Chapter 13 Section 3

Prevention And Detection

1.0 FRAUD AND ABUSE

1.1 Abuse is defined in 32 CFR 199.2 as:

"...any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary costs, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim."

1.2 Fraud is defined in the Regulation as:

"...1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payments, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRICARE claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence."

2.0 CONTROLS, EDUCATION, TRAINING

2.1 Prevention And Detection Of Fraudulent Or Abusive Practices

The contractor shall establish procedures for the prevention and detection of fraudulent or abusive patterns and trends in billings by providers, pharmacies, and beneficiaries on a pre- and postpayment basis. (These procedures shall be made available to the TRICARE Management Activity (TMA) Program Integrity Office (PI).) The key functions include, but are not limited to:

- Eligibility verifications for beneficiaries and providers/pharmacies.

- Duplicate payment prevention. On a quarterly basis each fiscal year, the contractors shall generate and utilize reports from the automated TRICARE Duplicate Claims System (DCS) to identify the reasons for actual duplicate payments. The automated TRICARE DCS contains pre-formatted reports which will assist in identifying the reasons for actual duplicate payments (see Chapter 9 for report formats). Based on review of these reports, contractors shall develop and implement corrective actions to improve prepayment duplicate detection and reduce actual duplicate payments.

- Coordination of benefits.

- Prepayment utilization control as applied to program exclusions and limitations and detection and/or control of fraud and abuse. This shall include utilization of discretionary or coordinated placement of providers/beneficiaries on prepayment review. (See also, Section 2.)

- Application of utilization review and quality assurance standards, norms and criteria.

- Postpayment utilization review to detect fraud and/or abuse by either beneficiaries, pharmacies, or providers and to establish dollar loss to the government.

- Application of security measures to protect against embezzlement or other dishonest acts by employees.

- Enforcement of conflict of interest provisions and dual compensation prohibitions.

2.2 Internal Management Control Reviews

2.2.1 The contractor shall perform internal management control reviews as described in Chapter 1, Section 4, paragraph 3.0.

2.2.2 In accordance with the Financial Manager's Integrity Act, an Annual Letter of Assurance (ALA) will be issued by the contractor on October 1 of each year. The period covered by the ALA will be for the just completed government fiscal year (i.e., October 1st through September 30th). In the letter, the contractor shall certify that there is a corporate commitment to having controls in place to prevent and detect fraudulent and abusive practices and that the contractor understands and will comply with its contractual obligations in that respect (Addendum A, Figure 13.A-7).

2.3 Fraud And Abuse Education

2.3.1 The contractor shall establish and maintain a formal training program for all contractor personnel in the detection of potential fraud or abuse situations. This may be included as a specific segment of the contractor's regular training programs. (See Chapter 1, Section 4, paragraph 5.0.) Training program material shall be made available to TMA PI. The contractor shall provide desk procedures to the staff which include methods for control of claims/encounters exhibiting unusual patterns of care, over or under utilization of services, or other practices which may indicate fraud or abuse and shall include specific criteria for referral of cases to professional or supervisory review concerning issues with patterns of care, abnormal utilization practices, or suspect billing practices. Copies of desk procedures (along with revisions/changes) shall be made available to TMA PI (see Section 1, paragraph 1.4.7).

2.3.2 The contractor shall establish a public education program addressed to beneficiaries, providers, and pharmacies which provides information about identified fraudulent or abusive practices and how individuals may identify and report such practices. This may be accomplished by including information in the provider quarterly newsletters and by periodic notices on explanation of benefits or envelope stuffers to beneficiaries. Newsletters and notices shall be provided to TMA PI at the same time distribution is made to providers/beneficiaries. Electronic versions are acceptable.

2.4 Claim/Encounter Review Procedures And Controls

The contractor shall subject all TRICARE claims/encounters to appropriate review, analysis, and/or audit to ensure payment for only authorized medically or psychologically necessary benefits provided by authorized providers to eligible beneficiaries and to identify potentially fraudulent or abusive practices. Section 2 provisions shall be followed as necessary.

2.5 Beneficiary And Provider Flags

The contractor must have the capability for automated flagging of specific providers of care, pharmacies, and TRICARE beneficiaries for prepayment or postpayment review when fraud, overutilization or other abuses are known or suspected. If a network Primary Care Manager (PCM) or pharmacy is determined to be engaged in potential fraudulent practices, the contractor at its discretion, may terminate the network agreement. The contractors shall reassign the beneficiaries to another PCM. The contractor's actions shall be in a manner so as to not jeopardize the Government's investigation.

