Figures

FIGURE 13.A-1 TRICARE FRAUD AND ABUSE REPORT, TMA FORM 435

TRICARE FRAUD AND ABUSE REPORT

ACTION OFFICER

KEYWORD (Region #)	**CONTRACTOR CODE**	**STATE (USPS CODE)**	**DATE REFERRED TO TMA**

SUBJECT	**NAME (LAST, FIRST, MI)**	**SSAN/EIN/TIN**	**ADDRESS (City, State)**
	CROSS REFERENCE (Last, First, MI)		

SECTION (A) **POTENTIAL FRAUD OR ABUSE ISSUE** **(NO MORE THAN 4 SELECTIONS)**	**POTENTIAL ABUSE** (257) ____ OVERUTILIZATION (273) ____ QUALITY OF CARE (282) ____ SERVICES NOT MEDICALLY NECESSARY (298) ____ WAIVER OF BENEFICIARY COST-SHARE (299) ____ IMPROPER BILLING PRACTICES (385) ____ OTHER (Abuse) _____ *Was case identified using Artificial Intelligence?* ____ *Yes* ____ *No*	**POTENTIAL FRAUD** (200) ____ MISREPRESENTATION OF CREDENTIALS (206) ____ ALTERING BILLS/RECEIPTS (389) ____ BALANCE BILLING LIMITATION (209) ____ BREACH OF PROVIDER PARTICIPATION AGREEMENT (211) ____ BILLING FOR SERVICES NOT RENDERED (230) ____ ELIGIBILITY (231) ____ EMBEZZLEMENT (235) ____ FALSIFYING RECORDS/DOCUMENTS (237) ____ FORGERY OF CHECK (244) ____ KICKBACKS/REBATES (248) ____ MISREPRESENTING SERVICES/DIAGNOSES (256) ____ FAILURE TO DISCLOSE OTHER HEALTH INSURANCE (386) ____ MISREPRESENTATION OF PATIENT (387) ____ MISREPRESENTATION OF PROVIDER (384) ____ OTHER (Fraud) _____
SECTION (B) **CLASSIFICATION OF SUBJECT** **(Check One)**	(101) ____ BENEFICIARY (120) ____ CONTRACTOR EMPLOYEE **PHYSICIAN** (102) ____ GENERAL PRACTICE (103) ____ SURGEON (104) ____ PSYCHIATRIST (105) ____ OBSTETRICIAN (106) ____ INTERNAL MEDICINE (108) ____ DENTIST (112) ____ ANESTHESIOLOGY (133) ____ OTHER (Physician) (Specify) _____ **HOSPITAL** (110) ____ ACUTE GENERAL (111) ____ PSYCHIATRIC (113) ____ RESIDENTIAL TREATMENT CENTER (114) ____ SPECIALIZED TREATMENT FACILITY	(107) ____ PSYCHOLOGIST (109) ____ PODIATRIST (115) ____ CLINIC, GROUP PRACTICE (116) ____ LABORATORY (117) ____ MEDICAL SUPPLIER (118) ____ AMBULANCE SERVICE (119) ____ PHARMACY (121) ____ CLINICAL SOCIAL WORKER (122) ____ MARRIAGE & FAMILY COUNSELOR (129) ____ MENTAL HEALTH COUNSELOR (130) ____ OTHER (Specify) _____ (131) ____ OTHER (Hospital) (Specify) _____ (134) ____ REGISTERED NURSE (135) ____ OCCUPATION/PHYSICAL THERAPIST (140) ____ PARTNERSHIP PHYSICIAN (141) ____ OTHER (Specify) _____
SECTION (C) **REFERRAL SOURCE** **(Check One)**	(01) ____ BENEFICIARY/SPONSOR (02) ____ CONTRACTOR (03) ____ LEAD AGENT (Region_____) (05) ____ HEALTH BENEFITS ADVISOR (06) ____ PROVIDER OF CARE (08) ____ MEDIA	(09) ____ DEFENSE ELIGIBILITY ENORLLMENT REPORTING SYSTEM (10) ____ TMA/OCHAMPUS PROGRAM INTEGRITY BRANCH (12) ____ OTHER (FI) (Specify) _____ (13) ____ OTHER GOVERNMENT SOURCE (Specify) _____ (14) ____ QUITAM (15) ____ DEFENSE CRIMINAL INVESTIGATIVE SERVICE
SECTION (D) **CASE DISPOSITION** **(Check One)**	(PR) ____ PLACED ON PREPAYMENT REVIEW (PC) ____ PROVIDER CONSULTATION (MR) ____ REFERRED TO MEDICAL REVIEW (IG) ____ REFERRED TO DOD IG (CD) ____ CASE DISMISSED (RL) ____ REFERRED TO LICENSING BOARD (TR) ____ TRANSFERRED	(DI) ____ REFERRED TO TMA/CHAMPUS PROGRAM INTEGRITY (DP) ____ DENIED PAYMENT (RF) ____ RECOUPED FUNDS (FR) ____ REFERRED TO CONTRACTORS RECOUPMENT SECTION (LT) ____ REFERRED TO TMA/OCHAMPUS RECOUPMENT SECTION (NC) ____ NOT CHASED (Conviction, but for hardship reason no recoupment) (PS) ____ PROVIDER SANCTIONED (Terminated or Excluded)

SECTION (E) **DOLLAR IMPACT**	(01) DOLLARS CURRENT CASE	(02) DOLLARS IDENTIFIED FOR RECOUPMENT	(03) DOLLARS RECOUPED

TMA/OCHAMPUS FORM 435 **PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE**
JAN 2002

FIGURE 13.A-1 TRICARE FRAUD AND ABUSE REPORT, TMA FORM 435 (CONTINUED)

Instructions

This form is to be completed for each potential fraud or abuse case opened.

A. Fraud or Abuse Issue: May select up to four issues. If more than one applies, rate them from most to least important.

B. Classification of Subject: Self-explanatory. Check the category which most appropriately identified the subject. When one individual provider within a clinic or group is involved, use the individual provider classification.

