ALLOWABLE CHARGE REVIEWS (INCLUDES DRGS)

1.0. GENERAL

Beneficiaries and providers have the right to question the amount allowed for services received or rendered for non-network care. (Network providers should have complaint procedures included in their contracts or the administrative procedures established with the TRICARE contractor.) The amount of the allowance is not an appealable issue under the appeals procedures and regulations of the program. When a complaint is received, the accuracy of the application of the reimbursement methodology, including the procedure code and the profile development must be verified. The rights of the beneficiaries and providers must be protected by careful review of each case. For allowable charge complaints related to reimbursement based on the TRICARE National Allowable Charge System, see paragraph 4.0., below.

2.0. ALLOWABLE CHARGE REVIEW CRITERIA

2.1. Requirements

The allowable charge inquiry must be received or postmarked within 90 days from the date of the EOB or it may be denied for lack of timeliness. If the inquiry is in writing and the issue is not clearly a question of allowable charge, any doubt must be resolved in favor of handling the case as an appeal. Allowable charge complaints shall be reported on the workload report as required by Chapter 15, Section 4. The contractor shall respond only to a person entitled to the information; i.e., beneficiary, parent/guardian, participating provider, other TRICARE contractors, or to TMA.

2.2. Allowable Charge Complaint Procedures

An allowable charge complaint need not be submitted in writing. Oral inquiries (complaints) shall be documented on a contact report, by contractor staff. The handling requirements for timeliness of contractor processing are the same as for routine or priority correspondence. Upon receipt of an allowable charge complaint, the contractor shall recover the claim and related documents, including the "Beneficiary History and Deductible File", to completely review the case and establish accuracy of processing. The following checklist is suggested:

2.2.1. Was the correct procedure code used?

2.2.2. Were there other clerical errors, such as wrong type of service code, which may have caused the difference?

2.2.3. Did the case go to medical review?

2.2.4. Was all needed medical documentation present to make a completely accurate determination?

2.2.5. Should the case be further documented and referred to medical review?

2.2.6. Was the profiled fee calculated correctly?

NOTE: Contractors need not routinely validate the fee calculation; however, if the difference between billed and allowed is 20% or more, the dollar value of the difference is significant and all other factors appear to be correct, there is reason to question the validity of the fee.

2.3. Responses To Allowable Charge Complaints

A written response to allowable charge complaints is preferred, but the inquiry can be handled by documented telephone call, as may other correspondence. The beneficiary or provider must be offered a written response. If the complaining party indicates dissatisfaction with the contractor's oral explanation of an adverse determination, the contractor will send a detailed letter advising of the results. Occasionally the allowable charge complaint or inquiry will be sent directly to the TMA instead of the contractor. When this occurs, the complaint/inquiry will be forwarded to the contractor for response.

2.3.1. Adverse Determination

If the processing and payment were correct, the inquirer shall be told of the outcome and advised of the methodology for determining allowable charges. The explanation should clearly indicate that the determination was based on the information presented and, if more complex procedures were involved or if the case was unusually complex, whether additional information could change the determination. If such information is available to the inquirer, it should be submitted to the contractor for further review. If, after the contractor's review, it is determined that the original amount is still correct, the inquirer shall be informed that this is the final determination.

2.3.2. Additional Payment Due

If it is found that an error has occurred, or if added information is secured which changes the determination, an adjustment shall be made. The notice of the determination shall explain the reason for the adjustment, e.g., correction of clerical error, added claim information provided, correction of information provided on the claim, etc. Adjustments shall be prepared in accordance with instructions in Chapter 11.

3.0. EXCESS CHARGES BILLED IN PARTICIPATING PROVIDER CLAIM CASES

If an allowable charge inquiry/complaint indicates a participating provider is improperly billing for more than the allowable charge, refer to Chapter 14.

4.0. CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM

4.1. For allowable charge complaints involving reimbursement based on the CHAMPUS Maximum Allowable Charge System, the contractor shall adhere to the limitations stated in paragraph 2.1. In addition, the contractor will follow the instructions stated in paragraph 2.2., including paragraphs 2.2.1. through 2.2.5. The contractor will have no responsibility for determining whether or not the profiled fee for any given Medicare locality was calculated correctly. Once the contractor verifies that the correct procedure code was used, no data entry errors were made (including determination of where the service was rendered), and that referral to second level or medical director review was appropriate, the contractor shall respond to the inquiry stating that the payment calculation was correctly computed.

4.2. If it is determined that an error was made by the contractor in calculating the correct payment, the contractor shall follow the procedures in paragraph 2.3., above.

4.3. In the event the TMA, B&PS is notified by the contractor computing the CHAMPUS Maximum Allowable Charge (CMAC) that an error was made in the basic calculations, the contractor will receive a letter from TMA with the corrected CMAC directing the contractor to replace the incorrect CMAC as soon as possible but no later than ten working days after receipt of the TMA letter. Contractors are not required to adjust all the claims processed with the incorrect CMACS; however, contractors shall adjust any claims which were processed using the incorrect CMAC when a provider or beneficiary requests that adjustment.

5.0. DRG REVIEWS

The request from a hospital for reclassification of a claim to a higher DRG must be received or postmarked within 60 days from the date of the EOB; otherwise, the request will be denied for lack of timeliness. The contractor review is the final determination; there is no further review.