

Program Integrity

VI. PROVIDER EXCLUSIONS, SUSPENSIONS AND TERMINATIONS UNDER TRICARE

A. Provisions for Exclusions, Suspensions and Terminations

1. Authority for Sanctioning Providers

a. The [32 CFR 199.9](#), provides that the Director, TRICARE Management Activity (TMA), or a designee, shall have the authority to exclude or suspend an otherwise authorized TRICARE provider from the program based on:

(1) Any criminal conviction or civil judgement involving fraud by the provider;

(2) Fraud or abuse under TRICARE by the provider;

(3) Exclusion or suspension of the provider by another agency of the Federal Government, a state or local licensing authority;

(4) Participation in a conflict of interest situation by the provider; or

(5) When it is in the best interests of the program or TRICARE beneficiaries to exclude or suspend a provider under TRICARE.

b. The Director, TMA, has delegated sole authority for excluding or suspending all providers listed in the Regulation to the Director, Beneficiary and Provider Services.

c. The [32 CFR 199.9](#) provides that the Director, TMA, or a designee, shall terminate the provider status of any provider determined not to meet the qualifications established by the Regulation to be an authorized TRICARE provider.

(1) The contractor has authority to terminate any providers for which the contractor has certifying responsibility when the provider fails to meet the requirements of the Regulation.

(2) The contractor shall refer institutions found to be in noncompliance with required standards to the TMA Program Integrity Branch.

d. In all cases the exclusion or suspension of a provider shall be effective fifteen (15) calendar days from the date the written initial determination was issued under [32 CFR 199.9](#). When a provider has been suspended or excluded, no payment may be made or treatment authorized. At the end of the sanction period, the provider may request reinstatement to the TMA Program Integrity Branch. Refer to [OPM Part Two, Chapter 7, Section VI](#) of this chapter. Restitution of funds owed to the Government must be made prior to reinstatement of provider status. The TMA Program Integrity Branch shall consult the contractor concerning any amounts owed prior to reinstatement of a suspended, excluded, or terminated provider. See [Section VI.D.](#), for contractor actions required.

2. Definition of Suspension and Exclusion

The terms “exclusion” and “suspension,” when referring to a provider under TRICARE, both mean the denial of status as an otherwise authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under TRICARE. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized TRICARE provider based on:

a. Conviction, judgement or administrative finding related to one or more of the conditions in [Section VI.A.1.a.](#) above.

3. Definition of Termination

Termination is the removal of a provider as an authorized TRICARE provider based on a finding that the provider does not meet the qualifications (as defined by 32 CFR 199.6) to be an authorized TRICARE provider. (This includes those categories of providers who have signed specific participation agreements.) For example, a provider who never had the minimum requirements could be terminated retroactively to the date he was first listed as a TRICARE authorized provider.

B. Causes for Exclusion

There are several primary reasons for which a provider may be excluded as a TRICARE provider. If the individual authorized provider or institution has been found to be in serious violation of the law or Regulations under TRICARE, Medicare or Medicaid, exclusion will be imposed by the Director, TMA or designee, as required or provided by law.

1. Fraud

Fraudulent actions by a provider are among the most serious of offenses. Willfully making false, fictitious or misleading statements or submitting claims with the intent of obtaining payment for self or another's gain is a criminal act. Acts of this type against Medicare, Medicaid or TRICARE may result in exclusion as provided in [Section VI.A.1.](#) of this chapter.

2. Abuse

Abuse usually takes the form of delivering unneeded services. The delivery may be excessive quantity of the same services or services which have no true relationship to the diagnosis or treatment of a valid medical problem. Excessive charges for services rendered or, less frequently, in providing treatments outside the scope of accepted or acceptable medical practice are also included. Educational contacts by the Medical Director or other peers can often correct these problems.

3. Discrimination

Institutional providers which practice discrimination in violation of Title VI, of the Civil Rights Act of 1964, shall be excluded. Payment may not be made for inpatient or outpatient care provided and billed by an institutional provider found by the Federal Government to practice discrimination in the admission of patients to its services on the basis of race, color, or national origin. Reimbursement may not be made to a beneficiary who pays for care provided by such a facility and submits a claim for reimbursement except under those conditions as specified in the 32 CFR 199.6.