C. Referral Source: Select the one which most appropriately identifies the referral of this case.

D. Case Disposition: Select the one which most appropriately identifies the disposition of this case. Do not complete if referred to TMA, Program Integrity Office.

E. Dollar Impact: Complete (01) Dollars Current Case, i.e., erroneous or overpayment amount, when referred to TMA, Program Integrity Office.

FIGURE 13.A-2 SAMPLE LETTER TO BENEFICIARY IN EXTERNAL AUDIT CASES

(**Beneficiary Address**)

Dear_____:

We are pleased that we were recently of service to you. Now we ask your participation in this survey to help us improve service to you and all other TRICARE beneficiaries. We are requesting that you review the following information to determine whether our records are correct. Our records show that you received the following services:

Provider: **(Name of physician, dentist, pharmacy, hospital, or other supplier)**

Date of Service: **(List by each date of service. Do not use range dates.)**

Place of Service:

Type of Service: **(List by narrative description, not by procedure code.)**

Amount Billed to Patient:

Amount Paid by Patient, Sponsor, or Parent/Guardian:

Cost-share Amount or Other Health Insurance Amount:

If the "amount paid by patient" was not actually paid to the provider of care or pharmacy by the patient, sponsor, or parent/guardian, explain below or on the reverse side of this letter.

Please circle any of the above items which appear to be wrong and explain on the reverse side of this letter. In addition, please provide the following information:

Did you sign a claim form or an authorization form supplied by the provider of care for the services shown above? YES _____, NO _____.

Did you sign a "benefit assignment" form which stated you were responsible for the full charges over and above what your insurance (or TRICARE) would pay? YES_____ NO _____.

Your work phone number: _____ Home phone number: _____,

We appreciate your assistance in responding to this request and have enclosed a self-addressed stamped envelope for your convenience. If you have any questions, please call (Telephone Number). Thank you for your cooperation.

Sincerely,

Name, Title and Office

Enclosure:
Self-Addressed Stamped Envelope

FIGURE 13.A-3 SAMPLE LETTER TO PROVIDER/PHARMACY IN EXTERNAL AUDIT CASES

(**Provider or Pharmacy Address**)

Dear_____:

Recently, we received a claim filed by a beneficiary who reported services, pharmaceuticals, and/or supplies furnished by you. Now we ask your assistance in this survey to help us improve service and benefits to all TRICARE beneficiaries and providers. Please review the following information in your records to determine whether our information is correct.

Patient Name:

Sponsor SSN:

Date of Service:

Place of Service:

Type of Service:

Total Amount Billed Patient:

Please circle any of the above items which appear to be in error, provide the correct information next to it, and return this letter in the enclosed self-addressed, stamped envelope. If the information is correct, write the word "correct" on this letter and return it.

In addition, please provide the following information:

1. Procedure, diagnosis or additional description of services or pharmaceuticals provided this patient:

2. Your telephone number:

Thank you for your attention to this matter. Your assistance in responding to this survey is appreciated.

Sincerely,

Name, Title and Office

Enclosure:
Self-Addressed Stamped Envelope

FIGURE 13.A-4 SPECIAL NOTICE TO PROVIDER/PHARMACY WHEN THE PROVIDER'S OR NETWORK PHARMACY'S CLAIMS ARE SUSPENDED (SAMPLE)

(**Provider Address**)

Dear_____:

This is to inform you that we have been notified by the TRICARE Management Activity (TMA) to suspend payment for present and future claims for services provided by you or your organization. This action is being taken immediately under the provisions of the 32 CFR 199.9 because of further investigation by the Government of your organization's medical and/or financial records. This suspension is for an indefinite period of time as determined by TMA.

Please note that any participation agreement with your patients remains in full force and effect and you cannot repudiate the agreement as a result of the delay in final disposition of the claims. The assessment of a finance charge, either to the beneficiary or the Government, on these suspended claims is also prohibited.

Within 30 days of the date of this notice, you may present to the Director, Program Integrity Office, TMA, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts, or you may submit a written request to present in person, evidence to the Director, TMA, or a designee. All such presentations shall be made at TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066 at your expense.

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA Program Integrity Office will be the sole authority for the direction of issuance of a notice of the suspension of a provider's or pharmacy's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension provided by TMA.

FIGURE 13.A-5 SPECIAL NOTICE TO BENEFICIARY WHEN THE BENEFICIARY'S CLAIMS ARE SUSPENDED DUE TO POSSIBLE BENEFICIARY FRAUD (SAMPLE)

(**Beneficiary Address**)

Dear_____:

This is to inform you that your claims have been suspended pending review by the TRICARE Management Activity (TMA), effective **(Date)** for an indefinite period of time. This action is being taken by the TMA under the provisions of the 32 CFR 199.9, because of further investigation by the Government of your claims.

Within 30 days of the date of this notice, you may present to the Director, Program Integrity Office, TMA, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts or you may submit a written request to present, in person, evidence to the Director, TMA, or a designee. All such presentations shall be made at TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066, at your expense.

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA Program Integrity Office will be the sole authority for the direction of issuance of a notice of the suspension of a provider's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension provided by TMA.

FIGURE 13.A-6 SPECIAL NOTICE TO BENEFICIARY'S WHEN A BENEFICIARY'S CLAIMS ARE SUSPENDED DUE TO POSSIBLE PROVIDER/PHARMACY FRAUD (SAMPLE)

(**Beneficiary Address**)

Dear_____:

This is to inform you that your claim(s) for services provided by (**Provider's/Pharmacy's Name and Address**) has been suspended pending review by the TRICARE Management Activity (TMA), for an indefinite period of time. This action is being taken by the TMA under the provisions of the 32 CFR 199.9, because of further review by the Government of services/supplies provided by (**Name of Provider/Pharmacy**).

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA Program Integrity Office will be the sole authority for the direction of issuance of a notice of the suspension of a provider's or pharmacy's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension provided by TMA.

