



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

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TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 102  
6010.51-M  
AUGUST 27, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE: CAPITAL AND DIRECT MEDICAL EDUCATION (CAP/DME) UPDATE**

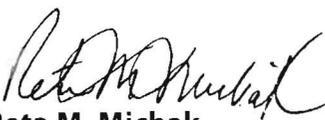
**CONREQ:** 15042

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change requires the Managed Care Support Contractors (MCSCs) to take responsibility for tracking CAP/DME over and under payments; reporting them to the TRICARE Regional Offices (TROs); recouping overpayments; and making additional payments when an underpayment is identified. In addition, the MCSCs are now responsible for proactively researching Medicare Cost Reports to ensure all CAP/DME payments are accurate and reflect the latest information reported on the hospital's Medicare Cost Report. This change will eliminate the need for the TRICARE Management Activity (TMA) to have outside audits performed on CAP/DME payments and puts the responsibility for managing this on the TROs who are responsible for overseeing MCSCs' claims payments/processing.

**EFFECTIVE AND IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**This change is made in conjunction with Aug 2002 TRM, Change No. 119.**

  
**Reta M. Michak**  
**Director, Operations Division**

**ATTACHMENT(S): 6 PAGES**  
**DISTRIBUTION: 6010.51-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 102**  
**6010.51-M**  
**AUGUST 27, 2010**

**REMOVE PAGE(S)**

**CHAPTER 15**

Table of Contents, pages i and ii

Section 5, pages 1 and 2

Section 6, pages 1 and 2

**INSERT PAGE(S)**

Table of Contents, pages i and ii

Section 5, pages 1 and 2

Section 6, pages 1 and 2

## AUDITS, INSPECTIONS, AND REPORTS

SECTION	SUBJECT
<b>1</b>	<b>AUDITS AND INSPECTIONS</b> 1.0. General 2.0. Contract Performance Reviews 3.0. Renegotiation Audits
<b>2</b>	<b>WEEKLY REPORTS TO TMA</b> 1.0. Incoming Contractor Weekly Status Report 2.0. Outgoing Contractor Weekly Status Reporting 3.0. Enrollment And Claims Processing Statistics Report 4.0. TRICARE Dual Eligible FI Contract Claims Processing Statistics Report 5.0. Claims Aging Report By Status/Location
<b>3</b>	<b>MONTHLY REPORTS</b> 1.0. Network Adequacy Report 2.0. Network Inadequacy Report 3.0. Network Status Report 4.0. Implementation Of Enrollment plan Report 5.0. Monthly Referral Report 6.0. Resource Sharing Reporting and Certification 7.0. Medical Management Report 8.0. Quality Management Activity Report 9.0. Beneficiary Services And Access Reports 10.0. Education Presentation Report 11.0. Toll-Free Telephone Report 12.0. Customer Satisfaction Report 13.0. Productivity Report 14.0. Debt Collection Assistance Officer Program Collection Report 15.0. Financial Reports 16.0. Clinical Support Agreement Report 17.0. Quality Intervention Report 18.0. Contractor Records Accountability Report <i>19.0. Originating Site Report</i>
<b>4</b>	<b>MONTHLY WORKLOAD AND CYCLETIME REPORTS</b> 1.0. Instructions 2.0. TRICARE Contractor Monthly Cycle Time/Aging Report Instructions

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**  
CHAPTER 15 - AUDITS, INSPECTIONS, AND REPORTS

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<b>SECTION</b>	<b>SUBJECT</b>
<b>5</b>	<b>QUARTERLY REPORTS</b> 1.0. Fraud And Abuse Reports 2.0. Congressional/HBA Visit Report 3.0. Utilization Management Reporting 4.0. Providers and Beneficiaries on Prepayment Review Report 5.0. Health Care Finder Report <i>6.0. Quarterly Capital and Direct Medical Education Over And Under Payment Report</i>
<b>6</b>	<b>ANNUAL REPORTS</b> 1.0. Clinical Quality Management Program Annual Report (CQMP AR) 2.0. Fraud Prevention Savings Report <i>3.0. Annual Capital and Direct Medical Education Report</i>
<b>7</b>	<b>SPECIAL REPORTS</b> 1.0. General 2.0. Reports To MTF Commanders
<b>ADDENDUM A</b>	<b>FIGURES</b> FIGURE 15-A-1 TRICARE Contractor Monthly Workload Report - Network/ Non-Network/Medicare BRAC, TMA Form 742 FIGURE 15-A-2 TRICARE Contractor Monthly Cycle Time/Aging Report - Network/Non-Network/Medicare BRAC, TMA Form 743

## QUARTERLY REPORTS

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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.