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4. Violation of Participation Agreement or Reimbursement Limitations

Those providers, whether institutional or individual professionals, who persist in violation of the assignment agreement to accept the TRICARE allowable charge or the reimbursement limitations may be excluded, suspended or subjected to administrative action. This includes those special categories of providers (i.e., Residential Treatment Center, Psychiatric Partial Hospitalization programs, Substance Use Disorder Rehabilitation Facilities, marriage/family therapists) who have signed specific provider participation agreements. Violation of this agreement may also be cause for termination.

C. TMA Actions in Sanctions

1. TMA Administrative Decision

When the TMA makes an administrative decision to exclude or to suspend a provider based on the TMA findings that the provider submitted false, fictitious or fraudulent claims or has furnished services and/or supplies substantially in excess of need, of inferior quality or harmful to beneficiaries, TMA will notify the provider by certified mail with a copy to the contractor. The Director, Beneficiary and Provider Services Directorate, TMA will advise the provider that TRICARE benefits will be denied for the period as stipulated in the court order or as determined by the TMA and will continue throughout the period of the sanction. Any TMA administrative decision to terminate a provider based on the finding that the provider does not meet the qualifications to be an authorized provider will require the TMA to notify the provider by certified mail with a copy to the contractor. Any claims cost-shared or paid under TRICARE for services or supplies by the provider on or after the effective date of termination, even when the effective date is retroactive, shall be deemed an erroneous payment unless specific exception is provided in 32 CFR 199.9. All erroneous payments are subject to collection. The provider shall be given the right to appeal the determination unless the sanction is not appealable as stated in 32 CFR 199.10.

2. Department of Health and Human Services (DHHS)

Listings

DHHS will provide the TMA Program Integrity Branch with monthly listings of providers who have been terminated, excluded or suspended and who have been reinstated or on whom the action has been withdrawn. Biannually, DHHS will provide the TMA Program Integrity Branch an updated list of the status of all currently suspended, excluded and terminated providers. The TMA Program Integrity Branch will send the contractor a copy of all such documents for the contractor's action.

3. Other Listings

As identified, other listings of actions affecting provider authorization status, e.g., Federation of State Medical Boards of the United States, will be sent to each contractor. A provider who has licenses to practice in two or more jurisdictions and has one or more license(s) suspended or revoked shall be terminated as a TRICARE provider in all jurisdictions.

a. When a TRICARE provider status is terminated due to the loss of the provider's license, the effective date shall be retroactive to the date the provider lost the license. In the case of a professional provider having licenses in two or more states, the

effective date of the termination for those states, for the purpose of claims processing, will be fifteen (15) calendar days from the date of the written initial determination of termination from the jurisdiction in which the provider still has a valid license.

b. Professional providers shall remain terminated from TRICARE until the jurisdiction(s) suspending or revoking the provider's license to practice restores it or removes the impediment to restoration and the provider requests reinstatement.

c. Institutional providers shall remain terminated under TRICARE until their license is restored. In the event the facility is sold, transferred, or reorganized as a new legal entity, and a license issued under a new name or to a different legal entity, the new entity must submit an application to become an authorized TRICARE provider.

D. Contractor Actions in Sanctions

Contractors have a major role in ensuring the enforcement of all actions taken against providers who are sanctioned under TRICARE and in notifying such providers, beneficiaries and HBAs of the action taken and its effect upon payment by TRICARE for any services provided or received. The paragraphs below provide detail of required actions in each case.

1. Provider Notices

a. When the contractor receives a notice with a DHHS listing of sanctioned providers from the TMA Program Integrity Branch, the contractor shall issue a letter to the provider(s) within their regional contract(s) advising that based on DHHS action, TRICARE benefits will be denied for services provided during the period beginning fifteen (15) days following the date of the contractor's letter to the provider (Figure 2-7-A-9). The letter issued by the contractor to the provider shall be sent by return receipt requested mail no later than fourteen (14) calendar days following receipt of the listing from TMA Program Integrity Branch. This applies only to those sanction actions for which the provider's license has not been revoked by the state.

b. For those providers terminated by DHHS, contact the appropriate licensing agency and determine the date his/her license was revoked. Terminate the provider following procedures in Section VI.D.3. below. The termination action will be retroactive to the date the provider lost the license.

c. The exclusion/suspension will continue until the provider is reinstated by DHHS and a request from the provider for TRICARE reinstatement has been approved by TMA Program Integrity Branch. Refer to Section VII.D. of this chapter.