FIGURE 13.A-7 ANNUAL LETTER OF ASSURANCE (SAMPLE)

XXXXXXXXXXXX
Procuring Contracting Officer (PCO)
TRICARE Management Activity (TMA)
16401 East Centretech Parkway
Aurora, Colorado 80011-9066

Dear_____:

An evaluation of the system of internal accounting and administrative control of (name of contractor) in effect during the fiscal year ended (date) was performed in accordance with Guidelines for the Evaluation and Improvement of and Reporting on Internal Control Systems in the Federal Government, issued by the Director of the Office of Management and Budget, in consultation with the Comptroller General, as required by the Federal Managers' Financial Integrity Act of 1982, and accordingly included an evaluation of whether the system of internal accounting and administrative control of (name of contractor) was in compliance with the standards prescribed by the Comptroller General.

The objectives of the system of internal accounting and administrative control of (name of contractor) are to provide reasonable assurance that:

1. Obligations and costs are in compliance with applicable law;

2. Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and

3. Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial statistical reports and to maintain accountability over the assets.

The concept of reasonable assurance recognizes that the cost of internal control should not exceed the benefits expected to derive therefrom, and that the benefits consist of reductions in the risks of failing to achieve the stated objectives. Estimates and judgements are required to assess the expected benefits and related costs of control procedures. Furthermore, errors or irregularities may occur and not be detected because of inherent limitations in any system of internal accounting and administrative control, including those limitations resulting from resource constraints, Congressional restrictions, and other factors. Finally, projection of any evaluation of the system to future periods is subject to the risk that procedures may be inadequate because of changes in conditions or that the degree of compliance with the procedures may deteriorate.

The results of the evaluation described in the first paragraph, assurances given by appropriate (name of contractor) officials, and other information provided, indicate that the system of internal accounting and administrative control of (name of contractor) in effect during the fiscal year ended (date), taken as a whole, complies with the requirement to provide reasonable assurance that the above-mentioned objectives were achieved within the limits described in the preceding paragraph. Controls are in place to prevent and detect fraudulent and abusive practices, and comply with contractual requirements in that respect. The evaluation, however, did disclose the following weaknesses: (1)

(List The Material Weaknesses (2))

FIGURE 13.A-7 ANNUAL LETTER OF ASSURANCE (SAMPLE) (CONTINUED)

Attachment A to this statement contains the (name of contractor) plans and schedules for correcting such weaknesses (1), and the status of actions taken to correct weaknesses identified in prior years' reports. (3)

Sincerely,

Name, Title and Office

Enclosure(s)
(if any)

NOTE TO CONTRACTOR

(1) If there are no material weaknesses, this sentence should be deleted, and there would be no list or Attachment A containing plans and schedules for correcting such weaknesses.

(2) If material weaknesses in systems subject to these guidelines are found, this sample letter constitutes the statement and report required by the Federal Managers' Financial Integrity Act. If material weaknesses are not found, this sample, as adjusted, constitutes the statement required by the Act.

(3) If there were no actions taken during the past year to correct weaknesses, or no identified weaknesses for which corrective actions remain to be taken, this phrase would be deleted.

FIGURE 13.A-8 NOTICE TO PROVIDER/PHARMACY EXCLUDED OR SUSPENDED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) (SAMPLE)

(**Provider Address**)

Dear_____:

The Department of Defense, TRICARE Management Activity (TMA), has been advised by the Department of Health and Human Services (DHHS) that you have been (**Excluded** or **Suspended**) from Medicare participation. This (**Exclusion** or **Suspension**) for the period **(Terms of Sanction, i.e., One Year, Two Years, etc.)**, was effective 15 days from the date of DHHS' notice of **(Date of DHHS' Notice)** and will remain in effect for the period of time determined by the Secretary of the Department of Health and Human Services.

Based on the provisions of the regulation governing the operations of TRICARE, 32 CFR 199.9, payments under TRICARE will also be denied for services or supplies furnished 15 days after the date of DHHS' letter. As the actions taken by TRICARE are based on a DHHS determination, no administrative appeal rights are available under 32 CFR 199.10 which specifically provides that:

> "Any sanction, including the period of the sanction, imposed under Chapter 9 of this Regulation which is based solely on a provider's exclusion or suspension by another agency of the Federal Government, a state, or a local licensing authority is not appealable under this chapter. The provider must exhaust administrative appeal rights offered by the other agency that made the initial determination to exclude or suspend the provider."

If you wish to provide services under TRICARE after you are reinstated by DHHS, you must apply for reinstatement to the Director, Program Integrity Office, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066. Include a copy of your DHHS reinstatement letter and documentation sufficient to establish that you meet the qualifications under the TRICARE Regulation to be an authorized provider.

Sincerely,

Name, Title and Office

cc:
Program Integrity Office
TMA

NOTE TO CONTRACTOR

Letter is to be sent by Return Receipt Requested or any other method requiring a signature documenting receipt.

FIGURE 13.A-9 NOTICE TO BENEFICIARY WHEN PROVIDER/PHARMACY IS EXCLUDED OR SUSPENDED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) (SAMPLE)

(**Beneficiary Address**)

Dear_____:

This is to inform you that (**Name of Provider/Pharmacy**) has been (**Excluded** or **Suspended**) as an authorized provider under the TRICARE Management Activity (TMA) effective **(Give Actual TRICARE Effective Date)**. This action is being taken by the TMA based upon a Department of Health and Human Services (**Exclusion** or **Suspension**) and the 32 CFR 199.9. Therefore, we will not pay for any services provided to you by **(Name of Provider/Pharmacy)**, on or after **(Actual TMA Effective Date)** for a period of time determined by TMA. The provider has been notified by the Department of Health and Human Services and TMA of this action.

If you need assistance in selecting an alternative facility or professional provider, please contact your Beneficiary Counseling and Assistance Coordinator (BCAC) or call **(Give Appropriate Contractor Telephone Number)**.

Sincerely,

Name, Title and Office

FIGURE 13.A-10 NOTICE OF PROPOSED ACTION TERMINATING A PROVIDER/PHARMACY (SAMPLE)

Note: For Pharmacy please change "provider" to "pharmacy" or "network pharmacy" as applicable.

