who received the erroneous payment is responsible for the refund. This provision may be modified by applicable state laws. Should the contractor choose to not pursue overpayment recoupments, it shall not include, as part of its experience under the contract, any services related to an uncollected overpayment which it has not made a reasonable effort to recover. In the case of care delivered by a contractor owned or operated in-system provider to a person not eligible for care under TRICARE, the provider shall be responsible for collection and that expense shall not be attributed to TRICARE contract experience.

3.0. PROVIDER OVERPAYMENTS

3.1. Overpayment refunds shall be sought from the provider who received the incorrect payment in the following situations:

3.2. The overpayment resulted because the beneficiary had paid the provider more than the deductible, copayment, or other cost-sharing amounts and this was not indicated on the claim.

3.3. The payment was based on an amount in excess of that allowable.

3.4. The provider received and retained duplicate TRICARE payments.

3.5. The overpayment was due to a mathematical or clerical error; e.g., an error in calculation of overlapping or duplicate bills. This does not include a failure to properly assess the deductible. Where a provider has been incorrectly paid a deductible, recovery shall be sought from the beneficiary.

3.6. The overpayment was for noncovered services or supplies.

3.7. The services or supplies were not received by the beneficiary, or there is no documentation to substantiate that the provider performed the services claimed. (See Chapter 14, if fraud is suspected.)

3.8. The services or supplies were furnished by a provider not authorized under TRICARE.

3.9. The beneficiary and the provider were paid for the same services, resulting in a duplicate payment, and the beneficiary turned his or her payment over to the provider.

3.10. The TRICARE payment was made to the participating provider and a primary health insurance plan also made a benefit payment to the provider or beneficiary for the same services or supplies, and the combined payments exceed the billed charges.

3.11. The payment was made to the wrong provider or to a nonparticipating provider. In such cases, the contractor shall issue payment to the correct payee and initiate recoupment action against the erroneously paid provider concurrently. The contractor shall **not** postpone issuing payment to the correct payee pending completion of the recoupment. If only in-system providers are involved, follow the agreement and/or administrative procedures for this situation.

4.0. BENEFICIARY LIABLE

Recoupment should be sought from the beneficiary in the following situations:

4.1. The overpayment was caused by incorrect application of the deductible, copayment, or other cost-share.

4.2. The patient was not an eligible beneficiary at the time services were provided and the payment was made to a participating provider for whom a good faith payment has been authorized by TRICARE Management Activity (TMA). (See paragraph 6.0., below.)

4.3. A provider who received a duplicate TRICARE payment certifies the payment was refunded to the beneficiary.

4.4. The TRICARE payment was made to the beneficiary and his or her primary health insurance plan made a benefit payment for the same services or supplies.

4.5. The TRICARE payment was made to the beneficiary instead of the non-network participating provider. The contractor shall immediately issue payment to the non-network participating provider and concurrently take recoupment action against the beneficiary.

4.6. Any other instance in which the erroneous payment was made directly to the beneficiary, except paragraph 3.9.

5.0. OVERPAID PARTY IS DECEASED

If the contractor determines that liability for an overpayment rests with a beneficiary or provider who is deceased, the contractor shall seek recoupment of the overpayment from the estate of the deceased person under state laws. The procedures described in this section shall be followed.

6.0. GOOD FAITH PAYMENT

6.1. With prior approval from TMA, a contractor may make a good faith payment to a participating provider, or allow a previous payment to stand, for care provided to a patient, but only in the following situations.

- An ineligible patient holds an ID card showing TRICARE eligibility and the provider exercised reasonable care in accepting the apparently valid ID card as evidence of eligibility;

- An ineligible patient sees a Resource Sharing provider and there is evidence from DEERS indicating the patient had been shown as eligible at the time of service; or

- An ineligible beneficiary enrolls in Prime, claims are filed and denied as TRICARE ineligible, and the contractor can document via evidence from DEERS that the individual had in fact been shown on DEERS as eligible on the date of Prime enrollment and for the period covering the dates of medical care.

- A claim was filed and denied as TRICARE ineligible because the patient was Medical eligible, under age 65 who was not eligible for Part B. (Refer to the paragraph below for processing these claims.)