2.6 Gag Clauses

The contractor shall ensure there are no gag clauses in their contracts or policies with providers. Gag clauses are provisions that prevent providers, explicitly or implicitly, from giving patients information about treatment options that may be taken or from referring very ill patients outside the network to authorized providers with rare expertise in the types of care needed. The American Medical Association's (AMA's) Code of Ethics has declared gag clauses an unethical interference in the physician-patient relationship.

3.0 EXAMPLES OF FRAUD AND ABUSE SITUATIONS

3.1 Managed Care Fraud

3.1.1 Misrepresenting actual provider of service when the services were provided by a lower level provider or a provider not authorized to provide the service by virtue of failing to meet regulatory requirements.

3.1.2 Misrepresenting patient encounters, treatment outcomes and/or diagnoses to disguise undertreatment or to artificially inflate the amounts of future capitation payments. In some cases it may be necessary to look at the financial arrangements (contract) with the provider to determine the financial incentive of the provider.

3.1.3 Referral patterns that indicate kickbacks or result in additional expenses.

3.1.4 Frequent changes in contracts or agreements with supplier groups (Durable Medical Equipment (DME) and supplier companies) in an effort to preclude payment to them at the discounted amount.

3.1.5 Failure to document verbal referrals in writing resulting in claims denial for lack of authorization.

3.1.6 Inclusion of gag clauses in managed care provider contracts/agreements or that which prevents providers from providing information to their patients regarding benefits, risks and costs or appropriate treatment alternatives.

3.1.7 Where the provider or the providers' employee has an investment and/or financial interest, the patient shall be informed prior to the referral and provided information regarding alternative referral sources whenever such alternatives exist. Failure to inform the patient constitutes a potential fraudulent/abusive situation.

3.2 TRICARE Beneficiary Eligibility Questionable

3.2.1 If there is reason to question the eligibility of a beneficiary and fraud is suspected, e.g., through correspondence, Defense Enrollment Eligibility Reporting System (DEERS) response, or contractor file data which raises some question about the eligibility of a beneficiary, the contractor shall immediately investigate internally to eliminate obvious clerical errors. If the internal investigation does not resolve the possibility of fraud, the contractor shall contact the Defense Manpower Data Center (DMDC), 400 Gigling Road, Seaside, California 93955.

3.2.2 In cases where eligibility fraud is evident, the contractor shall take the following action:

3.2.2.1 Prime Enrollees

No care shall be approved for services on/after the date eligibility reportedly ended.

3.2.2.2 Non-Enrollees and Pharmacy Claims

Flag the beneficiary file to suspend all claims for services provided on/after the date eligibility reportedly ended. The beneficiary is not to be contacted or informed of the investigation. If the participating provider inquires about the claim he/she can be advised that the claim is under review and requested to send in a copy of the Identification (ID) card, both sides, if the provider has one on file. Upon receipt, a "good faith" payment may be considered. See Chapter 10, Section 3, paragraph 7.0. The contractor shall retain a copy of the Explanation Of Benefits (EOB) and cancelled check in the case file. If the beneficiary inquires about the claim(s), he or she will be informed that the claim requires review and he or she will be advised when processing is complete. The contractor shall establish procedures for control of these claims and for keeping them in a suspense status until the eligibility status has been established.

3.2.3 If the DEERS response indicates that the beneficiary is not eligible, the contractor shall research claims/encounter history for other erroneous claims from the date TRICARE eligibility ended. If the contractor's history does not date back far enough, request a history printout from TMA PI. The contractor shall report the circumstances to TMA PI in accordance with the procedures for case referrals.

3.3 Provider Authorized Status Questionable

3.3.1 The contractor shall attempt to verify the provider's status in such a way that the provider is not alerted to a possible investigation. Credentials or licensure shall be verified with the appropriate credentialing or licensing agency. School accreditation and required education shall be verified with the appropriate school.

3.3.2 The contractor shall review reports of findings or recommendations of state licensure boards, boards of quality assurance, other regulatory agencies, state medical societies, peer review organizations, or other professional associations for possible fraud or abuse issues. The contractor shall terminate a provider when the finding or recommendation results in loss of licensure or certification. Licensure/certification must be at full clinical practice level. Refer to the TRICARE Policy Manual (TPM), Chapter 11, Section 3.2. The reports may be used to also cancel a network provider's contract since a non-authorized provider cannot be a network provider. The contractor shall submit a copy of the report to the TMA PI.