(**Provider Address**)

Dear_____:

This is to notify you of our proposed action to terminate you as an authorized TRICARE provider. This decision is based on the fact that you do not meet the qualifications as an authorized TRICARE provider as established by the 32 CFR 199.6, based on the documentation submitted to us. (**NOTE: The contractor shall give the reasons and supporting facts for the proposed termination**.)

The effective date of this termination is retroactive to (**Date and provide one of the following statements: The date on which you did not meet these requirements, or June 10, 1977, the effective date of the Regulation, WHICHEVER DATE IS LATER**). The period of termination is indefinite and will end only after you have successfully met the established qualifications for authorized provider status under TRICARE and have been reinstated as an authorized TRICARE provider.

Authority for this termination can be found in the 32 CFR 199.9, which provides administrative remedies for fraud, abuse and conflict of interest, and for termination when the provider has not met or satisfied the criteria for TRICARE authorized provider status. This Regulation applies whether you are a participating or a nonparticipating provider. Since a provider is expected to know the TRICARE requirements for qualification as an authorized provider, and we have no evidence that you meet the qualification requirements, you are considered to have forfeited or waived any right or entitlement to bill the beneficiary for the care involved in the TRICARE claims. If you do bill the beneficiary, restitution to the beneficiary may be required by the Director, TMA, or a designee, as a condition for consideration of reinstatement as a TRICARE authorized provider. Beneficiaries who choose to continue to use the services of an unauthorized TRICARE provider shall not be reimbursed by TRICARE.

The retroactive effective date of termination shall not be limited due to the passage of time, erroneous payment of claims, or any other events which may be cited as a basis for TRICARE recognition of the provider, notwithstanding the fact that the provider does not meet program qualification requirements. Unless specific provision is made to "grandfather" or authorize a provider who does not otherwise meet the qualifications established in the 32 CFR 199.6 all unqualified providers shall be terminated.

Any claims cost-shared or paid under TRICARE for services or supplies furnished by the provider on or after the effective date of termination, even when the effective date is retroactive, shall be deemed an erroneous payment. All erroneous payments are subject to collection. Any further claims processing will be suspended unless you provide documentation that you meet the requirements as an authorized provider.

FIGURE 13.A-10 NOTICE OF PROPOSED ACTION TERMINATING A PROVIDER/PHARMACY (SAMPLE) (CONTINUED)

We will consider any documentary evidence or written argument regarding the proposed action submitted within 30 days of the date of this letter. You may also submit within 30 days a written request to present in person, evidence or argument to (**Unit** or **Name Of Person And Address To Whom The Provider Is To Submit Certification Documentation**). All such presentations shall be made at the above mentioned office at your expense.

Any requests or submittals to **(Unit or Person's Name Mentioned Above)**, must be received within 30 days of the date of this letter or, if received after 30 days, must be postmarked within 30 days of the date of this letter. If you cannot present additional information within 30 days, upon written request and for good cause shown, you may request that additional information be submitted within 60 days from the date of this letter. All communications with this office should be in writing.

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

This letter is to be sent by Return Receipt Requested or any other method which will document receipt.

FIGURE 13.A-11 INITIAL DETERMINATION TERMINATING A PROVIDER/PHARMACY (SAMPLE)

(**Provider Address**)

} Initial Determination
} Contractor Name
} Case File YY-"#"

Dear_____:

By letter dated **(Date of Proposed Action Notice)**, you were given notice of a proposed action to terminate you as an authorized **(Provider/Pharmacy Type)** under TRICARE. By that notice, you were offered the opportunity to submit, within 30 days, either documentary evidence supporting your contention that you meet the requirements for authorization as a **(Provider Type)** and written argument contesting the proposed action or a written request to present in person, and at your sole expense, evidence or argument supporting your contention that you meet the requirements for authorization as a **(Provider Type)**.

(State what the provider did: i.e., by letter dated ___, you submitted additional information, or on {Date} you personally appeared before {State Name and Position of the Informal Review Official}, or you failed to take advantage of the opportunity to submit any documentation or argument contesting the proposed action.)

After reviewing all available information, this initial determination is issued terminating your status as an authorized TRICARE provider effective **(Insert Either June 10, 1977, the Effective Date of the CHAMPUS Regulation or the Date on which the Provider was first approved or lost their license, WHICHEVER IS LATER)**, the date on which you first failed to meet the requirements as a **(Provider/Pharmacy Type)** under the 32 CFR 199.6 This termination action is being taken under authority of the 32 CFR 199.9. The retroactive date of termination is not limited due to the passage of time, erroneous payments of claims, or any other event which may be cited as a basis for TRICARE recognition of a provider notwithstanding the fact that the provider does not meet program qualifications. Termination under TRICARE shall continue even if you obtain a license to practice in a second jurisdiction during the period of exclusion or revocation of your license by the original licensing jurisdiction. Any claims previously cost-shared or paid under TRICARE for services or supplies furnished on or after the effective date of termination shall be deemed an erroneous payment and shall be subject to collection action under appropriate law and regulation

Under the 32 CFR 199.6, to be an authorized (**Provider/Pharmacy Type**), an individual must be licensed or certified by the state and meet the following requirements:

(List Specific Requirements From The Regulation)

Records available for review indicate that you do not meet the requirements for authorization as a **(Provider/Pharmacy Type)** under TRICARE because **(Give specific basis for your decision; if the provider submitted any evidence or argument in writing or in person, identify that evidence or argument here and discuss its relevance to this decision.)**

FIGURE 13.A-11 INITIAL DETERMINATION TERMINATING A PROVIDER/PHARMACY (SAMPLE) (CONTINUED)

The period of your termination as an authorized **(Provider/Pharmacy Type)** under TRICARE is indefinite under the provisions of the 32 CFR 199.9. The period of termination will end only upon receipt of documentation that you have successfully met the established qualifications and receipt of your request for reinstatement as an authorized provider under the procedures established by the 32 CFR 199.9. All requests for reinstatement of terminated providers must be submitted to the Chief, Program Integrity Office, TRICARE Management Activity (TMA), 16401 East Centretech Parkway, Aurora, Colorado 80011-9066.

