



DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCRM-F

ACSRM Policy 07-001
8 June 2007

MEMORANDUM FOR Chiefs of Staff, MEDCOM Major Subordinate Command,
ATTN: Resource Management

SUBJECT: Refund Procedures for Uniform Business Office (UBO), Third Party
Collection (TPC) Program, Medical Affirmative Claims (MAC) and Medical Service
Accounts (MSA) Program

1. Reference:

- a. DOD Financial Management Regulation, Volume 4, Chapter 3, paragraph 030311, "Erroneous Accounts Receivable;" 030312, "Invalid Accounts Receivable;" and 030313, "Unsubstantiated Accounts Receivable."
- b. DOD Financial Management Regulation, Volume 4, Chapter 8, paragraph 80102 (A), "Financial Control of Liabilities."
- c. DOD Financial Management Regulation, Volume 5, Chapter 10, paragraph 100306, "Collections Overpaid or Underpaid by \$10 or Less."
- d. DOD Financial Management Regulation, Volume 5, Chapter 11, paragraph 1102, "Processing Disbursement Vouchers;" 110301, A-2, "Disposition of Funds in Deposit Fund Accounts;" and paragraph 110303, "Overages."
- e. DOD Financial Management Regulation, Volume 5, Chapter 32, paragraph 320603, "Funding the Payment of Collected Debt Refunds."

2. Purpose: To provide guidance to the MEDCOM Medical Treatment Facilities Resource Management (RM) and UBO Staff for processing refunds of overpayments from the TPC, MAC, and MSA programs.

3. Refunds for the TPC/MAC programs:

- a. Refunds of overpayments for TPC and MAC programs must be made from the year in which the money was collected. The refund voucher should have the same appropriation on the refund voucher as when the funds were collected on the original DD 1131 (Cash Collection Voucher).

MCRM-F

SUBJECT: Refund Procedures for Uniform Business Office (UBO), Third Party Collection (TPC) Program, Medical Affirmative Claims (MAC) and Medical Service Accounts (MSA) Program

b. For prior year refunds, resource managers must review their activity's undistributed funds. If there are no available funds to cover the accounts receivable, resource managers must request prior year funds from HQ MEDCOM. Note: STANFINS will generate an accounts receivable when the refund voucher for TPC or MAC is processed.

4. Refunds for the MSA programs:

a. Refunds for the MSA program must be made from the same fiscal year in which the healthcare was provided to the patient and the account receivable established in CHCS. The refund voucher should have the same appropriation as the collection voucher.

b. If the MSA Office receives an over-payment in the current year for healthcare provided in a prior year, CHCS will generate two collection vouchers when the payment is posted in CHCS. One collection voucher will be for the prior fiscal year in which service was provided in the amount of the debt. A second collection voucher will be created for the current fiscal year which will cite the line of accounting (LOA) that the refund for the overpayment will be charged to.

c. An example of a collection posted in CHCS in a current year (FY 07) for healthcare provided in a prior year (FY 06) MSA account follows:

September 2006 – MTF provided \$100.00 of healthcare to a civilian emergency.

January 2007 – MSA Office receives payment for \$120.00 and posts collection in CHCS.

January 2007 – CHCS generates a DD 1131 with FY 06 LOA for \$100.00 and a DD 1131 with FY 07 LOA for \$20.00.

January 2007 – MSA Office is required to run CHCS 'Notify Roster' to process the refund voucher SF 1049. (Public Voucher for Refunds)
The refund voucher will have FY 07 LOA for the \$20.00.

5. If a remitter overpays by \$10 or less, deposit the fund into the receipt account. If the remitter requests the refund, then refund the amount according to procedures.

6. All refunds will be processed on the SF 1034 (Public Voucher for Purchases and Services Other Than Personal). The SF 1034 replaces the SF 1049. An example of a SF 1034 is attached. (Reference: Tab 1.)

MCRM-F

SUBJECT: Refund Procedures for Uniform Business Office (UBO), Third Party Collection (TPC) Program, Medical Affirmative Claims (MAC) and Medical Service Accounts (MSA) Program