2. Beneficiary, Lead Agent and HBA Notice Requirements

a. The contractor shall provide notice of all terminations to the Lead Agents in the geographic area(s) of the provider's practice by providing a copy of the Initial Determination to the Lead Agent. The notice shall be sent within fourteen (14) calendar days after the date the Initial Determination is mailed to the provider.

b. The contractor shall provide notice of all exclusions, suspensions and terminations to all known HBAs located within the provider's service area (approximately

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one-hundred (100) miles) of the practice address of the terminated, excluded or suspended provider. The notice shall be sent within fourteen (14) calendar days after the date the contractor mails the Initial Determination to the provider. The contractor shall also provide notice of all exclusions, suspensions, and terminations which are initiated by the TMA. The contractor shall follow the same procedure used when they initiate Initial Determinations.

c. Contractors shall send a special and specific notice to any beneficiary who submits a claim, or for whom a claim is submitted, which includes services involving a sanctioned provider (Figure 2-7-A-10). The notice may be enclosed with the EOB, whether the claim is payable or not, or a separate letter may be sent. If the contractor's data system provides the flexibility, the message may be printed on the EOB; however, the substance of any message must be similar to the example. Documentation that the notice has been sent is required.

d. When the termination, exclusion or suspension ends and the provider is reinstated, the same offices will be notified by the contractor (refer to OPM Part Two, Chapter 7, Section VII.C.).

3. Contractor Requirements for Terminating a Provider Failing to Meet Regulation Requirements (Refer to 32 CFR 199.9)

a. Notice of Proposed Administrative Sanction

The contractor shall notify the provider in writing of the proposed action to terminate the provider's status as an authorized TRICARE provider when the provider falls within the contractor's certifying responsibility and the provider fails to meet the requirements of the Regulation. The provider is not to be terminated when he/she fails to return certification packets. Such providers will be flagged as "inactive." Section VI.D.3.e. of this chapter. A sample letter is found at Figure 2-7-A-11. (Do not send a copy of the proposed notice to the TMA Program Integrity Branch.)

(1) The notice shall state that the provider will be terminated as of the effective date of the sanction.

(2) The notice shall inform the provider of the situation(s) or action(s) which form the basis for the proposed termination.

(3) If a network provider, the notice shall inform the provider that his/her patients will be referred to another provider pending final action.

(4) The notice will be sent to the provider's last known business or office address (or home address if there is no known business address).

(5) The notice shall offer the provider an opportunity to respond within thirty (30) days (or upon written request received by the contractor during the thirty (30) days and for good cause shown, within sixty (60) days) from the date on the notice with either:

(a) Documentary evidence and written argument contesting the proposed action; or

(b) A written request to present in person evidence or argument to a Contractor designee (usually the Manager of Provider Certification) at the

contractor's designated address. Expenses incurred by the provider are the responsibility of the provider.

b. Suspension of Claims/Transfer of Patients

(1) Once the notice of proposed administrative sanction is sent to the provider, the provider's claims shall be suspended from claims processing until an Initial Determination is rendered. The provider will be notified via the proposed notice that the claims will be suspended from claims processing. The beneficiaries will not be notified of the temporary suspension.

(2) If the provider being sanctioned is a Primary Care Manager (PCM), the contractor shall assist Prime enrollees with selecting a new PCM. Once the Notice of Proposed Administration Sanction is sent to the provider the contractor is responsible for assuring that patient's medical resources are transferred to the new PCM. See NOTE below.

c. Initial Determination

Once the provider has failed to comply with or has exhausted the procedures outlined in [Section VI.D.3.a.](#), above, and the contractor's preliminary decision is unchanged, the contractor shall send a written notice of the initial determination to the provider by certified mail.