The 32 CFR 199.10, sets forth policies and procedures for appealing decisions that affect the rights and liabilities of providers whose status as an authorized provider under TRICARE has been terminated. In order to appeal, however, there must be an appealable issue, that is, there must be a disputed question of fact which, if resolved in your favor, would result in your approval as a TRICARE authorized provider. The administrative appeal process may not be used to challenge the propriety, equity, or legality of any provision of law or regulation. If you disagree with this initial determination and you believe a disputed question of fact exists, you may appeal. Your written request for a hearing must be mailed within 60 days from the date of this letter to the Chief, Office of Appeals and Hearings, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066. A copy of this letter should be included with your request for a hearing. You should also include any additional documentation or evidence you wish considered in support of your contention that you meet the TRICARE criteria for authorization as a **(Provider/Pharmacy Type)**.

Sincerely,

Name, Title and Office

cc:
Program Integrity Office
TMA

NOTE TO CONTRACTOR

This letter is to be sent by Return Receipt Requested or any other method which will document receipt.

FIGURE 13.A-12 VIOLATION OF THE PARTICIPATION AGREEMENT (SAMPLE)

(**Provider Address**)

Dear_____:

We have been notified that you are in breach of the participation agreement. **(Name of Patient)** advised us that **(He/She)** has been billed for amounts in excess of **(His/Her)** cost-share for services provided on **(Dates)**, which is a violation of your participation agreement.

Please be advised that by signing the TRICARE claim form and indicating your willingness to accept assignment for these services, you agreed to accept the TRICARE, determined allowable charge for medical services/supplies listed on the claim form as payment in full, minus any deductible and cost-share. This is true even if you requested the beneficiary to complete a form agreeing to pay the full amount not paid by other health coverage or insurance plans.

Under TRICARE, authorized professional providers and institutional providers, other than certain hospitals, have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating but which are subject to the TRICARE DRG-based payment system must sign agreements to participate on all TRICARE inpatient claims in order to be authorized providers under TRICARE. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable TRICARE claims form and submitting it to the appropriate TRICARE contractor. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This signature certifies that the provider has agreed to accept the amount paid by TRICARE or the TRICARE payment combined with the cost-sharing amount paid by or on behalf of the beneficiary as full payment for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the TRICARE-determined allowable cost or charge for authorized medical services or supplies.

A breach of the participation agreement which results in the patient being billed in excess of the allowable amount is specifically listed in the 32 CFR 199.9 as a fraudulent act. Your failure to honor the participation agreement is considered to be a serious infraction of TRICARE rules and regulations which could have repercussions with your TRICARE-authorized provider status as well as that of other Government agencies, such as Medicare and Medicaid.

To preclude any adverse action against your authorized provider status, please notify **(Name of Patient)** in writing that all attempts to collect amounts in excess of **(His/Her)** deductible and cost-share have ceased.

The total billed amount is **(Amount)** and the correct TRICARE allowable is **(Allowable Amount)**. **(Name of Patient)** cost-share amount is **(Appropriate Percentage)**, of **(Put In Dollar Amount)**. The total payment amount to you is **(Government's Cost-Share Plus Patient's Deductible and Cost-Share Amount)**. **(Name of Patient)** is only responsible for (His/Her) cost-share amount **(Amount)**. Any amounts billed to the patient in excess the patient's cost-share and deducible amount **(Deductible Amount, if any)**, is a violation of your participation agreement.

Please provide to us a copy of your letter to **(Name of Patient)** within 15 days of the date of this letter. Please contact me in writing if you have any questions regarding this matter.

FIGURE 13.A-12 VIOLATION OF THE PARTICIPATION AGREEMENT (SAMPLE) (CONTINUED)

Sincerely,

Name, Title and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

Letter must be addressed to an individual. Do not use "Dear Provider."

FIGURE 13.A-13 VIOLATION OF THE PARTICIPATION AGREEMENT - FOLLOW-UP (SAMPLE)

(**Provider Address**)

Dear_____:

By letter dated **(Date)**, you were advised that you were in violation of your participation agreement for a TRICARE beneficiary. You were requested to write to **(Name of Patient)** and advise **(Him/Her)** that attempts to collect amounts in excess of the deductible and cost-share amount are cancelled and to provide a copy of the letter to us within 15 days of the date of our letter. To date, we have not heard from you.

The 32 CFR 199.9 cites a breach of provider participation agreement which results in the beneficiary being billed for amounts which exceed the TRICARE-determined allowable charge or cost as an example of fraud. Further, administrative remedies for fraud may result in a provider being excluded or suspended as an authorized TRICARE provider.

Please cease collection action for amounts in excess of the TRICARE-determined allowable amount and advise **(Name of Patient)** of this action; provide a copy of your letter to us within 15 days of the date of this letter. We will refer this matter to the TRICARE Management Activity (TMA), Program Integrity Office, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066 if we do not hear from you.

Sincerely,

Name, Title and Office

cc:
Beneficiary

FIGURE 13.A-14 VIOLATION OF REIMBURSEMENT LIMITATION (BALANCE BILLING) (SAMPLE)

(**Provider Address**)

RE: Patient:
Sponsor:
Sponsor SSN:
Date(s) of Service:
ICN:
Total Charges:

Dear_____:

We have been advised that you have billed **(Name of Patient)** for an amount greater than 115 per cent of the CHAMPUS Maximum Allowable Charge (CMAC). Please be advised that, 10 USC 1079(h)(4) limits the amount that a nonparticipating provider may bill a beneficiary in excess of the CMAC to the same percentage as that used by Medicare.

Provisions of the law were implemented by the DoD in a final rule published in the **Federal Register** on October 1, 1993. The effective date of the rule is November 1, 1993, and applies to all services provided on or after that date. Failure by a nonparticipating provider to comply with this requirement is a basis for exclusion from TRICARE as an authorized provider.