- a. UBOs will coordinate all refunds through their activities' RM offices. The resource managers must ensure that funds are available to cover the refunds.
 - b. The SF 1034 can be supported with the CHCS generated SF 1049, the original DD 1131, copies of check(s) (if applicable), Insurance 'explanation of benefits' (EOB), and/or copies of the CHCS or TPOCS account ledgers.
 - c. All refund vouchers to individuals or insurance companies must be consecutively numbered starting at the beginning of each fiscal year and recorded on a DD 2659 (Voucher Control Log). At a minimal, the DD 2659 must contain the disbursement voucher number, name of the payee, and amount. (Reference: Tab 2.)
 - d. Mail or FAX the refund voucher and supporting documentation for processing to DFAS-Rome. DFAS-Rome's address is: DFAS-ROME, ATTN: AIEAJB (Ms. Anne Wright), 325 Brooks Road, Rome, New York 13411-4527; and FAX number is: (315) 709-6613 or DSN: 220-6613.
7. Our point of contact is Charlene Busanet, Office of the Assistant Chief of Staff for Resource Management, Finance and Accounting Division, Commercial (210) 295-2894, DSN 421-2894 or e-mail Charlene.Busanet@amedd.army.mil.

FOR THE COMMANDER:

Encls


DARYLL SPENCER
Colonel, MS
Assistant Chief of Staff for
Resource Management

Manual Instructions for Standard Form 1034

"Public Voucher for Purchased and Services Other Than Personal"

<small>Standard Form 1034 Revised October 1997 Department of the Treasury 17F M 4-2000 1034-121</small>	PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL				VOUCHER NO. #27: DOV-System Process
U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION #1: MTF Address		DATE VOUCHER PREPARED #2: Voucher DATE		SCHEDULE NO.	
		CONTRACT NUMBER AND DATE #3: UBO, MSA/TPC Refund Voucher			
PAYEE'S NAME AND ADDRESS #5: PAYEE'S Name Payee's Complete Address If Payee is an Insurance Company, must include TAX ID. TAX ID: 12-3456789		REQUISITION NUMBER AND DATE #4: MTF-Document Control NO./Date		PAID BY	
		SHIPPED FROM TO WEIGHT			
GOVERNMENT S/L NUMBER		DATE NOTICE RECEIVED		DISCOUNT TERMS	
		PAYEE'S ACCOUNT NUMBER			
DISCOUNT TERMS		PAYEE'S ACCOUNT NUMBER		GOVERNMENT S/L NUMBER	
NUMBER AND DATE OF ORDER #11: CK NO./ DATE of CK.	DATE OF DELIVERY OR SERVICE #12: PT DOS	ARTICLES OR SERVICES <small>(Every description, item number of contract or Federal supply schedule, and other info must be described necessary)</small> #13: Patient Name, SSN Patient Account Number *Brief description for Refund.	QUANTITY #14: 1	UNIT PRICE COST PER 100.00 each	AMOUNT (1) 100.00
(Use only in case of partial payment) (Payee must NOT use the space below) TOTAL					100.00
PAYMENT: <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> COMPLETE <input type="checkbox"/> PARTIAL <input checked="" type="checkbox"/> FINAL <input type="checkbox"/> PROGRESS <input type="checkbox"/> ADVANCE		APPROVED FOR BY: #23: Budget Analyst, Resource Management POC. "Signature and Date" TITLE #24: Budget Analyst, RMI "Title and Phone Number"		EXCHANGE RATE \$1.00 DIFFERENCES Amount verified; correct for 100.00 (Signature or initials) [] #22: UBO: MSAO/TPC Point of Contact	
Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.					
(Date)		(Authorized Certifying Officer):		(Title)	
ACCOUNTING CLASSIFICATION					
#26: Line of Accounting: 97 # 0130.1881 74- #ASN P840000 APC/DPI:##### EOR: 0000 Customer Number##### FSN #####					
CHECK NUMBER CASH	ON ACCOUNT OF U.S. TREASURY DATE		CHECK NUMBER PAYEE	ON (Name of bank)	
1 When issued in foreign currency, list name of currency. 2 If the ability to certify and authority to approve are contained in one person, one signature only is necessary, otherwise the approving officer will sign in the space provided, over his official title. 3 When a voucher is received in the name of a company or corporation, the name of the person within the company or corporation name, as well as the capacity in which he signs, must appear. For example: "John Doe Company, per John Smith, Secretary," or "Treasurer," as the case may be.				PER TITLE	

Previous edition obsolete

PRIVACY ACT STATEMENT

The information requested on this form is required under the provisions of 31 U.S.C. 82b and 82c for the purpose of disbursing Federal money. The information requested is to identify the particular creditor and the amounts to be paid. Failure to furnish this information will hinder discharge of my payment obligation.