NOTE:

The Initial Determination shall not automatically be mailed on the thirtieth day without first ensuring that there is no correspondence in-house from the provider. The Initial Determination shall include:

- (1)** *A unique identification number indicating the fiscal year of the Initial Determination, a consecutive number within that fiscal year and the contractor's name (Figure 2-7-A-12).*
- (2)** *A statement of the sanction being invoked.*
- (3)** *A statement of the effective date, which is the date the provider no longer meets the regulatory requirements. If there is no documentation that the provider ever met the requirements, the effective date will be either June 10, 1977, (the effective date of the Regulation) or the date on which the provider was first approved, whichever date is later.*
- (4)** *A statement of the facts, circumstances or actions which form the basis for the termination and a discussion of any information submitted by the provider relevant to the termination.*
- (5)** *A statement of the provider's right to appeal. (There is no objection to stating in an initial determination that in order for an appeal to be accepted, there must be a disputed issue of fact and the official issuing the initial determination does not believe the provider has raised a disputed issue of fact.)*
- (6)** *The requirements and procedures for reinstatement.*

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d. Notification to the TMA

A copy of the letter terminating the provider will be sent to the TMA Program Integrity Branch, along with supporting documentation, e.g., documentation provided which shows the provider failed to meet the qualifications. Initial determinations terminating providers which are modified or withdrawn at the reconsideration level shall be reported to the TMA Program Integrity Branch.

e. Requirement to Recoup Erroneous Payments

After the initial determination has been sent, the contractor shall initiate recoupment for any claims cost-shared or paid for services or supplies furnished by the provider on or after the effective date of termination, even when the effective date is retroactive, unless a specific exception is provided by 32 CFR 199. This applies to claims processed by previous contractors as well. All monies paid by previous contractors and recouped by the current contractor will be refunded to the TMA Finance and Accounting Branch.

4. File Requirements for a Terminated Provider

a. The initial determination file should be indexed and dividers separating each section should be utilized. This file generally should include the following three sections:

- (1) Contractor initial determination.
- (2) Contractor provider certification file (i.e., the documentation upon which the original certification of the provider was based).
- (3) All remaining correspondence and documentation relating to the termination, arranged in chronological order. When a document refers to enclosures, copies of the enclosures must be attached to the copy of the original correspondence. This category would include, for example, all documentation relating to the contractor's decision, any correspondence between the TMA and the contractor regarding the termination, and any evidence or document relating to the provider's professional qualifications.

NOTE:

The initial determination file should only include documents that are releasable to the provider. Further, the file should only include documents that the contractor considered or relied upon. If a document is not in the initial determination file, the contractor may not consider it or rely upon it, in making its determination.

5. Special Action/Notice Requirements when an Institution is Terminated

When a TMA determination is made that an institutional provider does not meet qualifications or standards to be an authorized TRICARE provider, the Contractor shall take action as directed by the TMA, in accordance with [32 CFR 199.9](#).

a. Beneficiary Notification

(1) Instruct the institution by certified mail to immediately give written notice of the termination to any TRICARE beneficiary (or his/her parent, guardian, or other representative) admitted to or receiving care at the institution on or after the effective date of the termination.

(2) When the termination effective date is after the date of the initial determination, notify by certified mail any beneficiary (or their parent, guardian, or other representative) admitted prior to the termination date of the termination and end of the TRICARE cost-sharing as of the termination date. Advise the beneficiary (or their parent, guardian, or other representative) of their financial liability.

(3) If an institution is granted a grace period to effect correction of a minor violation, notify any beneficiary (or his/her parent, guardian, or other representative) admitted prior to the grace period of the violation and that TRICARE cost-sharing of otherwise covered care will continue during that period. (Cost-sharing is to continue through the last day of the month following the month in which the institution is terminated.)

(4) In addition, notify any beneficiary (or their parent, guardian, or other representative) admitted prior to a grace period of the institution's corrective action, when such has been determined to have occurred, and the continuation of the institution as an authorized TRICARE provider.

(5) For a beneficiary admitted during a grace period, cost-share only that care received after 12:01 a.m., on the day written notice of correction of a minor violation was received or the day corrective action was completed.

b. Cost-Sharing Actions

(1) Deny TRICARE cost-sharing for any new patient admitted after the effective date of the termination.

(2) Deny TRICARE cost-sharing for any beneficiary admitted during a grace period granted an institution involved in a minor violation.

(3) Deny TRICARE cost-sharing for any beneficiary already in an institution involved in a major violation beginning with the effective date of the termination.

(4) Cost-share otherwise covered care for those beneficiaries admitted prior to a grace period.