Please provide a refund to the beneficiary within 30 days of the date of this letter. If no overpayment was made by the beneficiary, then credit the account within 30 days of the date of this letter and cease billing efforts for the amount in excess of the 115% of the CMAC. The enclosed Explanation of Benefits (EOB) contains the procedure code(s) for each service rendered, the date(s) of service, and the CMAC for each procedure. The 115% of the CMAC can be easily calculated from the information provided on the EOB (1.15 x CMAC = Balance Billed Amount.)

If you have any further questions regarding this matter, please contact our Service Department at **(Telephone Number)** or your Provider Relations Representative.

Sincerely,

Name, Title and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

Letter must be addressed to an individual. Do not use "Dear Provider."

FIGURE 13.A-15 VIOLATION OF REIMBURSEMENT LIMITATION (BALANCE BILLING) FOLLOW-UP (SAMPLE)

(**Provider Address**)

RE: Patient:
Sponsor:
Sponsor SSN:

Dear_____:

In a letter dated **(Date of Initial Letter)**, copy enclosed, you were advised of an incorrect billing practice, and advised to refund to the beneficiary (or credit the account) any amount billed in excess of 115% of the CHAMPUS Maximum Allowable Charge (CMAC). To date, we have not heard from you. Please respond to our letter, within 15 days of the date of this letter, of your intention to correct this practice to conform with the public law. The TRICARE 115% limitation is based on a similar Medicare law. Because TRICARE is a much smaller federal program than Medicare, not all providers are as familiar with the TRICARE requirements as they are with Medicare requirements. If you require additional information or you disagree with our interpretation of your billing, please contact us.

Please contact our Service Department at **(Telephone Number)** or your Provider Relations Representative if you have any questions concerning this matter.

Sincerely,

Name, Title and Office

cc:
Beneficiary

FIGURE 13.A-16 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS

In each case where the purpose is to determine the probable scope and extent of overpayments, regardless of how the overpayment was incurred, the sample size shall be calculated at 90% confidence level, 10% precision level, and a 50% occurrence rate. The 50% occurrence rate is used when there is no established rate of occurrence. If the occurrence rate is known by a previously documented statistically valid analyses of the units of audit (e.g., same provider, same procedures, same time period) of the possible fraudulent practice by a Federal health care entitlement program, that occurrence rate may be used to calculate the sample size. The sample size shall be determined using the parameters discussed above. The sample shall be selected using random numbers generated by an electronic random number table using a random number function, using a known seed number.

A same seed number, other than zero, will provide the same set of random numbers with the same sample and universe size. An oversample of 20% shall always be requested for the beginning of an audit. The universe of claims shall not include denied claims or claims where TRICARE paid zero dollars. Only netted records shall be used.

In all claim audits using statistical techniques to extrapolate findings of a sample to a universe of claims, the audit addresses the average overpayment per claim as the single unit of measurement. The claim and the explanation of benefits are the evidentiary documents which demonstrate the billed services submitted by a provider or beneficiary and the payments made to a provider or beneficiary. The claim is compared to the contents of the medical record to validate whether a service was provided, whether it was provided at the level billed, whether it was provided by the authorized provider shown on the claim, or any other data which may be relevant to a dollar loss to the Government or a contractor. This information shall be recorded on a spreadsheet generated by Microsoft® Excel, or compatible software, with a .xls file extension spreadsheet for compatibility with other widely used spreadsheet software. Each claim in the sample is totaled for an overpayment or no overpayment. No overpayment for a claim must be placed in the array of the total sample calculation as zero.

The overpayments are expressed in dollars and cents. The total is then summed and divided by the number of claims in the sample (remembering that claims with no overpayments are shown in the column to be summed as zero). The product is the average mean overpayment per claim in the sample. The average mean overpayment per claim in the sample is multiplied by the number of claims in the universe from which the sample was taken and this product expressed in dollars and cents is the probable dollar loss to the Government or contractor.

To demonstrate the validity of the sample, it is necessary to calculate the standard deviation and the sampling error. The contractor shall have the electronic capability to accomplish this check of validity. In order to establish the actual confidence level for any given sample, it is necessary to calculate the standard deviation of the sample and, subsequently, the standard error of the average mean. In the sample technique discussed above, if the sample has been properly designed and selected, there is a probability that 90 out of 100 observations (claim overpayments) will fall within the range of the arithmetical mean plus or minus 1.96 times the calculated standard deviation. The standard deviation is determined by calculating the difference between each claim observation and the average mean, and squaring the product. The total of the squared differences is summed and divided by the number of observations in the sample. The square root of this calculation is the standard deviation expressed in dollars and cents. If the standard deviation is greater than 1.96 times the arithmetic mean, this is an indicator that the sample does not demonstrate the confidence level required for validity.

FIGURE 13.A-16 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS (CONTINUED)

The standard error of the mean is calculated by dividing the standard deviation by the square root of the sample size. The sampling error is calculated by multiplying the standard error of the mean by the "Z" score (for a 90% confidence level the "Z" score is 1.645). The high and low (plus or minus) estimate of overpayments is calculated by adding or subtracting the sampling error from the average overpayment per claim and multiplying the plus or minus product by the universe of claims. If the high estimate of overpayments is greater than the universe amount or the low estimate of overpayments is less than zero then the computed overpayment amount shall not be used.

If there are services subject to audit where there are large differences in payments, e.g., surgical and medical, there will be a necessity to stratify the services shown on claims to two or more separate universes for separate sample selection. Please seek consultation for such sample techniques from a certified statistician.

The standard reference for auditing with samples is the Handbook of Sample for Auditing and Accounting, Third Edition, by Herbert Arkin, McGraw-Hill Book Company, copyright 1984.

FIGURE 13.A-17 QUARTERLY FRAUD/ABUSE REPORT

REPORTING PERIOD ENDED _____,

The TRICARE Fraud and Abuse Case Report, TMA Form 435, will be completed on every case opened for initial investigation of potential fraud or abuse. The following information, which is essentially the same as on Form 435, will be submitted to the Program Integrity Office (PI), TRICARE Management Activity (TMA), within 30 days of the last day of each calendar quarter.