3.4 Conflict Of Interest; Federal Employees And Active Duty Military

3.4.1 Conflict of Interest

3.4.1.1 Conflict of interest includes any situation where an active duty member of the Uniformed Services (including a reserve member while on active duty, active duty for training, or inactive duty training) or civilian employee (which includes employees of the Department of Veterans Affairs (DVA)) of the U.S. Government, through an official federal position has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of beneficiaries to himself/herself or others with some potential for personal gain or the appearance of impropriety. Although individuals under contract to the Uniformed Services are not considered "employees," such individuals are subject to conflict of interest provisions by express terms of their contracts and, for purposes of the 32 CFR 199.9 may be considered to be involved in conflict of interest situations as a result of their contract positions. In any situation involving potential conflict of interest of a Uniformed Service employee, the Director, TMA, or a designee, may refer the case to the Uniformed Service concerned for review and action.

3.4.1.2 If such a referral is made, a report of the results of findings and action taken shall be submitted to the Director, TMA, within 90 days of receiving the referral, by the Regional Director (RD) having jurisdiction. For pharmacies, the Contracting Officer's Representative (COR) shall submit the report. TRICARE cost-sharing shall be denied on any claim in which a conflict of interest situation is found to exist. This denial of cost-sharing applies whether the claim is submitted by the individual who provided the care, the institutional provider in which the care was furnished, or the beneficiary.

3.4.2 Federal Employees And Active Duty Military

The Regulation prohibits active duty members of the Uniformed Services or employees (including part-time or intermittent), appointed in the civil service of the U.S. Government, from authorized TRICARE provider status. This prohibition applies to TRICARE payments for care furnished to TRICARE beneficiaries by active duty members of the Uniformed Services or civilian employees of the government. The prohibition does not apply to individuals under contract to the Uniformed Services or the Government.

3.4.3 Exceptions

3.4.3.1 National Health Service Corps

TRICARE payment may be made for services furnished by organizations to which physicians of the National Health Service Corps (NHSC) are assigned. However, direct payments to the NHSC physician are prohibited by the dual compensation provisions.

3.4.3.2 Emergency Rooms

Any off-duty government personnel employed in an emergency room of an acute care hospital will be presumed not to have had the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries. However, since they cannot be recognized as TRICARE-authorized providers, there is no cost-sharing of professional services by the provider.

3.4.3.3 Reserves Generally Exempt

Conflict of interest provisions do not apply to medical personnel who are Reserve members of the Uniformed Services or who are employed by the Uniformed Services through personal services contracts, including contract surgeons. Although Reserve members, not on active duty, and personal service contract medical personnel are subject to certain conflict of interest provisions by express terms of their membership or contract with the Uniformed Services, resolution of any apparent conflict of interest issues which concern such medical personnel is the responsibility of the Uniformed Services, not the TMA. Reservists on active duty are not exempt during the period of their active duty commitment.

3.4.3.4 Part-Time Physician Employees Of The U.S. Government

Refer to Chapter 4, Section 1, paragraph 3.0.

3.4.3.5 Referrals From Uniformed Services Facilities

Referrals from Uniformed Services facilities to individual civilian providers should, in every practical instance, be made to participating providers. However, referring of TRICARE beneficiaries by Uniformed Services personnel to selected individual providers in the civilian community when other similar participating providers are available may involve a conflict of interest. Contractors should document any apparent problem of this nature and refer the case to the TMA PI for investigation.

3.5 Cover-Ups In Coordination Of Benefits

Coordination of benefits is a standard part of TRICARE claims processing requirements. Listed below are frequently overlooked common clues to the existence of another health plan.

- "Benefits Assigned" notation
- Large bills filed late
- Large credits
- Bills or statements that appear to have been altered
- Odd partial payments

- Other Carrier inquiries

3.6 Cost-Share/Copayment Collection Questionable

The 32 CFR 199.4, sets forth the financial liability of the TRICARE beneficiary for a cost-share and deductible. This regulatory requirement is derived from the statutory requirements of 10 United States Code (USC) 1079 and 1086. Claim payments are subject to the provision that reasonable efforts are to be made by the provider to collect the cost-share. A provider's failure to make a reasonable effort to collect the cost-share may result in reduction of payment or may result in a suspension of authorized provider status under TRICARE. Reasonable efforts would include several documented attempts to collect and set procedures by the provider to refer cases to a collection agency. Under managed care programs, cost-share amounts may also apply, which must be collected from the beneficiary. The pharmacy contractor shall ensure that network pharmacies collect copayments before dispensing any prescription.

3.6.1 The contractor shall establish procedures for detecting providers who waive cost-shares. Possible methods for detection of the waiver of cost-shares include:

- Itemized receipts attached to non-assigned claims which reflect an annotation that such amounts have been waived.
- Changes in charging practices or erratic charge practices for the same procedure.
- Complaints or notices from beneficiaries, other providers or interested third parties.
- Advertisements of such practices by providers.

3.6.2 The contractor shall establish procedures for detecting network providers/pharmacies who waive the copayment amounts.