6. Contractor Denial Action Guidelines - DHHS Sanctions

a. Claims for services/supplies furnished by a provider during the fifteen (15) day period following the date of the notice of DHHS suspension or exclusion shall not be denied on the basis of suspension, exclusion, or termination, since the services/supplies were provided prior to the effective date shown in the Notice. A special beneficiary notice (Figure 2-7-A-11) shall be sent for claims having a date of service following the date of notice to provider. However, any claim for services rendered prior to that date, which involves prohibited acts; e.g., fraud, abuse, etc., shall be denied. Those providers who are

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found to have never qualified for authorized provider status will be terminated retroactively and recoupment initiated.

b. Neither the provider nor the patient will be entitled to TRICARE cost-sharing once a termination, exclusion or suspension is effective.

7. Cancellation of Network Provider Agreements

The contractor shall ensure that a network provider whose contract has been canceled clearly understands his/her status as an authorized TRICARE provider. If the cancellation is due to the provider failing to meet Regulation requirements for authorized provider status, the termination procedures listed in [Section VI.D.3.](#) of this chapter must have been taken. Cancellation of a network provider contract and the termination of a TRICARE provider are to be handled as two separate distinct actions. Cancellation notices shall not be sent to the TMA Program Integrity Branch.

E. Contractor Actions in Cases Involving Potential Violations by Providers

1. Complaint of TRICARE Requirement Violation by an Institution

a. In any case when it comes to a contractor's attention that a facility may not be in compliance with TRICARE requirements, the TMA Program Integrity Branch shall be notified immediately. Complaints of violations in hospitals and skilled nursing facilities shall be fully documented by the contractor and forwarded to the TMA Program Integrity Branch.

b. A detailed description of the suspected violation must be obtained by the contractor from the source of the complaint. The names of all TRICARE beneficiaries known or believed to be currently in the facility shall be included with the contractor's report of the complaint.

c. On occasion, the TMA will request the contractor to conduct an on-site evaluation of a specific facility or to assist the TMA in conducting such a facility review. The TMA will provide specific instructions to the contractor when participation in an on-site evaluation is required. Refer to the [OPM Part Two, Chapter 2, Section III.A.2.](#)

2. Violation of the Participation Agreement or Reimbursement Limitation

a. The contractor is responsible to ensure that providers adhere to their participation agreements (to accept the TRICARE-allowable charge) and the reimbursement limitation. Corrective action is required for a provider who submits participating claims but does not honor the agreement to accept as the full charge the amount the contractor determines to be the allowable charge for the service or the provider who violates the 115 percent reimbursement limitation. Whenever possible, beneficiary complaints about breach of the allowable charge participating agreement or reimbursement limitation should be resolved by the contractor staff, e.g., explaining to the provider the commitment made in accepting participation or regarding the Appropriations Act. For violations involving institutional providers, the letter should be addressed by name to the hospital administrator. The contractor should get assurance that the provider will identify

and refund any money inappropriately collected and refrain from billing beneficiaries for the reductions on participating claims or in violation of the 115 percent reimbursement limitation in the future ([Figure 2-7-A-14](#), [Figure 2-7-A-15](#), [Figure 2-7-A-16](#) and [Figure 2-7-A-17](#)).

b. If, after two notices, a provider refuses to make refunds, continues to violate participation agreements or reimbursement limitations, or brings suit against beneficiaries who refuse to pay the amount of the reduction, the contractor shall bring the matter to the attention of the TMA, Program Integrity Branch. The contractor shall submit a copy of all supporting documents to the TMA Program Integrity Branch. This includes claims, EOBs, educational letters to the provider, patient's canceled check copy or provider's billing statement.

c. The contractor shall follow the same procedures listed above for those providers signing special TRICARE participating provider agreements (RTCs, PHPs, SURRFs and MFCCs).

3. Non-Compliance of Claims Submittal (National Defense Appropriations Act for Fiscal Year 1992)

a. The contractor shall ensure that providers are in compliance with the claims submittal requirements. Refer to the [OPM Part Two, Chapter 1, Section I.B.2](#).

b. The contractor shall first make two documented notifications to the provider that the provider must submit the claim for the beneficiary. The contractor shall flag the provider file to indicate the notices.

c. Upon the third infraction, the contractor shall refer the case to the TMA Program Integrity Branch, with a copy of all supporting documents. This includes the three claims on which the infractions occurred, the EOBs, any educational letters or personal contact records, and a copy of any educational materials mailed, such as EOB stuffers, quarterly newsletters, etc.