A. Case Workload Report

Number of cases over 25,000 (10,000 for pharmacy & dual-eligible) opened during quarter

Number of cases under 25,000 (10,000 for pharmacy & dual-eligible) opened during quarter

Number of cases referred to the TMA PI during quarter

Number of cases closed during quarter

Number of cases over 25,000 (10,000 for pharmacy & dual-eligible) opened during calendar year to date

Number of cases under 25,000 (10,000 for pharmacy & dual-eligible) opened during calendar year to date

Number of cases referred to the TMA PI during calendar year to date

Number of cases closed during calendar year to date

Number of cases over 25,000 (10,000 for pharmacy & dual-eligible) pending during quarter

Number of cases under 25,000 (10,000 for pharmacy & dual-eligible) pending during quarter

Total number of beneficiaries on prepayment review

Total number of providers on prepayment review

Attach a separate listing of cases opened/pended/closed during each quarter

B. Categorical Information on Cases Opened During this Quarter

CLASSIFICATION OF SUBJECT	NUMBER OF CASES
Beneficiary	
Physician	
General Practice	
Surgeon	
Psychiatrist	
Obstetrician	
Internal Medicine	
Anesthesiologist	
Psychologist	
Podiatrist	
Other (Specify)	
Hospital	
Acute General	
Psychiatric	
Other (Specify)	

FIGURE 13.A-17 QUARTERLY FRAUD/ABUSE REPORT (CONTINUED)

B. Categorical Information on Cases Opened During this Quarter (Continued)

Skilled Nursing Facility
Residential Treatment Center
Specialized Treatment Facility
Clinic, Group Practice
Laboratory
Medical Supplier
Ambulance Service
Registered Nurse
Clinical Social Worker
Marriage, Family and Pastoral Counselor
Mental Health Counselor
Occupational Therapist
Pharmacy/Pharmacist
Physical Therapist
Others
Total

POTENTIAL FRAUD OR ABUSE ISSUES--REPORT AS FOLLOWS

POTENTIAL ABUSE	NUMBER OF CASES OPENED	TOTAL DOLLAR AMOUNT BY ISSUE
Services Not Medically Necessary		$
Overutilization		$
Failure to File Claims (Provider)		$
Billing Administrative Charge for Filing Claims		$
Quality of Care		$
Other (Specify)		$

FRAUD -- REPORT AS FOLLOWS	NUMBER OF CASES OPENED	TOTAL DOLLAR AMOUNT BY ISSUE
Billing for Services Not Rendered		$
Misrepresenting Services/Diagnosis		$
Altering Bill/Receipt		$
Falsifying Records/Documents		$
Kickbacks/Rebates		$
Eligibility		$
Embezzlement		$
Forgery of Check		$
Other Health Insurance		$
Misrepresentation of Credentials		$
Breach of Provider Participation Agreement		$

FIGURE 13.A-17 QUARTERLY FRAUD/ABUSE REPORT (CONTINUED)

FRAUD -- REPORT AS FOLLOWS (CONTINUED)	NUMBER OF CASES OPENED	TOTAL DOLLAR AMOUNT BY ISSUE
Balance Billing Limitation		$
Misrepresenting Patient		$
Misrepresenting Provider		$
Other (Specify)		$
Total		$

FRAUD OR ABUSE REFERRAL SOURCE -- REPORT AS FOLLOWS	NUMBER OF CASES OPENED
Beneficiary/Sponsor	
Clerical Identification	
Prepayment Review	
Postpayment Review	
Health Benefits Advisor	
Provider of Care	
Medical Review (Third Level)	
Media	
DEERS	
TMA	
DCIS	
Other Investigative Agency (Specify)	
Other Contractor	
OHI	
Public/anonymous	
Hotline Complaint	
Other (Specify)	

DISPOSITION OF FRAUD AND ABUSE CASES -- REPORT AS FOLLOWS	NUMBER OF CASES
Place on Prepayment Review	
Provider Consultation	
Referred for Medical Review	
Referred to the TMA Program Integrity Office	
Case dismissed (no issue)	
Referred to Licensing Board	
Denied Payment	
Recouped Funds	
Referred to Contractor Recoupment Section	
Referred to the TMA Recoupment Section	
Provider Sanctioned (terminated or excluded)	
Other (specify)	

FIGURE 13.A-17 QUARTERLY FRAUD/ABUSE REPORT (CONTINUED)

SAVINGS	RECEIVED THIS QUARTER	RECEIVED CY TO DATE
Provider Prepay/Review	$	$
Beneficiary Prepay Review	$	$
Provider Recoupment	$	$
Beneficiary Recoupment	$	$
Offsets	$	$
Denials (Specify)	$	$
Other (Specify) (For example: "claimcheck", OHI, Drug Seeking Beneficiary controls, etc.)	$	$
Total	$	$

BENEFICIARY PREPAYMENT REVIEW REPORT							
NAME	SSN/TIN	DOB	BASIS	# SUSPENDED	# DENIED	$ SUSPENDED	$ DENIED

List in alphabetical order.

PROVIDER PREPAYMENT REVIEW REPORT							
NAME	SSN/EIN	SPEC	BASIS	# SUSPENDED	# DENIED	$ SUSPENDED	$ DENIED

List in alphabetical order.

FIGURE 13.A-18 CONTROLLED PRESCRIPTION DRUGS

1.0 CONTROLLED PRESCRIPTION DRUG SCHEDULES

The Controlled Substances Act of 1970 (Public Law 91-513) classifies drugs covered by the law in five schedules according to their potential for abuse and risk of bodily harm. The schedules follow:

1.1 Schedule I

Substances with a high potential for abuse and that have no current accepted medical use in treatment. These drugs circulate through, and are available through, illegal channels.

1.2 Schedule II

Drugs which have a high abuse potential with severe psychic or physical dependence liability. Drugs should have a current acceptable medical use in treatment. This schedule includes the narcotics, stimulants and depressants that are commonly obtained through legal channels but have high potential for drug dependency. The following control measures prevail that affect prescribing and dispensing of the drugs in this schedule:

- Prescription must be signed by the prescribing physician.
- Prescriptions are nonrefillable.