3.6.3 When the contractor identifies a provider who has waived a cost-share/copayment, the contractor shall notify the provider in writing that such action is not allowed and explain the law governing the collection of cost-shares/copayments and that payments to the provider may be reduced if reasonable efforts are not made to collect the cost-share. The contractor shall also explain that the provider may be suspended as an authorized TRICARE provider if corrective action is not taken. See Section 2 for referral protocols, if referral is warranted.

Note 1: Certain heart and lung hospitals are exempt from the cost-share collection requirement.

Note 2: Refer to the TRICARE Reimbursement Manual (TRM), Chapter 2, Section 1, for waiver of cost-shares and/or deductibles for medical services provided to family members of active duty personnel from August 2, 1990, until the date the "Persian Gulf Conflict" ends as prescribed by Presidential proclamation or by law.

Note 3: The hospice benefit is exempt from the cost-sharing and deductible provisions normally associated with standard TRICARE reimbursement with the exception of small cost-sharing amounts for biological and inpatient respite care. The collection of these cost-sharing amounts is optional under the TRICARE Hospice Benefit (TRM, Chapter 11, Section 4).

3.7 Procedure Code Unbundling

3.7.1 The contractor shall identify those providers who continue to submit unbundled billings and refer them to their Program Integrity Unit. From those providers referred to the contractor's program integrity staff, the contractor shall select the 10 most egregious providers (i.e., those providers, clinics, who most often unbundle and whose unbundling would have the highest dollar impact) for referral to the TMA PI.

3.7.2 Following the referral to TMA of the 10 most egregious providers, who continue to submit unbundled billings, the contractor shall conduct a review of those providers to determine if they are engaging in other aberrant billing practices. If warranted, follow the requirements for referring a case to TMA with a statement that the provider has already been referred for continuing to submit unbundled billings.

3.7.3 The contractor shall not initiate recoupment or take any adverse action against the providers being referred to the TMA PI. The contractor shall keep a record of the providers selected to be sent to the TMA so that no provider is referred more than once (except as stipulated in paragraph 3.7.2) even if the provider continues to be identified for unbundling.

3.8 Automated TRICARE DCS

On a quarterly basis each fiscal year, contractors shall generate and utilize reports from the automated TRICARE DCS to assist in detecting fraud and abuse. The automated TRICARE DCS contains pre-formatted reports which will assist in detecting duplicate billings and inappropriate Current Procedural Terminology, 4th Edition (CPT-4) coding modifications by providers (see the TRM, Chapters 3 and 4 for report formats).

3.9 Violation Of Participation Agreement Or Reimbursement Limitation

Breach of a participation agreement/or billing in excess of the reimbursement limitation amount as provided by Congress as part of the Department of Defense (DoD) Appropriations Act, 1993, are considered abuse and/or fraud under authority of 10 USC 1079(h)(4). See Section 2 if a case referral is warranted. The contractor shall take action as stated in Section 6, paragraph 5.2. Also, refer to the TRM, Chapter 3, Section 1.

3.10 Failure To File TRICARE Claims

Failure by a provider to comply with the claim submittal requirements is considered abuse (see Section 6, paragraph 5.4 and Chapter 8, Section 1, paragraph 2.1).

3.11 Pharmacy Fraud

3.11.1 Comparing reversal rates. Pharmacies with low reversal rates should be targeted for further evaluation.

3.11.2 Examination of pharmacy claims for excessive partial fill submissions or pharmacies with no partial fill submissions. If appropriate, compare the percentage and/or number of partial fills to the overall average across the entire pharmacy program.

3.11.3 Screening for high use patients (e.g., high number of prescriptions per patient) by measuring the total number of new prescriptions generated for individual patients over a given time period.

3.11.4 Review of copayments or dispensing fees, which should be appropriate for the drug category and conditions.

3.11.5 Coordination with other contractors for double billing from both the medical benefit and pharmacy benefit. Applies to medications routinely administered under a medical benefit but obtained in the retail pharmacy network.

3.11.6 Screening for gross errors in quantity dispensed and for high dollar claims. A review of outliers would then be conducted.

3.11.7 Reconcile diagnostic codes with medication therapy for high cost agents.

3.11.8 Review of pharmacy claims with high average ingredient cost.

3.11.9 Review of brand/generic fill rates.

3.11.10 Review of top pharmacies per generic code rate.

3.11.11 Review of controlled substance prescription rates.

3.11.12 Ability to conduct on-site audits to facilitate prevention, identification and referral of cases involving any of the above listed items.

Note: At a minimum, the contractor shall perform onsite audits of the top one percent of providers who meet the indicators above.

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