17F M 4-2000-00-00-0234

DEAPA V4.00

Manual Instructions for Standard Form 1034
“Public Voucher for Purchased and Services Other than Personal”

I. Blocks that must be filled out as follows:

1. MTF's Name and Address
2. Voucher Date Prepared
3. Type: *“UBO, MSA/TPC Refund Voucher”*
4. MTF-Document Control Number
(ASN-Control Number from CHCS and/or Unique Sequence Number.
Example: 7415-MAY07-001)
5. PAYEE'S Name and Address
(Insurance Company must include: TAX ID.)
11. Check NO and DATE of Check
12. Patient Date of Service
13. Patient NAME, SSN, Account Number
*Brief description for the REFUND Voucher
14. a. QUANTITY- TYPE: *“1”*
b. Unit Price COST- *Amount to be REFUNDED*
c. PER- TYPE: *“Each”*
22. UBO Point of Contact (POC) Responsible for the Refund Voucher:
“Signature /Title”
23. The POC: *“Signature/Date”* who must have knowledge of the payment.
POC should be from the MTF's, Resource Management Office.
26. Line of Accounting
27. DOV-Document Voucher Number
(DOV is system generated after DFAS processes the payment.)

II. Send Voucher to MTF supporting DFAS for processing.

ARMY: DFAS-ROME

ATTN: AIEAJB (Ms. Anne Wright)

325 BROOKS ROAD

ROME, NY 13411-4527

FAX COM: (315)330-6613 DSN: 220-6613

III. Reference: DoD 7000.14-R, Volume 4, Chapter 11

http://www.dod.mil/comptroller/fmr/05/05_11.pdf

Information Paper

SUBJECT: Refunds on TPCP Claims

This information paper provides general guidance regarding refund requests from insurance companies on TPCP claims. This guidance does not apply to MSA or MAC claims. Military treatment facility (MTF) personnel should contact their legal representative (Regional Claims Settlement Office (RCSO)) for guidance regarding specific refund requests.

1. Legitimate Refund Requests.

a. Payers must specify in writing the reason for requesting a refund.

b. MTFs should issue refunds in cases when the payment was due (1) to a duplicate claim submitted by the MTF, or; (2) when the payer paid more than the billed amount, or; (3) when the plan is a non-billable plan under the TPCP. In any circumstance either evidencing or alleging fraud or wrongdoing by the MTF, contact your legal representative (RCSO) immediately.

c. As a general rule, refunds on overpayments of \$10.00 or less are not required.¹

2. Basis for Denial of Refund Request. UBO personnel may not deny a refund using the following legal arguments without first consulting with their supporting legal representative (RCSO).

Do not assume the payer is factually correct and due a refund since quite often payers are incorrect in their assertions. Even if the payer paid more than was owed under the plan benefit rules and their legal responsibility, there are several legal arguments that can be made to support a refusal to issue a refund.

a. Laches – This theory is that the payer waited an unreasonable amount of time to request a refund. Generally a refund will not be made if the payer requests the refund after nine (9) months from the date of the payment or in a different fiscal year.

Refunds requested within nine (9) months from the date of payment, may not be appropriate and will vary on a case by case basis dependent upon the situation. Each request must be reviewed carefully to ensure the request is valid.

¹ DoD Financial Management Regulation, Volume 5, Chapter 10, Paragraph 100306.

b. Estoppel/Detrimental reliance – An equitable theory to prevent unfairness to one party. It is the payer's responsibility to determine patient coverage at the time of treatment and determine the correct payment prior to issuing a payment. Payers are not necessarily entitled to restitution when the overpayment was made due to the payer's mistake and not due to any misrepresentation by the provider.² This argument is strengthened when the payment was deposited in a prior fiscal year because of the nature of federal appropriations law.

c. Debt Collector – Refer requests for a refund received from a debt collection firm to the supporting legal representative (RCSO). The Anti-Assignment Act³ prohibits the assignment of any claim or cause against the United States from the interested party to another party such as a debt collector unless certain requirements are met and without the agreement of a government representative.

d. Statute of Limitations – Payers must file suit to recover within six (6) years, so no refunds should be issued six years after receiving the payment⁴.

e. State insurance laws – State laws may apply to the insurer's refund request and limit the timeframe within which the payer may seek a refund.

3. Offsets: Payers may not, without the consent of an authorized government official, offset or reduce payment amounts the payer considers due them as a refund.⁵ Notify the payer to adjust an offset. Refer the claim to your legal representative (RCSO) if they do not comply.

However, the government may offset a payer's request for refund against amounts the payer owes the government.⁶ The government offset is limited to legal actions; therefore, MTFs must coordinate with their legal representative (RCSO) prior to denying a refund based on a government offset.

4. Refund requests when a DOD beneficiary is covered by Medicare and a third party payer: The following applies only to a DOD Beneficiary covered by Medicare. It does *not* apply to MSA civilian Medicare patients.