1.3 Schedule III and IV

The drugs or other substances in Schedules III or IV have less potential for abuse than the drugs or other substances in Schedules I and II. The drugs have currently acceptable medical use in treatment in the United States. Abuse of the drugs or other substances may lead to moderate or low physical dependence or high psychological dependence:

- Drugs may be prescribed orally (by phone) or written.
- Prescriptions may be refilled up to five times within six months of initial issuance if authorized by the prescribing physician and if state law permits. After the five or less authorized refills are received or after the expiration of six months from date of issuance (whichever comes first), the prescription is non-refillable and a new and separate written prescription, or an oral prescription if state law permits, is required. (Additional refill authorization cannot be added to the prescription. A new prescription must be developed.)

1.4 Schedule V

Includes certain narcotic drugs containing nonnarcotic active medical ingredients. The Schedule V drugs have less potential for concern of abuse than drugs in Schedule IV and use in treatment.

2.0 CONTROLLED PRESCRIPTION DRUG SYMBOLS

Controlled drugs are identified in the American Druggist Blue Book or Drug Topics Red Book by the following symbols:

- Schedule II: C-II
- Schedule III: C-III
- Schedule IV: C-IV
- Schedule V: C-V

FIGURE 13.A-18 CONTROLLED PRESCRIPTION DRUGS (CONTINUED)

3.0 UTILIZATION REVIEW RECOMMENDED CRITERIA AND PROCEDURES

Prescription drug claims should be developed for medical necessity prior to payment if the claim contains at least one controlled drug and exceeds one or more of the prepayment utilization review screening criteria developed by the contractor.

3.1 Claims For Controlled Drugs

Claims for controlled drugs that fail any prepayment screening criterion should be subjected to review. Subsequent drug claims should be suspended pending completion of the review.

3.2 Claims History

The claims history, particularly claims for services performed by the prescribing physician, should be reviewed. This review may demonstrate that the drugs are medically necessary and that drug abuse is unlikely, particularly in terminal patients. In that event, the drug claim(s) may be paid. If the claim history review does not resolve the question of possible abuse, recommend that the contractor submit the case to professional review.

3.3 Medical Review

If medical review determines that care is appropriate, the claim may be paid. If drug abuse is confirmed, the abused drugs will be denied. The beneficiary is to be notified that no payment will be made and that the decision is based on lack of medical necessity. If appropriate, the prescribing physician shall be notified. If there is a documented diagnosis of a morbid addictive state (rather than abuse), all narcotics shall be denied. The beneficiary is to be offered appropriate appeal rights and informed that his/her attending physician may discuss the case with the contractor's medical advisor or pharmacy consultant. For a period of six months, all drug claims for this beneficiary should be reviewed by a professional advisor before payment. The professional advisor may extend the period of review.

FIGURE 13.A-19 CASE REFERRAL EVALUATION (SAMPLE)

CASE REFERRAL EVALUATION
TRICARE, PROGRAM INTEGRITY OFFICE

Case Name: _____
Contractor: _____
Date TMA PI Received: _____
Case Referral Number: _____

Determine the following:

1. What are the allegations (What part of 32 CFR 199.9, section (b) or (c) has been violated.)?

_____

_____

2. Does the case referral identify a pattern of **fraud/abuse**? Did the contractor summarize those findings in order to determine probable method of fraud/abuse?
*(NOTE: Patient harm by itself is a **utilization review/malpractice issue** and not fraud.)*

• Pattern & findings summarized	5
• Pattern & findings not summarized	3
• Failed to develop case beyond a single indicator of fraud (or failed to document that development only resulted in single indicator of fraud)	1
• Case does not establish an egregious pattern of fraud (e.g., one level of E & M upcoding, excessive ultrasounds, etc.)	0

Rationale for rating less than 5:

3. Have the allegations been substantiated in the referral? Yes/No
(NOTE: If no, then no points are awarded)
How?

• Statistically valid random audit using accepted PI criteria.	5
• Alternate method of substantiating fraudulent pattern (e.g., 100% audit).	5
• Audit (e.g., calendar, beneficiary survey).	3
• Sample Claims (e.g., probe audit).	1

Rationale for rating less than 5:

Date: _____ Case Name: _____

FIGURE 13.A-19 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

4. How has TRICARE been affected (monetarily, patient harm, etc.)?

- Actual patient Harm with fraud component: 5

Dollar Damages:

- >$75,000 5
- $40,000 - $75,000 3
- <$40,000 1

Note: Maximum score for this section is 5 points.

Provide actual dollar loss and extrapolated loss, if possible:

5. Were all applicable TRICARE regulatory provisions cited in the referral in regard to each substantiated allegation and were copies included with the referral?

- Yes 5
- Not all applicable provisions cited or incorrect provisions provided 3
- No 0

If not, print the applicable policy and/or regulation to include with the referral.

Rationale for rating less than 5:

6. Is this case referral complete in accordance with Chapter 13 requirements (the fraud/abuse is thoroughly documented, the pattern of fraud/abuse is supported by evidence, and all supporting documentation is included and well organized), and ready to send to DCIS?

- Yes 5
- Needs minimal work that can be completed by TMA Program Integrity 3
- Needs work by contractor 1
- Referral did not meet criteria 0

Note: If items from #5 were missing deduct points in that section; do NOT deduct points in this section.

Rationale for rating less than 5:

Date: _____ Case Name: _____

FIGURE 13.A-19 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

7. Does referral comprehensively document all action taken to identify and capture total TRICARE exposure (e.g., all provider TINs identified, necessary coordination made with other contractors for additional billings information, etc.)? Provide documentation if no additional exposure found.

• Yes	5
• Not all exposure captured (e.g., captured TDEFIC exposure and failed to coordinate with other contractor in neighboring state)	3
• No	0

Rationale for rating less than 5:

8. Case Rating:

30	5
27-29	4
24-26	3
18-23	2
8-17	1

NOTE: Cases are rated on a scale of 1-5 with a score of 5 representing the best case referrals.

Rated by: _____
Title: _____
Reviewed By: _____
Date: _____

Form Date: January 1, 2008 [Form subject to change]

- END -