6.2. Whether the claim is initially paid or denied, the provider is expected to make reasonable efforts to collect payment from the ineligible patient prior to requesting approval of a good faith payment unless the beneficiary was Medicare eligible, under age 65 who did not have Medicare Part B. Documentation of the unsuccessful effort is to be submitted to TMA with the request. Immediately prior to submitting a request for approval of a good faith payment, the contractor shall recheck the current DEERS records to confirm that the person is not eligible and include the documentation of the results. The contractor is not financially responsible for making good faith payments. The contractor's costs will be separately reimbursed by the government.

6.3. If the contractor made payment to the participating provider, the contractor shall advise the participating provider and the patient of the patient's ineligibility and then follow

recoupment procedures. If, during the recoupment process, the participating provider alleges that he or she relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to TMA for consideration of a good faith payment and advise the participating provider of the action taken. The file shall include documentation of all contact with the participating provider and patient.

6.4. If the contractor has not made payment to the participating provider, the contractor shall deny the claim based upon ineligibility of the patient. If the participating provider alleges that he/she/it relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to TMA and advise the participating provider of the action taken. The file shall include documentation of all contacts with the participating provider and patient.

6.5. If the claim was denied because the beneficiary was Medicare eligible under age 65, and did not have Medicare Part B, the contractor shall refer the case to the Beneficiary and Provider Services Directorate (BPS), TMA, Aurora, Colorado, Attn: Good Faith Payment Considerations. The contractor shall notify the beneficiary of the referral. Case files shall include the following: Patient information (name, address, telephone number), Sponsor information (name, SSN), Claim Information/Claim copies (including dates of service, claim numbers, provider name, address and phone number; EOBs for paid and denied claims).

6.6. If BPS determines that a good faith payment is appropriate, they will notify the beneficiary that good faith payments have been authorized up to a specific date (normally 5 calendar days from the date of the notice) and inform the beneficiary that he or she must enroll in Part B during the next Medicare open enrollment period (January-March) if they wish to remain eligible for TRICARE. BPS will also advise the patient that they may request equitable relief from Medicare for penalty amounts from the date stated in the letter. The contractor shall not initiate recoupment from the beneficiary unless BPS advises them to do so.

6.7. A provider who erroneously furnishes services and/or supplies to an ineligible beneficiary as a result of careless identification procedures is not entitled to a good faith payment. DMDC is responsible for providing beneficiaries with accurate and appropriate means of identification.

7.0. OVERPAYMENTS RESULTING FROM ALLEGED MISINFORMATION

An allegation by a patient or provider that information obtained from a health benefits advisor, contractor, or other party caused the overpayment does not alter the liability for the overpayment, or is it grounds for termination of recoupment activity.

8.0. DENIAL OF BENEFITS PREVIOUSLY PROVIDED

In those instances in which clarification, interpretation or a change in the TRICARE Regulation would result in denial of services or supplies previously covered, no action should be taken to recover payments expended for those benefits paid prior to the date of such clarification or change, unless specifically directed by TMA.

9.0. DOUBLE COVERAGE SITUATIONS - PRIMARY HEALTH INSURANCE PLAN LIABLE

A "Primary Plan," under TRICARE Law and Regulation is any other health insurance coverage the patient has, except Medicaid (Title XIX) or a supplement plan which is specifically designed to pay only TRICARE deductibles, coinsurance and other cost-shares. (See the TRICARE Reimbursement Manual, Chapter 4.) The liability for refunding overpayments in all double coverage situations shall rest with the primary health insurance plan. When that plan has not already made its benefit payment to the beneficiary or provider, the contractor shall attempt recoupment directly from the primary plan in such cases. If the other plan has made payment, then the TRICARE payment shall normally be recouped from the party to whom the TRICARE payment was made.

10.0. THIRD PARTY RECOVERIES

When potential recovery from or actual payment by a liable third party is discovered, the contractor shall take recoupment action under the provisions of Chapter 11, Section 5.