² Federated Mutual Insurance Company v. Good Samaritan Hospital, 191 Neb. 212, 214 N.W. 2d 493; 1974, Supreme Court of Nebraska

³ 31 U.S.C. 3727; 6 Am. Jur. 2d Assignments § 95

⁴ 28 U.S.C. §2401

⁵ 32 C.F.R. 220.7(d)

⁶ 31 U.S.C. § 3716; 28 U.S.C. §2415

a. Refund and payment criteria when a patient is hospitalized more than once during a Medicare benefit period:

(1) Only one Medicare Part A (inpatient) deductible is applied to a Medicare benefit period, and it is applied to the first hospitalization in the period. A patient may be hospitalized several times during a benefit period; but, the Part A deductible is charged only once during any Medicare benefit period. There is no limit on the number of benefit periods. A Medicare benefit period begins on the first day the patient receives covered inpatient hospital services and extends until the Medicare enrollee has been out of a hospital or skilled nursing facility for 60 consecutive days.

(2) Generally, third party payers (such as Medigap, EGHP and FEHB plans) should pay the Medicare Part A (inpatient) deductible for the initial admission within a Medicare benefit period and 20% of the professional component of the DRG charge when these are covered benefits under the plan. For any subsequent admissions within a benefit period, these plans generally pay 20% of the professional component of the DRG. Many plans also pay the co-insurance amounts for the 61st thru 90th days of hospitalization when these charges are covered benefits under the plan.

b. Refunds when a Patient is **admitted to an MTF first** during a Medicare benefit period:

(1) Medicare does not recognize a DOD beneficiary's admission to a military treatment facility for purposes of assessing the patient's Part A deductible or co-insurance charges. Therefore, if a DOD beneficiary is admitted *first* to an MTF and then to a civilian facility in the same benefit period, the civilian facility will charge the patient the Part A deductible for the admission to the civilian facility. Upon verification of the admission to a civilian facility within the same benefit period, the MTF should refund to the third party payer the Part A deductible collected for that benefit period.⁷ This will allow the third party payer to pay the civilian facility for that benefit period and ensure the patient is not penalized. The third party payer should still pay the MTF the 20% of the professional component of the DRG charge for that inpatient admission.

(2) The same refund policy applies to co-insurance amounts for the 61st thru 90th days of hospitalization when a patient is also hospitalized in a civilian facility within a hospital benefit period. If the MTF received payment for the co-insurance days, upon verification that co-insurance benefits are due to a civilian facility for an admission within the same benefit period, the MTF should refund the co-insurance payment to the payer. This will allow the payer to pay the civilian facility for that benefit period and ensure the patient is not penalized.

⁷ 32 C.F.R. 220.10

c. Refunds when a patient is **admitted to a civilian facility first during a Medicare benefit period and then to a DOD MTF**:

(1) If a patient is admitted to a civilian facility first and then subsequently admitted to an MTF in the same Medicare benefit period, the third party payer should pay the civilian facility the Part A deductible for the initial admission within the benefit period. There would be no payment for the Part A deductible made to the MTF for subsequent admissions during that Medicare benefit period. The payer should pay the MTF 20% of the professional component of the DRG charge for any subsequent admissions within the benefit period and any co-insurance charges for the 61st thru 90th days of hospitalization when applicable and a covered benefit under the plan.

(2) If the payer incorrectly pays the MTF the Part A deductible for a subsequent hospitalization within a Medicare benefit period, and later seeks a refund, seek guidance from your RCSO regarding the request as previously outlined legal arguments may apply that would preclude refunding the payer.

d. Refunds when a patient is **admitted to an MTF more than once during a Medicare benefit period**.

(1) The payer should pay the MTF the Part A deductible for only the first admission and also pay the MTF 20% of the professional component of the DRG charge for any admission within the benefit period and any co-insurance charges for the 61st thru 90th days of hospitalization when applicable and a covered benefit under the plan.

(2) See previously outlined general refund guidance if a payer pays the MTF the Part A deductible more than once during a Medicare benefit period, and later seeks a refund.

e. Refund Criteria when a third party payer requests a refund of a primary payment stating the plan should have paid a secondary payment to a non-existent Medicare payment:

(1) If the request is received *within* a reasonable time, generally nine (9) months, of receiving the payment or within the same fiscal year (hence reducing the likelihood of any actual detrimental reliance), the MTF should obtain information sufficient to determine whether the payer should have paid secondary by sending the payer the attached sample letter and questionnaire.⁸ If you already have this information, the questionnaire is not necessary. Then determine whether the payer should have paid primary or secondary benefits in accordance with the plan benefits

⁸ USA Medical Command, Office of the Staff Judge Advocate (MCJA) Medicare Secondary Payer (MSP) Guidance

and MSP guidance paper. If it is clear that all criteria is met for paying a secondary benefit and the outlined legal arguments do not apply to the request, then process the refund request. If there is a question that the previously outlined legal arguments may apply to support not issuing a refund, request review by your legal representative RCSO.