#### **6.0. QUARTERLY CAPITAL AND DIRECT MEDICAL EDUCATION OVER AND UNDER PAYMENT REPORT**

*The contractor shall submit the quarterly Capital and Direct Medical Education Over and Under Payment Report. For each hospital on the initial calendar year report, the quarterly reports shall identify the: cumulative amount collected/refunded; amount still needing to be collected/refunded for each hospital; total collections; and total underpayments and the case status. All reports submitted shall contain totals for each of the financial fields on the report.*

## ANNUAL REPORTS

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The contractor shall submit the following management reports in magnetic medium or a disc. These reports shall contain information about contractor performance, plans, and problems in administering the contract. These reports shall require separate breakouts of data for network and non-network providers; TRICARE Prime, TRICARE Extra, and TRICARE Standard; and Prime Service *Areas (PSAs)* and non-*PSAs*. The format for these reports shall be agreed upon by the Contracting Officer (CO), Regional Director (RD), and the contractor. Copies of the reports are either furnished to or through the RD.

### 1.0. CLINICAL QUALITY MANAGEMENT PROGRAM ANNUAL REPORT (CQMP AR)

*1.1. Annually, within 45 calendar days following the beginning of the fiscal year, the contractor shall provide the CQMP AR to the CO. Attached to the report shall be a copy of the Annual Plan and include the status of active Quality Improvement Initiatives (QIIs), Quality Improvement Projects (QIPs), and Clinical Quality Studies (CQSs), and the contractor's most recent National Accreditations letter(s) indicating accreditation status (if accreditation is required). The Government will provide these documents to NQMC for evaluation. See Chapter 7, Section 4, Figure 7-4-1, for timeline.*

*1.2. The format and content of the CQMP AR shall address:*

- *Table of Contents*
- *Executive Summary*
- *Clinical Quality Program Report*
  - *Outcomes of Quality Improvement Initiatives (QIIs), Quality Improvement Projects (QIPs), and Clinical Quality Studies (CQSs)*
    - *Contractors will report on QIIs/QIPs/CQSs selected from the following areas:*
      - *Beneficiary Health, Error Reduction or Safety*
      - *Beneficiary Functional Status*
      - *Beneficiary Satisfaction*
      - *Provider Satisfaction (if applicable)*
      - *Clinical Administrative Processes or Program Related Issues*
    - *CQS and/or QIP will be submitted as an attachment in the contractor's national accreditation format*
    - *Outcomes of Patient Safety/Quality Programs such as, but not limited to:*
      - *Effect on reduction of medical errors*
      - *Effect on increasing patient safety*
      - *Effect on health promotion and disease and/or injury prevention*
      - *Provider and beneficiary educational activities initiated as a result of findings*

- Annual analysis of all potential QIs and all confirmed QIs stratified by event/indicator and severity levels/sentinel events including actions taken and improvements as a result of the findings
  - Annual analysis of all grievances (beneficiary, provider, etc.) stratified by category including actions taken and improvements as a result of the findings
  - Annual analysis of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator screening, interventions and outcomes
  - Annual analysis report of mortality in low-risk Diagnosis Related Groups (DRGs), interventions and outcomes
  - Assessment of the measurable goals and thresholds for the Internal Monitoring and Improvement of the CQMP Plan and the CQMP
- Measurable goals and recommendations for revisions to the CQMP Plan based on the year end outcomes.

## **2.0. FRAUD PREVENTION SAVINGS REPORT**

At least annually, the contractor shall report to the TMA Program Integrity Office the potential dollar amounts saved as a result of the activities/intervention of the anti-fraud/ investigative units (e.g., disallowed services that otherwise would have been paid if the provider suspected of billing the program inappropriately had not been placed on prepayment review).

## **3.0. ANNUAL CAPITAL AND DIRECT MEDICAL EDUCATION REPORT**

*The contractor shall submit the annual Capital and Direct Medical Education Report. The report shall identify the hospitals that submitted amended Medicare cost reports directly to the TRICARE contractor and those hospitals which the TRICARE contractor identified on the Centers for Medicare and Medicaid Services (CMS) web site. The report shall include the following data elements: the name of the hospital, both those that submitted an amended cost report to the contractors and those who were identified by the contractors' reviews of the CMS cost report web sites; the report shall clearly distinguish the hospitals who submitted an amended cost report and the hospitals which were identified by the contractors' review of the CMS cost report web site; the amount identified as either an underpayment or overpayment, and the status of their overpayment collection efforts.*