11.0. RECOUPMENT OF OVERPAYMENTS

For the purpose of determining the amount of the overpayment in a particular case, the contractor should include all claims overpaid for the same reason/case/episode of care. It is normally not economically feasible to pursue low dollar overpayments, e.g. under $50. The contractor should apply its corporate policy in determining the level at which to waive recoupment. However, if the overpayment is attributable to failure to properly assess the deductible, it should be recouped, even if less than established threshold.

12.0. OVERPAYMENTS RECOVERY

The contractor should take recovery actions in accordance with applicable laws of the states in the jurisdiction. The procedures for recovery shall be documented and subject to review and approval by TMA. The recovery actions shall include issuing a letter to the participating provider requesting payment and establishing a system for offsetting from subsequent claims. At the same time, the beneficiary shall be notified, in writing, that a recoupment action has been initiated against the rendering provider. This letter shall identify the beneficiary specific claims included in the recoupment action. The letter should advise the beneficiary that no response is required and refer the beneficiary to the Beneficiary Service Representative (BSR) if they have further questions. The contractor has discretion in developing its own demand letters as long as it includes the information required by paragraph 14.0. (See Chapter 11, Addendum A, Figure 11-A-1, Sample Letter to Beneficiary.). Because the recovery actions are for the collection of "financially underwritten" funds, demand letters should not reference the Federal Claims Collection Act as authority for collection nor should they advise debtors that delinquent debts may be collected by administrative offset from other federal monies owed, or referred to the Department of Justice for enforced collection or offset from tax refunds.

13.0. OFFSET PROCEDURES

If the initial and follow-up refund requests and the offset attempt, if any, are unsuccessful for a period of 60 days from the date of the initial demand letter, the contractor should leave an offset flag or similar control on the file of the overpaid party (including a provider) for the term of the TRICARE contract for potential future offset. If at any time all or part of an overpayment is offset, prepare an EOB for each claim against which offset was made and send a notice to the overpaid party explaining the overpayment and the offset. If the offset is against the provider, the provider shall be advised that reimbursement for the claim against which the offset was made may not be sought from the patient on whose behalf the services were provided. Any requests for offset from other government agencies and orders for garnishment issued by the courts shall be handled under the laws of the state(s).

14.0. REFUND REQUESTS

Refund requests shall include a preaddressed return envelope and the following:

- Name and Address of the Beneficiary and Provider
- *Last four digits of* Sponsor*'s* SSN
- Internal Control Number
- Date(s) and Type(s) of Service
- Principle Amount of Debt
- Date(s) of Check(s)
- Name of Payee

14.1. A clear explanation of why the payment was not correct.

14.2. The amount of the overpayment and how it was calculated, and the amount of the correct payment, if any.

14.3. A notice that the overpaid party is required to refund the overpayment, or make acceptable arrangements to make the refund, within thirty (30) days of the date of the request.

14.4. A notice that:

- Interest shall be assessed at the rate of ___ percent. (**Enter the rate which would be collected under the Federal Claims Collection Act or the rate allowed by applicable state law, whichever is lower**.) Interest shall begin to accrue from the date of this letter.

- Accrued interest will be waived if payment is received within 30 days.

- Administrative costs may also be assessed for expenses in collecting the debt. TMA must be informed of the procedures, policies, and any charges, which are subject to TMA approval.

14.5. A notice of the possibility of offset if the overpayment is not refunded.

14.6. Instructions that the refund shall be by check or money order made payable to the contractor.

14.7. A notice, when appropriate, that unless a refund is made, or arrangements for a refund are made, the case may be referred to a credit reporting agency which could result in the assessment of added administrative costs, penalties and interest.

14.8. An explanation of rights to an administrative review and/or to appeal rights. (See paragraph 18.0.)

15.0. CONTRACTOR RESPONSES TO DEBTORS

There shall 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 30 days from receipt of any communication from the debtor.

16.0. BENEFICIARY INSTALLMENT REFUNDS

16.1. 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 paragraph 17.0.). The contractor shall acknowledge each payment received in writing. The acknowledgment shall 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 TRICARE Systems Manual, Chapter 1, for instructions on adjustments to the TED.)

16.2. The size of the monthly installment should normally allow for complete refund of the overpayment within 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 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.

16.3. 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 shall be treated as an installment payment. Suspended claims should be processed and paid normally.