(2) Request review by your RCSO, if the refund request is received *more than* nine months from receiving the payment. Do not send the payer a questionnaire since it is unlikely that the RCSO will recommend issuing a refund *even if* the payer should have paid secondary benefits.

POC: Jackie Russell, UBO Paralegal, Office of the Staff Judge Advocate, USA Medical Command, (210) 221-6758, Jackie.russell@amedd.army.mil

Prepared by: Jackie Russell, UBO Paralegal, MEDCOM OSJA
Approved by: Maurice Deaver, Attorney-Advisor, MEDCOM OSJA

Research Contributor: Derald Stange, Claims Paralegal, W. Beaumont AMC OSJA

Sample Letter Sending MSP Questionnaire to

EGH or FEHB Plan in Response to Request for Refund of Primary Payment

This letter is in response to your letter, dated _____, requesting a refund in the amount of \$ _____ on a claim for treatment provided to ___(Patient Name)_____ on ___(Date of Service)_____. Your letter states the refund is requested because ___(Name of Payer)_____ incorrectly paid these claims as a primary payer instead of a secondary payment when the patient had primary Medicare coverage at the time of service.

In order for your plan to be considered a secondary payer the patient must be covered by Medicare and covered by the ___(Name of Plan)___ as a retiree, or spouse of a retiree, or otherwise not meet the Medicare Secondary payer requirements. There is no indication in your letter to indicate this patient was not covered by your plan as an active employee or that no other category of situation when the plan would pay secondary to Medicare applied to this patient at the time of treatment.

Please complete the attached Medicare Secondary Payer Questionnaire and return it to ___(Name of MTF)___, ___(Address of MTF)_____. Your refund request will be reviewed upon receipt of this information.

Please note ___(Name of Plan)_____ may not offset this amount against any future claims. This is expressly prohibited by 32 C.F.R. 220.7(d), which states that a health insurance company may not, without consent of the appropriate U.S. official, offset or reduce any payment on the grounds the payer considers itself due a refund. Consent is not granted on this matter.

Please contact _____ at ___(Telephone &/or email address)_____, name of facility _____, if you have any questions.

MEDICARE SECONDARY PAYER QUESTIONNAIRE
FOR REFUND CONSIDERATION

To be completed by third party payers or others prior to consideration of a refund request for charges for services or items provided to persons covered by the plan and eligible for MEDICARE.

1. Patient's Name _____

2. Group Number / Name _____

3. Patient's Age / Date of Birth _____

4. Patient's Spouse's Name _____

5. Patient's Spouse's Age / Date of Birth _____

6. Policyholder's/Insured's Name (if family member other than above) _____

7. Policyholder's/Insured's Age / Date of Birth _____

8. Basis for patient's entitlement to Medicare (Check as applicable):

_____ age 65 or older; _____ disability (under age 65);

_____ end stage renal disease (ESRD)(any age)

Date eligible for coverage due to ESRD _____

9. Is the patient or the patient's spouse (or in the case of disability or ESRD, a family member) currently employed with the employer providing the plan coverage?

_____ Yes

No _____

IF YES: Name & address of current employer providing plan coverage for this patient

Phone Number _____ Group Number _____

Prescription Drug Administrator Name & Address

Drug coverage number if different from group number

10. Retirement date of plan enrollee from the employer providing the plan coverage & former employer's name, address, and phone number

11. Retirement date, from the employer providing the plan coverage, of policyholder (family member in the case of Medicare coverage due to disability) & former employer's name, address, and phone number

12. If the patient, spouse, or family member is employed:

Are there 20 or more employees? ___yes ___no

Are there 100 or more employees? ___yes ___no

Is the employee currently working? ___yes ___no

13. Does the employer/employee sponsored group health plan subscriber benefit booklet have a Medicare secondary payer provision? Yes ___ No___.

IF YES, attach a copy of the employer/employee sponsored group health plan subscriber benefit booklet, as authorized by 32 CFR 220.4(d).

Signature of authorized payer representative, and title

Date

Type or print name and title

Phone number