

QUARTERLY REPORTS

TMA requires the contractor to prepare and submit routine workload and management reports used to establish a uniform format for recording data on contractor operations and to provide historical data for continued evaluation of contractor performance. While the data contained in the reports are essential to TMA for purposes of program management, they are equally essential for a contractor's management of the program. A contractor is accountable for assuring that reports contain accurate and complete data. Each contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. In addition, the contractor shall establish a quality assurance program to assure a high degree of reporting accuracy. All reports must be supported with sufficient documentation and audit trails by the contractor for TMA on-site and desk audit inspections. An officer of the contractor shall sign and date each report submitted to attest to the accuracy and completeness of the report.

1.0. FRAUD AND ABUSE REPORTS

The contractor shall provide a system for reporting suspected fraud and abuse cases, utilization review, and quality assurance activities quarterly and in a form consistent with the requirements of [Chapter 14](#). The contractor shall send the Regional Director copies of all reports at the same time as they are sent to the Contracting Officer in the format required by the Regional Director.

2.0. CONGRESSIONAL/HBA VISIT REPORT

By the 30th day following the close of each contract quarter, the contractor shall submit a summary report only, with the number and the types of contacts (Congressional, HBA, etc.) actually completed. The report shall show, for example, 100 visits, 50 HBA contacts, etc. The actual visit or contact reports, plus the internal contractor management monitoring reports shall remain a requirement. This report shall be available for TMA review at the contractor's office but shall not routinely be sent to the TMA. A special report shall be sent to the TMA when there is any special accomplishment achieved, special problems encountered or when the contractor's representative receives a recommendation or request from a provider which needs special attention at TMA.

3.0. UTILIZATION MANAGEMENT REPORTING

The contractor shall report on the review activities for TRICARE Prime, TRICARE Extra, and TRICARE Standard to prevent under-utilization or over-utilization of services. Separate reports shall be submitted for the TRICARE Prime, TRICARE Extra, and TRICARE Standard. Reports summarizing the activities of the utilization management program are to be submitted on a quarterly basis, within 45 calendar days following the end of the calendar quarter. Proposed changes in pre- and post-payment screens must be reported to each

Regional Director and approved by the Contracting Officer prior to implementation of such changes. (See [Chapter 14.](#))

4.0. PROVIDERS AND BENEFICIARIES ON PREPAYMENT REVIEW REPORT

The contractor shall forward a report to the Contracting Officer with a copy to the Regional Director 45 calendar days following the end of each calendar quarter beginning with Option Period 1 of the providers and beneficiaries on prepayment review, listing each provider by name, specialty, and provider SSN/EIN and each beneficiary by social security number, relationship code, and date of birth. The report shall include the basis for placing the provider and/or beneficiary on prepayment review, the number of services suspended, the number of services denied, and the dollar amounts suspended and denied.

5.0. HEALTH CARE FINDER REPORT

The contractor shall provide summary reports which distinguish between enrolled and nonenrolled populations for health care finders and beneficiary satisfaction. Within ten calendar days following the end of each contract quarter, submit to the Contracting Officer and the Regional Director a Health Care Finder activity report by MTF and a summary report by state. The reports shall include:

- the number of referrals for TRICARE Prime, TRICARE Extra, and TRICARE Standard beneficiaries (by enrolled and nonenrolled populations) and for non-TRICARE eligible beneficiaries (by beneficiary category, i.e., Medicare eligible, active duty family member, parent, etc.);
- the source and reason for referral;
- the provider type to whom the beneficiary was referred; and
- the number of authorizations by medical/surgery and mental health services and by both inpatient and outpatient services.