16.4. 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 30 calendar days following notice of the overpayment, if payment is made within the 30 calendar 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.

17.0. INSTALLMENT DELINQUENCIES

If the debtor fails to comply with an established repayment agreement, the contractor shall notify the debtor of the delinquent amount and urge that the account be brought current. A written delinquency notice shall be sent 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 30 calendar 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 full installment payments are past due. An offset flag may, however, be set and maintained on all delinquent installment cases.

18.0. RECOUPMENT ACTION AND THE APPEALS PROCESS

The determination that an overpayment was made is not, in itself, an appealable issue. 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 Chapter 13, Appeals and Hearings. 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. 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.

19.0. OFFSET RECOUPMENT/PARTIAL PAYMENT

If the full amount is recouped through offset, follow adjustment procedures in the TRICARE Systems Manual, Chapter 1, and report the correction in the next TRICARE Encounter Data (TED) submission. If a partial recoupment is made by offset, the current claim check shall 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. 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 shall be applied only to principal.

20.0. REQUESTS FOR RELIEF OF INDEBTEDNESS

The contractor 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 shall be carefully reviewed. This does not apply to automatic waiver of interest on accounts paid within the first 30 days. After a case is established, the contractor shall take appropriate corrective action to stop or amend a recoupment when a contractor error is discovered.

21.0. ADMINISTRATIVE REVIEW OF INDEBTEDNESS

21.1. If a debtor requests an administrative review of his indebtedness, the contractor shall 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 Chapter 13, 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:

- 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.
- The action was initiated to recoup a duplicate payment.
- The action was initiated because an error was made in the original determination that a claim was a participating or a nonparticipating claim.
- The action was initiated because the payee was incorrect.

21.2. 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 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.

22.0. 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 Chapter 14.

23.0. BANKRUPTCY

When the contractor learns that any debtor has filed a petition in a bankruptcy, all recoupment actions shall cease. If the debtor is on offset, the contractor shall terminate the offset immediately. Until the bankruptcy is resolved, no further recoupment action shall 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 financially underwritten funds are retained by the contractor for appropriate action. They are not forwarded to TMA.

24.0. 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 TEDs recouped in full and/or negative adjustments for those TEDs partially recouped. Offset and partial refund repayments shall 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.

25.0. INTEREST, PENALTIES AND ADMINISTRATIVE COSTS

25.1. 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 30 days after the date of the initial demand letter.

25.2. If the contractor applies penalties, debtors shall be notified in the initial demand letter. A penalty shall not exceed six percent per year, if to be charged. It will only be applied on any portion of the debt which is delinquent for more than 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.

25.3. The contractor shall collect interest only when the debtor enters into an installment repayment agreement as described in above. The rate of interest shall be the rate established as described above. Each installment payment shall be applied first to the accrued interest and then to the outstanding principal balance.

25.4. 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 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 shall 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.

25.5. 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 shall 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.

26.0. 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 TRICARE Reimbursement Manual, Chapter 11, Section 4 for additional information).

26.1. 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 TRICARE Reimbursement Manual, Chapter 11, Section 4.

26.2. If the hospice fails to submit the refund, the contractor shall issue additional demand letters as required under paragraph 11.0. and Chapter 11, Section 4, paragraph 11.0. Copies of the demand letters shall not be sent to the beneficiary, and providers shall not be placed on offset to collect overpayments.

26.3. The processing of recoupments under a managed care support contract is dependent on whether financially underwritten funds (payment of services for residents within the contract area) or non-financially underwritten funds (payment for services provided to beneficiaries that come from outside the contract area) are being used. In the case of financially underwritten funds, recoupments are retained by the contractor while those associated with non-financially underwritten funds shall be returned to TMA.

26.3.1. 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 30 TRICARE beneficiaries electing hospice care during the period, of which five resided outside the *Prime service* area. The separation of funding would dictate that 16.7% of the recoupment be returned to TRICARE while the remaining amount would be retained by the contractor.

26.3.2. If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, the non-financially underwritten portion of the recoupment case shall be transferred to TMA in compliance with Chapter 11, Section 4, paragraph 11.0.